

State of California
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

November 4-5, 2010



Enforcement Committee	November 4	9:00 a.m. - 10:15 a.m.
Wellness Committee	November 4	10:15 a.m. - 11:00 a.m.
Wellness Working Group	November 4	11:15 a.m. - 12:45 p.m.
Licensing Committee	November 4	11:15 a.m. - 12:15 p.m.
Panel A	November 4	1:15 p.m. - 2:30 p.m.
Panel B	November 4	1:15 p.m. - 2:30 p.m.
Full Board / Hospital Tour	November 4	2:30 p.m. - 5:00 p.m.
Full Board	November 5	9:00 a.m. - 2:30 p.m.

MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Long Beach Memorial Medical Center
Miller Children's Hospital
Long Beach, CA 90806
916-869-3377
562-933-0102

November 4-5, 2010

Thursday, November 4

- 9:00 a.m. – 10:15 a.m. **Enforcement Committee – Room A1-A2**
(Members: Low, Chin, Levine, Schipske)
- 10:15 a.m. – 11:00 a.m. **Wellness Committee –Room A1-A2**
(Members: Duruisseau, Carreon, Chin, Giang, Gregg, Norcross, Nye)
- 11:15 a.m. – 12:45 p.m. **Wellness Working Group – Room C**
(Duruisseau, Chin, Giang, Gregg, Norcross, Nye)
- 11:15 a.m. – 12:15 p.m. **Licensing Committee - Room A1-A2**
(Members: Salomonson, Carreon, Chang, Levine, Low, Schipske)
- 12:15 p.m. – 1:15 p.m. **Lunch Break – Room B**
(Members & Staff Only)
- 1:15 p.m. – 2:30 p.m. **Panel A – Room A1-A2**
(Members: Duruisseau, Carreon, Chin, Diego, Salomonson, Yaroslavsky, Zerunyan)
- 1:15 p.m. – 2:30 p.m. **Panel B – Room C**
(Members: Chang, Esrailian, Levine, Low, Moran, Schipske)
- 2:30 p.m. – 5:00 p.m. **Full Board / Hospital Presentation & Tour – Room A1-A2**
(All Members)

Friday, November 5

- 9:00 a.m. – 2:30 p.m. **Full Board Meeting –Room A1-A2**
(All Members)



MEDICAL BOARD OF CALIFORNIA
Executive Office

**MEMBERS OF THE BOARD**

Barbara Yaroslavsky,
President
Frank V. Zerunyan, J.D.,
Vice President
Hedy Chang, Secretary
Jorge Carreon, M.D.
John Chin, M.D.
Silvia Diego, M.D.
Shelton Duruisseau, Ph.D.
Eric Esrailian, M.D.
Sharon Levine, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.

QUARTERLY BOARD MEETING

November 4-5, 2010

Long Beach Memorial Medical Center
Miller Children's Hospital
Long Beach, CA 90806
916-869-3377
562-933-0102

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

AGENDA

Thursday, November 4, 2010

2:30 p.m. – 5:00 p.m.

Friday, November 5, 2010

9:00 a.m. – 2:30 p.m.

**The November 5, 2010 portion of this
meeting will be webcast.**

ORDER OF ITEMS IS SUBJECT TO CHANGE**Thursday, November 4, 2010**

1. Call to Order / Roll Call
2. Introduction and Swearing in of New Board Member
3. 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)]
4. Approval of Minutes from the July 30, 2010 meeting
5. Review of Selective Discipline Processes – Mr. Heppler and Ms. Scuri
6. Enforcement Committee Update – Dr. Low

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. Wellness Committee Update – Dr. Duruisseau
8. Licensing Committee Update – Dr. Salomonson
9. Physician Responsibility in the Supervision of Affiliated Health Care Professionals Advisory Committee Update and Consideration of Committee Recommendations – Dr. Moran
10. Physician Assistant Committee Update – Dr. Low
11. Federation of State Medical Boards Update - Ms. Chang
12. Nomination(s) to Federation of State Medical Boards - Ms. Yaroslavsky
13. Telemedicine Pilot Program Status Report – Mr. Schunke
14. Licensing Outreach Report – Mr. Schunke
15. Presentation on and Tour of Miller Children’s Hospital - Dr. Nicholas

Friday, November 5, 2010

16. Call to Order / Roll Call
17. 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 1113, 11125.7(a)]
18. 9:00 a.m. REGULATIONS – PUBLIC HEARING – Mr. Worden and Mr. Heppler
 Limited License Regulations: (CCR, Title 16, Division 13, Chapter 1, Article 4.5). This proposal establishes the procedures for the issuance of a limited physician’s and surgeon’s certificate, including the requirements for an independent clinical evaluation.
19. 9:05 a.m. REGULATIONS – PUBLIC HEARING – Mr. Worden and Mr. Heppler
 Polysomnography Technologist Regulations: (CCR, Title 16, Division 13, Chapter 3.5, Articles 1 through 6). This proposal sets forth the requirements for the registration and supervision of polysomnographic technologists, technicians, and trainees as required by SB 132.
20. 9:10 a.m. REGULATIONS – PUBLIC HEARING – Ms. Cady and Ms. Scuri
 Disciplinary Guidelines Regulations: (CCR, Title 16, Section 1316). This proposal amends the Manual of Model Disciplinary Orders and Disciplinary Guidelines to reflect changes in law, clarify existing language, and make technical changes to reflect the current probationary environment.
21. Board Member Communications with Interested Parties – Ms. Yaroslavsky
22. President’s Report - Ms. Yaroslavsky
23. Health Care Reform Presentation - Mr. Schultz

24. Executive Director's Report – Ms. Whitney
 - A. Budget Overview
 - B. Staffing Update
 - C. Strategic Plan: Consideration of 2011 Update
 - D. Confirm Board Meeting Dates and Locations for 2011
 - E. On-going Board Evaluations

25. Board Evaluation Presentation and Discussion – Mr. Zerunyan, Dr. Salomonson, Mr. Frank

26. Legislation – Ms. Simoes
 - A. 2010 Legislation Wrap-Up and Implementation
 - B. 2011 Legislative Proposals
 - C. 2011 Legislation – Other

27. Status of Regulatory Action – Mr. Schunke

28. Update on Special Task Force on International Medical School Recognition– Dr. Low
 - A. Status of Schools Being Reviewed
 - B. American University of Antigua – Mr. Worden
 - C. Discussion of Periodic Compliance Requirements

29. Consideration of Request for Recognition of Ross University / Bahamas – Dr. Servis

30. Licensing Chief's Report – Mr. Worden
 - A. Licensing Program Update
 - B. Application Review Process for Probationary Licenses – Mr. Worden and Ms. Scuri

31. Midwifery Advisory Council Update – Ms. Ehrlich

32. Enforcement Chief's Report – Ms. Threadgill
 - A. Approval of Orders Following Completion of Probation, Orders Issuing Public Letter of Reprimand, and Orders for License Surrender During Probation
 - B. Expert Utilization Report
 - C. Enforcement Program Update

33. Vertical Enforcement Program Report – Ms. Threadgill and Mr. Ramirez

34. Update on Board's Mechanism for Impaired Physicians – Ms. Whitney
 - A. Law
 - B. Probation: Terms and Conditions
 - C. Wellness Committee

35. Department of Consumer Affairs Update – Ms. Kirchmeyer
 - A. Budget / Hiring Freeze Update
 - B. Consumer Protection Enforcement Initiative (CPEI)
 - C. Board Meeting Protocol
 - D. BreZE Update

36. Agenda Items for January 27-28, 2011 Meeting in San Francisco, CA

37. 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.

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 cheryl.thompson@mbc.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.



MEDICAL BOARD OF CALIFORNIA
Executive Office



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

July 29-30, 2010

MINUTES

Agenda Item 1 Call to Order/ Roll Call

Ms. Yaroslavsky called the meeting of the Medical Board of California (Board) to order on July 29, 2010 at 8:10 a.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Barbara Yaroslavsky, President
Hedy Chang, Secretary
John Chin, M.D.
Shelton Duruisseau, Ph.D.
Eric Esrailian, M.D.
Gary Gitnick, M.D.
Sharon Levine, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.

Members Absent:

Jorge Carreon, M.D.
Frank V. Zerunyan, J.D., Vice President

Staff Present:

Fayne Boyd, Licensing Manager
Susan Cady, Enforcement Manager
Candis Cohen, Public Information Officer
Kurt Hepler, Legal Counsel
Teri Hunley, Business Services Manager
Ross Locke, Business Services Office
Regina Rao, Business Services Office
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement

Laura Sweet, Deputy Chief of Enforcement
Kathryn Taylor, Licensing Manager
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Executive Director
Paulette Romero, Central Complaint Unit Manager
Valerie Moore, Discipline Coordination Unit Manager
Letitia Robinson, Licensing Manager
Arlene Kryzinski, Discipline Coordination Unit

Members of the Audience:

Peter Bell, M.D., American University of Antigua
Teri Boughton, California Health Care Foundation
Claudia Breglia, California Association of Midwives
Yvonne Choong, California Medical Association (CMA)
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Merv Dymally, Member of the Public
Karen Ehrlich, L.M., Midwifery Advisory Council (MAC) Member
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Ben Frank, Benjamin Frank, LLC
Beth Grivett, P.A., California Academy of Physician Assistants
Ruth Haskins, M.D., Midwifery Advisory Council (MAC) Member
Alice Huffman, National Association for the Advancement of Colored People (NAACP)
Kimberly Kirchmeyer, Department of Consumer Affairs
Roberto Moya, Deputy Attorney General
Jagbir Nagra, M.D., American University of Antigua
James Nuovo, M.D., UC Davis
Alberto Perez, Deputy Attorney General
Elberta Portman, Executive Officer, Physician Assistant Committee
Carlos Ramirez, Senior Assistant Attorney General
Leonard A. Scafani, American University of Antigua
Rehan Sheikh, Member of the Public
John Toth, M.D., California Citizens for Health Freedom
Richard Pan, M.D., Communities and Physicians Together Program

Agenda Item 2 Introduction and Swearing in of New Board Member

Ms. Yaroslavsky introduced and administered the Oath of Office to new Board Member, Dr. Eric Esrailian, a physician from UCLA who was appointed by the Governor on June 9, 2010.

CLOSED SESSION

Agenda Item 3 *Schlie, et al. v. Medical Board of California, et al., Superior Court of California, County of Sacramento, Case No. 05AS03244*

OPEN SESSION

Agenda Item 4 Presentation of Physician Humanitarian Award

Ms. Yaroslavsky presented the Physician Humanitarian Award to Dr. Richard Pan in recognition of his commitment and contribution to the health and wellbeing of California's children. Dr. Pan is a leading child health advocate, medical educator, and health care reform activist focused on bringing community and health care organizations together. He is board certified in pediatrics and has a Masters degree in Public Health. Dr. Pan is the Founder and Director of the Communities and Physicians Together Program which teaches young pediatricians to gain a broader perspective about patients by understanding their home environment and community and places physicians in disadvantaged communities to promote population-based health. He has served as a medical consultant for the Sacramento City Unified School District since 2003, providing in-service training to school nurses and advocates for adequate school nursing staff in public schools.

Dr Pan accepted his award and thanked the Board for honoring his work.

Agenda Item 5 Public Comment on Items Not on the Agenda

Frank Cuny, California Citizens for Health Freedom, complimented the Board for its history of dealing with physicians' rights to practice non-conventional medicine. He expressed his hope that the Board would consider and support the integrative treatment of cancer in any future legislation.

Agenda Item 6 Approval of Minutes from the April 29-30, 2010 Meeting

Dr. Gitnick moved to approve the minutes from the April 29-30, 2010 meeting; s/Chang; motion carried.

Agenda Item 7 REGULATIONS – PUBLIC

Ms. Yaroslavsky opened the public hearing on the proposed regulations to amend Section 1306 of Title 16 of the California Code of Regulations as described in the notice published in the California Regulatory Notice Register and sent by mail to those on the Board's mailing list. For the record, Ms. Yaroslavsky stated the date was July 30, 2010; the hearing began at approximately 9:10 a.m.

Ms. Scuri explained the proposal would amend the regulation related to the abandonment of applications to keep it current and useful. Specifically, this rulemaking will replace obsolete, ambiguous terminology with concise language that establishes what actions are necessary on the part of an applicant to prevent his or her application from being deemed abandoned by the Board. The proposal would also require that applicants notify the Board of a change of address within 30 days. Ms. Scuri noted a minor amendment to the lettering values within the regulation.

No written comments were received by the July 26, 2010 deadline. No oral testimony was offered during the public hearing. Ms. Yaroslavsky closed the hearing.

Dr. Levine made a motion to adopt the proposed changes to the regulations as amended; s/Moran; motion carried.

Agenda Item 8 Board Member Communications with Interested Parties

Ms. Yaroslavsky reported that she met with the City of Hope's medical director, president and chief executive officer and government relations team regarding their move to a medical foundation model from their existing model. She also met with Senator Gil Cedillo on the Board's opposition to SB 1410, which would remove the limitation that an applicant for licensure must pass Step III of the USMLE within four attempts; no conclusions were reached. On July 13, 2010 Ms. Yaroslavsky participated in a conference call with the DCA Director, Brian Stiger, his deputies, and other healing arts board presidents and executive directors. Items discussed included a budget update, federal health care reform, licensing reform, regulations, DCA-sponsored training for board members, and uniform standards for diversion programs. These calls will be held on a monthly basis; if Ms. Yaroslavsky is unable to participate, the vice president or other Board member will take her place.

Agenda Item 9 President's Report

Ms. Yaroslavsky reported the Education Committee met on July 29, 2010. Four physician experts addressed the Committee on the subject of educating both physicians and the public on hepatitis. All physician experts agreed more education on this topic is necessary. The Committee will follow up to determine appropriate actions for the Board at its next meeting.

Ms. Yaroslavsky acknowledged Debbie Nelson, Public Information Analyst, for creating the newly revised and published "Guides to Laws Affecting Physician Practice". Newly licensed physicians are mailed a copy of the booklet, which provides a practical guide on how to follow the law.

Ms. Yaroslavsky expressed the Board's appreciation for the many years of service of Dr. Gary Gitnick, whose term on the Board ends on this date. Dr. Gitnick was appointed to the Board's Division of Licensing in April 2000. In addition to serving as the President of the Division of Licensing, Dr. Gitnick has served on numerous committees over the past 10 years and as President of the Full Board from 2002 to 2003. He has consistently upheld public protection as the Board's number one priority. Dr. Gitnick was instrumental in increasing the amount of information the Board provides to the public on its licensees, and is also credited with the creation and support of the Steven Thompson Loan Repayment Program, which provides an economic incentive for newly licensed physicians to practice in underserved areas. Ms. Yaroslavsky presented Dr. Gitnick with a plaque from fellow Board members and staff as a token of gratitude for his many valuable contributions.

Dr. Gitnick thanked the Board and staff for their hard work. He provided an overview of the responsibilities and challenges of being a Board member and recapped some of the issues the Board has faced and accomplishments during his tenure. Dr. Gitnick concluded by offering suggestions for the future, including the need to establish a media relations committee and a legislative relations committee. He also suggested developing a merit-based appointment system for Board members, working more closely with the California Medical Association, having regular, objective audits of the Board's performance, and extending the term for the president of the Board to two years.

Agenda Item 10 Election of Officers

Ms. Yaroslavsky noted the Board voted at the July 29, 2009 meeting to change the date it holds its election of officers from the last meeting of the calendar year to its July meeting. The Board also voted that the newly elected officers officially enter these positions at the conclusion of the July meeting.

Dr. Gitnick nominated Barbara Yaroslavsky for the position of President; s/Salomonson. There were no other nominations. Ms. Yaroslavsky was elected as President of the Board by unanimous vote.

Ms. Chang nominated Frank Zerunyan for the position of Vice President; s/Salomonson. There were no other nominations. Mr. Zerunyan was elected as Vice President of the Board by unanimous vote.

Dr. Salomonson nominated Hedy Chang for the position of Secretary; s/Levine. There were no other nominations. Ms. Chang was elected as Secretary by unanimous vote.

Agenda Item 11 Executive Director's Report

A. Budget Overview

Ms. Whitney directed members to the Analysis of Fund Condition of the Board located on page 139 in their packets. She noted FY 2009-10 is projected to have a 5.8 month balance in reserve at the end of the year; this is primarily due to reductions in staff salaries.

Under expenditures, the 2009/10 Budget Change Proposals (BCPs) for Probation Monitoring were approved and staff was added, but no funding was received. Hence, the funding for Probation Monitoring, which is an on-going function of the Board, was absorbed within the budget.

Operation Safe Medicine (OSM) was a two-year 2009/10 BCP that was approved with no associated funding; staff was added. The Board was asked to return with a proposed augmentation to its budget to request the continuation of the OSM program; a request has been submitted and is reflected in the proposed 2011/12 budget.

Additional augmentation requests are for the BreEZe Project (integrated licensing and enforcement computer system), Licensing Support (Web Applicant Access System/Scanning of documents), and increasing the number of District Medical Consultants (classified as temporary help) in order to expedite the investigation process. Ms. Whitney has met with the Budget Subcommittee to review these items. These augmentations will impact the fund reserve, hence, no proposal has been submitted to reduce fees at this time.

B. Staffing Update

Ms. Whitney reported the vacancy rate remains low in the Enforcement Program. The first round of interviews has been completed for the vacant Chief of Licensing position; Ms. Whitney expects to have the position filled by the end of August. All licensing review staff positions have been filled or individuals identified for hire. Vacancies exist in the Executive Office. The Deputy Director position will remain vacant in order to address required salary savings.

C. Strategic Plan: Consideration of 2011 Update

Ms. Whitney reported she will provide a plan for the timing of the 2011 Strategic Plan Update at the November 2010 meeting. The Department has offered to provide assistance in developing the plan through its SOLID Division. Ms. Whitney will work with Ms. Yaroslavsky to establish a committee to work on the update.

D. Potential Board Meeting Dates for 2011

Ms. Whitney directed Members to the proposed meeting dates and locations for 2011 located on page 148 of their packets. Ms. Yaroslavsky requested that Members email Ms. Whitney with their availability and preferences for the proposed dates.

E. Bureau of State Audits Evaluation

A review of the Board's licensing function was recently completed and a Board evaluation with a specific focus is currently being conducted by Ben Frank. As recommended by Dr. Gitnick at the April 2010 meeting, Ms. Whitney would like to continue to pursue an overall review of the Board which is similar to that which is performed by the Bureau of State Audits for the State Bar. She will bring forward suggestions on how this might be implemented and what should be systematically assessed at the November 2010 meeting with the assistance of the Board president and a medical consultant.

Ms. Whitney provided a copy of the Executive Order from the Governor's Office to close state offices, including the Medical Board, on the second, third, and fourth Friday of each month, effective August 2010.

*****Due to timing for invited guests to provide their presentations, the agenda items below are listed in the order they were presented.***

Agenda Item 14 Health Care Reform Presentation

Teri Boughton, Senior Program Officer, Health Reform and Public Program Initiative, delivered a presentation on the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (Affordable Care Act or ACA). She noted there are three components of the health reform: health insurance reform, Medicaid Program changes, and Medicare Program changes.

The bill promised to expand coverage to 32 million individuals by 2019. In California, up to two-thirds of its uninsured could be covered. The cost would be \$938 billion dollars over 10 years at the same time reducing the federal deficit by \$124 billion dollars. Ms. Boughton provided an overview of the provisions of the bill, including the requirement that all Americans have health coverage (with limited exceptions), that health benefit exchanges be created to provide options for the purchase of insurance and to administer subsidies, and that Medicaid (MediCal in California) undergo major expansions. Maintenance of Effort requirements are imposed on states so that programs such as Healthy Families cannot be reduced; this adds to California's budget challenges. Increases in MediCal payments to primary care providers are required; the incremental increase will be federally financed for FY 2013/14. Insurers cannot institute pre-existing condition requirements and are limited on the rates they are allowed to

charge. There are also new requirements for employers. Children may remain on their parents' health insurance policies up to age 26. There are changes in the tax code to enforce the individual mandates and help pay for the subsidies and program expansion.

Ms. Chang asked how the shortage of physicians will be addressed with the addition of so many previously uninsured individuals into the medical system, specifically within California. Ms. Boughton agreed this will present a challenge, particularly in the short term. Possible solutions being contemplated include using providers such as physician assistants and nurse practitioners (with supervision) to perform some of the primary care duties and utilizing telemedicine, particularly in underserved communities. Dr. Duruisseau stated the Board should be proactive in considering the impact these issues will have on the Board's role and operations.

Agenda Item 13 Legislation

A. Status of Regulatory Action

Ms. Whitney directed Members to the Status of Pending Regulations on page 150 of their packets. She noted the Disciplinary Guidelines have been withdrawn due to concerns over some materials in the regulation packet that the consultant at the Office of Administrative Law wanted to discuss. Staff and legal counsel will be working with the consultant on the regulations during the first week of August in order to address these concerns so they can be resubmitted within the timeframe set by law.

B. 2010 Legislation

Ms. Simoes referred Members to the Legislative Packet.

- **AB 1767** (Hill) Enforcement: expert reviewers – DCA requested clarifying amendments to this Board-sponsored bill. Language was added to extend the sunset date of the two members of the Health Professions Education Foundation for five years until January 1, 2016. The bill is currently on the Senate Floor. No problems are anticipated.
- **SB 1489** (B&P Committee) Omnibus – This bill includes amendments that are technical in nature. The bill will be heard in the Assembly Appropriations Committee next week.
- **AB 2600** (Ma) Continuing Education Requirements – Ms. Chang requested a discussion on this bill, which would require the Board to consider including a continuing education course in the diagnosis and treatment of hepatitis. The Board previously took a neutral position on this bill. While acknowledging Ms. Chang's concerns over hepatitis education, Ms. Yaroslavsky recommended that the Board not change its position to begin mandating continuing medical education (CME) credit. She stated the Board should actively participate in "getting the word out" on hepatitis diagnosis and treatment, possibly through the Education or Access to Care Committee.

Dr. Levine agreed with Ms. Yaroslavsky, noting there is no evidence that CME changes behavior. She felt it becomes a matter of compliance only and creates a false sense of confidence that an issue has been adequately addressed. Dr. Levine stated a broader and more thorough approach to create awareness and demand for better information on the part of patients and physicians would be more effective.

- **AB 2386 (Gilmore) Armed Forces: Medical Personnel** – This bill would allow non-military hospitals to enter into an agreement with the Armed Forces to authorize a physician, physician assistant (PA), or registered nurse (RN) to provide medical care in the hospital under specified conditions. The physician would have to hold a valid license in good standing in another state. In addition, the medical care must be provided as a part of a training or educational program designed to promote combat readiness. The agreement must comply with federal law. The bill contains consumer protection provisions and also requires the physician to register with the Board. Staff suggests a neutral position on the bill.

Ms. Chang made a motion to take a neutral position on AB 2386; motion was seconded and carried.

- **AB 2699 (Bass) Healing Arts: Licensure Exemption** – This bill would exempt specified health care practitioners, who are licensed and certified in other states, from California state licensure for the purpose of providing voluntary health care services to uninsured and underinsured Californians on a short-term basis and in association with a sponsoring entity that complies with specified requirements. Practitioners would be required to register with the respective board in advance of these events. Staff recommends a position of “neutral if amended” to include oversight of the registration of the sponsoring entities under one organization instead of with each individual board, replace the word “revoke” with “rescind”, limit the sponsoring entities to non-profit entities and require that they disclose that some health care practitioners may not be licensed in California.

The bill may be substantially amended in the Senate Appropriations Committee next week. These amendments include changing it from a registration program to an authorization program where the practitioners would be *authorized* to practice without a license, require the respective boards to collect more information, and charge a fee for processing the forms. Regulations and fees would be set by each individual board or bureau. Staff is particularly concerned with the authorization component of the proposed amendments.

Ms. Scuri raised legal concerns over enforcement logistics and the ability to obtain patient records. She noted there is no time limitation on the number of events per year that an individual could participate in. Further, she stated it would be better if it were clear that there was *no* payment to the practitioners, as “volunteer” can be loosely interpreted.

Various Members voiced their opposition to the bill.

Dr. Levine made a motion to oppose AB 2699; s/Salomonson; motion carried.

- **SB 294 (Negrete McLeod) DCA: Regulatory Boards – Sunset Dates**
This bill changes the sunset review dates on various DCA regulatory boards and bureaus, including the Medical Board. The Board’s sunset date would change from 2013 to 2014. No position is necessary.

Agenda Item 23 Enforcement Committee Update and Consideration of Committee Recommendations

Dr. Low reported the Enforcement Committee met on July 29, 2010. The Committee recommends that the Full Board adopt the following as the vision statement for the Enforcement Committee:

The Enforcement Committee will act as an expert resource and advisory body to members of the Medical Board and its enforcement program by educating board members and the public on enforcement processes and by identifying program improvements in order to enhance protection of health care consumers.

Dr. Low made a motion that the Board adopt this vision statement for the Enforcement Committee; s/Levine.

Ms. Yaroslavsky suggested removing the word "expert" from the statement.

Dr. Low amended his motion to accept this change; s/Salomonson; motion carried.

The Committee also received an update on the progress of the Expert Reviewer training program. UC Davis Medical School has offered their state of the art training facilities for the Board's use. Staff is preparing an agenda for the training program that will take place in the spring of 2011. Dr. Low believes this training will help standardize expert review throughout the state.

Dr. Low reported the Committee heard a training presentation on the Enforcement Program to help understand the division of responsibilities between the enforcement operations in the field and the investigation components of the program. The next training presentation will focus on the Probation Monitoring Section and how the terms and conditions of probation are implemented.

Dr. William Norcross made a presentation to the Committee on the Physician Assessment and Clinical Education Program (PACE) through UC San Diego, including the results of its 2007 program audit, how the recommendations were implemented, and a program status report. Dr. Low reported the Enforcement Program determines whether other clinical assessment programs are comparable to PACE.

Agenda Item 26 Licensing Committee Update and Consideration of Committee Recommendations

Dr. Salomonson reported the Licensing Committee met on July 29, 2010. The Committee voted to recommend that the Board direct staff to schedule a public hearing for the November 5, 2010 Board meeting to adopt regulations for a limited practice license.

Dr. Salomonson made a motion to accept the Committee's recommendation and set the limited practice license matter for regulatory hearing at the November 2010 meeting; s/Chang; motion carried.

The Committee also voted to recommend that the Board direct staff to schedule a public hearing for the November 2010 Board meeting to adopt regulations for polysomnographic technologists.

Ms. Chang made a motion to accept the Committee's recommendation and set the polysomnographic technologists matter for regulatory hearing at the November 2010 meeting; s/Levine; motion carried.

Other items discussed by the Committee included processing times for physician and surgeon applications and the primary recommendations from the Business Process Re-engineering Study (BPR). Ms. Whitney provided an update on the feasibility of a Licensing Program audit. Kathryn Taylor gave an update on the training program for new licensing staff and Breanne Humphreys discussed the possibility of adding a photograph to the wallet ID card and/or to the Board's online physician profiles for license verification purposes. Future agenda items include the regulatory issues regarding the limited practice license and polysomnographic technologists.

Agenda Item 28 Wellness Committee Update

Dr. Duruisseau stated the mission of the Wellness Committee is to further the Board's goal of consumer protection by encouraging and guiding licensees to promote a sound balance in their personal and professional lives so that, as healthy physicians, they can offer quality care to their patients. One of the avenues by which the Committee strives to fulfill its mission is to help identify, assess and share information on available resources. Last winter, the Committee created and published an online survey that was sent to the members of the California Hospital Association, the California Association of Physician Groups, and the California Medical Association, inviting them to identify their wellness practices and resources. The results of the survey were presented at the January 2010 Board meeting. The survey revealed that, while many of California's larger hospitals and physician groups have already established successful wellbeing committees, many other hospitals have struggled to make such a program operational. Using the results of the survey, the Committee will host a meeting in Sacramento on August 17, 2010 to start developing a "best practices" model for wellness committees which can be used by other entities. Dr. Duruisseau noted he would present the outcomes from this meeting at the November 2010 Board meeting.

Agenda Item 29 Physician Assistant Committee Update

Dr. Low introduced Elberta Portman, Executive Officer of the Physician Assistant Committee (PAC). Ms. Portman thanked the Members and Ms. Whitney for their support of the PAC. Dr. Low reported that at the July 26, 2010 PAC meeting, Ms. Portman briefed the Committee on the status of the Consumer Protection Enforcement Initiative (CPEI) and implementation of uniform standards under SB 1441. Improvements to the enforcement program continue to be implemented, which have resulted in reduced timelines. Criminal and arrest documents are now directly forwarded to the AG's Office. The Committee continued to report all disciplinary actions, including denials, to the National Practitioner Data Bank (NPDB). For the past year, the Committee has checked the data bank or NPDB for all applicants applying for licensure.

New continuing medical education (CME) regulations were approved by the Office of Administrative Law on June 12, 2010. Physician assistants must now complete 50 hours of CME every two years or may maintain certification through the National Commission for Certification of Physician Assistants. A notice has been sent to all licensees and information posted on the Board's web site regarding these new requirements.

The PAC also received approval for amending the Citation-and-Fine Program. The list of specific laws and regulations for which the Committee may issue a citation was deleted; the PAC may now issue a citation-and-fine for any violation of the Medical Practice Act.

Proposed legislative changes include changing the name of the PAC to the Physician Assistant Board. The Committee has directed staff to work with the Department's Legislative Unit to seek an author to include the Committee in the reporting requirements under Business and Professions Code 800 series; staff will then work with the author to implement changing the Committee to a board. This should not affect the relationship the Committee has with the Medical Board.

The next PAC meeting will be held on October 21, 2010.

Ms. Portman provided a brief overview of the PAC, reporting they have approximately 7,500 licensees. Roughly 58 new physician assistants (PAs) are licensed each month. PAs were originally created to assist physicians in underserved communities; they now work in all areas of the state in hospitals and clinics. With the implementation of Health Care Reform, continued growth is expected. The Pas' scope of practice allows them, with a Delegation of Services Agreement, to perform any procedure that their supervising physician allows and that they have been trained to do, including opening and closing for surgeries.

Agenda Item 30 Federation of State Medical Boards Update

Ms. Chang, who serves on the Federation of State Medical Boards (FSMB) Executive Committee, reported Dr. Salomonson serves on the Education Committee, Ms. Yaroslavsky on the Bylaws Committee, and Dr. Moran on the Nominating Committee. Ms. Chang reported the Maintenance of Licensure (MOL) is the most important issue currently being addressed by FSMB. There are three phases to implementation: Phase I will address CME issues, ensuring that all required CME be practice related; Phase II will address assessment; and Phase III will involve patient and use evaluation. Physicians with specialty board certification will be considered to have met MOL requirements.

Ms. Chang reported she was elected to the FSMB Foundation Board. The Foundation undertakes educational and scientific research projects designed to expand public and medical professional knowledge and awareness of challenges impacting health care and health care regulation.

Agenda Item 27 Physician Responsibility in the Supervision of Affiliated Health Care Professionals Advisory Committee Update

Dr. Moran reported the Committee met on June 23, 2010 in Sacramento. The goal of the Committee is to discuss under what circumstances it is appropriate to delegate the performance of procedures and if it is legal or appropriate to delegate to non-physicians the selection of patients and procedures and, if so, under what circumstances. Candis Cohen will replace Janie Cordray, who recently retired, as the staff member assigned to the Committee. During the recent meeting, the Committee heard from many professional organizations including the Northern California Aesthetic Nurses Association, the American Society of Dermatologic Surgery, the California Society of Facial Plastic Surgery, the American Academy of Facial Plastic and Reconstructive Surgery, California Society of Plastic Surgeons, California Academy of Physician Assistants, California Academy of Cosmetic Surgery, and American Nurses Association. Their

interests and opinions were all represented at the meeting. Discussion was broad, ranging from supervision to training and education of physicians and the mid-level practitioners they supervise, pending legislation, and more. This was primarily an information gathering meeting with no action items agendaized.

A date has not yet been set for the next meeting, but discussion is planned on the enforcement of existing laws and regulations and ways to improve some of these laws/regulations, if necessary. Staff will consult with legal counsel, the Board of Registered Nursing, the Board's Enforcement Program, and other interested parties.

Agenda Item 16 Licensing Outreach Report

Ms. Whitney reported Mr. Schunke spends a considerable amount of time doing outreach and education at teaching hospitals and post-graduate training programs. His outreach provides a valuable service to prospective licensees and training programs. Dr. Gitnick praised Mr. Schunke for the work he performs.

Agenda Item 17 Update on Governor's Job Creation Initiative

Ms. Whitney directed Members to the summary of expenditures on the Governor's Job Creation Initiative located at Tab 17 in their packets. In March 2010, the Governor initiated a job creation initiative that allowed boards to spend additional temporary help monies funded out of the operation expenses held in reserve in order to ensure pending license application review time and pending mail review times were cut in half. The overtime in the summary represents staff coming in on weekends and working 10 hours per day to ensure the Governor's initiative was met. The temporary help represents putting into place the 7.8 positions earlier than the July 1, 2010 authorization date. This was a true team effort and shows great commitment from staff. The goals of the initiative were met with application review time reduced to 45 days and pending mail review time also reduced.

Agenda Item 18 Licensing Chief's Report

Ms. Whitney directed Members to page 169 of the packet for workload data for the end of the fiscal year. She thanked the Information Services Branch and recognized Natalie Lowe for her consistent and reliable work in producing these reports. Future reports will include a breakdown of the initial review pending data comparing the US/Canadian applications and international applications. Since international medical school graduates must request documents from out of the country, their applications often take longer before they are complete. Staff would like to analyze this data as it may not be effective to aim for a 45-day review period if every review results in a letter of deficiency. In the meantime, 45 days remains the review goal. Pending mail review times continue to drop with a goal of having all incoming mail reviewed within one week or sooner.

Agenda Item 19 Special Faculty Permit Review Committee Appointment

As required by Section 2168.1(c) of the B&P Code, a Special Faculty Permit Review Committee was established by the Board to review and make recommendations regarding applicants for a special faculty permit. This permit is a special classification of license that allows California medical schools to recruit top ranked medical professionals that are eminent in their fields but that may not qualify for licensure in California; the permit allows the physician to practice only at

the medical school. The physician can renew his/her permit just as a physician with a regular license can. Currently, there are approximately 16 individuals in the state holding such a permit.

The Committee is comprised of two members of the Board (one physician member and one public member) and one representative from each of the medical schools in California. Members of the Committee evaluate the qualifications of the applicant.

Kathryn Taylor, Licensing Program Manager, reported the Keck School of Medicine at the University of Southern California has nominated Dr. Frank R. Sinatra to replace the school's current representative.

Dr. Gitnick made a motion to approve Dr. Sinatra's nomination to the Special Faculty Permit Review Committee; s/Chang; motion carried.

Agenda Item 21 Approval of Bastyr University Midwifery Program

Cheryl Thompson, Midwifery Licensing Analyst, reported in 1994 the Seattle School of Midwifery (SMS) was approved by the Board as a three-year midwifery education program meeting the qualifications required by the B&P Code and Title 16 of the California Code of Regulations. On March 23, 2010, SMS merged with Bastyr University. The program, now known as the Bastyr University Department of Midwifery Program, is identical to the one offered by SMS that was previously approved by the Board. The SMS has been accredited by the Midwifery Education Accreditation Council (MEAC) since 1996. When the change of ownership was approved by MEAC, accreditation was conveyed to the new Department of Midwifery at Bastyr University. Board staff recommends granting recognition to the Bastyr University Midwifery Program with retroactivity to June 2010 when the first class graduated from Bastyr instead of SMS.

Ms. Chang made a motion to approve the Bastyr University Department of Midwifery Program with retroactivity to June 2010; s/Levine.

During public comment, Frank Cuny, California Citizens for Health Freedom, urged support for the motion.

Ms. Yaroslavsky called for the vote; motion carried.

Agenda Item 15 Discussion of MBC/UC Davis Telemedicine Pilot Program

Ms. Yaroslavsky stated in 2007, AB 329 (Nakanishi) authorized the Board to establish a pilot program to expand the practice of telemedicine in California. The purpose of the pilot is to develop methods using telemedicine to deliver health care to persons with chronic diseases. The pilot also will develop information on best practices for chronic disease management services and techniques and other health care information as deemed appropriate. The bill required the Board to report to the Legislature with findings and recommendations within one calendar year after the commencement date of the pilot. Ms. Yaroslavsky directed Members to tab 15 in their packets for the First Annual Report to the Legislature. The two subsequent Annual Reports will evaluate the effectiveness of the pilot. The final report in the summer of 2012 will include a summary of the pilot and evidence-based recommendations.

Dr. James Nuovo, UC Davis, is the principle investigator of the team guiding the project. Dr. Nuovo provided a summary of the pilot's milestones and accomplishments during the first year. The project represents the combined effort of the Board, UC Davis' Chronic Disease Management Program, Center for Health and Technology, and Center for Health Care Policy and Research. The pilot focused on developing a telemedicine model for the provision of modern diabetes self-management education and training classes for patients with diabetes living in a 33-county area of rural, underserved communities in northern and central California. The pilot has shown the importance of intervention and health coaching in preventing exacerbations of chronic illness and supporting lifestyle and behavior change. Site recruitment issues were discussed by Project Manager Glee Van Loon, R.D.

Tom Balsbaugh, M.D., project consultant for provider education, discussed the chronic care model (a team-oriented, evidence-based model that emphasizes self-management support) and continuous quality improvement as the foundations of the pilot's efforts in education. Discussions on telemedicine and other topics such as diabetes self-management tools, initiating insulin, practice redesign for improved chronic disease care, etc. are planned to be held during lunches at the various practice locations; some will be offered online. CME credit is planned for attending these sessions.

Bridget Levich, MSN, Director of Chronic Disease Management at UC Davis, serves as the educational advisor for the health coaches. She reported their educators work with patients through tele-video classes to empower them to take charge of and manage their chronic conditions. Gisela Escalera and Jennifer Fernandez, health coaches, discussed their role in recruiting, teaching, and working with patients.

Dr. Gitnick suggested that the pilot team contact the Health Professions Education Foundation to discuss ways the two programs might work together to address care to underserved communities.

Dr. Levine asked about the metrics that would be used to evaluate the impact of the intervention. Dr. Nuovo noted the pilot has both quantitative and qualitative methods for evaluating whether or not the intervention is effective.

Dr. Low asked if telemedicine is truly a cost effective modality that would work without third-party funding, given that both the primary physician and consulting telemedicine physician charge for their services and the costs associated with supporting the technology. Dr. Nuovo acknowledged the challenges given the way the current health care system works. He suggested telemedicine might need to be part of an initiative or health care reform package. Costs will be one of the outcomes measured in the pilot. Dr. Low suggested regular Webcasting might be effective for the education component without having to set up a telemedicine network. He asked if private industry could set up telemedicine to make it cost effective and self-supporting. Dr. Nuovo indicated this would be a topic to reflect on after assessing the outcomes from the pilot.

Dr. Levine echoed Dr. Low's comments. She noted the Center for Connected Health in Sacramento is working on a model statute for telehealth, looking at the issues of reimbursement, the scope of telemedicine, and obstacles that currently exist for more rapid deployment of the

telemedicine modality. Dr. Levine noted the real savings may exist in other applications of a telemedicine model of care delivery to augment, amplify, and support rather than replace the doctor's office face-to-face visit.

Agenda Item 22 Update on Special Task Force on International Medical School Recognition

Dr. Low reported the Task Force has been effective in improving review timelines. Six schools have submitted applications for recognition by the Board. He directed Members to tab 22 in the packets for a status on each of the applications. New medical consultants have been recruited to address the shortage of reviewers.

A. American University of Antigua

Dr. Nuovo, Professor and Associate Dean of Graduate Medical Education and Student Affairs at UC Davis, presented a summary of his assessment of the application from the University of Antigua College of Medicine (AUA) to determine if the medical education received at the school meets the requirements of the current California statutes and regulations for recognition by the Medical Board. Dr. Nuovo recommended that, in order to determine whether the school is in substantial compliance with the aforementioned statutes and regulations, the Board consider a site visit of the school. A site inspection of the campus and a representative sample of clinical sites will permit a review of records, a discussion of issues with school and hospital administrators, faculty, and students to assess the structure and content. This will allow a site team to assess the issues brought forth in the review including patient census data, the volume and nature of the experience for students, the impact of other trainees at the clinical training sites among others issues. Dr. Nuovo referenced his report for details of his initial evaluation and noted that this was a *preliminary* report and does not include information provided to the Board on July 21, 2010 by AUA as he has just received this material. If the Board eventually moves to approve the school, there will have to be a determination of retroactivity in terms of which students are approved or not. He concluded by stating the standards being used in his evaluation of AUA were not any higher than those used to evaluate other international schools or LCME accredited schools; the evaluation is based strictly on the current statutes and regulations.

Dr. Low thanked Dr. Nuovo for his work and thorough assessment of the school.

Dr. Low made a motion to direct staff to set up a site visit, if deemed necessary, after Dr. Nuovo's review of the additional materials received on July 20, 2010 so the Board can move forward with AUA's application for recognition; s/Esrailian.

During public comment, Leonard Sclafani, Vice President and General Counsel of AUA, stated that, in some cases, he believes AUA is being held to a higher standard than other LCME schools. He said he has seen many of the Board's recommendations and approvals of schools in Eastern Europe where no site visits were done, no hospital integration was done, and no visit to the hospitals was conducted. Mr. Sclafani announced that in January, AUA is proceeding to change their curriculum from a 16-week per quarter type curriculum to a 20-week per semester curriculum. Additionally, they will be using a two-semester system during the course of the year (instead of a three-semester system) to provide a better opportunity for students to gather the same essential material, but in a longer period of time. These sorts of changes are being made in

order to accommodate the comments, feedback, and data that the school receives on the performance of their students. He concluded by stating he believes that AUA has demonstrated through the submitted material sufficient information from which the Board can conclude that no site visit is necessary. Nevertheless, AUA would welcome a visit by the Board to their campus and hospitals in order to ensure that they are fully qualified.

Jagbir Nagra, Executive Dean, and Dr. Peter Bell, Executive Clinical Dean and Vice President of Academic Development, also offered public comment welcoming the Board to conduct a site visit of AUA.

Dr. Low amended his motion to authorize the Executive Director and Medical Consultant to set up a fiscally responsible site visit, if deemed necessary, after the Medical Consultant's review of all requested information so the Board can move forward with AUA's application for recognition; s/Esrailian; motion carried.

Agenda Item 20 Discussion on Midwifery Barriers to Care

Ruth Haskins, M.D., member of the Midwifery Advisory Council, provided an overview of barriers to care as reported by midwives that limit their ability to care for their clients. The obstacles include issues such as difficulty in securing diagnostic lab accounts, registering homebirths with the local County Registrar, obtaining syringes, IV equipment, oxygen, and necessary injectible medications, and more. The Committee requested permission from the Board to investigate these barriers and develop possible solutions.

Dr. Levine made a motion to authorize the Midwifery Advisory Council to form a Task Force to review the various barriers to care and develop possible solutions; the motion was seconded and carried.

Agenda Item 12 Board Evaluation Presentation and Discussion

Ben Frank reported that in July 2009 the Board authorized the Executive Director to undertake an evaluation of the Medical Board's programs. Mr. Frank's firm was contracted to conduct the assessment, which began in November 2009. A draft final report was delivered to Board management in July 2010. The purpose of the study was to review the Board's organizational and management structures and core programs to identify strengths and weaknesses of current operations and develop recommendations for improvements. The scope of the project also encompassed a review and analysis of the sufficiency of fees, the value of services provided by external agencies and contractors, and identification of functions that could possibly be eliminated to enable redirection of resources to more critical functions. A survey was disseminated to Members to assess the Board's governing structure; however, a sufficient number of completed surveys were not returned by the end of June to enable development of any findings, conclusions, or recommendations in this area.

With respect to the sufficiency of the Board's licensing fees and fund reserves, results show that within two to three years the Board's reserves are likely to decrease to a level equivalent to less than four months of operating expenditures. Consequently, an adjustment to fees is not supported at this time.

Only a limited review of the Licensing Program was conducted since the Business Process Reengineering (BPR) Study, which provided a detailed examination and recommendations for the licensing function, was completed earlier this year. The BPR study recommended increasing the number of authorized, permanent licensing positions from 26 to 41 positions. If fully implemented, this would result in a 33 percent increase in Licensing Program staffing. Eight new licensing positions were approved earlier this year and are presently being filled; these new positions fully restored positions lost earlier in the decade and, once filled, will exceed the total number of positions authorized for the Licensing Program at any point in the past decade by 10 to 20 percent. However, during this period, the Licensing Program's workload grew by approximately ten percent. His analysis supports the need for the previously authorized eight positions, but does not support the BPR's recommendation to seek an additional seven positions. Further, the BPR's recommendation to upgrade two of the three office technician positions and eliminate all student assistants would shift clerical and administrative support workload to higher level staff. Although the BPR's recommendation to increase the number of Licensing Program manager positions is supported, the creation of an Assistant Chief of Licensing is not supported. In summary, the results of Mr. Frank's analysis do not support increases in Licensing Program staffing at this time.

The principle focus of the report has been on the Board's Enforcement Program. A preliminary diagnostic review of the Boards' expenditures and Enforcement Program performance over the past five years was conducted. The results indicated that subsequent to implementation of Vertical Enforcement during 2006, costs for legal services provided by the Attorney General (AG) escalated rapidly, while other legal service costs declined. Concurrently, the number of cases referred for investigation, completed investigations referred for prosecution, accusations filed, stipulated settlements and proposed decisions submitted, and disciplinary actions all declined. Additionally, the average lapsed time to complete an investigation increased while the average lapsed time to complete prosecutions decreased. Given the amount of funding utilized for legal services provided by the AG's Office, currently more than one million dollars per month, and these performance trends, it was jointly determined that the primary focus of the assessment should be on: 1) identifying and assessing the impacts of Vertical Enforcement on the Enforcement Program, 2) identifying and assessing the benefits provided from the increased expenditures for Vertical Enforcement-related legal services, 3) identifying and assessing other factors contributing to the deteriorating Enforcement Program performance, and 4) developing Enforcement Program improvement plans.

To support the assessment, interviews were conducted with staff in the Central Complaint Unit, staff at six of the Board's District Offices, and representatives of the AG's Office in Sacramento, San Francisco, Los Angeles and San Diego. Board staff produced several dozen sets of statistical data pertaining to intake, screening, investigation and prosecution of complaints, disciplinary outcomes and numerous other related activities and events. Data was also provided by the AG's Health Quality Enforcement Section, including data on attorney time charges for investigation and prosecution-related services. Overall, the results of the assessment show that Vertical Enforcement has been implemented very differently in different geographic regions of the state with significantly different impacts in terms of cost effectiveness, service levels, and outcomes achieved. These differences provide an opportunity to identify best practices, reverse the deterioration in performance that has already occurred, and enhance consumer protection by

instituting a more uniform and effective statewide approach to investigating and prosecuting complaints. The geographic comparison and analysis have been difficult and complex; results are currently being reviewed with Board management and recommendations are being refined. The draft report should be submitted soon to the Board Evaluation Subcommittee. The Subcommittee will most likely require several weeks to complete their review. It is anticipated that the final report to the Full Board will occur at the November 2010 meeting.

Ms. Yaroslavsky inquired about any analysis that had been done on the necessary number of members on the Board in order to do the work it has been charged with. Mr. Frank noted this has not been specifically addressed, but added that, historically, the number of physician members on the Board is the lowest it has ever been in at least the past 20 years. Member input on this issue was not considered due to the low number of surveys returned to date.

Dr. Salomonson remarked that it was her impression from the BPR study that the volume of applications had increased more than 10 percent and that an increased proportion was due to international applications which take significantly more time and effort to process. She felt this factor was important to include in any analysis and conclusions that were to be drawn. Mr. Frank indicated his analysis of the Licensing Program was not detailed.

Ms. Yaroslavsky acknowledged the recent retirement of Janie Cordray, Board Research Specialist, who has been the staff person with oversight responsibilities for this evaluation report. Ms. Cordray has worked in state service since 1974 and for the Board since 1991. She has served the Board in various capacities and has been a highly valued resource and contributor for the past 19 years. Ms. Yaroslavsky extended the Board's thanks for her hard work and dedication and presented her with the state's retirement gift and a framed resolution.

Agenda Item 24 Enforcement Chief's Report

A. Approval of Orders Restoring License Following Satisfactory Completion of Probation, Orders Issuing Public Letter of Reprimand, and Orders for License Surrender During Probation.

Ms. Threadgill requested approval of 12 orders to restore licenses following satisfactory completion of probation and five orders for surrender of license during probation or an administrative action.

Dr. Moran made the motion to approve the orders; s/Duruisseau; motion carried.

B. Expert Utilization Report

Ms. Threadgill directed members to page 183 of the packets for a chart reflecting the use of experts by specialty during the past quarter. The number of experts in the Board's database has increased to 1,161 since the last quarter.

C. Enforcement Program Update

The Enforcement Program has an overall vacancy rate of approximately 9 percent; this number is reduced to 5 percent if vacant positions with identified candidates moving through the selection process are removed. The interview process has been refined to identify candidates most likely to commit and stay with the program, rather than move on to other opportunities.

The staff in the Central Complaint Unit, although short staffed, stepped up and covered their unit with no loss in productivity. Ms. Threadgill made special mention of Ramona Carrasco, Sharlene Smith, Fred Holbrook, Mike Ginni, Keith DeGeorge and Christina Haydon for their efforts.

The Discipline Coordination Unit processed 95 pleadings and 91 Decisions and Orders during the past quarter. The Operation Safe Medicine Unit (OSM) and the former Diamond Bar Office have relocated to the San Dimas Office location. OSM recently seized more than \$100,000 of contraband contact lenses and participated in the arrest of nine unlicensed individuals who were illegally selling them. All of the cases were filed with the District Attorney or City Attorney. This was a significant coup for public protection in light of the growing fad stemming from a "Lady Gaga" video.

The Office of Standards and Training (OST) is currently working on a variety of projects that will benefit the district investigative staff, including a statewide investigator training conference planned for October 2010. In addition, a new evidence policy and database for tracking evidence is almost complete and background investigations are being completed in record time.

The "Aged Case Council" concept continues to be effective. Since implementing this concept the overall case age average has been reduced by 25 days.

There was an overwhelming response to the recent advertisement for Medical Consultants that appeared in our Newsletter. Ms. Threadgill expects an abundant number of well-qualified physicians for the vacancies in Tustin, Fresno, and San Jose.

The Department has obtained a biological fluid testing contract that is in addition to the testing contract the Board has obtained. This affords the maximum amount of flexibility for the probationers who are subject to this condition of probation.

D. Consumer Protection Enforcement Initiative (CPEI)

The Consumer Protection Enforcement Initiative (CPEI) is sponsored by the Department. As a result of this initiative, it is likely that the Board will gain 22 additional, non-sworn enforcement positions to assist in reducing the time it takes from receipt of a complaint through the prosecution.

Ms. Kirchmeyer, Deputy Director of Board Relations, Department of Consumer Affairs, reported the Department has obtained approval for 140 CPEI positions overall for all of the healing arts boards. The Department is asking the boards to begin the recruitment process for filling these positions. DCA has begun to gather information and statistics on performance measurements including cycle time, volume of complaints, costs, customer service and probation monitoring. These measurements will be posted on each board's web site beginning in October 2010. The BCP for the BreEZe Project was approved and is moving forward. Ms. Kirchmeyer noted SB 1111, the legislation that carried many of the changes the Department was hoping to make in the enforcement process, was defeated. The Department is asking the boards to move forward with regulations to implement any of the provisions from SB 1111 that they can. Since many of the proposals in the bill were based on the Medical Board's existing practices, there are a limited number that the Board will need to address.

Ms. Threadgill directed Members to page 191 of the packets for a chart reflecting how the 22 CPEI positions will be utilized (note: the chart does not show the Probation Unit). These positions will be used in the upfront process to handle cases that do not require investigation by sworn investigative staff. The goal is to reduce the number of cases assigned to sworn investigative staff, thereby reserving this resource to focus on the most complex cases, and to limit the number of individuals who handle a complaint in the Complaint Unit. With the additional positions, the analyst will be able to take a complaint from beginning through the determination whether to close or refer to the field. Reducing the number of times a complaint is passed off should result in a time savings. Of the 22 anticipated positions, four are based on allied health workload. Ms. Threadgill has contacted these boards and committees to discuss how they envision implementing these positions.

Agenda Item 25 Vertical Enforcement Program Report

Carlos Ramirez, Senior Assistant Attorney General, reported the Health Quality Enforcement Section has continued to work with Enforcement Program staff on ways to expedite obtaining medical records and fine-tuning methods used in other aspects of investigation.

Agenda Item 31 Department of Consumer Affairs Update

Ms. Kirchmeyer provided an update on projects the Department is working on. The DCA is encouraging boards to implement the uniform standards contained in SB 1441. SB 1172, which includes the legislation needed to implement some of these standards, is still moving forward; there may be regulations and policy implementations resulting from this bill. The DCA is asking the boards to review these guidelines and move forward with the regulatory process.

Ms. Whitney noted the Board is not moving forward with any additional regulatory changes regarding SB 1441 until the outcome of SB 1172 is determined.

The Department will begin holding meetings to discuss the impact of Health Care Reform on the various boards' licensing and enforcement processes. As mentioned in Ms. Boughton's presentation, approximately eight million new individuals will enter the health care system. The DCA is requesting that the boards begin to put this topic as a standing item on their agendas. Ms. Kirchmeyer thanked the Board for being on top of this issue.

The DCA is beginning a project to address licensing reform in order to license individuals in a timely manner so they can join the workforce. Phase I, which is the gathering of statistics for current processes, has begun. Beginning September 8, 2010, monthly reports will be given to the State and Consumer Services Agency (SCSA) on each board's licensing statistics. Data will include the number of applications pending at the beginning of each month, how many applications were approved, withdrawn or denied, and the number pending at the end of each month. Phase II will involve the establishment of performance measurements. Since licensing processes vary considerable from board to board, this process may be more individualized with boards setting their own targets within the performance measurements. Laws and regulations will also be examined to see if there are changes necessary to streamline the licensing process. Best practices will also be identified.

Ms. Yaroslavsky asked for an update on Cooperative Personnel Service's review of the Department's Human Resources section. Ms. Kirchmeyer indicated the Department is undergoing a contracted review of its human resources area and its personnel staff in order to address problems that have been identified. Evaluations are currently being collected from the various boards. Ms. Kirchmeyer said she would check on the status and report back to the Board.

Agenda Item 32 Agenda Items for November 4-5, 2010 Meeting in Long Beach, CA

Dr. Moran requested a discussion on the void created by the termination of the Diversion Program, in that, currently, there is no way to ensure rehabilitation of physicians and simultaneously protect the public.

Ms. Yaroslavsky thanked staff for their hard work on the Board's behalf and in service to the people of California.

Agenda Item 22 Adjournment

There being no further business, the meeting was adjourned at 2:00 p.m.

Barbara Yaroslavsky, President

Hedy Chang, Secretary

Linda K. Whitney, Executive Director

**Differences Between
License and Discipline Cases**

Activity/Issue	License	Discipline
1. Origin	Application	Complaint/report
2. Process	APA hearing; stipulation	APA hearing; stipulation
3. Charging Document	Statement of Issues	Accusation
4. Burden of Proof	On applicant to show fitness if board establishes grounds for denial by preponderance of evidence	On board to show violation/unprofessional conduct by clear and convincing evidence
5. Hold	1 member	2 members
6. Voting	Majority. If at meeting, majority of those present	Majority of panel to nonadopt, remand to ALJ, or approve with altered penalty; 4 votes to revoke.
7. Nonadopt	No oral argument	Oral argument
8. Petitions for modification or termination of probation	Submitted on written argument only; staff attorney prepares decision.	Sent to hearing before ALJ; panel reviews Proposed Decision.

DATE: September 16, 2010

TO: Active Fellows of the Federation and
 Medical Board Executive Directors/Secretaries

FROM: Humayun J. Chaudhry, DO, FACP
 President and Chief Executive Officer

RE: FIRST Call for Nominations

Nominations of Candidates for Elected Office

Martin Crane, MD, Chair of the FSMB's Nominating Committee, requests that Member Boards and Fellows of the FSMB submit names of individuals for the Nominating Committee to consider as candidates for elective office. Elections will be held at the FSMB's April 30, 2011 House of Delegates annual business meeting. Nominees may include physicians as well as non-physicians who are Fellows of the FSMB. The FSMB Bylaws state: *Individual members of Member Medical Boards shall be Fellows of the corporation so long as they serve as members of a Member Medical Board, and for a period of 36 months thereafter.* Instructions for recommending candidates, including eligibility requirements with responsibilities of elected positions, are attached for your information. **Please refer to this information when submitting your letters of recommendation for consideration by the Nominating Committee.**

Under the FSMB Bylaws, the Nominating Committee must nominate one or more candidates for each position. Nominations are also permitted from the floor during the annual business meeting. Positions to be filled in 2011 are as follows:

- Chair-elect 1 Fellow, to be elected for 3 years: one year as chair-elect; one year as chair; and one year as immediate past chair
- Board of Directors 3 Fellows, each to be elected for a three-year term
- Nominating Committee 3 Fellows, each to be elected for a two-year term*

The Nominating Committee requests that all recommendations for nominations be submitted by **January 7, 2011**. **No nominations will be accepted after January 7.**

***No two Nominating Committee members shall be from the same member board. Continuing members of the Committee will be from Georgia, New York PMC and West Virginia Osteopathic.**

INSTRUCTIONS FOR RECOMMENDING CANDIDATES FOR NOMINATION TO FSMB ELECTED POSITIONS

Eligibility

Any person who is or will be a Fellow of the FSMB at the time of the election on April 30, 2011 is eligible for nomination. The Bylaws of the FSMB define Fellows as: *"Individual members of Member Medical Boards shall be Fellows of the corporation so long as they serve as members of a Member Medical Board, and for a period of 36 months thereafter. Only Fellows may run for elective office."*

Core Competencies of Candidates

A candidate for elective office should:

- Support the mission, vision and core values of the FSMB;
- Possess a positive outlook on the role and function of state medical boards in the medical regulatory field;
- Bring a broad, national perspective to specific issues;
- Have adequate time and commitment necessary to fulfill the responsibilities of the office; and,
- Demonstrate personal integrity.

Letter of Recommendation - Contents

The letter of recommendation to the Nominating Committee should specify (1) the name of the candidate to be considered; (2) the office for which the candidate is being recommended; (3) a description of the candidate's ability to demonstrate the core competencies as stated above; (4) the candidate's agreement to the submission of his/her name for potential nomination; and, (5) the candidate's mailing address, daytime telephone number, fax number and email address.

Attachments to Letter of Recommendation

The following materials should accompany the letter of recommendation:

1. **Candidate's General Information Questionnaire (form attached).** In the interest of uniformity and fairness to all candidates, the Nominating Committee requests that the information contained on the Candidate's General Information Questionnaire be limited to the space provided, *except where otherwise stated.*
2. **Candidate's photograph – color or black/white.** Copies of the photos will be included in the Nominating Committee agenda book. If the nominee is selected, the photos will also be used in the Election Manual that is distributed to Voting Delegates and placed on the Candidates Website. **Questions regarding photos should be directed to David Torres, Communications Coordinator, at 817-868-4076 or dtorres@fsmb.org.**
3. **Personal statement by the candidate (sample attached) – an *electronic* copy no greater than 500 words.** The candidate should state why he/she wants to serve in the particular position in which he/she will be campaigning for election; how he/she fulfills the core competencies of candidates, and what he/she will contribute to FSMB. The personal statement will be included in the Election Manual and placed on Candidates Website.

4. ***Electronic* copy of the candidate's curriculum vitae (CV) (a maximum of five pages) and a one-page bio or summary CV. Please provide relevant information including important appointments, honors and awards received, etc. Please note these documents will be published on the Candidates Website; therefore, social security numbers and all other private information must be removed prior to forwarding with letters of recommendation.**

Deadline for Submission of Letters and Materials

The members of the Nominating Committee request that all recommendations for nominations be submitted in writing by mail, fax or email to:

Martin Crane, MD, Chair
Nominating Committee
c/o Pat McCarty, Director of Leadership Services
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Eules, TX 76039-3855
Fax: (817) 868-4167
Email: pmccarty@fsmb.org

The National Office should receive letters and accompanying materials by **January 7, 2011**. **No nominations will be accepted after January 7.**

A confirmation acknowledging receipt of nominations will be sent within one week. If you do not receive confirmation, please contact Pat McCarty at (817) 868-4067 or at the email above.



State of California
 Medical Board of California
 2005 Evergreen Street, Suite 1200
 Sacramento, Ca 95815
www.mbc.ca.gov

Memorandum

Date: October 12, 2010
 To: Board Members
 From: Kevin A. Schunke
 Subject: Update on UCD/MBC Joint Telemedicine Pilot Program

In 2007, AB 329 (Nakanishi) authorized the Medical Board of California (Board) to establish a pilot program to expand the practice of telemedicine in California. The purpose of the pilot is to develop methods, using telemedicine, to deliver health care to persons with a chronic disease. The pilot also shall develop information on the best practices for chronic disease management services and techniques and other health care information as deemed appropriate.

On July 1, 2009, the Board entered into a contract with the University of California, Davis (UCD), of which the UCD Health System (UCDHS) is a major partner. The UCDHS Chronic Disease Management Program (CMD), in collaboration with the UC Davis Center for HealthCare Policy and Research (CHPR) and UCDHS Center for Health and Technology (CHT), was to develop a telemedicine model for the provision of modern diabetes self-management education and training classes for patients with diabetes living in a 33-county area of rural, underserved communities in northern and central California.

At the July 2010 Board meeting, a presentation was made by Dr. Jim Nuovo, the team's principle investigator, and several of his team members, presenting the first annual report and an update of current activities.

Since that meeting, the following activities can be reported from the participating health care clinics. The UCD team has set a goal of having 18 sites participating in the pilot.

Sites committed to participating in the pilot and started the process:

1. **Sierra Family (Nevada City, CA)** has completed 8 classes. There were 68 recruited and 33 attended classes; this no-show rate is similar to that of diabetes education classes at UCD. Follow-up surveys have been sent to a majority of the participants.
2. **Western Sierra Family (Downieville, CA)** held their second class mid-October. The follow-up surveys have been sent to the participants of the first class and the second class will receive theirs shortly. An unexpected issue was identified with regards to participants' mailing addresses versus their home addresses: some participants used a mailing address, others provided a home but indicated that there was no mail delivery to that address (some rural address do not have mail delivered by the US Postal Service and those residents must use a PO box). This new

information required discussion for the need to collect both addresses for reporting outcomes related to the participants' location relative to the clinic and would require an adjustment to the survey questionnaires and the master database.

3. Eastern Plumas (Portola, CA) has had numerous issues including telemedicine equipment relocation, securing the telemed line using VPN, the site "champion" being unavailable, etc. Recent discussions confirmed they want to move forward with their participation but will designate a new site champion. They need a bit of time to work through their logistics then they will move forward.

4. Karuk Indian Health (Yreka, CA) will have their first class in late-October; they still are working to determine the kick-off date. Like staff at numerous small clinics, the site champion only works a part-time schedule.

5. Lassen Medical Group (Red Bluff, CA) will have a kick off meeting soon—they have postponed two previously-set dates as they work through internal logistics. They likely will kick off by early November

Sites committed but not yet operational

- 1. Miners Family Health (Grass Valley, CA)**
- 2. Adventist Health Community Care (Hanford, Home Garden, CA)**
- 3. Tahoe Forest (Incline Village, CA)**

In discussion for potential participation or to seek other leads:

- 1. Mountain Valleys (Tulelake, CA)**
- 2. Redwoods Rural Health Center (Redway, CA)**
- 3. Northeastern Health Center (Susanville, CA)**

New outreach efforts and follow up to be made:

- 1. Dr. Sylvia Diego (Member, Medical Board of California and Chief Medical Officer at Golden Valley Health Centers)**
- 2. California Primary Care Association**
- 3. Health Alliance of Northern California**
- 4. California Telehealth Network**
- 5. Tulare County Medical Director of Primary Care**
- 6. Dr. Alan Nakanishi, author of the legislation which created the pilot**

Miscellaneous issues:

- 1. Trying to solidify placement of a medical student from the UCD Rural Prime program who will work on the pilot as an intern**
- 2. Database is completed and data is being input. Need to address some issues as they arise when surveys are returned.**
- 3. Team is working on "exit interviews" to be given to site champions.**

This summary is current as of the last team meeting held during the last week of September. If I can provide further input before the meeting, please contact me at (916) 263-2368 or via email: Kevin.schunke@mbc.ca.gov. Otherwise, I look forward to your questions in a few weeks.



MEDICAL BOARD OF CALIFORNIA
Executive Office



**LICENSING OUTREACH AND
INFORMATIONAL MEETINGS**

Tuesday, November 16, 2010

Kaiser Permanente Northern California
1950 Franklin St, Conf. Room E, 2nd Floor
Oakland, CA 94612
(for directions, tel: (510) 625-4762)

Wednesday, November 17, 2010

Kaiser Permanente Orange County
3460 E. LaPalma Ave, Conf. Rooms 3-4
Anaheim, CA 92806
(for directions, tel: (714) 381-5312)

AGENDA

10:30 am to 1:00 pm
(or until completion of business)

1. Welcome and Introductions
2. Review Meeting Objectives
3. Current Licensing Process and Timelines
4. Proposed Improvements to Process and Timelines
5. Common Licensing Pitfalls Delaying Licensure
6. Teaching Hospitals' and Residents' Expectations
7. Medical Board's Expectations and Commitments
8. Questions and Answers

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 Chair 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 to the Board no later than five working days before the meeting by contacting Kevin A. Schunke at (916) 263-2368 or sending a written request to Mr. Schunke at the address below. Requests for further information should be directed to the same address and telephone number.

**MEDICAL BOARD OF CALIFORNIA**
Executive Office

October 21, 2010

To All California GME Deans and Directors:

The Medical Board of California (Board) is continuing this year with another outreach to the Graduate Medical Education staff at California's teaching hospitals. We invite you to attend an informative meeting and discussion regarding the Board's Licensing Program and processes. We welcome your input and suggestions as we are continually seeking ways to improve the Licensing Program.

The dates and locations for the two scheduled meetings are as follows:

Tuesday, November 16, 2010

10:30 am to 1:00 pm

Kaiser Permanente Northern California
1950 Franklin St., Conf. Room E, 2nd Floor
Oakland, CA 94612

(for assistance with directions, tel: (510) 625-4762)

Wednesday, November 17, 2010

10:30 am to 1:00 pm

Kaiser Permanente Orange County
3460 E. LaPalma, Conf. Rooms 3-4
Anaheim, CA 92806

(for assistance with directions, tel: (714) 381-5312)

The licensing of physicians and surgeons is one of the Board's core mandates. Last year, when we held the first of these GME outreach meetings, it was obvious that we were not meeting your expectations – nor ours – to get applicants licensed in a timely manner. However, with input from those who attended the 2009 GME meetings, and with the implementation of new technologies and other internal process changes, we are proud to have made significant improvements in our customer service.

As of last week, applications filed by US and Canadian medical school graduates were being reviewed just 36 calendar days after receipt; applications submitted by international medical school graduates were being reviewed within 49 calendar days. This is a significant improvement from last year, when the initial review of applications was being conducted more than five months after receipt!

Nevertheless, there are areas in which we are sure we can continue to improve. We recently have begun the process of revising our application for physicians and surgeons to make it more user-friendly. Soon we will be requesting the names of your residents and fellows who need licensure by next summer (our annual matrix). And we continue to develop and implement internal changes to streamline the process. Yet we hope that you, the GME Deans and Directors with whom we work hand-in-hand as your residents apply for licensure, can offer more insight and suggestions as to what we can accomplish as we move forward with enhancements.

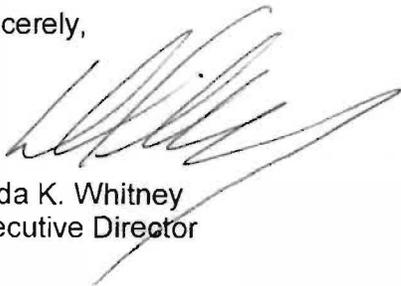
To receive your feedback, address your concerns, and answer your questions, I will be attending these meetings. Other Board staff attending the meetings will be Curt Worden, Chief of Licensing; Breanne Humphreys and Letitia Robinson, Licensing Managers; and Kevin A. Schunke, Licensing Outreach Manager.

We hope you or your representative(s) will attend to engage in a dialogue as we strive to meet mutual expectations. We can accommodate up to two representatives per teaching hospital. To ensure we have adequate space, **please RSVP by November 9, 2010** indicating who will be representing your hospital and which meeting they will attend: please contact Mr. Schunke at kschunke@mbc.ca.gov to send your RSVP.

If you have questions about the meetings, you may contact Mr. Schunke via his email or at (916) 263-2368 or Mr. Worden at curt.worden@mbc.ca.gov or at (916) 274-2986.

We look forward to seeing you at one of these meetings.

Sincerely,



Linda K. Whitney
Executive Director

ELISA NICHOLAS, M.D., M.S.P.H.
BIOGRAPHY

A pediatrician, public health practitioner, and health administrator, Dr. Elisa Nicholas has devoted her career to caring and advocating for underserved children and families. As Chief Executive Officer of The Children's Clinic, Serving Children and Their Families (TCC), she has led the growth from one site to the addition of 5 satellite clinics. Through Dr. Nicholas vision, TCC has become a dynamic system of non-profit community health centers in Long Beach that provide over 70,000 visits per year to a diverse and growing population, and is dedicated to caring and advocating for underserved children and their families

With her expertise in community pediatrics and a mother of a son with special health care needs, Dr. Nicholas continues to focus on addressing disparities by designing and/or implementing critical programs which include asthma coalitions, school-based health programs, immunization awareness campaigns, and healthy lifestyle programs such as the Long Beach Alliance for Food and Fitness. She is a Project Co-Chair of the YMCA Activate America: Pioneering Healthy Communities.

In addition to her role as CEO of TCC, Dr. Nicholas serves as Project Director for the Long Beach Alliance for Children with Asthma (LBACA), the American Academy of Pediatrics CATCH (Community Access to Child Health) District Co-Facilitator, a member of the Community Advisory Board for the National Children's Study of Los Angeles-Ventura Study Center, and a member of the LA Care Health Plan Children's Health Consultant Advisory Committee. An Associate Professor of Pediatrics at UC Irvine, she is also an active staff member and former Chief of Staff at Miller Children's Hospital where she worked closely with practicing pediatricians. She formerly served on the AAP Executive Committee for the Section on Community Pediatrics, Task Force on Youth and Education for strategic planning for the City of Long Beach, Los Angeles County Children's Planning Committee, and Board of LA Care Health Plan, to name a few. She has been the recipient of numerous community awards such as State Senator Alan Lowenthal's California Woman of the Year Award.

Dr. Nicholas is a graduate of the UCLA School of Medicine. She completed her pediatric residency training at the Yale University School of Medicine/New Haven Hospital and was a Robert Wood Johnson Clinical Scholar at the UCLA School of Medicine. She completed her Masters of Science in Public Health and a preventive medicine residency at UCLA.

TITLE 16. Medical Board of California

NOTICE IS HEREBY GIVEN that the Medical Board of California (hereinafter referred to as the "Board") is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held at Long Beach Memorial Hospital Miller Children's Hospital, 2801 Atlantic Avenue, Long Beach, California 90806, at 9:00 a.m., November 5, 2010. Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 p.m. on October 25, 2010 or must be received at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Section 2018 of the Business and Professions Code, and to implement, interpret or make specific Sections 2088 and 2441 of said Code, the Board is considering changes to Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Adopt Sections 1315.50, 1315.53, and 1315.55 in Article 4.5 in Chapter 1 of Division 13 of Title 16, Cal. Code Regs, relating to the Limited Practice License.

The Limited Practice License does not exist in current regulation.

This proposal sets forth the requirements and criteria for the limited practice license. Legislation, AB 501, effective January 1, 2010, authorizes the Licensing Program to issue a limited practice 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. Parallel language was also prepared to ensure the limited practice license issuance criteria is consistent with the criteria for the current disabled status.

FISCAL IMPACT ESTIMATES

Fiscal Impact on Public Agencies Including Costs or Savings to State Agencies or Costs/Savings in Federal Funding to the State: None

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

Cost to Any Local Agency or School District for Which Government Code Section 17500-17630 Require Reimbursement: None

Business Impact: The Board has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

Impact on Jobs/New Businesses:

The Board has determined that this regulatory proposal will have a small impact on the creation of jobs given that it will allow a physician who may not be eligible for a full and unrestricted physician's and surgeon's medical license due to a disability the opportunity to apply for a limited practice license and practice medicine in California.

The Board has determined that this regulatory proposal will not have any impact on the creation of new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

Cost Impact on Representative Private Person or Business:

The Board is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

Effect on Housing Costs: None

EFFECT ON SMALL BUSINESS

The Board has determined that the proposed regulations would not affect small businesses. The Board does not license businesses, the Board licenses individuals; therefore, there is no impact on small businesses or any business.

CONSIDERATION OF ALTERNATIVES

The Board must determine that no reasonable alternative it considered to the regulation or that has otherwise been identified and brought to its attention would either be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposal described in this Notice. Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

INITIAL STATEMENT OF REASONS AND INFORMATION

The Board has prepared an initial statement of the reasons for the proposed action and has available all the information upon which the proposal is based. Copies of the initial statement of reasons and all of the information upon which the proposal is based may be obtained from the person designated in the Notice under Contact Person or by accessing the Board's website: http://medbd.ca.gov/laws/regulations_proposed.html.

TEXT OF PROPOSAL

Copies of the exact language of the proposed regulations and of the initial statement of reasons, and all of the information upon which the proposal is based, may be obtained at the hearing or prior to the hearing upon request from the person designated in this Notice under Contact Person or by accessing the Board's website:

http://www.medbd.ca.gov/laws/regulations_proposed.html.

AVAILABILITY AND LOCATION OF THE FINAL STATEMENT OF REASONS AND RULEMAKING FILE

All the information upon which the proposed regulations are based is contained in the rulemaking file which is available for public inspection by contacting the person named below.

You may obtain a copy of the final statement of reasons once it has been prepared, by making a written request to the contact person named below, or by accessing the Board's website:

http://www.medbd.ca.gov/laws/regulations_proposed.html.

CONTACT PERSON

Inquiries or comments concerning the proposed rulemaking action may be addressed to:

Name:	Fayne Boyd, Licensing Manager Medical Board of California
Address:	2005 Evergreen Street, Suite 1200 Sacramento, CA 95815
Telephone No.:	(916) 274-5983
Fax No.:	(916) 263-2487
E-Mail Address:	regulations@mbc.ca.gov

The backup contact person is:

Name:	Kevin A. Schunke Medical Board of California
Address:	2005 Evergreen Street, Suite 1200 Sacramento, CA 95815
Telephone No.:	(916) 263-2389
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

Website Access : Materials regarding this proposal can be found at:
http://www.medbd.ca.gov/laws/regulations_proposed.html.

MEDICAL BOARD OF CALIFORNIA
INITIAL STATEMENT OF REASONS

Hearing Date: November 5, 2010

Subject Matter of Proposed Regulations: Limited Practice License

Sections Affected: Adopt Sections 1315.50, 1315.53, and 1315.55 in Article 4.5, of Chapter 1, Division 13, of Title 16.

Introduction

Legislation, AB 501, effective January 1, 2010, authorizes the Licensing Program to issue a limited practice license to an applicant who is otherwise eligible for a medical license in California, but is unable to practice all aspects of medicine safely due to a disability. Regulatory proposal sets forth the requirements and criteria for a limited practice license. In preparing the regulatory language, staff also considered current licensees who wish to go into this status due to a disability affecting their ability to practice some aspects of medicine safely. Parallel language was also prepared to ensure the limited practice license is consistent with the criteria for the current disability license.

On May 26, 2010, the Medical Board of California (Board) held an Interested Parties Meeting to review and discuss the proposed regulatory language. Based on feedback received at the meeting and in writing, suggestions were incorporated into the revised limited practice license proposed regulations.

Specific Purpose of each adoption:

Adopt Section 1315.50 - This section defines the requirement for an independent clinical evaluation.

Factual Basis/Rationale:

- This section establishes the requirements for an applicant seeking a limited practice license and a current licensee who seeks a disabled license.
- The applicant is aware of his/her limitations and is choosing to apply for the limited practice license.
- Consumer protection is the highest priority of the Board; therefore, an independent clinical evaluation is necessary to ensure that an applicant is eligible for a limited practice license and can practice medicine safely under that license.
- The report submitted to the Board will allow the tailoring of the license to the specific circumstances of the applicant or licensee.

Adopt Section 1315.53 – This section defines the criteria for the reviewing physician conducting an independent clinical evaluation.

- The Board determined that the independent clinical evaluation should be performed by a physician who specializes in the diagnosis and/or treatment of the disability of the same nature as that of the applicant. This benefits the applicants by allowing them to research and choose a physician that specializes in the area of their disability. In addition, the Board is assured that the physician conducting the evaluation is specialized in the area of the disability and the recommendations made regarding the limits of practice are most appropriate for the applicant's needs.
- The Board is relying on an outside independent evaluation from a qualified California physician. To ensure an impartial review, the Board requires that the independent clinical evaluation be performed by a physician who has no personal, professional, or social relationship with the applicant.
- The Board determined that the physician who completes the independent clinical evaluation shall possess a current California license with no history of discipline. To ensure public protection, the independent clinical evaluation shall be conducted by a physician that has met all of the requirements to practice medicine in California and is free from any limitations.

Amend Section 1315.55 - This section defines the required contents of the independent clinical evaluation report.

Factual Basis/Rationale:

- The Board determined that in order to issue a limited practice license, the independent clinical evaluation would need to include sufficient information to allow the Board to make a determination of the applicant's ability to practice medicine safely. This section describes the contents of the report to be prepared by the evaluating physician and submitted by the applicant. By requiring that the evaluation be on the evaluating physician's letterhead and signed under penalty of perjury will provide the Board with confidence that the evaluation is bona fide. The required assessment of the applicant's or licensee's disability, his or her treatment protocols, and the suggested practice limitations will provide the Board with a mechanism to tailor the limitations of the license to the particular situation of the applicant or licensee. Finally, the sixty-day time limit ensures that the evaluation is recent enough to provide the Board with current information.

Underlying Data:

Technical, theoretical or empirical studies or reports relied upon (if any): None

Business Impact:

This regulation will not have a significant adverse economic impact on businesses. This initial determination is based on the following facts or evidence/documents/testimony:

This regulation only impacts persons applying to the Medical Board for a limited practice license.

The Board does not license businesses, the Board licenses individuals; therefore, the proposed regulation has no business or economic impact.

Specific Technologies or Equipment

This regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives

No reasonable alternative to the regulation would be either more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed regulation.

Set forth are the alternatives which were considered and the reasons each alternative was rejected:

- If the Board does not have a regulation allowing an applicant to apply for a limited practice license, applicants with disabilities that impact their ability to practice some aspect of medicine safely might continue to be ineligible for licensure in California, as the Board issues only a full and unrestricted medical license.

Applicants who have previously applied were unable to be licensed due to our lack of a limited practice license. Therefore, they were unable to be employed as a physician to provide care to patients, or work in underserved areas, or provide voluntary services in California.

MEDICAL BOARD OF CALIFORNIA
Limited Practice License
Specific Language

(1) Add Article 4.5 in Chapter 1 of Division 13 of Title 16, Cal.Code Regs, to read as follows:

1315.50. Requirement for Independent Clinical Evaluation

(a) This section applies both to applicants for an initial license and licensees who seek a limited practice license pursuant to Section 2441 of the code.

(b) An applicant for a limited practice license shall obtain and submit to the board with his or her application the report of an independent clinical evaluation that meets the requirements of this Article regarding the applicant's ability to practice medicine safely.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2088 and 2441, Business and Professions Code.

1315.53. Criteria for Reviewing Physician

The independent clinical evaluation shall be performed by a physician who specializes in the diagnosis and/or treatment of disabilities of the same nature as that of the applicant, who is familiar with the applicant's areas of medical practice, and who has no personal, professional, business, or social relationship with the applicant. The term "professional relationship" includes but is not limited to, a current or previous physician-patient relationship with the applicant. The reviewing physician shall possess a current valid California license with no history of discipline.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2088 and 2441, Business and Professions Code.

1315.55. Required Contents of Report.

(a) A report submitted pursuant to this Article shall:

(1) Be on the reviewing physician's letterhead, dated, and signed under penalty of perjury, and shall contain the original signature of the reviewing physician.

(2) Describe how the reviewer meets the criteria set forth in section 1315.53.

(3) Include the applicant's name and the diagnosis or description of the applicant's disability.

(4) Describe all recommended practice limitations and how those limitations permit the applicant to practice medicine safely.

(5) Provide suggested intervals between evaluations, if the disability is caused by a disease that will progress or fluctuate in severity.

(6) Indicate whether the evaluation included a review of the applicant's medical records related to the disability.

(7) Describe the current treatment protocol and the applicant's compliance with that treatment protocol, if appropriate for the type of disability.

(b) The evaluation shall have occurred not more than sixty (60) days from the date on which the application was filed with the board.

NOTE: Authority cited: Sections 2018, Business and Professions Code.
Reference: Sections 2088 and 2441, Business and Professions Code.



State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

AGENDA ITEM 18

Memorandum

Date: October 28, 2010
To: Board Members
From: Fayne Boyd, Licensing Manager
Subject: Hearings on Proposed Regulations Hearings – July 29, 2010

At the Board meeting on July 29, 2010, a hearing has been scheduled to consider proposed regulations. The public comment period for this hearing closed at 5:00 pm on October 25, 2010.

Limited Practice License, Agenda Item 18: No public comments were received.

TITLE 16. Medical Board of California

NOTICE IS HEREBY GIVEN that the Medical Board of California (hereinafter referred to as the "Board") is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held at Long Beach Memorial Hospital Miller Children's Hospital, 2801 Atlantic Avenue, Long Beach, California 90806, at 9:05 a.m., November 5, 2010. Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 p.m. on October 25, 2010 or must be received at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Section 2018, 163.5 and 3577 of the Business and Professions Code, and to implement, interpret or make specific Section 163.5 and 3577 of said Code, the Board is considering changes to Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Adopt Sections 1378.1, 1378.3, 1378.5, 1378.7, 1378.9, 1378.11, 1378.13, 1378.15, 1378.17, 1378.19, 1378.25, 1378.27, 1378.29, and 1378.35 in Article 1 of Chapter 3.5 of Division 13, relating to the Polysomnography Program.

The Polysomnography Program is not addressed in current regulation.

This proposal requires the Medical Board of California to implement Legislation, SB 132, effective October 23, 2009. This bill requires the Medical Board of California to adopt regulations within one year after the effective date of this act relative to the qualifications for certified polysomnographic technologists, technicians and trainees. SB132 prohibits a person from using the title "certified polysomnographic technologist" or engaging in the practice of polysomnography unless he or she is registered as a certified polysomnographic technologist in California.

These proposed regulations will establish the Polysomnography Program, including the application and registration requirements, required education and examinations, disciplinary actions, etc.

The application [FORM: PST – 1A (8/10)] and work experience verification [FORM: PST-1WEV (8/10)] are incorporated by reference.

FISCAL IMPACT ESTIMATES

Fiscal Impact on Public Agencies Including Costs or Savings to State Agencies or Costs/Savings in Federal Funding to the State: None

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

Cost to Any Local Agency or School District for Which Government Code Section 17561 Requires Reimbursement: None

Business Impact: The Board has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

Impact on Jobs/New Businesses:

The Board has determined that this regulatory proposal will not have a significant adverse economic impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

The regulation impacts those persons applying to the Medical Board of Polysomnography technologist, technician and trainees registration as well as those licensed physicians and surgeons who elect to supervise them.

The proposed regulation may create jobs in California as it prescribes a pathway for persons to become licensed in a health care field. Supervising physicians may hire registrants to provide these services.

Cost Impact on Representative Private Person or Business:

The Board is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

Effect on Housing Costs: None

EFFECT ON SMALL BUSINESS

The Board has determined that the proposed regulations would not affect small businesses. The Board does not license businesses, the Board licenses individuals; therefore, there is no impact on small businesses or any business.

CONSIDERATION OF ALTERNATIVES

The Board must determine that no reasonable alternative it considered to the regulation or that has otherwise been identified and brought to its attention would either be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposal described in this Notice. Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

INITIAL STATEMENT OF REASONS AND INFORMATION

The Board has prepared an initial statement of the reasons for the proposed action and has available all the information upon which the proposal is based. Copies of the initial statement of reasons and all of the information upon which the proposal is based may be obtained from the person designated in the Notice under Contact Person or by accessing the Board's website: http://medbd.ca.gov/laws/regulations_proposed.html.

TEXT OF PROPOSAL

Copies of the exact language of the proposed regulations and of the initial statement of reasons, and all of the information upon which the proposal is based, may be obtained at the hearing or prior to the hearing upon request from the person designated in this Notice under Contact Person or by accessing the Board's website: http://www.medbd.ca.gov/laws/regulations_proposed.html.

AVAILABILITY AND LOCATION OF THE FINAL STATEMENT OF REASONS AND RULEMAKING FILE

All the information upon which the proposed regulations are based is contained in the rulemaking file which is available for public inspection by contacting the person named below. You may obtain a copy of the final statement of reasons once it has been prepared, by making a written request to the contact person named below, or by accessing the Board's website: http://www.medbd.ca.gov/laws/regulations_proposed.html.

CONTACT PERSON

Inquiries or comments concerning the proposed rulemaking action may be addressed to:

Name:	Fayne Boyd, Licensing Manager Medical Board of California
Address:	2005 Evergreen Street, Suite 1200 Sacramento, CA 95815
Telephone No.:	(916) 274-5983
Fax No.:	(916) 263-2487
E-Mail Address:	regulations@mbc.ca.gov

The backup contact person is:

Name:	Kevin A. Schunke Medical Board of California
Address:	2005 Evergreen Street, Suite 1200 Sacramento, CA 95815
Telephone No.:	(916) 263-2389
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

Website Access : Materials regarding this proposal can be found at: http://www.medbd.ca.gov/laws/regulations_proposed.html.

MEDICAL BOARD OF CALIFORNIA

INITIAL STATEMENT OF REASONS

Hearing Date: November 5, 2010

Subject Matter of Proposed Regulations: Polysomnography Program

Sections affected: Adopt Sections 1378.1, 1378.3, 1378.5, 1378.7, 1378.9, 1378.11, 1378.13, 1378.15, 1378.17, 1378.19, 1378.25, 1378.27, 1378.29, and 1378.35, in Article 1, of Chapter 3.5, Division 13, of Title 16.

Introduction

Senate Bill (SB) 132, Denham, (Statutes of 2009) adding Chapter 7.8 to Division 2 of the Business and Professions Code, took effect as an urgency measure on October 23, 2009. SB 132 requires the Medical Board of California (Board or board) to adopt regulations within one year of the effective date of this act relative to the qualifications for certified polysomnographic technologists, including requiring those technologists to: be credentialed by a board-approved national accrediting agency; have graduated from a board-approved educational program; and, have passed a board-approved national certifying examination (with a specified exception for that examination requirement for a three-year period).

Additionally, SB 132 prohibits a person from using the title "certified polysomnographic technologist" or engaging in the practice of polysomnography unless: he or she undergoes a Department of Justice background check, as specified; is registered as a certified polysomnographic technologist; is supervised and directed by a licensed physician and surgeon; and meets other requirements. SB 132 also defines polysomnography to mean the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders. SB 132 further requires the board to adopt regulations related to the employment of polysomnographic technologists, technicians and trainees.

Specific Purpose of each adoption:

1. Section 1378.1 (Definitions) This section defines terms mentioned throughout the proposed regulations.

Factual Basis/Rationale:

After extensive research, contact with other State Medical Boards and after the Board's interested parties meeting, the Board has determined that the following accredited programs are acceptable to accredit educational programs of this registrant category, because the standards in place support the Board's mission of public protection and are sufficient to reflect the services to be provided by the registrant.

Polysomnographic Educational Programs:

- The Commission on Accreditation of Allied Health Education Programs (CAAHEP) is the largest programmatic accreditor in the health science field. CAAHEP relies on its committees to develop standards and qualifications necessary for accreditation. The standards for polysomnography technology educational programs include core curricula that address the safe and effective care and monitoring of the patient and the education must be offered in a setting with sufficient educational and oversight resources.
- The Commission on Accreditation for Respiratory Care (CoARC) is the sole nationally recognized authority for the accreditation of first professional degree programs in respiratory care. CoARC's accreditation standards include requirements for curricula that address the safe and effective treatment and monitoring of the patient, and the education must be offered in a setting with sufficient educational and oversight resources.

Sleep Technologist Program

- The American Academy of Sleep Medicine (AASM) is the only entity that sets standards in sleep medicine health care, education and research. The AASM's A-STEP educational programs consists of an 80-hour course on sleep and sleep related issues and patient care, and that course is followed by a fourteen module self-study session undertaken while an individual receives on-the-job polysomnographic training.

After extensive research, contact with other State Medical Boards and after the Board's interested parties meeting the Board has determined that the following program is acceptable to assess the professional competence of this registrant category because the standards in place support the Board's mission of public protection and are sufficient to reflect the services to be provided by the registrant.

Examination and Credentials

- The Board of Registered Polysomnographic Technologists (BRPT) assesses the professional competence of practitioners performing polysomnography and associated therapeutic interventions. BRPT's credentialing program is accredited by the National Commission of Certifying Agencies (NCCA). Currently, the BRPT is the only organization that certifies Polysomnographic Technologists and Technicians.

After extensive research, contact with other State Medical Boards and after the Board's interested parties meeting the Board has determined that the following program is acceptable to assess the professional competence of this registrant category. The requirements to sit for the BRPT certification examination include direct polysomnography patient care experience or graduation from an approved polysomnography educational program.

Supervising Physician and Surgeon. This definition was used to ensure that the physician and surgeon(s) supervising polysomnographic registrants have the necessary expertise and knowledge to properly monitor and direct the actions of the registrants.

“Board” means the Medical Board of California. This definition is used to promote readability and brevity.

“Code” means the Business and Professions Code. This definition is used to promote readability and brevity.

2. Section 1378.3 (Delegation of Functions) This section delegates the Executive Director as the responsible party for administering all functions of this program except for those reserved to the agency (here, the Board) itself.

Factual Basis/Rationale:

Per existing law, the Executive Director of the Board is charged with overseeing the day to day activities of Board operations. This section would authorize the Executive Director to carry out administrative tasks associated with the implementation and operation of the polysomnographic registration program. This section helps to provide smooth and efficient functioning and administration of the polysomnography registration program.

3. Section 1378.5 (Applications) This section is necessary to establish a standard and uniform application to be used for all registration categories. The applicant will provide the contact information on the application, this is necessary in order to interact with the applicant. Additionally, the remaining provisions establish the requirements needed for registration.

Factual Basis/Rationale:

Per SB 132, polysomnography registrants must complete an application to ensure they meet the necessary requirements for registration. The application requires the applicant to provide: name, social security number, contact information, educational information, current and/or previous examination and certification information, current and/or previous registration/licensure information, denials and conviction of crimes. Also, the application, through the work experience verification form, provides the Board with the necessary information regarding the applicant's previous experience in providing polysomnographic services under the supervision of a licensed physician. The application also requires a current photograph and requires that the application be notarized. The application is attached.

4. Section 1378.7 (Abandonment of Application) This section requires an applicant for registration to complete the requirements for registration within one year of the date the application is filed. If an application is submitted after a previous application was deemed abandoned, the Board will treat that application as a new application, meaning that the applicant will have to include the applicable fees.

Factual Basis/Rationale:

The Board currently licenses physicians and surgeons and it is the Board's experience that dormant licensing applications consume resources, as these applications must be retained in both electronic and paper formats. In addition, Board staff is obligated to re-review these applications periodically to determine if the applicant's status has changed and then contact the applicants to ask if they intend to pursue or complete registration in the near future. Without

setting a date by which the process must be completed, an applicant can call the Board and request that the file be kept open without making any progress toward actually satisfying the registration requirements. The one year period gives the applicant ample time to provide the documents necessary to complete the registration process. This one year period has been the Board's existing policy for many years.

5. Section 1378.9 (Examination) This section specifies the certifying examination approved by the Board and how, in lieu of the examination, the applicant can apply for registration prior to October 23, 2012.

Factual Basis/Rationale:

Applicants will be required to take a certifying examination offered by the Board of Registered Polysomnographic Technologists (BRPT), the only entity offering such an exam for certification as a Registered Polysomnographic Technologist or Technician. The BRPT assesses the professional competence of practitioners performing polysomnography and associated therapeutic interventions. The BRPT credentialing program is accredited by the National Commission of Certifying Agencies (NCCA). Currently the BRPT is the only organization that certifies Polysomnographic Technologists and Technicians.

However, as specified in SB 132, an applicant who applies for registration as a technologist before October 23, 2012, can substitute five years of polysomnographic experience in lieu of successfully completing the examination. To ensure an applicant has five years of safe polysomnographic practice, he or she must submit declarations from a supervising physician or letters of good standing from another state in which the applicant is registered or licensed.

6. Section 1378.11 (Registration Requirements) This section specifies the requirements that must be met to register as a polysomnographic technologist, technician and trainee.

Factual Basis/Rationale:

The Board has reviewed the laws of two other State Medical Boards (Maryland and New Mexico) who are currently licensing/registering polysomnographic technologists, technician and trainees. The Medical Board of California has imposed similar requirements sufficient to protect California consumers and promote the safe practice of polysomnography.

The basic level of registration, the trainee, requires that the applicant possess a Basic Life Support certification (BLS) issued by the American Heart Association. This item was brought up at an interested parties meeting and the Board was agreeable to this suggestion and believes it is necessary to ensure public protection as the trainee would be able to administer cardio pulmonary resuscitation to a patient if the circumstances warrant. Additionally, a trainee must have a high school diploma (or equivalent) and six months of supervised patient care or be currently enrolled in an approved polysomnographic education program to meet the requirements for registration in California. Finally, a trainee applicant must not be subject to denial for criminal conviction or other acts involving incompetence, negligence, fraud, or other misconduct. This requirement is essential for public protection.

Polysomnographic technicians shall meet the above requirements relating to the BLS certificate

and not be subject to denial for misconduct and have requirements for more stringent educational and experience. These requirements are more comprehensive because the scope of practice is greater for technicians. Technologist applicants must comply with the registration requirements in SB 132 and possess the BLS certificate.

7. Section 1378.13 (Employment and Supervision of Registrants) This section defines who may supervise registrants and specifies the number of registrants a physician and surgeon or other licensed health care professional may supervise. This section also specifies the availability of a supervising physician and surgeon and establishes the requirements for a technologist if he/she supervises other polysomnographic registrants. Finally, this section provides that a supervising physician and surgeon is not relieved from the responsibility of the patient's welfare by the delegation of procedures to a polysomnographic registrant or other licensed health care professional.

Factual Basis/Rationale:

During the Polysomnography interested parties meeting, the physician to technologist ratio was discussed. Members of the audience indicated that the industry standard is one technologist for every two patients. For a 16 bed facility, this would require eight technologists to be onsite. One physician would be on call and the technologists would report to the one physician. The American Academy of Sleep Medicine supports this ratio. The Board agreed that the ratio of one supervising physician to every eight technologists is appropriate and a necessary standard for consumer protection. This is the same ratio for a technologist to supervise trainees or technicians. The Board believes that the eight to one ratio will allow for the efficient provision of services while maintaining an adequate level of consumer protection. The last item – the continued responsibility of the physician and surgeon – serves to reinforce the concept that polysomnographic services must be provided under the supervision and direction of a licensed physician and surgeon.

8. Section 1378.15 (Scope of Services – Polysomnographic Trainee) This section is necessary to define the scope of practice for polysomnographic trainees.

Factual Basis/Rationale:

The American Academy of Sleep Medicine (AASM) sets standards in sleep medicine health care, education and research. Using guidelines supported by the AASM, it was determined that a polysomnographic trainee under the direct supervision of a physician and surgeon, technologist or other licensed health care provider may provide basic supportive services as part of the trainee's educational program. As the trainee has limited expertise and education, public protection dictates that the scope of practice is not overly broad.

9. Section 1378.17 (Scope of Services – Polysomnographic Technician) This section is necessary to define the scope of practice for polysomnographic technicians.

Factual Basis/Rationale:

The American Academy of Sleep Medicine (AASM) sets standards in sleep medicine health care, education and research. Using guidelines supported by the AASM, it was determined that

a polysomnographic technician may provide services under general supervision and may implement appropriate interventions necessary for patient safety. As a technician has more experience and education, the scope of services is expanded.

10. Section 1378.19 (Notice to Consumers) This section requires a notice be posted or provided to the consumer. This notice informs the consumer that the practice of polysomnography is regulated by the Medical Board of California.

Factual Basis/Rationale:

By law, public protection is the highest priority of the Board, and the public protection is enhanced when patients and other interested parties are made aware of the Board's existence at a time close to when polysomnographic services are provided.

Public protection is the highest priority of the Board whenever it exercises its regulatory authority. The Board has recently implemented a similar notification requirement for consumers regarding physicians and surgeons.

This proposed regulation also comports with the provisions of section 138 of the Business and Professions Code, which requires constituent boards within the Department of Consumer Affairs to promulgate regulations regarding notice that a practitioner is licensed by the state. The Medical Board is a constituent board of the Department.

11. Section 1378.25 (Substantial Relationship Criteria) This section establishes that the conviction of specified crimes shall serve as a basis for the denial, revocation, or suspension of a registration and defines these crimes as substantially related to the practice of polysomnography.

Factual Basis/Rationale:

Section 480 of the Business and Professions Code provide that a board with the Department of Consumer Affairs may deny, revoke, or suspend a license or registration if the applicant or licensee has been convicted of a crime substantially related to the licensed activity. This regulation defines those crimes. Prudent policy dictates that the public may not be served best by allowing a person convicted of a crime of physical violence, dishonesty, or sexual misconduct to provide these services, especially when the patient may be in a vulnerable situation or a remote location.

12. Section 1378.27 (Criteria for Rehabilitation for Denial and Reinstatement) This section establishes the criteria by which the Board evaluates the reinstatement of a revoked registration or considers the denial of a registration.

Factual Basis/Rationale:

The Board recognizes that applicants and licensees may have committed offenses in the past. This section sets the criteria for the Board to determine if issuing a registration or reinstating a registration is inconsistent with or contrary to the public interest. The standard of evaluating the reinstatement of a revoked registration or the denial of a registration is set forth in Title 16 of the

California Code of Regulations. This criteria will allow the Board to determine if the individual has been sufficiently rehabilitated such that he or she may provide polysomnographic services safely.

13. Section 1378.29 (Rehabilitation Criteria for Suspensions and Revocations) This section establishes the process when the Board is considering the suspension or revocation of a registration based upon the conviction of a crime.

Factual Basis/Rationale:

The Board recognizes that applicants and licensees may have committed offenses in the past. This section sets the criteria for the Board to determine if issuing a registration or reinstating a registration is inconsistent with or contrary to public interest. The standard of considering the suspension or revocation of a registration is set forth in Title 16 of the California Code of Regulations. This criteria will allow the Board to determine if the individual has been sufficiently rehabilitated such that he or she may provide polysomnographic services safely.

14. Section 1378.35 (Fees) This section establishes different types of fees for this registration category.

Factual Basis/Rationale:

Since this is a new registration category for the Board, a fund has to be established to administer this registration program. The \$100.00 application fee will be used to defray the cost of time it will take the office staff to process the application for completeness and ensure the applicant has submitted all the documents needed to qualify the applicant for registration in California. The \$100.00 registration fee will be used to defray the cost of registration cards and to defray that cost of office staff to process the registration. The \$175.00 renewal fee will ensure the continued administration of the polysomnography registration program. The maximum fees were imposed, and adhere to the guidelines of SB 132, to ensure this new registration program has funds to administer the program as well as funds to develop the Applicant Tracking System, the Consumer Affairs System, enforce the law and to ensure the program has a reserve for economic uncertainties.

Underlying Data:

Technical, theoretical or empirical studies or reports relied upon (if any): Information from the American Academy of Sleep Medicine (AASM); Commission on Accreditation of Allied Health Education Programs (CAAHEP); Commission on Accreditation for Respiratory Care (CoARC); Board of Registered Polysomnographic Technologists (BRPT); California Sleep Society; New Mexico Medical Board; Louisiana State Medical Board; Maryland State Medical Board; and the June 16, 2010, interested parties meeting.

Business Impact:

This regulation will not have a significant adverse economic impact on businesses. This initial determination is based on the following facts or evidence/documents/testimony:

The regulation impacts those persons applying to the Medical Board for polysomnography technologist, technician and trainee registration as well as those licensed physicians and surgeons who elect to supervise them.

The proposed regulation may create jobs in California as it prescribes a pathway for persons to become licensed in a health care field. Supervising physicians may hire registrants to provide these services.

Specific Technologies or Equipment

This regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives

No reasonable alternative to the regulation would be either more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed regulation.

Set forth below are the alternatives that were considered and the reasons each alternative was rejected:

- No alternative was considered as the law requires polysomnographic technologist, polysomnographic technicians and polysomnographic trainees be regulated by the State of California.

MEDICAL BOARD OF CALIFORNIA
Polysomnography Program
Specific Language

Add Chapter 3.5 to Division 13 of Title 16, California Code of Regulations, to read as follows:

Chapter 3.5. Polysomnography

Article 1. General Provisions

1378.1. Definitions.

For the purposes of the regulations contained in this chapter and for purposes of Chapter 7.8 of Division 2 (commencing with section 3575) of the code:

(a) "Approved polysomnographic education program" means (1) a polysomnographic education program accredited either by the Commission on Accreditation of Allied Health Education Programs ("CAAHEP") or by the Commission on Accreditation for Respiratory Care; or (2) a sleep technologist program accredited by the American Academy of Sleep Medicine.

(b) "Board" means the Medical Board of California.

(c) "Code" means the Business and Professions Code.

(d) "National certifying examination" means the examination given by the Board of Registered Polysomnographic Technologists.

(e) "Polysomnography registrant" includes any person registered as a trainee, technician or technologist under this chapter.

(f) "Supervising physician and surgeon" means physician and surgeon who holds a valid license in California and who (1) possesses a current certification or subspecialty certification or is eligible for such a certification in sleep medicine by a member board of the American Board of Medical Specialties ("ABMS") or the American Board of Sleep Medicine ("ABSM"); or (2) holds active staff membership at a sleep center or laboratory accredited by the American Academy of Sleep Medicine or by the Joint Commission.

(g) "Valid, current credentials as a polysomnographic technologist issued by a national accrediting agency approved by the board" means current valid registration as a polysomnographic technologist issued by the Board of Registered Polysomnographic Technologists.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575, Business and Professions Code.

1378.3. Delegation of Functions.

Except for those powers reserved exclusively to the "agency itself" or for the adoption of stipulated settlements under the Administrative Procedure Act (Section 11500 et seq. of the Government Code), the board delegates and confers upon the executive director of the board, or his/her designee, all functions necessary to the dispatch of business of the board in connection with investigative and administrative proceedings under the jurisdiction of the board.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

Article 2. Applications

1378.5. Application for Registration as a Polysomnographic Technologist, Technician or Trainee.

An application for registration as a polysomnographic technologist, technician, or trainee shall be filed with the board at its principal office on the prescribed application form [PST – 1A (8/10)], which is incorporated by reference. The application shall be accompanied by such evidence, statements or documents as therein required and filed with the fee required by section 1378.35.

NOTE: Authority cited: Sections 2018 and 3577, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

1378.7. Abandonment of Applications.

An applicant shall be deemed to have abandoned an application if he or she does not complete the requirements for registration within one year from the date on which the application was filed. An application submitted subsequent to an abandoned application shall be treated as a new application.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

Article 3. Qualifications for Registration

1378.9. Examination

(a) The certification examination offered by the Board of Registered Polysomnographic Technologists is approved by the board for purposes of qualifying for registration pursuant to Chapter 7.8 of Division 2 of the code:

(b) An applicant who applies for registration as a polysomnographic technologist on or before October 22, 2012, may, in lieu of successful completion of the examination

approved by the board, submit any of the following as proof that the applicant has been practicing polysomnography safely for at least five years:

(1) One or more declarations under penalty of perjury by a supervising physician attesting to the period of time the physician supervised the applicant, the tasks performed by the applicant, and the applicant's ability to practice polysomnography safely.

(2) A letter of good standing from each state in which the applicant is registered or licensed.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

1378.11. Registration Requirements.

(a) Polysomnographic Trainee. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic trainee shall meet the following requirements:

(1) Not be subject to denial under Section 3576 of the code; and

(2) Have either (A) a high school diploma or GED and six months of supervised direct polysomnographic patient care experience; or (B) be currently enrolled in an approved polysomnographic education program; and

(3) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

(b) Polysomnographic Technician. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic technician shall meet the following requirements:

- (1) Not be subject to denial under Section 3576 of the code; and
- (2) Have successfully completed an approved polysomnographic education program;
and
- (3) Possess a minimum of six months experience as a registered polysomnographic trainee; and
- (4) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

(c) Polysomnographic Technologist. An applicant for registration as a polysomnographic technologist shall meet the requirements set forth in Sections 3575 and 3576 of the code and shall possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

Article 4. Polysomnography Practice

1378.13. Employment and Supervision of Registrants.

(a) A physician and surgeon who does not meet one of the requirements set forth in section 1378.1(e) shall not supervise polysomnography registrants . No physician and surgeon shall supervise more than eight polysomnographic technologists at any one time. A physician and surgeon shall comply with the supervision requirement of Section 3575(a) of the code.

(b) A supervising physician and surgeon, supervising polysomnographic technologist or other licensed health care professional shall not supervise more than a total of eight polysomnographic technicians and/or trainees at any one time. If a supervising

physician and surgeon is not physically present on the premises, a supervising polysomnographic technologist or other licensed health care professional shall be physically present on the premises and available to the polysomnographic technicians and/or trainees under his/her supervision. For purposes of this section, "other licensed health care professional" means registered nurse, physician assistant and respiratory care practitioner who possesses a current California license.

(c) A supervising polysomnographic technologist and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision by the technologist of polysomnographic technicians and trainees. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the technicians and trainees. Protocols shall be signed and dated by the supervising physician and surgeon and the polysomnographic technologist.

(d) The delegation of procedures to a registrant or other licensed health care professional shall not relieve the supervising physician of primary continued responsibility for the welfare of the patient.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

1378.15. Scope of Services—Polysomnographic Trainee.

Under the direct supervision of a supervising physician and surgeon, polysomnographic technologist or other licensed health care professional, a polysomnographic trainee may provide basic supportive services as part of the trainee's educational program, including but not limited to gathering and verifying patient information, testing preparation and

monitoring, documenting routine observations, data acquisition and scoring, and assisting with appropriate interventions for patient safety.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

1378.17. Scope of Services—Polysomnographic Technician.

A polysomnographic technician may perform the services described in section 1378.15 under general supervision and may implement appropriate interventions necessary for patient safety.

NOTE: Authority cited: Sections 2018 and 3575, Business and Professions Code. Reference: Section 3575-3577, Business and Professions Code.

1378.19 . Notice to Consumers.

(a) A polysomnography registrant shall provide notice to each patient of the fact that the person is registered and regulated by the board. The notice shall include the following statement and information:

NOTICE TO CONSUMERS

Medical doctors and polysomnographic technologists,
technicians, and trainees are licensed and regulated

by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

(b) The notice required by this section shall be provided by one of the following methods:

(1) Prominently posting the notice in an area visible to patients on the premises where the registrant provides the services for which registration is required, in which case the notice shall be in at least 48-point type in Arial font.

(2) Including the notice in a written statement, signed and dated by the patient or the patient's representative and retained in that patient's medical records, stating the patient understands the polysomnographic registrant is registered and regulated by the board.

(3) Including the notice in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in at least 14-point type.

NOTE: Authority cited: Section 2018, Business and Professions Code; Reference: Sections 138 and 680, Business and Professions Code.

Article 5. Enforcement

1378.25. Substantial Relationship Criteria.

For the purpose of denial, suspension, or revocation of the registration of a polysomnography registrant pursuant to Division 1.5 (commencing with Section 475) of the code, a crime or act shall be considered substantially related to the qualifications, functions, and duties of a polysomnographic registrant if to a substantial degree it evidences present or potential unfitness of a polysomnographic registrant to perform the functions authorized by his or her registration in a manner consistent with the public health, safety, or welfare. Such crimes or acts shall include, but not be limited to, those involving the following:

(a) Violating or attempting to violate, directly or indirectly, or assisting or abetting the violation of or conspiring to violate any provision or term of Chapter 7.8 of Division 2 of

the code.

(b) Conviction of a crime involving fiscal dishonesty, or theft.

(c) Battery or assault

(d) Sexual misconduct or abuse.

(e) Conviction of a crime involving lewd conduct, prostitution or solicitation thereof, or pandering and/or indecent exposure, as defined by the Penal Code.

Note: Authority cited: Sections 481 and 2558, Business and Professions Code.

Reference: Sections 481, 2555.1 and 2556, Business and Professions Code.

1378.27. Criteria for Rehabilitation for Denial and Reinstatement

When considering the denial of a registration under Section 480 of the code, or a petition for reinstatement under Section 11522 of the code, the board in evaluating the rehabilitation of the applicant and his or her present eligibility for registration, shall consider the following criteria:

(a) The nature and severity of the act(s) or crime(s) under consideration.

(b) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration which also could be considered as grounds for denial under Section 480 of the Business and Professions Code.

(c) The time that has elapsed since commission of the act(s) or crime(s) referred to in subdivision (a) or (b).

(d) The extent to which the applicant or petitioner has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against him or her.

(e) Evidence, if any, of rehabilitation submitted by the applicant or petitioner.

Note: Authority cited: Sections 482, 2018, and 3576, Business and Professions Code.
Reference: Sections 482, 3576, Business and Professions Code.

1378.29. Rehabilitation Criteria for Suspensions and Revocations.

When considering the suspension or revocation of a registration on the grounds that the registrant has been convicted of a crime, the board, in evaluating the rehabilitation of such person and his or her present eligibility for a registration, shall consider the following criteria:

(a) Nature and severity of the act(s) or offense(s).

(b) Total criminal record.

(c) Extent of time that has elapsed since commission of the act(s) or offense(s).

(d) Whether the registrant has complied with any or all terms of parole, probation, restitution or any other sanctions lawfully imposed against the registrant.

(e) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

(f) Evidence, if any, of rehabilitation submitted by the registrant.

Note: Authority cited: Sections 482 and 3576, Business and Professions Code.
Reference: Sections 482, 3576, Business and Professions Code.

Article 6. Fees.

1378.35. Fees.

The polysomnography registrant fees are fixed as follows:

(a) The application fee shall be \$100.00.

(b) The registration fee shall be \$100.00.

(c) The biennial renewal fee shall be \$150.00.

(d) The delinquency fee shall be \$75.00.

NOTE: Authority cited: Sections 163.5, 2018 and 3577, Business and Professions Code. Reference: Section 163.5 and 3577, Business and Professions Code.



MEDICAL BOARD OF CALIFORNIA
Licensing Program



POLYSOMNOGRAPHY REGISTRATION APPLICATION

CHECK ONE: Technologist Technician Trainee

1. Name:		Last	First	Middle
2. Other names you have used: (include maiden name)			3. U.S. Social Security Number:	
4. Date of Birth:	5. Gender:		6. E-mail Address (voluntary):	
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
7. Public/Mailing Address: (Please note: This information is public. If you are using a Post Office Box you must provide a confidential street address in box 8.)				
8. Confidential Address: (This information will not be released to the public.)				
9. Telephone Numbers: (Include area code)				
Home: ()		Work: ()		Cell: ()
10. Have you ever filed an Application for Polysomnography Registration in California? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Previous license number, if any: _____				
EDUCATION				
11. Are you a High School Graduate?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If you are not a High School Graduate did you receive your GED?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Graduation/Date Received GED: _____				
12. College/Universities/Professional Schools: Please list names and addresses of colleges/universities/professional schools attended:				
School Name	Address	City State	Dates of Attendance	Degree Awarded

EXAMINATION/CERTIFICATION

13. List all examinations and certifications: CPSGT, RPSGT, A-Step, Basic Life Support, or other Board approved examination/certification. If you have not passed a qualifying examination clearly document your work experience on the attached Form PST-1WEV (8/10).

Examination/Certification	Date	Result (Pass/Fail)

REGISTRATION/LICENSURE

14. Have you ever been licensed or registered to practice polysomnography or other healing art in another state/country?

Yes No

State or Country	License Number	Date of Issuance	Date of Expiration

APPLICANT ADVISORY: For any affirmative response to the questions on this page of the application, please provide official documentation regarding the matter, in addition to signed and dated written explanations. If applicable, an applicant should also provide official hearing/court documents. Applicants are also required to report any matter that is "Pending" or in which the charges have been dropped or expunged.

15. Have you ever been charged with, or been found to have committed unprofessional conduct, incompetence, gross negligence, or repeated negligent acts by any other licensing jurisdiction, surrendered a license with charges pending, or have any disciplinary action ever filed or taken regarding any healing arts license which you now hold or have ever held, or is any such action pending?

Yes No

16. Have you ever been denied a license, permission to practice polysomnography, or any other healing art in this or any other state, or is any such action pending?

Yes No

17. Have you ever been convicted of, or *pled nolo contendere* to ANY offense in any state in the United States or foreign Country?

This includes a citation, infraction, misdemeanor and/or felony, etc. Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 **MUST** be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you **MUST** disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence or alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked **MUST** be reported. This list is not all-inclusive. If in doubt, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a signed and dated descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants, who answer "NO" to the question but have a previous conviction or plea, may have their application denied or registration revoked for knowingly falsifying the application.

Yes No

PHOTO AREA
PASTE A PASSPORT TYPE PHOTO
HERE.

PHOTO MUST BE RECENT AND MUST
BE OF YOUR HEAD AND SHOULDER
AREAS ONLY WITH A CLEAR VIEW
OF FACE.

ALTERED PHOTOS ARE NOT
ACCEPTABLE.

NOTICE: All ITEMS IN THIS APPLICATION ARE MANDATORY, NONE ARE VOLUNTARY unless specified otherwise. Failure to provide any of the requested information may result in a delay in processing, or the application may be rejected as incomplete. The information provided will be used to verify and identify the applicant per Section 118 and 2081 of the Business & Professions Code. Applicant's have the right to review their application, subject to the provisions of the Information Practices Act. The Chief, Division of Licensing, is the Custodian of Records. Disclosure of your Social Security Number (SSN) or Federal Employer Identification Number (FEIN) is MANDATORY. Section 30 of the Business & Professions Code and Public Law 94 445 (42 USC 405(c) (2)(C) authorizes the collection of your SSN. Your SSN or FEIN will be used for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Family Code Section 17520, or for verification of licensure or examination status by a licensing examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or FEIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you. This application and the information contained therein may be disclosed pursuant to California Public Records Act Request.

APPLICANT DECLARATION, SIGNATURE & NOTARY

State of _____

County of _____

The applicant, _____, being first duly sworn upon his/her oath, disposes and says, that I am the person herein named and subscribing to this application; that I have read the complete application, know the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; were not procured with fraud or misrepresentation or any mistake of which the applicant is aware. Further, I hereby authorize all institutions or organization, my references, and all government agencies (local, state, federal or foreign) to release to the Medical Board of California or its successors any information, files, or records required by that Board in connection with this application; or my ability to safely engage in the practice of polysomnography. I further authorize the Medical Board of California or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent registration. I FURTHER UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS SUFFICIENT BASIS FOR DENYING OR REVOKING A REGISTRAION, IF ISSUED.

Signature of Applicant _____

Subscribed and sworn (or affirmed) before me on this _____ day of _____, 20 _____
by (applicant's name) _____, personally known to me or
proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL HERE

SIGNATURE OF NOTARY PUBLIC



MEDICAL BOARD OF CALIFORNIA

Licensing Program



WORK EXPERIENCE VERIFICATION

I am applying for Registration as a Polysomnographic Technologist/Technician/Trainee in the State of California. The Medical Board of California requires this form to be completed by the Supervising Physician. I hereby authorize release of all information in your files, favorable or otherwise.

Applicant Name:		Telephone Number:	
Address:	City:	State:	ZIP Code:
Signature of Applicant:			

THE SECTIONS BELOW MUST BE COMPLETED BY THE SUPERVISING PHYSICIAN

Name and Title of Person Completing this Form:		Telephone Number:	
Facility Name:			
Address:	City:	State:	ZIP Code:
Physician License Number: _____		State of Licensure: _____	

EVALUATION OF APPLICANT

Dates of Employment: Beginning (Month/Year) _____ Ending (Month/Year) _____

1. In your opinion, is this applicant able to practice polysomnography safely? Yes No

If you answered "NO" please provide a signed and dated written explanation and any supporting documentation that may be relevant.



State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

AGENDA ITEM 19

Memorandum

Date: October 28, 2010
To: Board Members
From: Fayne Boyd, Licensing Manager
Subject: Hearings on Proposed Regulations Hearings – July 29, 2010

At the Board meeting on July 29, 2010, a hearing has been scheduled to consider proposed regulations. The public comment period for this hearing closed at 5:00 pm on October 25, 2010.

Polysomnography Program, Agenda Item 19: Seven letters were received in a timely manner..

A. Changes to Section 1378.1 were submitted by the California Sleep Society, California Society for Respiratory Care, and the California Hospital Association.

1. Amend 1378.1 (a) (2).
2. Amend 1378.1 (e).
3. Clarify Section 1378.1 (d).
4. Amend Section 1378.1 (d) (g) (f).

B. Changes to Section 1378.13 were submitted by the California Sleep Society, Respiratory Care Board of California and the California Hospital Association.

1. Amend Section 1378.13 (b).
2. Modify Section 1378.13.
3. Amend Section 1378.13 (b).
4. Amend Section 1378.13.
5. Amend Section 1378.13 (c).
6. Amend Section 1378.13 (b).

**KAISER PERMANENTE®**Via Email: regulations@mbc.ca.gov

October 25, 2010

Ms. Fayne Boyd
Licensing Manager
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

RE: Polysomnography Program Proposed Regulations

Dear Ms. Boyd:

On behalf of Kaiser Foundation Health Plan, Inc. (“the Plan”), Kaiser Foundation Hospitals, The Permanente Medical Group (“TPMG”), and the Southern California Permanente Medical Group (“SCPMG”) (collectively “Kaiser Permanente”) I am submitting comments regarding the proposed regulations for the Polysomnography Program. Kaiser Foundation Hospitals owns and operates licensed health facilities. Throughout California, the Plan contracts with Kaiser Foundation Hospitals to provide hospital services to its members and with SCPMG and TPMG to provide medical services to its members in Southern and Northern California, respectively. As multi-specialty group practices, SCPMG and TPMG take direct responsibility for organizing and providing the professional medical care that Plan members receive.

Kaiser Permanente acknowledges and appreciates the efforts made by the Medical Board of California in developing regulations to establish the Polysomnography Program. We agree that the public interest requires the regulation of the practice of polysomnographers and the establishment of clear licensure standards for practitioners of polysomnography. The recommendations provided below are meant to further clarify and strengthen the proposed regulations to ensure the California standards are sufficient to protect consumers and support the safe practice of polysomnography.

The following are comments, suggestions, and or requests for clarification made by the Plan. Excerpts from the proposed regulations are included in bold-italic text while the Plan’s recommended changes are included as underlined text.

Comment 1

The Plan believes the intent of these regulations is to ensure that licensed staff, other than Respiratory Therapists (RT's), working with patients in either an ambulatory or overnight sleep lab have sufficient knowledge and skills to safely perform the tasks required in this type of clinical setting. While SB 132 (Denham), later codified as Business and Professions Code sections 3575–3579, and section 3709 exclude Respiratory Therapists (RTs) from the Medical Board's proposed regulations, the Plan recommends adding the following clarifying section and language:

Recommendation:1378.2 Applicability

These regulations do not apply to California licensed allied health professionals, including, but not limited to, respiratory care practitioners, working within the scope of practice of their license.

Comment 2

The Plan recommends adding a definition for the term “appropriate interventions for patient safety.”

Recommendation:

“Appropriate interventions for patient safety” is defined, but not limited to, the administration of (1) CPAP therapy, (2) Bi-level PAP therapy, (3) oxygen therapy, or (4) other similar respiratory-related therapies.

Comment 3*1378.9. Examination*

(a) The certification examination offered by the Board of Registered Polysomnographic Technologists is approved by the board for purposes of qualifying for registration pursuant to Chapter 7.8 of Division 2 of the code:

(b) An applicant who applies for registration as a polysomnographic technologist on or before October 22, 2012, may, in lieu of successful completion of the examination approved by the board, submit any of the following as proof that the applicant has been practicing polysomnography safely for at least five years:

(1) One or more declarations under penalty of perjury by a supervising physician attesting to the period of time the physician supervised the applicant, the tasks performed by the applicant, and the applicant's ability to practice polysomnography safely.

(2) A letter of good standing from each state in which the applicant is registered or licensed.

Although the Plan supports some level of grandfathering, we have concerns that the approach taken in the proposed regulations is insufficient to achieve an acceptable standard of care. It is not in the public's best interest to allow temporary licenses for these types of professionals for an undefined amount of time. As written, a technician that is unable to pass the exam could be eventually grandfathered into the program, even if they did not possess the minimum requisite clinical judgment to adequately perform these duties. Although documented experience performing polysomnography related tasks safely is important, alone it is inadequate proof that the technician possesses the level of expertise needed to ensure safe practices.

Recommendation:

1378.9. Examination

(a) The certification examination offered by the Board of Registered Polysomnographic Technologists is approved by the board for purposes of qualifying for registration pursuant to Chapter 7.8 of Division 2 of the code:

(b) An applicant who applies for registration as a polysomnographic technologist on or before October 22, 2012, may, in lieu of successful completion of the examination approved by the board, obtain a Transitional Certification by submitting any of the following as proof that the applicant has been practicing polysomnography safely for at least five years:

(1) One or more declarations under penalty of perjury by a supervising physician attesting to the period of time the physician supervised the applicant, the tasks performed by the applicant, and the applicant's ability to practice polysomnography safely.

(2) A letter of good standing from each state in which the applicant is registered or licensed.

The Transitional Certification is a registration granted under 1378.9(b), and shall expire on the earlier of two years from issuance or October 22, 2012. A Transitional Certification can only be renewed by meeting the requirements of 1378.9(a) and 1378.11.

Comment 4

1378.11. Registration Requirements.

(a) Polysomnographic Trainee. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic trainee shall meet the following requirements:

(1) Not be subject to denial under Section 3576 of the code; and

(2) Have either (A) a high school diploma or GED and six months of supervised direct polysomnographic patient care experience; or (B) be currently enrolled in an approved polysomnographic education program; and

(3) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

Recommendation:

1378.11. Registration Requirements.

(a) Polysomnographic Trainee. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic trainee shall meet the following requirements:

(1) Not be subject to denial under Section 3576 of the code; and

~~(2) Have either (A) a high school diploma or GED and six months of supervised direct polysomnographic patient care experience; or (B) be currently enrolled in an approved polysomnographic education program; and~~

(2) Be currently enrolled in an accredited polysomnographic education program. Prior to October 22, 2012, applicant can have a high school diploma or GED and twelve months of supervised direct polysomnographic patient care experience in lieu of current enrollment in an accredited polysomnographic education program;
and

(3) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

Comment 5*1378.11. Registration Requirements.*

(b) Polysomnographic Technician. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic technician shall meet the following requirements:

(1) Not be subject to denial under Section 3576 of the code; and

(2) Have successfully completed an approved polysomnographic education program; and

(3) Possess a minimum of six months experience as a registered polysomnographic trainee; and

(4) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

Recommendation:

(b) Polysomnographic Technician. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic technician shall meet the following requirements:

(1) Not be subject to denial under Section 3576 of the code; and

(2) Have successfully completed an approved accredited polysomnographic education program (or possess a minimum of 12 months of supervised direct polysomnographic patient care experience prior to October 22, 2012);

~~(3) Possess a minimum of 12 months experience as a registered polysomnographic trainee; and~~

(4 3) Possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

Comment 6***1378.15. Scope of Services – Polysomnographic Trainee.***

Under the direct supervision of a supervising physician and surgeon, polysomnographic technologist or other licensed health care professional, a polysomnographic trainee may provide basic supportive services as part of the trainee's educational program, including but not limited to gathering and verifying patient information, testing preparation and monitoring, documenting routine observations, data acquisition and scoring, and assisting with appropriate interventions for patient safety.

As written, this section could create unintended consequences by requiring a physician and a surgeon to be present in order to supervise a polysomnographic trainee, while a polysomnographic technologist or other licensed health care professional could do so alone. The Plan believes it is in the best interest of public safety to ensure an appropriate level of supervision for both trainees and technicians.

Recommended language**1378.15. Scope of Services – Polysomnographic Trainee.**

Under the direct supervision of a supervising physician ~~and~~ or surgeon, polysomnographic technologist or other licensed health care professional, a polysomnographic trainee may provide basic supportive services as part of the trainee's educational program, including but not limited to gathering and verifying patient information, testing preparation and monitoring, documenting routine observations, data acquisition and scoring, and assisting with appropriate interventions for patient safety, in the presence, and under the supervision, of a licensed respiratory therapist.

Comment 7***1378.17. Scope of Services – Polysomnographic Technician.***

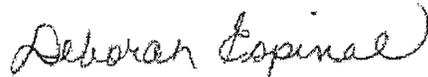
A polysomnographic technician may perform the services described in section 1378.15 under general supervision and may implement appropriate interventions necessary for patient safety.

Recommended language**1378.17. Scope of Services – Polysomnographic Technician.**

A polysomnographic technician may perform the services described in section 1378.15 under general supervision and may assist with appropriate interventions necessary for patient safety in the presence, and under the supervision, of a licensed respiratory therapist.

Kaiser Permanente appreciates the opportunity to provide comments to the proposed regulations specific to the polysomnography program. Should you have any questions or concerns regarding these comments, or need further information, please do not hesitate to contact me at (510) 627-2625.

Sincerely,

A handwritten signature in cursive script that reads "Deborah Espinal".

Deborah Espinal
Executive Director, Health Plan Policy
Kaiser Foundation Health Plan, Inc.



MARK B HORTON, MD, MSPH
Director

State of California—Health and Human Services Agency
California Department of Public Health



ARNOLD SCHWARZENEGGER
Governor

October 25, 2010

Fayne Boyd, Licensing Manager
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Dear Ms. Boyd:

RE: Comment on proposed regulation adding Chapter 3.5 to Division 13 of Title 16, California Code of Regulations (Polysomnography)

The Licensing & Certification Program (L&C) of the California Department of Public Health (CDPH) provides the following comments in this rulemaking action.

CDPH's L&C Program functions as an enforcement and regulatory agency and is responsible for licensing approximately 30 different types of health care facilities and providers so they may legally operate in California. L&C also certifies health care facilities and providers to be eligible for payment under the Medicare and Medicaid programs.

CDPH's comments are primarily in the context of its role of enforcing patient safety and care standards in its regulated facilities. Sleep labs that operate as an outpatient service under a general acute care hospital license (GACH) are an example of a CDPH facility in which polysomnography may be practiced. These sleep labs must also comply with GACH statutes and regulations enforced by CDPH.

Existing regulations applicable to sleep labs in a GACH state that a registered nurse shall directly provide ongoing patient assessments. These patient assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. (Title 22, California Code of Regulations (CCR), Section 70215(a)(1)).

CCR Title 22, Section 70529(c) requires that a registered nurse be responsible for the nursing service in the outpatient service. In addition, federal regulations state "a registered nurse must supervise and evaluate the nursing care for each patient." (Title 42 Code of Federal Regulations (CFR) Section 482.23 (b)(3)).

CDPH suggests that the proposed regulation include a provision clarifying that polysomnographic technologists, technicians, trainees and other licensed health care professionals practicing polysomnography in a health care facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code are subject to laws governing these facilities.

Proposed Section 1378.13(b) of the proposed regulation states:

A supervising physician and surgeon, supervising polysomnographic technologist or other licensed health care professional shall not supervise more than a total of eight polysomnographic technicians and/or trainees at any one time. If a supervising physician and surgeon is not physically present on the premises, a supervising polysomnographic technologist or other licensed health care professional shall be physically present on the premises and available to the polysomnographic technicians and/or trainees under his/her supervision. For purposes of this section, other licensed health care professional means registered nurse, physician assistant and respiratory care practitioner who possesses a current California license.

This provision could potentially make RNs in GACH outpatient sleep labs responsible for the supervision of polysomnographic technicians and/or trainees when a supervising physician and surgeon or supervising polysomnographic technologist is not available on the premises.

The provision also presents a potential problem because RNs typically make rounds elsewhere on GACH premises without physically standing present next to polysomnographic patients in the outpatient unit. Accordingly, MBC should more precisely define "premises" in the proposed regulation. Similarly, MBC should also more precisely define "available to the polysomnographic technicians and/or trainees under his/her supervision."

Another concern is the use of the term "adequate supervision" referenced at Section 1378.13(c):

A supervising polysomnographic technologist and his or her supervising physician and surgeon shall establish written guidelines for the **adequate supervision** by the technologist of polysomnographic technicians and trainees.

What constitutes "adequate" supervision? Since this term is not defined, the regulation should include specific standards for adequacy of supervision.

Fayne Boyd
Medical Board of California
Page 3
October 25, 2010

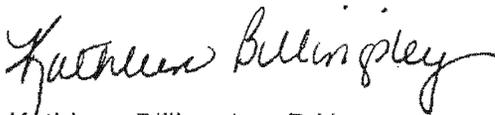
Section 1378.13 (b) allows a supervising polysomnographic technologist to stand in place of a supervising physician and surgeon not physically present on the premises. But nowhere does the proposed regulation define the qualifications, role and responsibilities of supervising polysomnographic technologists. This should be specified for polysomnographic technologists as well as "other licensed health professionals" who supervise polysomnographic technicians and trainees.

Proposed Section 1378.17 on "Scope of Services" states that a polysomnographic technician "may perform the services described in section 1378.15 under general supervision and may implement appropriate interventions necessary for patient safety."

CDPH is concerned that with this provision is a rather vague and potentially overbroad description of the polysomnographic technician scope of practice. Aside from having a certificate in Basic Life Support, how is it determined that a polysomnographic technologist or technician is qualified to make such interventions?

CDPH appreciates the opportunity to comment on these proposed regulations.

Sincerely,

A handwritten signature in cursive script that reads "Kathleen Billingsley".

Kathleen Billingsley, R.N.
Deputy Director



CALIFORNIA
HOSPITAL
ASSOCIATION

*Providing Leadership in
Health Policy and Advocacy*

October 25, 2010

Fayne Boyd
Licensing Manager
Medical Board of California
2005 Evergreen Street
Suite 1200
Sacramento, CA 95815

Re: Proposed Regulations – Polysomnography Program

Dear Ms. Boyd:

The California Hospital Association, representing over 400 general acute, long term care, and specialty hospitals throughout California, welcomes the opportunity to comment on proposed regulations for the Polysomnography Program as promulgated by the Medical Board of California under the authority of California Business and Professions Code § 3575. Numerous California hospitals operate sleep laboratories. As a result, we have an interest in the proposed regulations and ensuring an adequate supply of qualified polysomnographic technologists, technicians and trainees.

We appreciate the work that has been done to develop the proposed regulations. We do have the following comments, concerns and recommendations:

- 1) Proposed section 1378.1(d) defines “National certifying examination” as “the examination given by the Board of Registered Polysomnographic Technologists.” However, the BRPT gives two examinations: 1) the CPSGT examination; and 2) the RPSGT examination. It is not clear which examination is required. Clarification on this issue would be beneficial.
- 2) Many individuals working in hospital sleep laboratories are currently licensed as respiratory care practitioners (RCP). It is our understanding that if an employee is licensed as a RCP, he/she would not be required to register as a polysomnographic technologist but could continue to perform the full scope of services as a RCP. On the other hand, it is our understanding that RCPs have the option to register as a polysomnographic technologist if they otherwise meet the qualifications set forth in proposed section 1378.11(c). It would appear that is what was contemplated by the statute, California Business and Professions Code § 3575(f). Clarification on that issue would be beneficial.

- 3) It appears that section 1378.9 contains a grandfather provision for those individuals who are currently providing polysomnography services. However, reading 1378.9 together with 1378.11(c), it appears that individuals who have been providing polysomnography services for at least 5 years are only exempt from the requirement to take the national certifying examination. It appears that there is no alternative to the other two requirements in 1378.11(c) – (1) holding a valid, current credential as a polysomnographic technologist issued by BRPT (which requires that the individual have taken the national certifying examination); and (2) graduation from an accredited program. These two requirements are an absolute roadblock to many individuals who are currently working as polysomnographic technicians and are qualified to provide polysomnography services in a safe manner. This issue must be addressed. One option is identified in section 5 below.
- 4) Proposed section 1378.13(b) defines “other licensed health care professional” as “registered nurse, physician assistant **and** respiratory care practitioner who possesses a current California license.” We believe it would be appropriate to change “and” to “or” to clarify that an individual needs only have one of the qualifications, rather than all three.
- 5) The MBC proposed regulations appear to establish polysomnographic technicians as an independent classification with, what appears to be, a narrow scope of practice. Although proposed section 1378.11 requires a polysomnographic technician to have graduated from an accredited program, proposed section 1378.13, appears to limit their scope of practice to providing basic supportive services and implementing appropriate interventions necessary for patient safety. The regulations do not define “implementing appropriate interventions necessary for patient safety” and we are concerned that could be interpreted in an unnecessarily narrow fashion.

We believe the newly established requirements that include graduation from an accredited educational program ensure that technicians have met appropriate competency standards. As such, there does not appear to be any rationale for limiting the technician’s scope of practice as the proposed regulations could be interpreted to do. Allowing polysomnographic technicians to perform the full scope of services is consistent with New Mexico’s Polysomnographic Practice Act as well as the model job description developed by the American Academy of Sleep Medicine for polysomnographic technicians. www.aasmnet.org/resources/pdf/psgtechnician.pdf. Thus, both registered technicians and technologists would be authorized to perform the full scope of services set forth in the statute.

In addition, although not addressed by the regulations, we believe it would be appropriate for a technician to orient, train and assess the competencies of trainees and newly hired technicians. This approach is consistent with the approach taken in the nursing field. Thus, the distinction between a technician and a technologist would be that the technician may not supervise trainees or other technicians, within the meaning of proposed section 1378.13, while the technologist may provide such supervision.

Finally, to address the concern with the limited grandfather clause available for polysomnographic technologists raised above in point #3 above, we recommend adopting the following grandfather provision for polysomnographic technicians:

Add section 1378.11(b)(5); .An applicant who applies for registration as a polysomnographic technician on or before October 22, 2012, may, in lieu of meeting the requirements set forth in subsections (b)(2) and (b)(3), submit the following as proof that the applicant has been practicing polysomnography safely for at least three years:

- (a) one or more declarations under penalty of perjury by a supervising physician attesting to the period of time they physician supervised the applicant, the tasks performed by the applicant, and the applicant's ability to practice polysomnography safely; and
- (b) a letter of good standing from each state in which the applicant is registered or licensed, if the individual is registered or licensed in another state.

Again, on behalf of members of the California Hospital Association, thank you for the opportunity to provide input on the proposed Polysomnography Program regulations.

Sincerely,

/s/

Gail M. Blanchard-Saiger
California Hospital Association
Vice President, Labor & Employment



October 22, 2010

Fayne Boyd, Licensing Manager
 Medical Board of California
 2005 Evergreen Street, Suite 1200
 Sacramento, CA 95815

RE: Proposed Regulations for Polysomnography Program

Dear Ms. Boyd,

The Medical Board of California (Board) is considering changes to Division 13 of Title 16 of the California Code of Regulations relative to the qualifications for certified polysomnographic technologists, technicians and trainees as required through the enactment of SB 132. The California Society for Respiratory Care (CSRC) has comments on the proposed draft regulations.

The CSRC continuously strives for excellence in the cardiopulmonary profession. By these means, the CSRC is committed to health, healing and disease prevention in the California community. We are therefore supportive of the Board's efforts to implement SB 132 establishing the Polysomnography Program for California.

The CSRC finds that to codify the Board of Registered Polysomnographic Technologists as sole credentialing entity undermines the inclusion of respiratory therapists (RCP) elsewhere within the regulations. The CSRC recommends the following revisions to the proposed draft language for the Polysomnography Program under Article 1. General Provisions, 1378.1. Definitions:

- (d) —National certifying examination means the examination given by the Board of Registered Polysomnographic Technologists. Certifying examination means a polysomnographic technologist examination administered by a nationally recognized healthcare credentialing entity.
- (g) —Valid, current credentials as a polysomnographic technologist issued by a national accrediting agency approved by the board means shall include current valid registration as a polysomnographic technologist issued by the Board of Registered Polysomnographic Technologists.”

The CSRC is aware the Joint Commission is no longer the sole accrediting and certifying agency for health care organizations and programs in the United States. The CSRC therefore, requests the

following revision to the proposed draft language under Article 1. General Provisions, 1378.1.
Definitions:

- (f) —"Supervising physician and surgeon" means physician and surgeon who holds a valid license in California and who (1) possesses a current certification or subspecialty certification or is eligible for such a certification in sleep medicine by a member board of the American Board of Medical Specialties (ABMS) or the American Board of Sleep Medicine (ABSM); or (2) holds active staff membership at a sleep center or laboratory accredited by the American Academy of Sleep Medicine or by the Joint Commission any approved accrediting agency or group.

The CSRC will send a representative to the hearing on November 5th in addition to submitting these comments. Thank you for consideration of these revisions. Please contact me with any questions.

Sincerely,

Jack McGee
Chair, CSRC Government Affairs Committee



RESPIRATORY CARE BOARD OF CALIFORNIA

October 19, 2010

AGENDA ITEM 19

RECEIVED
MEDICAL BOARD OF
CALIFORNIA

2010 OCT 25 AM 11:40

LICENSING
PROGRAM

Fayne Boyd, Licensing Manager
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

RE: POLYSOMNOGRAPHY REGULATIONS

Dear Ms. Boyd,

Our office is in receipt of the notice, proposed text, and initial statement of reasons concerning the Medical Board of California's (MBC's) polysomnography regulations. The Respiratory Care Board (RCB) respectfully requests the MBC to consider the following comments as part of its rulemaking package:

Article 3, Section 1378.9, Examination

Subdivision (b) of Section 1378.9, provides that an applicant who applies for registration by October 22, 2012, "may, in lieu of successful completion of the examination"...submit proof (in the form of a declaration from a physician) that he/she has been practicing polysomnography safely for at least five years. The RCB suggests that this subdivision be eliminated in its entirety based on the "experience" pathway to take the Board of Registered Polysomnographic Technologists (BRPT) exam, as well as the importance to ensure some level of competency.

The "certification examination" offered by the BRPT is a nationally recognized "competency" examination accredited by the National Commission for Certifying Agencies. There are several pathways to qualify for the examination with, arguably, the easiest pathway requiring 18 months of paid work experience (at least 21 hours a week); high school or college education is *not* necessary. Therefore, any applicant who could document five years of "safe" practice, would qualify to take the BRPT competency exam. The only exception would be those applicants who worked less than 21 hours a week for the greater part of their five years of experience.

Further, the BRPT competency examination covers five domains directly related to sleep studies (e.g. pre-study procedures; study performance; therapeutic intervention; post-study procedures, and scoring and data analysis). Accepting declarations that suggest an applicant has practiced "safely" is not evidence that an applicant possesses the knowledge, skills and abilities that are fundamental to the performance of numerous tasks provided in all five of these domains.

Article 4, Section 1378.13. Employment and Supervision of Registrants

This section proposes to allow physicians, registered nurses, physician assistants, respiratory care practitioners and polysomnographic technologists provide "supervision." The RCB suggests that this be modified to provide that only properly licensed physicians and respiratory care practitioners be permitted to provide supervision based on the propensity for respiratory-related emergencies to arise.

Therapeutic intervention through the use of CPAP and BiPAPs is common during sleep studies. Respiratory care practitioners (RCPs) are specifically educated and trained in respiratory care and are the most qualified personnel to identify potential problems and respond to unforeseen complications that may arise in a sleep lab. There are numerous contraindications related to the use of CPAP and BiPAPs. It appears that there are no questions on the BRPT competency exam dedicated to responding to these contraindications and only a handful related to responding to medical emergencies in general. Without significant education and training, a registered polysomnographic technologist is not equipped to respond to such contraindications (e.g. hypoventilation, hypercapnia, or barotrauma, gastric distention, etc...).

The RCB appreciates the opportunity to provide comment and feedback to your proposed regulations. If you have any questions, please contact Stephanie Nunez, Executive Officer at 916.323.9983.

Sincerely,


Larry L. Renner
President



California Sleep Society

Board of Directors

James "Al"
Reichert, M.A.,
RPSGT
President
Sequoia Sleep
Disorders Center

Milton Erman, M.D.
President-Elect
Pacific Sleep
Medicine

Clete A. Kushida,
MD, PhD, RPSGT
Past-President
Stanford University
Sleep Disorders
Center

Michael Salemi,
RPSGT
Secretary-Treasurer
California Center for
Sleep Disorders

Alon Aidan, M.D.,
MPH
UCLA Sleep
Disorders Center

Michael Cohen,
M.D.
Contra Costa Sleep
Center

Sharon Keenan,
Ph.D., RPSGT
School of Sleep
Medicine, inc.

Glenn Roldan,
RPSGT
United Sleep Centers

Paul Selecky, M.D.
Hoag Hospital Sleep
Disorders Center

Kimberly Trotter,
M.A., RPSGT
UCSF Sleep
Disorders Center

October 18, 2010

Ms. Fayne Boyd, Licensing Manager
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

RE: Proposed Regulations for Certified Polysomnographic Technologist

Dear Ms. Boyd:

The California Sleep Society (CSS) is pleased to submit comments to the Medical Board of California (Board) regarding the proposed regulations outlining the educational and training requirements a sleep technologist must complete to obtain the designation of "certified polysomnographic technologist" by the Board. The CSS promotes and provides education in polysomnography and sleep medicine as well as increased public awareness of the field. The CSS encourages and assists in the advancement of scientific and technical standards of sleep technology, and promotes the highest standards of training and qualifications for sleep medicine physicians and sleep technologists.

After reviewing the proposed language, the CSS respectfully requests that the following amendments are incorporated into the regulatory language:

(1) Amend section 1378.1

Current language:

(a)—Approved polysomnographic education program means (1) a polysomnographic education program accredited either by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or by the Commission on Accreditation for Respiratory Care; or (2) a sleep technologist program accredited by the American Academy of Sleep Medicine.

We remain concerned with the use of the American Academy of Sleep Medicine (AASM) as the body that accredits polysomnographic training programs when it is the Board of Registered Polysomnographic Technologists (BRPT) that governs the national credentialing exam. If the proposed language is not amended there will be significant disparity between California law and the regulations that qualify sleep technicians for the national certifying examination.

The BRPT has approved sixteen training programs that satisfy the training requirement for the board exam. Two of these training programs are offered on line and are an important option to have ready access to qualified training programs. A-STEP is only one training option and there is no reason to question the judgment of the BRPT on setting the standards for its own exam. A-STEP is a trademark of the AASM and their 'accreditation' of training programs is subject to BRPT's approval of the A-STEP curriculum.

Proposed Language:

(a)—Approved polysomnographic education program means (1) a polysomnographic education program accredited either by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or by the Commission on Accreditation for Respiratory Care(CoARC); or (2) a sleep technologist program approved by the Board of Registered Polysomnographic Technologists(BRPT).

Supporting Information:

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From the Board of Registered Polysomnographic Technologists:

RPSGT Exam Requirements

- *Pathway #1 - 18 months of experience*
- *Pathway #2 - 6 months of experience*
- *Pathway #3 - CAAHEP/CoARC graduate*
- *Pathway #4 - 9 months of experience*

Pathway #1 - for candidates with 18-months of PSG experience (on-the-job training)

1. *Candidates must complete a minimum of 18 months of paid clinical experience where at least 21 hours per week per calendar year of on-the-job duties performed are Polysomnography direct patient recording and/or scoring. Duties must be within a 3-year period prior to the exam.*
2. *Candidates must complete the AASM A-STEP Self-Study (online) Modules or a BRPT-designated alternate educational program. Proof of completing the modules must be submitted with the application. Acceptable forms of proof are:
 1. *Copies of the 14 certificates of completion from each module, or*
 2. *An official transcript from the AASM.**
3. *Candidates must include proof of completing secondary education. Acceptable forms of proof are copies of transcripts or diplomas from high school, GED or equivalent, or college or university education.*

BRPT Designated Alternate Educational Programs:

Please note: A-STEP programs are not required for RPSGT recertification.

The programs listed below have been reviewed by the BRPT Education Advisory Committee and are BRPT-designated alternate educational programs. These programs have not been reviewed or endorsed in any way by the American Academy of Sleep Medicine (AASM) and are not recognized as meeting any criteria for AASM accreditation.

American Sleep and Breathing Academy - BRPT Exam Modules Online

Beaumont Hospitals Sleep Evaluation Services - Berkely Center Berkely, MI

Bluegrass Community & Technical College (Polysomnography Program) Lexington, KY

Community College of Baltimore County Baltimore, MD

Ervin Technical Center Tampa, Florida

Harrisburg Area Community College PSG Program Harrisburg, PA

Linn Benton Community College Albany, OR

London Health Sciences Centre - Sleep Lab London, Ontario, Canada

Madison Area Technical College PSG Program Madison, WI

Piedmont Virginia Community College with Keswick Sleep Center Charlottesville, Virginia

Sleep Evaluation Services - Berkely Center William Beaumont Hospitals - Berkely, MI

Sleep Multimedia Online

Southeast Technical Institute, ENDT Program Sioux Falls, SD

Southern Maine Community College South Portland, Maine

Toronto Sleep Institute Toronto, ON, Canada

University of Western Australia Nedlands WA, Australia

- (2) Eliminate the language requiring a sleep technologist or other licensed health care professional to directly supervise a sleep technician.

Current Language:

Section 1378.13 (b) "Employment and Supervision of Registrants"

"If a supervising physician and surgeon is not physically present on the premises, a supervising polysomnographic technologist or other licensed health care professional shall be physically present on the premises and available to the polysomnographic technicians and/or trainees under his/her supervision."

Proposed Language:

"If a supervising physician and surgeon is not physically present on the premises, a supervising polysomnographic technologist or other licensed health care professional shall be physically present on the premises and available to the polysomnographic trainees under his/her supervision."

Supporting Information:

The AASM job description for a polysomnographic technician states:

A Polysomnographic Technician performs comprehensive polysomnographic testing and analysis, and associated interventions under the general supervision of a Polysomnographic Technologist (RPSGT) and/or the clinical director (MD, PhD, DO) or designee. A Polysomnographic Technician can provide supervision of a Polysomnographic Trainee.

A sleep technician is an individual who has successfully completed an approved polysomnographic education program; possesses a minimum of six months experience as a registered polysomnographic trainee; and possesses a current certificate in Basic Life Support issued by the American Heart Association. The CSS requests that the language is amended to allow the sleep technician to work under general supervision of a RPSGT, clinical director or other appropriately qualified licensed health care professional.

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- (3) Eliminate or modify use of the term 'registered' when referring to technicians and trainees covered under the certification requirements of SB 132.

Supporting Information:

Sleep technologists who have passed the national credentialing exam receive the title "Registered Polysomnographic Technologist" and may use the credential RPSGT. In the profession of polysomnography the term 'registered' confers specific status. Similarly the term 'technologist' is reserved for one who has passed the exam vs. a 'technician' who has not. The use of the term, 'technologist' in SB 132 and the related regulations is consistent with these conventions. However the terms 'registered', 'registration' and 'registrant' as currently used in SB 132 and the regulations is inconsistent with the conventions of polysomnography and confusingly describes technicians and trainees. Here are two examples:

1378.1 (e) Polysomnography registrant includes any person registered as a trainee, technician or technologist under this chapter...

and

1378.11. (a) Polysomnographic Trainee. In addition to the requirements set forth in Section 3575(c) of the code, an applicant for registration as a polysomnographic trainee shall meet the following ...

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We believe that use of the term 'registered' should be modified or its use clarified to ensure that technicians and trainees do not inappropriately use the term in ways that would confuse the public or other members of the profession. Possible solutions include the following:

1. Substitute the terms 'certified' and 'certification' for 'registered' and 'registrant' when referring to trainees and technicians
or;
2. Place a disclaimer in the regulations stating that use of the terms "registered" and 'registration' when used in relation to polysomnographic trainees and technicians does not confer the right to use these terms in job descriptions or credentials. Further it should be clarified that the use of these terms when used to describe individuals who have satisfied certain provisions within SB 132 and its associated regulations does not indicate that they have met the requirements of any national certifying examination.

- (4) **Clarify that the national certifying exam means the RPSGT examination.**
Proposed Language:

1378.1 (d) National certifying examination means the RPSGT examination given by the Board of Registered Polysomnographic Technologists.

Supporting Information:

When SB 132 was conceived and written the BRPT had one certifying examination, the RPSGT Exam. Today there are two BRPT certifying examinations including the Certified Polysomnographic Technician (CPSGT) exam introduced in 2009 as an entry level certification. The RPSGT exam remains the highest certification for health care technologists in the field of sleep disorders and we recommend that it be specified as the certifying exam for sleep technologists in California.

Again, thank you for allowing the CSS to submit comments on these important regulations. If you have any questions or would like to discuss these issues further, please feel free to contact the CSS President, Al Reichert, MA, RPSGT at 650-367-5188.

Sincerely,

California Sleep Society Board of Directors

President:	Al Reichert, M.A., RPSGT
Past President:	Clete A. Kushida, MD, PhD, RPSGT
Secretary-Treasurer:	Michael Salemi, RPSGT
Directors:	Alon Avidan, M.D., MPH Michael Cohen, M.D. Milton Erman, M.D. Sharon Keenan, Ph.D., RPSGT Glenn Roldan, RPSGT Paul Selecky, M.D. Kimberly Trotter, M.A., RPSGT

Rhonda Baldo - Re: Medical Board of California - SB 132 - Polysomnographic Technologists**AGENDA ITEM 19**

From: <Joan.Spencer@kp.org>
To: <Rhonda.Baldo@mbc.ca.gov>
Date: 10/5/2010 2:09 PM
Subject: Re: Medical Board of California - SB 132 - Polysomnographic Technologists
CC: <regulations@mbc.ca.gov>

Hi Rhonda, Fayne and Kevin,

I need some clarification on:

"Defines polysomnography to mean the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders."

In an out patient clinic setting what, if any, of the following would be considered "engaging in the practice of polysomnography"? (the term CPAP is used in the general sense and refers to CPAP, APAP, BIPAP, AVAP, Servo...)

1. Instructing a patient in how to use a diagnostic testing device (WatchPAT or Embletta) that they then take home to use.
2. Downloading the above device, printing a report and providing it to an MD for interpretation.
3. Instructing a patient in how to use an oximeter with their CPAP that the patient will then take home to use.
4. Downloading the above device, printing a report and providing it to a Registered Respiratory Therapist or RPSGT to enter the results into the patients chart and then forward to an MD for interpretation.
5. Mask fitting by them self or
6. in the presence of a Registered Respiratory Therapist or RPSGT.
7. Returning patient calls to help troubleshoot problems with equipment.
8. Returning patient calls to determine correct appointment type.
9. Explaining signs, symptoms or treatment options for OSA.
10. Sending a patient out on an Auto CPAP machine that the patient will use for a specific period of time to assess pressure needs.
11. Downloading the above device to determine what pressure the patient needs to treat their OSA.
12. Distributing new CPAP equipment to patients.
13. Determine if a patient needs a heated humidifier for their CPAP use.
14. Instruct patients on the care and maintenance of their CPAP equipment.
15. Setting pressures on CPAP machines that patients will use.
16. Verify if a CPAP machine is properly working.
17. Clean CPAP machines or masks/tubing between patient use.
18. Determining when a patient needs to be referred back to the MD for further advanced testing.
19. In an out patient setting with the list above being done, will the MD supervising these staff need to meet 1378.1 f under definitions (from the staff report dated 6/20/10)? and if so, are they also limited to supervising eight polysomnographic technologists at any one time?
20. Will it be acceptable to have a unlicensed person do the work and say they are "working under" the license of another person, who is licensed and present at the same time?
21. If so, would they have to be present in the same room?, floor?, building?

I am asking for clarification so that we can adhere to the regulations as intended and to protect our RCP licenses and the patients that we serve.

Please respond in the written form after making a decision on the above items and make them part of the public record.

Thank you,

file:///C:/Documents and Settings/RBaldo/Local Settings/Temp/XPgmwise\4CAB31AAMBCGWHO100... 10/11/2010

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TITLE 16. Medical Board of California

NOTICE IS HEREBY GIVEN that the Medical Board of California is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at Long Beach Memorial Hospital Miller Children's Hospital, 2801 Atlantic Avenue, Long Beach, California 90806, at 9:10 a.m., November 5, 2010. Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 p.m. **on Monday November 1, 2010** or must be received by the Board at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Sections 2018 and 2220 of the Business and Professions Code, and to implement, interpret or make specific Sections 2228, 2229 and 2234 of said Code, as well as Sections 11400.20, 11400.21, 11425.50(e) of the Government Code, the Medical Board of California is considering changes to Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Amend Section 1361 in Article 4 of Chapter 2, Division 13, relating to the *Manual of Disciplinary Guidelines and Model Disciplinary Orders* to reflect current law and make technical changes.

Current law authorizes the Medical Board of California to investigate complaints filed against physicians and surgeons and take disciplinary action against the license should a violation of law be proven. Section 2227 of the Business and Professions Code (Code) authorizes the Board to place licensees on probation following an evidentiary hearing, a default decision or the execution of a stipulated settlement. Section 2228 of the Code specifies the terms and conditions that may be included in the term of a licensee's probation, including but is not limited to additional training, restrictions on practice, and successful completion of diagnostic examinations. Business and Professions Code Section 2229 also requires that, wherever possible, the Board should take action that is calculated to aid in the rehabilitation of the licensee and order actions to include further education, restrictions from practice, or other means, that will remove the identified deficiencies. The *Manual of Model Disciplinary Orders and Disciplinary Guidelines* referenced in the current regulation (10th Edition/2008) contains the approved terms and conditions that can be ordered to rehabilitate physicians as part of a probationary order while allowing the Board to honor its primary obligation of public protection.

The proposed amendment to existing regulation will incorporate by reference the 11th Edition/2010 of the *Manual of Model Disciplinary Orders and Disciplinary Guidelines*, reflecting changes in law, as well as making technical changes to address unnecessary and duplicative elements, and to more accurately reflect the current probationary environment.

FISCAL IMPACT ESTIMATES

Fiscal Impact on Public Agencies Including Costs or Savings to State Agencies or Costs/Savings in Federal Funding to the State: None

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

Cost to Any Local Agency or School District for Which Government Code Sections 17500-17630 Require Reimbursement: None

Business Impact: The board has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

There are no costs associated with the proposed regulatory action. This rulemaking only relates to physicians disciplined by the Medical Board of California.

Impact on Jobs/New Businesses:

The Medical Board of California has determined that this regulatory proposal will not have any impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

Cost Impact on Representative Private Person or Business:

The Medical Board of California is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

This proposed regulation only reflects the current law, and will only have an impact on physicians disciplined by the Medical Board of California.

Effect on Housing Costs: None

EFFECT ON SMALL BUSINESS

The Medical Board of California has determined that the proposed regulations would not affect small businesses. This proposed regulation only will have an impact on physicians disciplined by the Medical Board of California.

The new edition of the *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, incorporated by reference, makes no changes that would result in an increase of costs to licensees or small businesses.

CONSIDERATION OF ALTERNATIVES

The Board must determine that no reasonable alternative it considered to the regulation or that has otherwise been identified and brought to its attention would either be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposal described in this Notice. Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

INITIAL STATEMENT OF REASONS AND INFORMATION

The Medical Board of California has prepared an initial statement of the reasons for the proposed action and has available all the information upon which the proposal is based.

TEXT OF PROPOSAL

Copies of the exact language of the proposed regulations and of the initial statement of reasons, and all of the information upon which the proposal is based, may be obtained at the hearing or prior to the hearing upon request from the Medical Board of California at 2005 Evergreen Street, Suite 1200, Sacramento, California 95815.

AVAILABILITY AND LOCATION OF THE FINAL STATEMENT OF REASONS AND RULEMAKING FILE

All the information upon which the proposed regulations are based is contained in the rulemaking file which is available for public inspection by contacting the person named below.

You may obtain a copy of the final statement of reasons once it has been prepared, by making a written request to the contact person named below or by accessing the website listed below.

CONTACT PERSON

Inquiries or comments concerning the proposed rulemaking action may be addressed to:

Name:	Susan Cady, Enforcement Manager
	Medical Board of California
Address:	2005 Evergreen Street, Suite 1200
	Sacramento, CA 95815
Telephone No.:	(916) 263-2389
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

The backup contact person is:

Name:	Kevin A. Schunke
	Medical Board of California
Address:	2005 Evergreen Street, Suite 1200
	Sacramento, CA 95815
Telephone No.:	(916) 263-2389
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

Website Access: Materials regarding this proposal can be found at http://www.medbd.ca.gov/laws/regulations_proposed.html .

MEDICAL BOARD OF CALIFORNIA
INITIAL STATEMENT OF REASONS

Hearing Date: November 5, 2010

Subject Matter of Proposed Regulations:

To amend the *Manual of Model Disciplinary Orders and Disciplinary Guidelines* to reflect changes in law, clarify existing language, and make technical changes to reflect the current probationary environment.

Section(s) Affected:

Amend Section 1361 in Article 4 of Chapter 2, Division 13

Specific purpose of each adoption, amendment, or repeal:

The current *Manual of Model Disciplinary Orders and Disciplinary Guidelines* referenced in the regulation (10th Edition/2008) must be made consistent with current law. The proposed regulation will reference the 11th Edition/2010 of the *Manual of Model Disciplinary Orders and Disciplinary Guidelines*, reflecting changes in law, as well as making technical changes to address unnecessary and duplicative elements, and some technical changes to reflect the current probationary environment.

Factual Basis/Rationale:

The factual basis and rationale for the determination that each amendment is reasonably necessary to clarify the purpose for which technical changes are required, together with a description of the problem, administrative requirement, or other condition or circumstance that each amendment is intended to address, is as follows:

Condition 5-7. Controlled substances – Total Restriction/Partial Restriction

- Expand restriction to include “furnishing” controlled substances and amend the language regarding the appropriateness or necessity of prescribing controlled substances to patient.

B&P Code Section 2242 was amended to require that an “appropriate prior examination and a medical indication” must exist before prescribing medication to a patient. The Board is amending the *Guidelines* to be consistent with the current laws pertaining to prescribing. The current *Guidelines* restrict respondents from prescribing, administering and dispensing medication but do not restrict their ability to furnish or supply controlled substances to patients. This amendment is necessary to correct this omission.

Condition 8. Controlled Substances – Maintain records

- Deletes language stating that the failure to comply with the requirement to maintain logs and records constitutes a violation of probation.

Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation; therefore this language is redundant and unnecessary.

Condition 9-10 Controlled Substances/Alcohol Abstain from Use

- Allows the Board to impose a “cease practice” order when a positive biological fluid test is received for alcohol or a substance not legally prescribed and requires that an administrative action be filed timely so the respondent is afforded due process.

Due to a change in law, the Medical Board no longer has a Diversion Program to monitor physicians with substance abuse problems. In the past, physicians were ordered into the Diversion Program. The program had the authority to order a physician who tested positive from a biological fluid test, to cease practicing medicine. While the previous *Guidelines* were amended to reflect the elimination of the Diversion Program, it did not contain the specific condition that the Board could order physicians testing positive to cease practice. In addition, SB 1441 required the Department of Consumer Affairs (DCA) to develop guidelines for monitoring all licensees with substance abuse problems. (http://www.dca.ca.gov/about_dca/sacc/unistand_04_10.pdf). The *Guidelines* developed by DCA require that licensees be removed from practice should they test positive for drugs or alcohol. The Board is recommending that the licensee be given notification and shall be directed to cease practice within three days following the notification. The Board currently has the authority to direct the respondent to cease practice if a practice monitor is not replaced in a timely manner. The proposed language recommending that the cease practice order become effective three days after notification to the respondent is consistent with the existing guidelines currently in use and, in the Board's opinion, gives the respondent adequate notice to make the necessary arrangements to close the practice temporarily and redirect patients to covering physicians. The Board is required to file an accusation/petition to revoke probation within 15 days and, if requested, provide the respondent with a hearing in 30 days. The Board used the timeframes defined in Government Code Section 11529(f) for providing an expeditious hearing on interim suspension orders as the model for the timeframes for the filing of an accusation and the hearing on “cease practice” orders issued by the Board. The expedited timeframes being proposed are necessary to provide due process to licensees.

Condition 11. Biological Fluid testing

- Expands and defines “Biological Fluid Testing” to include blood, urine, breathalyzer, and hair follicle testing and removes the minimum number of tests required throughout the term of probation. Allows the Board to order the respondent to cease practice for failing to cooperate with the required testing. Deletes language stating that the failure to cooperate with the biological fluid testing constitutes a violation of probation.

Due to technological changes in drug testing, it is preferable to define “Biological Fluid Testing” to include other methods that may be able to detect some substances that are not picked up by a urine test. This is necessary to protect the public by allowing for better drug and alcohol testing. In addition, SB 1441 required the Department of Consumer Affairs to develop guidelines for monitoring all licensees with substance abuse problems.

(http://www.dca.ca.gov/about_dca/sacc/unistand_04_10.pdf) The guidelines developed by DCA identified specific testing frequencies; however, the number has been the subject of extensive debate within the Boards, licensee population and other interested parties. By removing reference to a specific number of minimum tests throughout the term of probation, the Board will be able to adjust the frequency according to the specific facts of the case and/or the *Guidelines* once finalized by DCA.

The Board is also proposing that a “cease practice” order be issued for failing to cooperate with the ordered biological fluid testing. The Board currently has the authority to direct the respondent to cease practice if a practice monitor is not replaced in a timely manner. The proposed language recommending that the cease practice order become effective three days after notification to the respondent is consistent with the existing guidelines currently in use and, in the Board’s opinion, gives the respondents adequate notice to make the necessary arrangements to close the practice temporarily and redirect patients to covering physicians. The Board is required to file an accusation/petition to revoke probation within 15 days and, if requested, provide the respondent with a hearing in 30 days. The Board used the timeframes defined in Government Code Section 11529(f) for providing an expeditious hearing on interim suspension orders as the model for the timeframes for the filing of an accusation and the hearing on “cease practice” orders issued by the Board. The expedited timeframes being proposed are necessary to provide due process to licensees.

Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation; therefore this language is redundant and unnecessary.

Condition 12. Community Service

- Deletes language indicating medical community service cannot be ordered or allowed when the board has charged the respondent with negligence or incompetence in a quality of care case unless and until the respondent has been tested and deemed competent and safe to practice. Amends this condition to preclude medical community service from being ordered when disciplinary action has been taken related to the quality of the medical care provided by respondent.

BPC Section 2228 (d) authorizes the Board to place an individual on probation and allow the option of alternative community service in cases *other than* violations relating to quality of care. It is not in the interest of public protection to permit a physician found to have been negligent or incompetent to provide medical care as part of his/her community service. This amendment is necessary to conform to the existing statute.

Condition 13. Education Course

- Expand acceptable continuing medical education courses beyond classroom, conference, and seminars, to reflect other types of educational delivery systems.

There has been a change in the educational environment, and respondents may be able to complete more appropriate coursework not offered in the traditional classroom. Online courses, CD Rom courses, workshops, and other methods of education may be more suitable to address a respondent's deficiencies. For this reason, the Board is proposing to allow other types of courses, rather than only those didactic courses taught in a classroom environment.

Condition 14. Prescribing Practices Course

- Allows for participation in equivalent programs other than those provided by the Physician Assessment & Clinical Education (PACE) Program offered by UCSD, if approved by the Medical Board. Requires that the respondent provide all documentation and material required by the program and sets specific timeframes for completing the ordered course. Deletes language stating that the failure to complete the prescribing practices course within six months constitutes a violation of probation and clarifies that any CME hours received for completing this course could not also be applied towards meeting the CME requirements for license renewal.

There are other comparable prescribing practices programs in various locations other than the San Diego PACE Program and the Board is proposing to allow

physicians to attend alternative but equivalent programs. A number of the education/training courses included in the *Guidelines* require that the physician provide materials prior to the classroom instruction or participate in exercises after completing the classroom instruction. This material can be used to either determine the areas of remediation required prior to classroom instruction or to provide longitudinal follow-up at six and twelve month intervals following the classroom instruction. This amendment is necessary to ensure that the respondent cooperates with all of the requirements of the course and to define the timelines and consequences for failing to comply. A one year deadline has been selected to ensure the longitudinal follow up requirement has been satisfied. The current *Guidelines* define a deadline for enrollment in the required course but there is no timeframe defined for completing the classroom instruction. Based on the Board's experience in this area, six months is an adequate amount of time to allow a physician to clear his/her schedule to devote to the classroom portion of the course.

It has been the Board's policy to not allow physicians to use the CME credits obtained while completing the board-ordered educational courses as meeting both the probation condition and a portion of the 25 hours of CME required each year for license renewal. This language is necessary to memorialize the existing policy and eliminate confusion for the respondents on the number of CME hours required to maintain licensure.

Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation; therefore this language is redundant and unnecessary.

Condition 15. Medical Recordkeeping Course

- Allows for participation in equivalent programs other than those provided by the Physician Assessment & Clinical Education (PACE) Program offered by UCSD, if approved by the Medical Board. Requires that the respondent provide all documentation and material required by the program and sets specific timeframes for completing the ordered course. Deletes language stating that the failure to comply with the requirement to maintain logs and records constitutes a violation of probation and clarifies that any CME hours received for completing this course could not also be applied towards meeting the CME requirements for license renewal.

There are other comparable medical recordkeeping programs in various locations other than the San Diego PACE Program and the Board is proposing to allow physicians to attend alternative but equivalent programs. A number of the education/training courses included in the *Guidelines* require that the physician

provide materials either prior to the classroom instruction or participate in exercises after completing the classroom instruction. This material can be used to either determine the areas of remediation required prior to classroom instruction or to provide longitudinal follow-up at six and twelve month intervals following the classroom instruction. This amendment is necessary to ensure that the respondent cooperates with all of the requirements of the course and to define the timelines and consequences for failing to comply. A one year deadline has been selected to ensure the longitudinal follow up requirement has been satisfied. The current *Guidelines* define a deadline for enrollment in the required course but there is no timeframe defined for completing the classroom instruction. Based on the Board's experience in this area, six months is an adequate amount of time to allow a physician to clear his/her schedule to devote to the classroom portion of the course.

It has been the Board's policy to not allow physicians to use the CME credits obtained while completing the board-ordered educational courses as meeting both the probation condition and a portion of the 25 hours of CME required each year for license renewal. This language is necessary to memorialize the existing policy and to eliminate confusion for the respondents on the number of CME hours required to maintain licensure.

Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation; therefore this language is redundant and unnecessary.

Condition 16. Professionalism Course/Ethics Course

- Requires that the respondent provide all documentation and material required by the program and sets specific timeframes for completing the ordered course. Deletes language stating that the failure to complete the course within the first year constitutes a violation of probation and clarifies that any CME hours received for completing this course could not also be applied towards meeting the CME requirements for license renewal.

There are other comparable professionalism programs in various locations other than the San Diego PACE Program and the Board is proposing to allow physicians to attend alternative but equivalent programs. A number of the education/training courses included in the *Guidelines* require that the physician provide materials prior to the classroom instruction or participate in exercises after completing the classroom instruction. This material can be used to either determine the areas of remediation required prior to classroom instruction or to provide longitudinal follow-up at six and twelve month intervals following the classroom instruction. This amendment is necessary to ensure that the

respondent cooperates with all of the requirements of the course and to define the timelines and consequences for failing to comply. A one year deadline has been selected to ensure the longitudinal follow up requirement has been satisfied. The current *Guidelines* define a deadline for enrollment in the required course but there is no timeframe defined for completing the classroom instruction. Based on the Board's experience in this area, six months is an adequate amount of time to allow a physician to clear his/her schedule to devote to the classroom portion of the course.

It has been the Board's policy to not allow physicians to use the CME credits obtained while completing the board-ordered educational courses as meeting both the probation condition and a portion of the 25 hours of CME required each year for license renewal. This language is necessary to memorialize the existing policy and to eliminate confusion for the respondents on the number of CME hours required to maintain licensure.

Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation; therefore this language is redundant and unnecessary.

Finally, the course has been renamed from "Ethics Course" to Professionalism Program. This amendment includes technical changes to reflect the name change.

Condition 17. Professional Boundaries Course

- Allows the Board to accept the completion of a professional boundaries program or course prior to the effective date of the decision as fulfillment of this condition. Clarifies that any CME hours received for completing this course could not also be applied towards meeting the CME requirements for license renewal.

The Board has traditionally accepted coursework taken before the effective date of the decision in all other educational conditions except the professional boundaries course. There is no reason why this course should not be subject to the same parameters. This amendment is necessary to correct this omission and to clarify that the Professional Boundaries Course used as the standard is the course offered by PACE.

It has been the Board's policy to not allow physicians to use the CME credits obtained while completing the board-ordered educational courses as meeting both the probation condition and a portion of the 25 hours of CME required each year for license renewal. This language is necessary to memorialize the existing policy and to eliminate confusion for the respondents on the number of CME hours required to maintain licensure.

Condition 18. Clinical Training Program

- Amends the language to clarify that the respondent must *successfully* complete the clinical training program six months after enrollment and allows the Board to order the respondent to cease practice if the clinical training program has not been successfully completed. Amends the language to require that the assessment and retraining be focused on the area of medicine that the respondent was alleged to be deficient in. Deletes language stating that the failure to participate in and complete all phases of the clinical training program constitutes a violation of probation. Adds a timeframe for enrolling in the professional enhancement program if ordered.

The current *Guidelines* define a deadline for enrollment in the clinical training program but there is no timeframe defined for completing the program. Based on the Board's experience in this area, six months is an adequate amount of time to allow a physician to clear his/her schedule to devote to the ordered clinical training program and for the PACE (or comparable program) to perform the initial assessment and develop the 40-hour clinical education component.

The objective in ordering a clinical training and assessment is to ensure that the physician is competent and safe to practice medicine. When a physician completes the clinical training program within the required time period but is deemed unsafe to practice medicine, the Board must act quickly to ensure that he/she is not allowed to continue treating patients. This amendment allows the Board to issue a "cease practice" order if necessary to immediately remove the physician from the practice of medicine if he/she did not successfully complete the clinical training program. The Board currently has the authority to direct the respondent to cease practice if a practice monitor is not replaced in a timely manner. The proposed language recommending that the cease practice order become effective three days after notification to the respondent is consistent with the existing guidelines currently in use and, in the Board's opinion, gives the respondent adequate notice to make the necessary arrangements to close their practice temporarily and redirect patients to covering physicians.

Physicians are licensed to practice medicine in any specialty they choose but are expected to meet the standard of care for the specialty they are practicing in. If a physician has been disciplined for practicing medicine in a specialty outside his/her area of training, the clinical assessment and retraining must correlate to the area(s) of practice in which he/she is found to be negligent. This amendment is necessary to clarify that requirement.

Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation; therefore this language is redundant and unnecessary.

The current *Guidelines* allow the Board to order a physician to enroll in the professional enhancement program but do not include a timeframe for enrollment. A 60-day time limit will ensure timely enrollment and, in the Board's experience, is adequate time to allow the respondent to complete the application and collect the patient charts needed as part of the enrollment process as well as allow the PEP program sufficient time to identify an appropriate monitor and arrange for on-site visits to begin the professional enhancement program.

Condition 19. Oral and/or Written/Examination

- Amends the language to ensure that oral examinations being administered as a condition of probation are consistent with the statutory requirements outlined in BPC section 2293. Allows the Board to issue a cease practice order if the respondent does not successfully complete the exam.

The current *Guidelines* do not specify how an oral examination should be conducted and this amendment corrects that omission to ensure all oral examinations follow a consistent protocol. The protocol is set forth in B&P 2293(a) and (b). Use of this protocol will result in consistency between the various types of oral examinations.

The objective in ordering an oral/written examination is to ensure that the physician is competent and safe to practice medicine. When a physician fails the test, the Board must act quickly to ensure that he/she is not allowed to continue treating patients. This amendment provides public protection by immediately removing the physician from the practice of medicine if he/she did not pass the oral or written examination.

Non-substantive grammatical changes are made for clarity and ease of reading.

Condition 20. Psychiatric Evaluation

- Deletes language stating that the failure to complete a psychiatric evaluation and psychological testing constitutes a violation of probation.

Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation; therefore this language is redundant and unnecessary.

Condition 21. Psychotherapy

- Deletes language stating that the failure to undergo and continue psychotherapy

constitutes a violation of probation. Amends language to add requirement that a treating physician must be licensed in California.

Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation; therefore this language is redundant and unnecessary. The current *Guidelines* give the Board the authority to approve the psychiatrist or psychotherapist nominated to provide the board ordered therapy. As part of the approval process, the Board must consider the nominee's complaint history and background to ensure there are no pending complaints, investigations or disciplinary actions which would suggest that the nominee's care might be outside the standard of practice in the medical community. This background information would not be available to the Board unless the individual is California licensed. This amendment is necessary to ensure that the Board has the necessary information to review and approve individuals providing board ordered psychotherapy.

Condition 22. Medical Evaluation and Treatment

- Requires that disciplined physicians provide pertinent documentation to the physician conducting a medical evaluation as part of a probationary condition and adds the requirement that the treating physician must be licensed in California. Deletes language stating that the failure to cooperate and/or comply with the condition constitutes a violation of probation.

As a condition of probation for physicians who may be suffering from a medical condition that may affect their medical practice skills, a medical evaluation conducted by a physician may be ordered. In order for physicians conducting the evaluations to effectively do their work, full cooperation is needed. For that reason, the *Guidelines* have been amended to require the disciplined physician to cooperate with the evaluator and provide any relevant documentation requested. Otherwise, the resulting evaluation may not be complete.

The current *Guidelines* give the Board the authority to approve the physician nominated to provide medical treatment deemed necessary following an independent medical evaluation. As part of the approval process, the Board must consider the nominee's complaint history and background to ensure there are no pending complaints, investigations or disciplinary actions which would suggest that the nominee's care might be outside the standard of practice in the medical community. This background information would not be available to the Board unless the individual is California licensed. This amendment is necessary to ensure that the Board has the necessary information to review and approve individuals providing recommended and/or board ordered medical treatment.

Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation; therefore this language is redundant and unnecessary.

Condition 23. Monitoring – Practice/Billing

- Provides the ability to issue a cease practice order if the respondent fails to obtain an approved practice monitor within 60 calendar days from the effective date of the Decision. Minor grammatical changes have been made to the language to ensure that notification is sent to the respondent prior to imposing a cease practice order and to clarify the timeframe for the order to become effective. Deletes language stating that the failure to cooperate and/or comply with the condition constitutes a violation of probation.

The current Guidelines allow the Board to issue a “cease practice” order to the respondent if the approved practice/billing monitor resigns and the respondent is unable find a replacement within 60 days. However, if the respondent does not find an acceptable practice/billing monitor within the first 60 calendar days after the decision becomes effective, the Board has no authority to order a “cease practice”. There is no reason why the initial appointment of a practice/billing monitor should not be subject to the same parameters as securing a replacement. This amendment is necessary to correct this omission. In addition the language was amended to clarify that the Board or designee must approve any modifications made to the monitoring plan. The current *Guidelines* confirm that the Board or designee must approve the initial monitoring plan but there is no provision to address any adjustments or changes made to the monitoring plan. This amendment is necessary to address that omission.

The time period to secure a replacement monitor was clarified to identify “calendar” days to be consistent with all other timeframes outlined in this condition. Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation; therefore this language is redundant and unnecessary.

Condition 24. Solo Practice Prohibition

- Defines the term “solo practice” by a licensee on probation and provides the ability to issue a cease practice order if the respondent fails to secure an approved practice setting within 60 calendar days from the effective date of the Decision or from a change in an approved practice setting.

The current language does not provide a sufficient explanation as to what the Board is requiring when a respondent is prohibited from engaging in “solo”

practice which has resulted in ambiguity for the probationer. The clarifying language added to the condition defines what is meant by the solo practice prohibition and clarifies that a probationer cannot just have another physician, who is sharing office space, or employ other health care practitioners, such as registered nurses or physician assistants, to comply with this condition. The goal of this condition is to ensure that the physician, who has been found to be negligent, dishonest or to have engaged in inappropriate relationships with patients, has another physician colleague or peer to consult with and give guidance on patient care issues. Neither a registered nurse, a physician assistant, nor an independent contract physician can fulfill this role. By including the parameters of the condition it clarifies for the respondents what is required of them when they have this condition and provides for greater public protection by ensuring that requirements of this condition can be clearly understood.

This amendment would also allow the Board to issue a "cease practice" order to remove the physician from the practice of medicine if he/she is in practice setting that is inconsistent with the solo practice prohibition. The Board currently has the authority to direct the respondent to cease practice if a practice monitor is not replaced in a timely manner but has no such provision on the "solo practice" prohibition. This amendment is necessary to correct that omission. The proposed language requiring that the cease practice order become effective three days after notification to the respondent is consistent with the existing guidelines currently in use and, in the Board's opinion, gives the respondent adequate notice to make the necessary arrangements to close the practice temporarily and redirect patients to covering physicians.

Condition 25. Third Party Chaperone

- Amends this condition to require that chaperones record their presence on the medical record and incorporates privacy protection for the patient by only requiring the patient's initials. Adds protection for the chaperone by informing the respondent that the chaperone cannot be terminated from the position because he/she reports a finding to the Board. Allows the Board to order the respondent to cease practice for failing to have an approved third party chaperone. Deletes the recommendation regarding the practice environment most suitable for sexual offenders.

The Board is also proposing that a "cease practice" order be issued for not having or failing to replace a third party chaperone. The Board currently has the authority to direct the respondent to cease practice if a practice monitor is not replaced in a timely manner but no such provision for the third party chaperone requirement. This amendment is necessary to correct that omission. The proposed language requiring that the cease practice order become effective three days after notification to the respondent is consistent with the existing

guidelines currently in use and, in the Board's opinion, gives the respondent adequate notice to make the necessary arrangements to close their practice temporarily and redirect patients to covering physicians

History has shown that failure of the third party chaperone to properly document the medical record can result in a lack of evidence when a violation is detected. By including the signature instead of initials in the medical record the Board can more easily identify the name of the third party chaperone that was in attendance. To reflect the privacy laws, the log maintained by respondent will only have the patient's initials and not the full name. To remove the fear of retaliation against the third party chaperone, the Board has added the prohibition that respondent cannot terminate a third party chaperone as a result of his/her cooperation with the Board. All of these changes will strengthen the enforceability of this term of probation. BPC Section 2232 requires, with some limited exceptions, license revocation for any physician required to register as a sex offender. This amendment is needed to reflect this statutory change.

Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation; therefore this language is redundant and unnecessary.

Condition 26. Prohibited Practice

- Amended language to remove additional requirement for written notification to be provided at subsequent patient visits. Deletes language stating that the failure to cooperate and/or comply with condition constitutes a violation of probation.

The current *Guidelines* require that the respondent make a verbal notification to any patient seeking the prohibited service and must document that notification in a log. In addition, at any subsequent visits, each time the patient seeks the prohibited service, the respondent must provide a written notification to the patient and place the written notification in the file. However, in the Board's experience, this protocol is not consistent with how a medical practice functions. Typically, a patient will contact the physician's office and schedule an appointment through the office staff. The staff will identify the reason for the appointment and what "service" is needed. If the patient wishes to be scheduled for a procedure or service that the respondent is prohibited from providing, the patient would be advised at that time that the requested service/procedure could not be provided and no appointment would be scheduled. The amended language requires that all patients be notified after the decision becomes effective that the respondent is prohibited from providing specific services or procedures and that notification must be documented in a log. If all patients are provided with the notification when it becomes effective, it is highly unlikely that

patients would continue to “request” the prohibited service or be scheduled by the physician’s office staff for a service or procedure the physician could not provide. To require the respondent to provide additional notifications (either written or verbal) appears unnecessary and burdensome.

Standard Condition #35 states that the failure to comply with any term and condition is a violation of probation, therefore this language is redundant and unnecessary.

Condition 27. Notification

- Clean-up language to clarify when respondents must provide notification to their employer.

The current language implies that respondents are not practicing when placed on probation. This makes it clear that within seven (7) days from the effective date of the Decision they must provide notification. Based on the Board’s experience, seven days is sufficient time for respondents to make the necessary notification to their employer, hospitals where they have privileges and malpractice insurance carriers.

Condition 31 General Probation Requirements

- Amends the formatting to make it clearer to the respondent what the general requirements are while serving on probation. Aside from adding the headings, the first section explains that respondents will have to comply with the Board’s probation unit and the terms and conditions of probation. Other enhancements include requesting the respondent’s e-mail address and telephone number for contact purposes; clarifying that the respondent cannot practice at a patient’s residence unless the patient resides in a skilled nursing facility or other similar licensed facility. The notification for travel or residence outside California was incorporated from the previous Condition 33, “Residing or Practicing Out of State.”

During the probationary term, the Board needs to maintain contact with the respondent to schedule appointments and interviews and to ensure compliance with the ordered terms and conditions. Adding phone numbers and e-mails addresses (if applicable) to the contact information that must be provided enhances the Board’s ability to maintain regular contact with the respondent.

The current *Guidelines* do not allow respondents to practice medicine in their residence. It is not in the interest of public protection to permit a physician found to have been negligent or incompetent to provide medical care in a patient’s

residence. However, there are some settings where the patient may be seen somewhere other than the physician's office; such as a skilled nursing facility and licensed board and care facility, etc. By including the parameters of the condition it clarifies for the respondents what is required of them when they have this condition. These limitations provide greater public protection by ensuring practice occurs in an organized health care setting.

Condition 32 Interview with the Board

- Non-substantive grammatical changes are made for clarity and ease of reading.

Condition 33 Residing or Practicing Out of State

- This condition was repealed and portions were consolidated into condition number 31, "General Probation Requirements" and the new number 33 "Non-Practice While on Probation."

It was determined that the information in this condition and condition #34 were redundant; therefore the two conditions were combined to remove unnecessary language.

Condition 34 Failure to Practice Medicine

- This condition was repealed and portions were consolidated into condition number 31, "General Probation Requirements" and the number 33 "Non-Practice While on Probation."

It was determined that the information in this condition and the previous condition #33 were redundant; thereby the two conditions were combined to remove unnecessary language.

Underlying Data:

As specified above, the 10th Edition (2008) of the *Manual of Model Disciplinary Orders and Disciplinary Guidelines* is referenced in current regulation. The 11th Edition (2010) of the *Guidelines* has been amended to reflect changes in law, changes in educational and probationary environments, and has also been amended for clarity and consistency.

The Medical Board has worked on the changes in the *Guidelines* for several months, culminating with a meeting on June 18, 2009 with interested parties, including professional associations and consumer organizations, defense counsels and prosecutors. (Minutes attached.) Suggestions made at that meeting, if appropriate, were incorporated into the 11th Edition of the *Guidelines*. In summary, the proposed changes were not controversial, and the Board would expect little comment, if any, in

opposition to this rulemaking as a result of the comments heard at that meeting.

As discussed in the "Factual Basis" above, changes to the Guidelines have been made to clarify conditions, tighten requirements, remedy ambiguities in the previous edition, and offer alternatives that reflect the current law, educational opportunities, technological advances, and the probationary environment. The Board consulted with all interested parties, including prosecutors, defense counsels, professional organizations, probation officers and individual physicians to solicit comment into the proposed changes.

Business Impact

This regulation will not have a significant adverse economic impact on businesses. This initial determination is based on the following facts or evidence/documents/testimony:

This regulation only impacts physicians disciplined by the Medical Board.

Description of alternatives which would lessen any significant adverse impact on business:

Not applicable, as the proposed regulation has no business or economic impact.

Specific Technologies or Equipment:

This regulation does not mandate the use of specific technologies or equipment.

This regulation mandates the use of specific technologies or equipment. Such mandates or prescriptive standards are required for the following reasons:

Consideration of Alternatives:

No reasonable alternative to the regulation would be either more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed regulation.

**Medical Board of California
Disciplinary Guidelines
Specific Language**

1. Amend section 1361 in Article 4 of Chapter 2, Division 13, to read as follows:

1361. Disciplinary Guidelines.

In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Medical Board of California shall consider the disciplinary guidelines entitled "Manual of Disciplinary Guidelines and Model Disciplinary Orders" (~~10th Edition/2008~~ 11th Edition/2010) which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the Medical Board of California in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such a deviation -- for example: the presence of mitigating factors; the age of the case; evidentiary problems.

NOTE: Authority cited: Sections 2018, Business and Professions Code; and Sections 11400.20 and 11400.21, Government Code. Reference: Sections 2227, 2228, 2229, and 2234, Business and Professions Code; and Sections 11400.20 and 11425.50(e), Government Code.

**State of California
State and Consumer Services Agency
MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS
AND DISCIPLINARY GUIDELINES
1140th Edition
20082010
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA**

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Secretary**

The Board produced this Manual of Model Disciplinary Orders and Disciplinary Guidelines, 1140th Edition for the intended use of those involved in the physician disciplinary process: Administrative Law Judges, defense attorneys, physicians-respondents, trial attorneys from the Office of the Attorney General, and the Board's disciplinary panel members who review proposed decisions and stipulations and make final decisions. These guidelines are not binding standards.

The Federation of State Medical Boards and other state medical boards have requested and received this manual. All are welcome to use and copy any part of this material for their own work.

For additional copies of this manual, please write to the address below or visit
http://www.medbd.ca.gov/publications/disciplinary_guide.pdf:

Medical Board of California
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Revisions to the Manual of Model Disciplinary Orders and Disciplinary Guidelines, are made periodically. Listed below are the most recent changes included in the 1140th edition approved by the Board following open discussion at a public meeting.

Summary of Changes

The former "Disciplinary Guidelines – Index" printed after the last "Standard Conditions" has been moved to the Table of Contents (a formatting change only) and has been renamed the "Recommended Range of Penalties for Violations" for clarity.

Model Condition Number:

5. Controlled Substances – Total Restriction

Eliminated the term “good faith” prior examination to reflect amendments made to statute that now requires an “appropriate prior examination and a medical indication” and adds “furnish” to the list of prohibited activities.

6. Controlled Substances – Surrender of DEA Permit

References to the “Division” (Division of Medical Quality) changed to “Board.”

7. Controlled Substances – Partial Restriction

Eliminated the term “good faith” prior examination to reflect amendments made to statute that now requires an “appropriate prior examination and a medical indication” and adds “furnish” to the list of prohibited activities.

8. Controlled Substances - Maintain Records and Access To Records and Inventories

References to the “Division” (Division of Medical Quality) changed to “Board.”

Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

9. Controlled Substances - Abstain From Use

References to the “Division” (Division of Medical Quality) changed to “Board.”

Added language that respondent shall cease the practice of medicine based upon a positive biological fluid test and that the Board must meet time requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.

10. Alcohol - Abstain From Use

Added language that respondent shall cease the practice of medicine based upon a positive biological fluid test and that the Board must meet requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.

11. Biological Fluid Testing

Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. Expands the parameters of biological fluid testing to include various testing mechanisms. Added language that respondent shall cease the practice of medicine based upon a positive biological fluid test and that the Board must meet requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.

The following language was deleted:

~~Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon the request of the Division or its designee. A certified copy of any laboratory test results may be received in evidence in any proceedings between the Board and the respondent. Failure to submit to, or failure to complete the required biological fluid testing, is a violation of probation.~~

The following language replaces the above:

Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. Prior to practicing medicine, respondent

~~shall, at respondent's expense, contract with a laboratory or service approved in advance by the Board or its designee that will conduct random, unannounced, observed, urine testing a minimum of four times each month. The contract shall require results of the urine tests to be transmitted by the laboratory or service directly to Board or its designee within four hours of the results becoming available. Failure to maintain this laboratory or service during the period of probation is a violation of probation. A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and respondent. Failure to submit to or comply with the time frame for submitting to, or failure to complete the required biological fluid testing, is a violation of probation.~~

Former # 12 "Diversion Program" was eliminated:

12 was formerly entitled "Diversion Program." As the Diversion Program is eliminated on June 30, 2008, the following language was deleted:

~~Within 30 calendar days from the effective date of this Decision, respondent shall enroll and participate in the Board's Diversion Program until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Upon enrollment, respondent shall execute a release authorizing the Diversion Program to notify the Division of the following: 1) respondent requires further treatment and rehabilitation; 2) respondent no longer requires treatment and rehabilitation; and 3) respondent may resume the practice of medicine. Respondent shall execute a release authorizing the Diversion Program to provide confirmation to the Division whenever the Diversion Program has determined that respondent shall cease the practice of medicine.~~

~~Within 5 calendar days after being notified by the Diversion Program of a determination that further treatment and rehabilitation are necessary, respondent shall notify the Division in writing. The Division shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Within 24 hours after being notified by the Diversion Program of a determination that respondent shall cease the practice of medicine, respondent shall notify the Division and respondent shall not engage in the practice of medicine until notified in writing by the Division or its designee of the Diversion Program's determination that respondent may resume the practice of medicine. Failure to cooperate or comply with the Diversion Program requirements and recommendations, quitting the program without permission, or being expelled for cause is a violation of probation.~~

12. Community Service - Free Services

Reworded the language regarding non-medical community service.

Formerly # 13, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

13. Education Course

Deleted language limiting the education program or course to classroom, conference or seminar settings.

Formerly # 14, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

14. Prescribing Practices Course

Added language to require the course be equivalent to the course offered at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine. Also added language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.

~~Formerly # 15, it is re-numbered to reflect the deletion of former #12." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

15. Medical Record Keeping Course

Added language to require the course be equivalent to the course offered at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine. Also added language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.

~~Formerly # 16, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

16. Ethics Course Professionalism Program (Ethics Course)

Amended the name and language to comport with subsequent regulations setting requirements for a professionalism program (previously referred to as an ethics course). Also added language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.

~~Formerly # 17, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

17. Professional Boundaries Program

Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. Added language permitting discretionary acceptance of a course taken prior to the effective date of the decision.

~~Formerly # 18, it is re-numbered to reflect the deletion of former #12." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

18. Clinical Training Program

Amended the language regarding completion of program and replaced the terms specialty and sub specialty with area of practice in which respondent was deficient. Added language that respondent shall cease the practice of medicine for failing to successfully complete the clinical training program. Also eliminated the subsequent optional term and made it a requirement.

~~Formerly # 19, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

19. Oral or Written Examination

Added that if the examination is an oral examination, it is to be administered in accordance with Business and Professions Code section 2293(a) and (b). Also eliminated the subsequent optional term and made it a requirement. Made technical changes. Formerly # 20, it is re-numbered to reflect the deletion of former #12." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

20. Psychiatric Evaluation

Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

Formerly # 21, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

21. Psychotherapy

Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

Formerly # 22, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

22. Medical Evaluation and Treatment

Added language requiring the respondent to provide pertinent documents/information to the evaluating physician. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

Formerly # 23, it is re-numbered to reflect the deletion of former #12." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

23. Monitoring - Practice/Billing

Restructured the formatting to clarify the type of monitor required. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

Added language that respondents shall cease the practice of medicine until they obtain a monitor if they do not meet the required timeline for obtaining a monitor.

Formerly # 24, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

24. Solo Practice Prohibition

Clarified the title to show it was a prohibition and clarified what constitutes solo practice.

Added language that respondent shall cease the practice of medicine for failing to secure an approved practice setting within 60 days.

Formerly # 25, it is re-numbered to reflect the deletion of former #12.

25. Third Party Chaperone

Restructured the formatting to clarify the type of patient in which respondent is required to have a chaperone. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. In addition, language was added prohibiting employment termination of a chaperone for reporting to the Board. Added language that respondent shall cease the practice of medicine for failing to have an approved third-party chaperone.

Formerly # 26, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

26. Prohibited Practice

Restructured the formatting of the condition to clarify the type of practice prohibition and to require that all patients be notified of prohibition. Deleted language that required a written notification in addition to verbal. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

Formerly # 27, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

27. Notification

Required notification to be within seven days of the effective date of the decision rather than prior to practicing medicine.

Formerly # 28, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

31. General Probation Requirements Unit Compliance

Reformatted the conditions and added clarification regarding notification of residence or practice out-of-state and of email and telephone number.

Formerly # 32, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

32. Interview with the Board or its designee

Reworded for clarity. Formerly # 33, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

Formerly 33. Residing or Practicing Out-of-State

Deleted condition due to combining conditions 33 and 34 to clarify non-practice regardless of physician location.

Formerly # 34, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

Formerly 34. Failure to Practice Medicine- California Resident

Deleted condition due to combining conditions 33 and 34 to clarify non-practice regardless of physician location.

Formerly # 35, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

New 33. Non-Practice While on Probation

Combined former conditions #33 and #34. Clarified non-practice regardless of physician location. Added clinical training for non-practice of more than 18 calendar months, defined non-practice, and required physician to practice in two years.

35,34. Completion of Probation

Formerly # 36, it is re-numbered to reflect the deletion of former #12. Formerly # 35, it is re-numbered to reflect the combination of conditions #33 and #34. Reference to "cost recovery" is deleted condition due to elimination of authority to order cost recovery. See Business and Professions Code section 125.3(k).

36-35. Violation of Probation

Formerly # 37, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board." Formerly # 36, it is re-numbered to reflect the combination of conditions #33 and #34.

Formerly 37. Cost Recovery

Deleted condition due to elimination of authority to order cost recovery. See Business and Professions Code section 125.3(k).

Formerly # 38, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

38. 36. License Surrender

Formerly 38, it is re-numbered to reflect the combination of conditions #33 and #34 and the deletion of condition #37. Also, reworded for clarity.

Formerly # 39, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

39. 37. Probation Monitoring Costs

Formerly 39, it is re-numbered to reflect the combination of conditions #33 and #34 and the deletion of condition #37. Also, deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

Formerly # 40, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

**STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
MODEL DISCIPLINARY ORDERS AND
DISCIPLINARY GUIDELINES**

Business and Professions Code section 2229 mandates protection of the public shall be the highest priority for the Medical Board and for the Administrative Law Judges of the Medical Quality Hearing Panel. Section 2229 further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees. To implement the mandates of section 2229, the Board has adopted the Manual of Model Disciplinary Orders and Disciplinary Guidelines (guidelines), 1140th Edition. Consistent with the mandates of section 2229, these guidelines set forth the discipline the Board finds appropriate and necessary for the identified violations. In addition to protecting the public and, where not inconsistent, rehabilitating the licensee, the Board finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection.

The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, and demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

The Model Disciplinary Orders contain three sections: three (3) Disciplinary Orders; twenty-three (23) Optional Conditions whose use depends on the nature and circumstances of the particular case; and ~~eleven thirteen~~ (113) Standard Conditions that generally appear in all probation cases. All orders should place the Disciplinary Order(s) first, ~~optional condition(s)~~ Optional Condition(s) second, and ~~standard conditions~~ Standard Condition(s) third.

~~The Model Disciplinary Guidelines list proposed terms and conditions for more than twenty four (24) sections of the Business and Professions Code.~~

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MODEL DISCIPLINARY ORDERS

1. Revocation - Single Cause

Certificate No. _____ issued to respondent _____ is revoked.

2. Revocation - Multiple Causes

Certificate No. _____ issued to respondent _____ is revoked pursuant to Determination of Issues (e.g. I, II, and III), separately and for all of them.

3. Standard Stay Order

However, revocation stayed and respondent is placed on probation for (e.g., ten) years upon the following terms and conditions.

OPTIONAL CONDITIONS

4. Actual Suspension

As part of probation, respondent is suspended from the practice of medicine for (e.g., 90 days) beginning the sixteenth (16th) day after the effective date of this decision.

5. Controlled Substances - Total Restriction

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

If respondent forms the medical opinion, after ~~a an appropriate good-faith~~ prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following ~~an appropriate prior good-faith~~ examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

6. Controlled Substances - Surrender of DEA Permit

Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Board or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

7. Controlled Substances - Partial Restriction

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s) _____ (e.g., IV and V) of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If respondent forms the medical opinion, after an appropriate good faith prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior good faith examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Note: Also use Condition 8, which requires that separate records be maintained for all controlled substances prescribed.

(Option)

Respondent shall immediately surrender respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, respondent shall submit proof that respondent has surrendered respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, ~~the~~ respondent shall submit a true copy of the permit to the Board or its designee.

8. Controlled Substances- Maintain Records and Access to Records and Inventories

Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

~~Failure to maintain all records, to provide immediate access to the inventory, or to make all records available for immediate inspection and copying on the premises, is a violation of probation.~~

9. Controlled Substances - Abstain From Use

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawfully prescribed lawful prescription medications, respondent shall notify the Board or its designee of the: issuing practitioner's name, address, and telephone number; medication name, and strength, and quantity; and issuing pharmacy name, address, and telephone number.

If respondent has a positive biological fluid test for any substance not legally prescribed and not reported to the Board or its designee, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

10. Alcohol - Abstain From Use

Respondent shall abstain completely from the use of products or beverages containing alcohol.

If respondent has a positive biological fluid test for alcohol, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

11. Biological Fluid Testing

Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. "Biological fluid testing" may include, but is not limited to, urine, blood, breathalyzer, hair follicle testing, or similar drug screening approved by the Board or its designee. Within 30 calendar days of this Decision, Prior to practicing medicine, respondent shall, at respondent's expense, contract with a laboratory or service approved in advance by the Board or its designee that will conduct random, unannounced, observed, urine biological fluid testing a minimum of four times each month. The contract shall require results of the urine tests to be transmitted by the laboratory or service directly to the Board or its designee within four hours of the results becoming available. Respondent shall Failure to maintain this laboratory or service contract during the period of probation is a violation of probation.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and respondent. Failure to submit to or comply with the time frame for submitting to, or failure to complete the required biological fluid testing, is a violation of probation."

If respondent fails to cooperate in a random biological fluid testing program within the specified time frame, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good

cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

12. Community Service - Free Services

[Medical community service shall only be authorized in cases not involving quality of care.]

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval a community service plan in which respondent shall within the first 2 years of probation, provide _____ hours of free services (e.g., medical or nonmedical) to a community or non-profit organization. If the term of probation is designated for 2 years or less, the community service hours must be completed not later than 6 months prior to the completion of probation.

Prior to engaging in any community service respondent shall provide a true copy of the Decision(s) to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where respondent provides community service and shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition. ~~Note: In quality of care cases, only non-medical community service is allowed unless respondent passes a competency exam or otherwise demonstrates competency prior to providing community service.~~

13. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified-~~limited to classroom, conference, or seminar settings.~~ The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

14. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices, ~~at respondent's expense,~~ equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program,

University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

15. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

16. ~~Ethics Course~~ Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of

Regulations (CCR) section 1358.1 course in ethics, at respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

~~An ethics course~~ A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course program would have been approved by the Board or its designee had the program course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

17. Professional Boundaries Program

Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program, ~~at respondent's expense,~~ equivalent to the Professional Boundaries Program, offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine ("Program"). Respondent, at the Program's discretion, shall undergo and complete the Program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The Program shall evaluate respondent at the end of the training and the Program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire Program not later than six (6) months after respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the Program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with Program recommendations. At the completion of the Program, respondent shall submit to a final evaluation. The Program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

~~The Program's determination~~ Program has the authority to determine whether or not respondent successfully completed the Program ~~shall be binding~~.

A professional boundaries course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

~~Failure to participate in and complete successfully all phases of the Program, as outlined above, is a violation of probation.~~

(Option # 1: Condition Precedent)

Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Board or its designee in writing.

(Option # 2: Condition Subsequent)

If respondent fails to complete the Program within the designated time period, respondent shall cease the practice of medicine within ~~72 hours~~ three (3) calendar days after being notified by the Board or its designee that respondent failed to complete the Program.

18. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's area of practice in which respondent was alleged to be deficient ~~specialty or sub-specialty~~, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. ~~The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.~~ Determination as to whether respondent successfully completed the

examination or successfully completed the program is solely within the program's jurisdiction.

~~Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Board or its designee agrees in writing to a later time for completion.~~

~~Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.~~

[Note: The following language shall be included in this condition unless Option #1 is included: If respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the respondent did not successfully complete the clinical training program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.]

(Option #1: Condition Precedent)

Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Board or its designee in writing, except that respondent may practice in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

(Option#2: Condition Subsequent)

~~If respondent fails to complete the clinical training program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the Board or its designee that respondent failed to complete the clinical training program.~~

(Option#23)

~~After~~ Within 60 days after respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

~~Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.~~

19. Oral and/or Written Examination

[NOTE: This condition should **only** be used where a clinical training program is not appropriate.]

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass an oral and/or written examination, administered by the Board or its designee Probation Unit. The Board or its designee shall designate a subject matter and administer the oral and/or written examination in a subject to be designated by the Board or its designee and the oral examination shall be audio tape recorded.

If the examination is an oral examination, it shall be conducted in accordance with section 2293(a) and (b) of the Code.

If respondent is required to take and pass a written exam, that examination shall be either the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Board or its designee.

~~If respondent fails the first examination, respondent shall be allowed to take and pass a second examination, which may consist of an oral and/or written examination. The waiting period between the first and second examinations shall be at least 90 calendar days.~~

Failure to pass the required oral and/or written examination within 180 calendar days after the effective date of this Decision is a violation of probation. Respondent shall pay the costs of all examinations. ~~For purposes of this condition, if respondent is required to take and pass a written exam, it shall be either the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Board or its designee.~~

[Note: The following language shall be included in this condition unless Option #1 is included: If respondent fails to pass the first examination, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not practice medicine until respondent successfully passes the examination, as evidenced by written notice to respondent from the Board or its designee.]

~~(Continue with either one of these two options:-)~~

(Option 1: Condition Precedent)

Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Board or its designee in writing. This prohibition shall not bar respondent from practicing in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

Note: The condition precedent option is particularly recommended in cases where respondent has been found to be incompetent, repeatedly negligent, or grossly negligent.

(Option 2: Condition Subsequent)

~~If respondent fails to pass the first examination, respondent shall be suspended from the practice of medicine. Respondent shall cease the practice of medicine within 72 hours after being notified by the Board or its designee that respondent has failed the examination.~~

~~Respondent shall remain suspended from the practice of medicine until respondent successfully passes a repeat examination, as evidenced by written notice to respondent from the Board or its designee.~~

20. Psychiatric Evaluation

Within 30 calendar days of the effective date of this Decision, and on a whatever periodic basis thereafter may be required by the Board or its designee, respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

~~Failure to undergo and complete a psychiatric evaluation and psychological testing, or comply with the required additional conditions or restrictions, is a violation of probation.~~

(Option: Condition Precedent)

Respondent shall not engage in the practice of medicine until notified by the Board or its designee that respondent is mentally fit to practice medicine safely. The period of time that respondent is not practicing medicine shall not be counted toward completion of the term of probation.

21. Psychotherapy

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require respondent to undergo psychiatric evaluations by a Board-appointed board certified psychiatrist. If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice

of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations. ~~Failure to undergo and continue psychotherapy treatment, or comply with any required modification in the frequency of psychotherapy, is a violation of probation.~~

Note: This condition is for those cases where the evidence demonstrates that the respondent has had impairment (impairment by mental illness, alcohol abuse and/or drug self-abuse) related to the violations but is not at present a danger to respondent's patients.

22. Medical Evaluation and Treatment

Within 30 calendar days of the effective date of this Decision, and on a periodic basis thereafter as may be required by the Board or its designee, respondent shall undergo a medical evaluation by a Board-appointed physician who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. Respondent shall provide the evaluating physician any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If respondent is required by the Board or its designee to undergo medical treatment, respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician of respondent's choice. Upon approval of the treating physician, respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Board or its designee indicating whether or not the respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment, ~~that the Board or its designee deems necessary.~~

If, prior to the completion of probation, respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

~~Failure to undergo and continue medical treatment or comply with the required additional conditions or restrictions is a violation of probation.~~

(Option- Condition Precedent)

Respondent shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that respondent is medically fit to practice safely.

Note: This condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations.

23. Monitoring - Practice/Billing

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a _____ (~~i.e.,~~ **[insert:** practice, billing, or practice and billing]) monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's _____ (~~i.e.,~~ **[insert:** practice, billing, or practice and billing]) shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of **[insert:** medicine or billing, or both], and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. ~~be suspended from~~ Respondent shall cease the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. ~~Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Board or its designee.~~

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

~~Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.~~

24. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the respondent's practice setting changes and the respondent is no longer practicing in a setting in compliance with this Decision, the respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

25. Third Party Chaperone

During probation, respondent shall have a third party chaperone present while consulting, examining or treating _____ (e.g., [insert: male, female, or minor]) patients. Respondent shall, within 30 calendar days of the effective date of the Decision, submit to the Board or its designee for prior approval name(s) of persons who will act as the third party chaperone.

If respondent fails to obtain approval of a third party chaperone within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a chaperone is approved to provide monitoring responsibility.

Each third party chaperone shall ~~initial~~ sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient ~~name~~ initials, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation. ~~Failure to maintain a log of all patients requiring a third party chaperone, or to make the log available for immediate inspection and copying on the premises, is a violation of probation.~~

Respondent is prohibited from terminating employment of a Board-approved third party chaperone solely because that person provided information as required to the Board or its designee.

If the third party chaperone resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name of the person(s) who will act as the third party chaperone. If respondent fails to obtain approval of a replacement chaperone within 60 calendar days of the resignation or unavailability of the chaperone, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement chaperone is approved and assumes monitoring responsibility.

(Option)

Respondent shall provide written notification to respondent's patients that a third party chaperone shall be present during all consultations, examination, or treatment with (e.g., [insert: male, female or minor]) patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the notification for the entire term of probation.

Note: Sexual offenders should normally be placed in a monitored environment.

26. Prohibited Practice

During probation, respondent is prohibited from _____ (e.g., insert: practicing, performing, or treating)] _____ (e.g., insert: a specific medical procedure; surgery; on a specific patient population)]. After the effective date of this Decision, ~~the first all time that patients being treated by the seeking the prohibited services makes an appointment, orally~~ respondent shall be notified the patient that the respondent does not is prohibited from _____ (e.g., insert: practice, perform or treat)] _____ (e.g., insert a specific medical procedure; surgery; on a specific patient population)]. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order; shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee; and shall retain the log for the entire term of probation. ~~Failure to maintain a log as defined in the section, or to make the log available for immediate inspection and copying on the premises during business hours is a violation of probation.~~

~~In addition to the required oral verbal notification, after the effective date of this Decision, the first each time that a patient who seeks the prohibited services presents to respondent, respondent shall provide a written notification to the patient stating that respondent does not _____ (e.g., insert: practice, perform or treat)] _____ (e.g., insert: a specific medical procedure; surgery; on a specific patient population)]. Respondent shall maintain a copy of the written notification in the patient's file, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the notification for the entire term of probation. Failure to maintain the written notification as defined in the section, or to make the notification available for immediate inspection and copying on the premises during business hours is a violation of probation.~~

STANDARD CONDITIONS

27. Notification

~~Prior to engaging in the practice of medicine~~ Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of ~~the this Decision(s) and Accusation(s)~~ to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum

tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

28. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

29. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

30. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

31. General Probation Unit Compliance Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

32. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, ~~with the Board or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.~~

33. Residing or Practicing Out of State

~~In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.~~

~~All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.~~

~~Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.~~

(Optional)

~~Any respondent disciplined under B&P Code sections 141(a) or 2305 (another state discipline) may petition for modification or termination of penalty: 1) if the other state's discipline terms are modified, terminated or reduced; and 2) if at least one year has elapsed from the effective date of the California discipline.~~

34. Failure to Practice Medicine – California Resident

~~In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.~~

~~All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.~~

~~Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.~~

33. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 19 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

35. 34. Completion of Probation

Respondent shall comply with all financial obligations (e.g., ~~cost recovery~~, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

36. 35. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

37. Cost Recovery

~~Within 90 calendar days from the effective date of the Decision or other period agreed to by the Board or its designee, respondent shall reimburse the Board the amount of \$_____ for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent his/her obligation to reimburse the Board for its costs.~~

38. 36. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to the voluntary surrender of his or her respondent's license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation ~~and the surrender of respondent's license shall be deemed disciplinary action~~. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

39. 37. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. ~~Failure to pay costs within 30 calendar days of the due date is a violation of probation.~~

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RECOMMENDED RANGE OF PENALTIES FOR VIOLATIONS

DISCIPLINE BY ANOTHER STATE DISCIPLINARY ACTION TAKEN BY OTHERS **[B&P 141(a) & 2305]**

Minimum penalty: Same for similar offense in California

Maximum penalty: Revocation

~~1. Oral or Written Examination as a condition precedent to practice in California~~

MISLEADING ADVERTISING (B&P 651 & 2271)

Minimum penalty: Stayed revocation, 15 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [13]
3. ~~Ethics Course~~ Professionalism Program (Ethics Course) [16]
4. Monitoring-Practice/Billing [23]
5. Prohibited Practice [26]

EXCESSIVE PRESCRIBING (B&P 725), or **PRESCRIBING WITHOUT AN APPROPRIATE PRIOR EXAMINATION (B&P 2242)**

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances-Total DEA restriction [5],
Surrender DEA permit [6] or,
Partial DEA restriction [7]
3. Maintain Records and Access to Records and Inventories [8]
4. Education Course [13]
5. Prescribing Practices Course [14]
6. Medical Record Keeping Course [15]
7. ~~Ethics Course~~ Professionalism Program (Ethics Course) [16]
8. Clinical Training Program [18] ~~or Oral or Written Examination [19]~~
9. Monitoring-Practice/Billing [23]

EXCESSIVE TREATMENTS (B&P 725)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Medical Record Keeping Course [15]
4. ~~Ethics Course~~ Professionalism Program (Ethics Course) [16]
5. Clinical Training Program [18] ~~or Oral or Written Examination [19]~~
6. Monitoring-Practice/Billing [23]
7. Prohibited Practice [26]

SEXUAL MISCONDUCT (B&P 726)

Minimum penalty: Stayed revocation, 7 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [13]
3. ~~Ethics Course~~ Professionalism Program (Ethics Course) [16]
4. Professional Boundaries Program [17]
5. Psychiatric Evaluation [20]
6. Psychotherapy [21]
7. Monitoring-Practice/Billing [23]
8. Third Party Chaperone [25]
9. Prohibited Practice [26]

SEXUAL EXPLOITATION (B&P 729)

Minimum penalty: Revocation

Effective January 1, 2003, Business and Professions Code 2246 was added to read, "Any proposed decision or decision issued under this article that contains any finding of fact that the licensee engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge."

MENTAL OR PHYSICAL ILLNESS (B&P 820)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Oral or Written Examination [19]
2. Psychiatric Evaluation [20]
3. Psychotherapy [21]
4. Medical Evaluation and Treatment [22]
5. Monitoring-Practice/Billing [23]
6. Solo Practice Prohibition [24]
7. Prohibited Practice [26]

REGISTRATION AS A SEX OFFENDER (B&P 2232)

Minimum penalty: Revocation

Effective January 1, 2004 section 2232(a) was added to the Business and Professions Code read, "Except as provided in subdivisions (b), (c), and (d), the Board shall promptly revoke the license of any person who, at any time after January 1, 1947, has been required to register as a sex offender pursuant to the provisions of section 290 of the Penal Code."

GENERAL UNPROFESSIONAL CONDUCT (B&P 2234), or GROSS NEGLIGENCE [B&P 2234 (b)], or REPEATED NEGLIGENT ACTS [B&P 2234(c)], or INCOMPETENCE [B&P 2234(d)], or FAILURE TO MAINTAIN ADEQUATE RECORDS (B&P 2266)

Minimum penalty: Stayed revocation, 5 years probation

NOTE: In cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered.

Maximum penalty: Revocation

1. Education course [13]
2. Prescribing Practices Course [14]
3. Medical Record Keeping Course [15]
4. ~~Ethics Course~~ Professionalism Program (Ethics Course) [16]
5. Clinical Training Program [18]
6. ~~Oral or Written Examination [19] (preferably Condition Precedent)~~
7. ~~6.~~ Monitoring-Practice/Billing [23]
8. ~~7.~~ Solo Practice Prohibition [24]
9. ~~8.~~ Prohibited Practice [26]

DISHONESTY - Substantially related to the qualifications, functions or duties of a physician and surgeon and *arising from* or occurring during patient care, treatment, management or billing [B&P 2234(e)]

Minimum penalty: Stayed revocation, one year suspension at least 7 years probation

Maximum penalty: Revocation

1. ~~Ethics Course~~ Professionalism Program (Ethics Course) [16]
2. ~~Oral or Written Examination [19]~~
23. Psychiatric Evaluation [20]
34. Medical Evaluation [22]
45. Monitoring-Practice/Billing [23]
56. Solo Practice Prohibition [24]
67. Prohibited Practice [26]
7. Victim Restitution

DISHONESTY - Substantially related to the qualifications, function or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing [BP 2234 (e)]

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Community Service [12]
2. ~~3.~~ Ethics Course Professionalism Program (Ethics Course) [16]
3. ~~4.~~ Psychiatric Evaluation [20]
4. ~~5.~~ Medical Evaluation [22]
5. ~~6.~~ Monitoring-Practice/Billing (if financial dishonesty or conviction of financial crime) [23]
6. ~~7.~~ Restitution to Victim Restitution

PROCURING LICENSE BY FRAUD (B&P 2235)

1. Revocation [1] [2]

CONVICTION OF CRIME - Substantially related to the qualifications, functions or duties of a physician and surgeon and *arising from* or occurring during patient care, treatment, management or billing (B&P 2236)

Minimum penalty: Stayed revocation, one year suspension, at least 7 years probation

Maximum penalty: Revocation

1. Community Service [12]

- ~~1.~~ 2. Ethics Course Professionalism Program (Ethics Course) [16]
- ~~2.~~ Oral or Written Examination [19]
3. Psychiatric Evaluation [20]
4. Medical Evaluation and Treatment [22]
5. Monitoring-Practice/Billing [23]
6. Solo Practice Prohibition [24]
7. Prohibited Practice [26]
7. Victim Restitution

CONVICTION OF CRIME - Felony conviction substantially related to the qualifications, functions or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing (B&P 2236)

Minimum penalty: Stayed revocation, 7 years probation

Maximum penalty: Revocation

1. Suspension of 30 days or more [4]
2. Community Service [12]
- ~~2.~~ 3. Ethics Course Professionalism Program (Ethics Course) [16]
- ~~3.~~ 4. Psychiatric Evaluation [20]
- ~~4.~~ 5. Medical Evaluation and Treatment [22]
- ~~5.~~ 6. Monitoring-Practice/Billing (if dishonesty or conviction of a financial crime) [23]
- ~~6.~~ 7. Victim Restitution

CONVICTION OF CRIME - Misdemeanor conviction substantially related to the qualifications, functions or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing (B&P 2236)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Community Service [12]
- ~~1.~~ 2. Ethics Course Professionalism Program (Ethics Course) [16]
- ~~2.~~ 3. Psychiatric Evaluation [20]
- ~~3.~~ 4. Medical Evaluation and Treatment [22]
- ~~4.~~ 5. Victim Restitution

CONVICTION OF DRUG VIOLATIONS (B&P 2237), or VIOLATION OF DRUG STATUTES (B&P 2238), or EXCESSIVE USE OF CONTROLLED SUBSTANCES (B&P 2239), or PRACTICE UNDER THE INFLUENCE OF NARCOTIC (B&P 2280)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances - Total DEA restriction [5], Surrender DEA permit [6], or Partial DEA restriction [7]
3. Maintain Drug Records and Access to Records and Inventories [8]
4. Controlled Substances - Abstain From Use [9]
5. Alcohol-Abstain from Use [10]
6. Biological Fluid Testing [11]
7. Education Course [13]

8. Prescribing Practices Course [14]
9. Medical Record Keeping Course [15]
10. ~~Ethics Course~~ Professionalism Program (Ethics Course) [16]
- ~~11. Oral or Written Examination [19]~~
- ~~12. 11. Psychiatric Evaluation [20]~~
- ~~13. 12. Psychotherapy [21]~~
14. ~~13.~~ Medical Evaluation and Treatment [22]
- ~~15. 14.~~ Monitoring-Practice/Billing [23]
- ~~16. 15.~~ Prohibited Practice [26]

ILLEGAL SALES OF CONTROLLED SUBSTANCES (B&P 2238)

Revocation [1] [2]

EXCESSIVE USE OF ALCOHOL (B&P 2239) or PRACTICE UNDER THE INFLUENCE OF ALCOHOL (B&P 2280)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances-Abstain From Use [9]
3. Alcohol-Abstain from Use [10]
4. Biological Fluid Testing [11]
5. ~~Ethics Course~~ Professionalism Program (Ethics Course) [16]
- ~~6. Oral or Written Examination [19]~~
- ~~7. 6.~~ Psychiatric Evaluation [20]
- ~~8. 7.~~ Psychotherapy [21]
- ~~9. 8.~~ Medical Evaluation and Treatment [22]
- ~~10. 9.~~ Monitoring-Practice/Billing [23]

PRESCRIBING TO ADDICTS (B&P 2241)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances- Total DEA restriction [5],
Surrender DEA permit [6], or
Partial restriction [7]
3. Maintain Drug Records and Access to Records and Inventories [8]
4. Education Course [13]
5. Prescribing Practices Course [14]
6. Medical Record Keeping Course [15]
7. ~~Ethics Course~~ Professionalism Program (Ethics Course) [16]
8. Clinical Training Program [18]
- ~~9. Oral or Written Examination [19]~~
- ~~10. 9.~~ Monitoring-Practice/Billing [23]
- ~~11. 10.~~ Prohibited Practice [26]

ILLEGAL CANCER TREATMENT (B&P 2252 and 2258)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education course [13]
3. Prescribing Practices Course [14]
- ~~3.~~ 4. Ethics Course Professionalism Program (Ethics Course) [16]
- ~~4.~~ 5. Clinical Training Program [18]
- ~~5.~~ Oral or Written Examination [19]
6. Monitoring-Practice/Billing [23]
7. Prohibited Practice [26]

**MAKING FALSE STATEMENTS (B&P 2261), or
ALTERATION OF MEDICAL RECORDS (B&P 2262)**

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Medical Record Keeping Course [15]
3. ~~Ethics Course~~ Professionalism Program (Ethics Course) [16]
4. If fraud involved, see "Dishonesty" guidelines

AIDING AND ABETTING UNLICENSED PRACTICE (B&P 2264)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [13]
3. ~~Ethics Course~~ Professionalism Program (Ethics Course) [16]
- ~~4.~~ Oral or Written Examination [19]
5. ~~4.~~ Monitoring-Practice/Billing [23]
6. ~~5.~~ Prohibited Practice [26]

FICTITIOUS NAME VIOLATION (B&P 2285)

Minimum penalty: Stayed revocation, one year probation

Maximum penalty: Revocation

IMPERSONATION OF APPLICANT IN EXAM (B&P 2288)

1. Revocation [1] [2]

PRACTICE DURING SUSPENSION (B&P 2306)

1. Revocation [1] [2]

BUSINESS ORGANIZATION IN VIOLATION OF CHAPTER (B&P 2417)

Minimum penalty: Revocation

Effective January 1, 2002, Business and Professions Code section 2417 was added to read, in part, "(b) A physician and surgeon who practices medicine with a business organization knowing that it is owned or operated in violation of Section 1871.4 of the Insurance Code, Section 14107 or 14107.2 of the Welfare and Institutions Code, or Section 549 or 550 of the Penal Code shall have his or her license to practice permanently revoked."

VIOLATION OF PROBATION

Minimum penalty: 30 day suspension

Maximum penalty: Revocation

The maximum penalty should be given for repeated similar offenses or for probation violations revealing a cavalier or recalcitrant attitude. A violation of any of the following conditions of probation should result in, at minimum, a 60 day suspension:

1. Controlled Substances -Maintain Records and Access to Records and Inventories [8]
2. Biological Fluid Testing [11]
3. Professional Boundaries Program [17]
4. Clinical Training Program [18]
5. Psychiatric Evaluation [20]
6. Psychotherapy [21]
7. Medical Evaluation and Treatment [22]
8. Third Party Chaperone [25]



October 18, 2010

Susan Cady
Enforcement Manager
Medical Board of California
2005 Evergreen St, Suite 1200
Sacramento, CA 95815

Subject: Comments on
“Manual of Model Disciplinary Orders and Disciplinary Guidelines (11th Edition/2010)”

Dear Ms. Cady:

The California Medical Association (CMA) respectfully submits the following comments for consideration related to the proposed amendments to the “Manual of Model Disciplinary Orders and Disciplinary Guidelines (11th Edition/2010)”. The comments are in response to the solicitation for comments in a notice of proposed rulemaking posted on September 13, 2010 for Division 13 of Title 16 of the California Code of Regulations.

The California Medical Association is an advocacy organization that represents 35,000 California physicians. Dedicated to the health of Californians, CMA is active in the legal, legislative, reimbursement and regulatory areas on behalf of California physicians and their patients.

I. Background

We understand that the purpose of the proposed amendments to the Manual of Model Disciplinary Orders and Disciplinary Guidelines is to reflect changes in law, clarify existing language, and make technical changes to reflect the current probationary environment. CMA would like to offer additional revisions for your consideration.

II. CMA’s Comments

CMA has several concerns regarding the proposed disciplinary guidelines as follows:

- A. **Section 9. Controlled Substances - Abstain From Use**
- Section 10. Alcohol - Abstain From Use**
- Section 11. Biological Fluid Testing**

These sections essentially provide for an automatic suspension of a license in the event the respondent has a positive biological fluid test for certain substances or fails to cooperate in a random biological fluid testing program. While we acknowledge that such events are a violation of probation, as was the case with the diversion program, we have serious reservations that the Medical Board may lawfully order the cessation of medical practice under these circumstances.

First, the Legislature, in its detailed statutory scheme governing Medical Board disciplinary powers, has not authorized an automatic suspension in these cases, as it has where a licensee has been convicted of a felony. See Business & Professions Code §2236.1. Accordingly, the Medical Board lacks the statutory authority to issue such suspensions. See *Medical Board of California v. Superior Court* (2003) 111 Cal.App.4th 163 (Business & Professions Code provision governing a physician's participation in the diversion program did not permit disciplinary action against a physician solely on his failure to complete the program).

Further, there are serious questions as to the constitutionality of the proposed guidelines purporting to authorize automatic suspension of the license. For example, in *Ralph Williams Ford v. New Car Dealers policy and Appeals Board* (1973) 30 Cal.App.3d 494, at issue was whether the Director of Motor Vehicles could lawfully suspend a license in the event the licensee violated a condition of probation. Recognizing the constitutional infirmity of the activity, the court stated:

The Fourteenth Amendment protects the pursuit of one's profession from abridgment by arbitrary state action, and a state cannot exclude a person from any occupation in a manner or for reasons that contravene due process of law. (*Endler v. Schutzbank*, 68 Cal.2d 162, 169-170, 65 Cal.Rptr. 297, 436 P.2d 297.) Here, the revocation of probation, and therefore the revocation of Williams' dealer's license, is left to the discretion of the Director of Motor Vehicles. But "an individual must be afforded notice and an opportunity for a hearing before he is deprived of any significant property interest, ..." (*Randone v. Appellate Department*, 5 Cal.3d 536, 541, 96 Cal.Rptr. 709, 488 P.2d 13.) Although Williams received notice and a hearing on its past violations, the conditions of probation dispense with notice and hearing on any future violations that may bring about a revocation of its license.

In criminal law "fundamental principles of due process and fair play demand, ... that after a summary revocation of probation and before sentencing a hearing is required at which the defendant is entitled to be represented by counsel, to be advised of the alleged violation and given an opportunity to deny or explain it, and, if necessary, present witnesses on his own behalf." (*People v. Youngs*, 23 Cal.App.3d 180, 188, 99 Cal.Rptr. 101; *People v. Vickers*, 8 Cal.3d 451, 458-461, 105 Cal.Rptr. 305, 503 P.2d 313; see also, *Morrissey v. Brewer*, 408 U.S. 471, 33 L.Ed.2d 484, 92 S.Ct. 2593.) Due process requires a comparable opportunity for notice and hearing on the revocation of an occupational license. (Cf. *Goldberg v. Kelly*, 397 U.S. 254, 25 L.Ed.2d 287, 90 S.Ct. 1011.)

Accordingly, CMA believes licensees under probation should be accorded a pre-deprivation hearing on the issue to determine whether the licensee in fact imposes a danger to patients. If the Medical Board truly believes the licensee poses a threat to patient care, the Board can certainly take steps to prevent harm by seeking a temporary restraining order or interim suspension.

B. Section 16. Professionalism Program (Ethics Course)

This section requires respondents to enroll in a professionalism program that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. To be consistent with the other sections of the guidelines that require respondents to participate in educational courses and specify that the courses must be “equivalent to the ... Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program),” we recommend that this section be amended to state that the professionalism program must be “equivalent to the Professionalism Program offered by the Institute for Medical Quality (IMQ).” Providing more information regarding the content of a recognized professionalism program will clarify the type of professionalism program that meets the Medical Board’s standards.

The IMQ Professionalism Program was developed to comply with the requirements established by the Medical Board of California. The program centers on both the legal and ethical dimensions of the practice of medicine in California, and it introduces participants to a range of resources to address present or future problems. Full participation and completion of all assignments are required for completion of the program. The Program is divided into three components.

The pre-course component consists of a background assessment application, a baseline knowledge test and pre course reading. The purpose of this component is to determine the participant’s knowledge/awareness of ethical/legal issues related to the practice of medicine in California, as well as information about the participant’s knowledge of the legal and ethical issues related to the specific case(s) for which the participant has been referred to the program. Participants prepare an assessment of their expectations of the program, recognition of need for change and commitment to change.

The second component is the two-day ethics course. It includes a series of components that move from demonstration to practice and application. Issues covered include: what are ethical issues and when they arise, clarification of legal issues, resources to analyze situations and a decision making model. The course is very interactive, and it is designed to provide participants with a full understanding of the ethical and legal aspects of their own violations and knowledge about how to access resources to deal with future issues.

The third component is required assessments over a one-year period following the course. It consists of the post-course test on California law and ethics given at the end of the two-day course, and 6 month and 12 month follow-up assessments. At 6 months, participants submit information regarding their practice during the period since the course and complete a skills review exercise. At 12 months they provide a final report on changes in their practice profile and

a self-assessment status report. On completion of the course, a report is sent to the Medical Board.

III. Conclusion

In conclusion, the CMA believes that the recommended changes will improve the disciplinary guidelines making it a more useful document for those involved in the physician disciplinary process.

Sincerely,

Yvonne Choong
Associate Director, Center for Medical and Regulatory Policy
California Medical Association

Cc: Lisa Folberg, CMA Vice-President, Center for Medical and Regulatory Policy

*Standing Committees, Task Forces & Councils
of the Medical Board of California
October 2010*

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*Legislation Subcommittee	Sharon Levine, M.D. Shelton Duruisseau, Ph.D.		Jennifer Simoes		

Revised: 10/26/10

*For internal reference only; not posted on web



Herb K. Schultz was recently appointed by President Barack Obama to serve as Regional Director at the U.S. Department of Health and Human Services' (HHS) Region IX. Region IX includes the states of Arizona, California, Nevada, Hawaii, the territories of American Samoa, Commonwealth of the Northern Marianas Islands, and Guam, as well as the freely associated states of the Federated States of Micronesia, Republic of Marshall Islands, and Republic of Palau. In this role, he serves as HHS Secretary Kathleen Sebelius' key representative in the Region, ensuring that close contact is maintained by the federal government with state, local, tribal, and territorial governmental and external, non-governmental partners on a wide range of health and social service issues. In addition, the HHS

Secretary's 10 Regional Directors/Regional Offices work actively to address the needs of communities and individuals served through HHS programs and policies.

HHS Secretary Sebelius, in announcing Mr. Schultz's appointment, said: "Herb Schultz brings an extensive, working-level knowledge of our department's most important issues, as well as a knowledge of the people and institutions in Region IX," said Secretary Sebelius. "His experience and talents will be invaluable as our department works to effectively implement the Patient Protection and Affordable Care Act."

Previously, Mr. Schultz was Senior Advisor to Governor Arnold Schwarzenegger, and since January of this year, also the Director of the California Recovery Task Force. In this role, he is responsible for the oversight and implementation of the American Recovery and Reinvestment Act of 2009. As Senior Advisor to the Governor from 2008-2010, he represented the Governor on major domestic policy issues, which included serving as a principal advisor on health care reform. Previously, he served as the Senior Health Policy Advisor to the Governor during California's 2006-2008 state debate on comprehensive health care reform. From 2005-2006, he served as Vice President of Government Programs for McKesson Health Solutions, where he oversaw the company's disease management and nurse advice programs for Medicaid and Medicare beneficiaries. During the first year of Governor Schwarzenegger's Administration, Mr. Schultz served as Acting Director of the California Employment Development Department. He also previously served as a member of former Governor Gray Davis' Cabinet as Acting Secretary for the Labor and Workforce Development Agency. He served as the Agency's Undersecretary before his Cabinet-Level appointment, and remained in both roles until the end of the Davis Administration. Prior to that, he was Deputy Director of External Affairs for the California Department of Managed Health Care, and served as Director of the Advisory Committee on Managed Health Care. Mr. Schultz received his BA in Political Science and International Studies from The American University in Washington, DC and has a Masters Degree in Public Policy from Georgetown University, also in Washington, DC.

**0758 - Medical Board
Analysis of Fund Condition**

(Dollars in Thousands)

	Actual 2009-10	Current Year 2010-11	BY 2011-12	BY+1 2012-13	BY+2 2013-14
BEGINNING BALANCE	\$ 24,379	\$ 27,903	\$ 24,058	\$ 21,397	\$ 17,883
Prior Year Adjustment	\$ 41	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 24,420	\$ 27,903	\$ 24,058	\$ 21,397	\$ 17,883
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	\$ 271	\$ 314	\$ 313	\$ 313	\$ 313
125700 Other regulatory licenses and permits	\$ 5,321	\$ 5,533	\$ 5,533	\$ 5,533	\$ 5,533
125800 Renewal fees	\$ 44,670	\$ 43,357	\$ 44,838	\$ 45,226	\$ 45,621
125900 Delinquent fees	\$ 94	\$ 96	\$ 96	\$ 96	\$ 96
142500 Miscellaneous services to the public	\$ 37	\$ 25	\$ 25	\$ 25	\$ 25
150300 Income from surplus money investments	\$ 178	\$ 155	\$ 137	\$ 113	\$ 84
160400 Sale of fixed assets	\$ 19	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 23	\$ -	\$ -	\$ -	\$ -
161400 Miscellaneous revenues	\$ 1	\$ 20	\$ 20	\$ 20	\$ 20
164300 Penalty assessments - Probation Monitoring		\$ 1,100	\$ 1,100	\$ 1,100	\$ 1,100
Totals, Revenues	\$ 50,614	\$ 50,600	\$ 52,062	\$ 52,426	\$ 52,792
Transfers:					
TOTALS, REVENUES AND TRANSFERS	\$ 50,614	\$ 50,600	\$ 52,062	\$ 52,426	\$ 52,792
TOTAL RESOURCES	\$ 75,034	\$ 78,503	\$ 76,120	\$ 73,824	\$ 70,675
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	\$ 40	\$ 81	\$ -	\$ -	\$ -
8880 FSCU (State Operations)		\$ 31			
<u>Budget Act of 2009</u>					
1110 Program Expenditures (State Operations)	\$ 47,091	\$ 54,333	\$ 54,853	\$ 55,950	\$ 57,069
<u>2010-11 Approved BCPs:</u>					
License Application Processing		\$ -	\$ -	\$ -	\$ -
Cal-Licensing System-BCP 1B: BreEZe			\$ 11	\$ 150	\$ 252
<u>Proposed 2011-12 Augmentations (Board):</u>					
Operation Safe Medicine				Disapproved	
Staff Programmer				Disapproved	
Temp Help (District Medical Consultant \$)				Disapproved	
WAAZ/Scanning				Disapproved	
AB 2699: Exemption from Licensure (Volunteer Physicians)				Pending	
<u>Proposed 2011-12 Budget Adjustment (Department):</u>					
CPEI Technical Adjustment			\$ (141)	\$ (160)	\$ (160)
Totals, Disbursements	\$ 47,131	\$ 54,445	\$ 54,723	\$ 55,940	\$ 57,161
FUND BALANCE					
Reserve for economic uncertainties	\$ 27,903	\$ 24,058	\$ 21,397	\$ 17,883	\$ 13,514
Months in Reserve	6.1	5.3	4.6	3.8	2.8

NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2010-11 AND BEYOND.
- B. INTEREST ON FUND ESTIMATED AT .68% in FY 09/10 and beyond.
- C. MED BOARD'S 2009-2010 PROB MONITORING AND OSM BCPs APPROVED WITH NO FUNDING (Prob Mon = \$294,000; OSM = \$510,000); OSM APPROVED FOR 2 YEARS; CONTINUATION OF OSM BEYOND 2 YEARS MUST BE AUTHORIZED VIA SUBMISSION/APPROVAL OF A BCP FOR FY 2011/12.
- D. FY 10-11 RENEWAL FEE REVENUE INCLUDES A ONE-TIME CREDIT OF \$22 FOR EACH PHYSICIAN RENEWING (ELIMINATION OF THE DIVERSION PROGRAM)
- E. OSM (\$567,000, 6.0 PY); ISB (\$106,000, 1.0 PY); Temp Help-MCs (\$196,000); WAAZ/Scanning (\$116,000, 2.0 PY); AB 2699 (\$43,000, 0.5 PY)

10/20/2010

Medical Board of California
 FY 10/11
 Budget Expenditure Report
 (As of August 31, 2010)
 (16.7% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages (Staff & Exec Director)	17,073,307	2,157,208	12.6	14,916,099
Board Members	31,500	0	0.0	31,500
Phy Fitness Incentive Pay	29,623	2,925	9.9	26,698
Temp Help	1,144,410	196,018	17.1	948,392
Overtime	12,143	2,559	21.1	9,584
Staff Benefits	7,155,001	876,234	12.2	6,278,767
Salary Savings	(907,724)			(907,724)
TOTALS, PERS SERVICES	24,538,260	3,234,944	13.2	21,303,316
OPERATING EXP & EQUIP				
General Expense	242,662	19,675	8.1	222,987
Fingerprint Reports	333,448	0	0.0	333,448
Minor Equipment	253,500	0	0.0	253,500
Printing	483,755	214,631	44.4	269,124
Communications	287,780	0	0.0	287,780
Postage	280,511	0	0.0	280,511
Insurance	41,053	0	0.0	41,053
Travel In-State	494,098	0	0.0	494,098
Travel Out-of-State	1,200	0	0.0	1,200
Training	76,895	0	0.0	76,895
Facilities Operation (Rent)	2,758,140	1,933,912	70.1	824,228
Consult/Prof Services	982,594	572,773	58.3	409,821
Departmental Prorata	4,339,488	0	0.0	4,339,488
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	646,809	70,088	10.8	576,741
Data Processing	128,492	2,324	1.8	126,168
Central Admin Svcs (Statewide Prorata)	1,718,857	0	0.0	1,718,857
Attorney General Services	13,347,280	2,092,975	15.7	11,254,305
Office of Administrative Hearings	1,862,591	0	0.0	1,862,591
Evidence/Witness	1,893,439	0	0.0	1,893,439
Court Reporter Services	175,000	0	0.0	175,000
Major Equipment	563,000	0	0.0	563,000
Other Items of Expense	81	30,185	37,265.4	(30,104)
Vehicle Operations	261,925	0	0.0	261,925
TOTALS, OE&E	31,177,740	4,936,543	15.8	26,241,197
TOTALS, EXPENDITURES	55,716,000	8,171,487	14.7	47,544,513
Scheduled Reimbursements	(384,000)	(52,038)	13.6	(331,962)
Distributed Costs	(999,000)	(136,413)	13.7	(862,587)
NET TOTAL, EXPENDITURES	54,333,000	7,983,036	14.7	46,349,964
Unscheduled Reimbursements		(48,655)		
		7,934,381		

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2010 - AUGUST 31, 2010

	FY 10/11 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	10,887,860	1,400,398	current
Staff Benefits	<u>4,367,055</u>	<u>515,474</u>	current
TOTAL PERSONAL SERVICES	15,254,915	1,915,872	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	104,200	13,175	1-2
Printing	214,944	198,860	1-2
Communications	140,780	0	2
Postage	50,000	0	2
Insurance	38,235	0	2
Travel In-State	282,139	0	2
Training	35,209	0	2
Facilities Operations	2,056,940	1,391,438	current
Consultant/Professional Services	300,000	90,019	1-2
Departmental Services	3,175,637	0	current
Interagency Services	3,767	0	current
Data Processing	18,000	0,000	1-2
Statewide Pro Rata	1,257,860	0	current
Attorney General 1/	13,197,280	2,078,865	current
OAH	1,862,591	0	2
Evidence/Witness Fees	1,820,939	0	2
Court Reporter Services	174,750	0	2
Major Equipment	503,000	0	2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	29,798	1-2
Vehicle Operations	210,925	0	2
Minor Equipment	<u>1,600</u>	<u>0</u>	2
TOTAL OPERATING EXPENSES & EQUIPMENT	25,448,877	3,802,155	
DISTRIBUTED COSTS	(945,405)	(136,413)	
TOTAL BUDGET/EXPENDITURES	39,758,387	5,581,614	
Unscheduled Reimbursements		<u>(4,827)</u>	
		<u>5,576,787</u>	

1/See next page for monthly billing detail

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 10/11
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)
page 1 of 1

		<u>Number of Hours</u>	<u>Rate</u>	<u>Amount</u>
July	Attorney Services	5,876.75	170.00	999,047.50
	Paralegal Services	442.75	120.00	53,130.00
	Auditor/Analyst Services	92.25	99.00	9,132.75
	Cost of Suit			<hr/> 1,061,310.25
August	Attorney Services	5,669.25	170.00	963,772.50
	Paralegal Services	376.00	120.00	45,120.00
	Auditor/Analyst Services	87.50	99.00	8,662.50
	Cost of Suit			<hr/> 1,017,555.00
September	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst Services		99.00	0.00
	Cost of Suit			<hr/> 0.00
October	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst Services		99.00	0.00
	Cost of Suit			<hr/> 0.00
November	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst		99.00	0.00
	Cost of Suit			<hr/> 0.00
December	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst		99.00	0.00
	Cost of Suit			<hr/> 0.00

July - Dec Total = 2,078,865.25
FY 10/11 Budget = 13,157,280.00

Revised 9/15/10

ENFORCEMENT/PROBATION RECEIPTS

MONTHLY PROFILE: JULY 2008 - AUGUST 2010

	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Total
Invest Cost Recovery	18,069	1,850	2,935	6,569	3,616	4,564	8,445	14,535	2,716	5,585	3,650	5,200	77,734
Criminal Cost Recovery	0	5,694	0	0	0	0	3,500	0	0	0	0	0	9,194
Probation Monitoring	56,999	17,107	28,739	109,603	53,626	75,517	218,781	232,169	82,153	52,220	44,309	37,530	1,008,753
Exam	825	75	50	3,495	50	2,150	125	5,740	100	75	75	50	12,810
Cite/Fine	3,050	3,200	9,050	2,400	1,500	5,650	4,300	10,400	9,415	5,375	5,700	8,300	68,340
MONTHLY TOTAL	78,943	27,926	40,774	122,067	58,792	87,881	235,151	262,844	94,384	63,255	53,734	51,080	1,176,831
FYTD TOTAL	78,943	106,869	147,643	269,710	328,502	416,383	651,534	914,378	1,008,762	1,072,017	1,125,751	1,176,831	
													FYTD
	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Total
Invest Cost Recovery	4,486	1,050	1,250	740	67	1,161	7,409	11,613	0	2,186	11,388	1,500	42,850
Criminal Cost Recovery	0	0	0	0	0	0	0	0	0	0	0	0	0
Probation Monitoring	46,225	21,354	22,836	34,983	22,419	186,279	345,366	200,249	60,048	59,731	29,879	42,043	1,071,412
Exam	150	250	105	330	3,480	1,658	292	200	1,500	300	325	500	9,090
Cite/Fine	3,500	3,025	2,425	3,225	3,055	5,320	475	4,723	4,600	5,200	3,261	5,340	44,149
MONTHLY TOTAL	54,361	25,679	26,616	39,278	29,021	194,418	353,542	216,785	66,148	67,417	44,853	49,383	1,167,501
FYTD TOTAL	54,361	80,040	106,656	145,934	174,955	369,373	722,915	939,700	1,005,848	1,073,265	1,118,118	1,167,501	
													FYTD
	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Total
Invest Cost Recovery	3,981	971											4,952
Criminal Cost Recovery	0	0											0
Probation Monitoring	43,697	74,202											117,899
Exam	2,475	3,730											6,205
Cite/Fine	5,500	8,250											13,750
MONTHLY TOTAL	55,653	87,153	0	0	0	0	142,807						
FYTD TOTAL	55,653	142,807	142,807	142,807	142,807								

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MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2010 - AUGUST 31, 2010

	FY 10/11 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,532,051	359,287	current
Staff Benefits	<u>1,092,068</u>	<u>135,603</u>	current
TOTAL PERSONAL SERVICES	3,624,119	494,890	
OPERATING EXPENSES & EQUIPMENT			
General Expense	15,000	0	2
Fingerprint Reports*	329,248	0	2
Printing	30,000	7,999	1-2
Communications	50,000	0	2
Postage	73,511	0	2
Travel In-State	25,000	0	2
Training	3,500	0	2
Facilities Operation	225,000	218,708	current
Consult/Professional Services	506,873	75,900	1-2
Departmental Services	421,364	0	current
Interagency Services	499	0	current
Data Processing	3,000	2,324	1-2
Statewide Pro Rata	166,901	0	current
Attorney General	150,000	14,110	current
Evidence/Witness Fees	7,500	0	2
Court Reporter Services	250	0	2
Major Equipment	12,000	0	2
Minor Equipment	<u>67,500</u>	<u>0</u>	2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,087,146	319,041	
SCHEDULED REIMBURSEMENTS	(384,000)	(52,038)	
DISTRIBUTED COSTS	(49,282)	0	
TOTAL BUDGET/EXPENDITURES	5,277,983	761,893	

*Department of Justice invoices for fingerprint reports, name checks, and subsequent arrest reports

Medical Board of California
Board Members' Expense Report
July 1, 2010 - August 31, 2010

	<i>Per Diem*</i>		<i>TOTAL</i>	<i>Travel Expenses*</i>	<i>Total Jul-Aug</i>	<i>Total FYTD</i>
	JUL	AUG				
Dr. Carreon	600	800	1,400	0.00	1,400.00	1,400.00
Ms. Chang	0	0	0	0.00	0.00	0.00
Dr. Chin	0	0	0	0.00	0.00	0.00
Dr. Diego	0	100	100	81.50	181.50	181.50
Dr. Duruisseau	1,000	700	1,700	110.00	1,810.00	1,810.00
Dr. Esrailian	500	300	800	979.76	1,779.76	1,779.76
Dr. Gitnick	0	0	0	747.33	747.33	747.33
Dr. Levine	0	0	0	0.00	0.00	0.00
Dr. Low	0	0	0	0.00	0.00	0.00
Dr. Moran	0	0	0	0.00	0.00	0.00
Dr. Salomonson	400	0	400	1,003.09	1,403.09	1,403.09
Ms. Schipske	0	0	0	0.00	0.00	0.00
Ms. Yaroslavsky	0	0	0	0.00	0.00	0.00
Mr. Zerunyan	1,400	1,400	2,800	208.66	3,008.66	3,008.66
BOARD TOTAL	3,900	3,300	7,200	3,130.34	10,330.34	10,330.34

*includes claims paid/submitted through September 24, 2010

Board Members Expense Report.xls
Date: September 29, 2010

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	DIVERSION	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 07/08									
\$ Budgeted	1,896,000	35,696,000		4,334,000	2,855,000	1,397,000	3,078,000	2,750,000	52,006,000
\$ Spent *	1,796,000	33,478,000		4,077,000	2,113,000	1,037,000	2,696,000	1,647,000	46,844,000 *
Positions									
Authorized	8.8	147.6		44.5	15.0	14.0	16.0	19.0	264.9
FY 08/09									
\$ Budgeted	2,158,000	36,659,000		4,599,000	2,048,000		3,370,000	1,914,000	50,748,000
\$ Spent *	1,875,000	34,026,000		4,522,000	1,697,000		2,668,000	625,000	45,413,000 *
Positions									
Authorized	8.8	146.6		45.5	15.0		16.0	20.0	251.9
FY 09/10									
\$ Budgeted	2,030,000	36,539,000	567,000	4,262,000	1,558,000		2,953,000	1,589,000	49,498,000
\$ Spent *	2,920,000	34,130,000	494,000	4,772,000	1,547,000		2,728,000	500,000	47,091,000 *
Positions									
Authorized	8.8	146.6	6.0	45.5	15.0		16.0	25.0	262.9
FY 10/11									
\$ Budgeted	1,935,000	39,758,000	621,000	5,278,000	1,699,000		3,212,000	1,830,000	54,333,000
\$ Spent thru 8/31 *	617,000	5,577,000	81,000	762,000	257,000		391,000	249,000	7,934,000 *
Positions									
Authorized	8.8	165.0	6.0	53.3	15.0		17.0	24.0	289.1

* net expenditures (includes unscheduled reimbursements)

9/28/2010

Budget Overview by Program.xls

**PROPOSED
BOARD MEETING DATES
FOR 2011**

January 27, 28	San Francisco
May 5, 6	Los Angeles
July 28, 29	Sacramento (MBC Headquarters)
October 27, 28	San Diego

AGENDA ITEM 25
BOARD EVALUATION
PRESENTATION AND DISCUSSION

Full report and response from the Attorney General's Office are under separate cover and are posted on the Board's website at www.mbc.ca.gov



Medical Board of California

Program Evaluation

Volume I

Summary Report

**BENJAMIN
FRANK LLC**
MANAGEMENT
CONSULTANTS

August 31, 2010

Ms. Linda Whitney, Executive Director
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, California 95815

**Program Evaluation
Volume I – Summary Report**

Dear Ms. Whitney,

We are pleased to present this *Summary Report* which documents the major findings, conclusions, and recommendations resulting from our review of the Medical Board's programs. The report presents results of extensive analyses we performed of the Medical Board's complaint intake and screening, investigation, and prosecution processes, including numerous analyses targeted specifically on assessing fiscal and program performance impacts resulting from implementation of Vertical Enforcement (VE) during 2006. Additionally, we completed assessments of other aspects of the Board's programs as required pursuant to our contract with the Board.

Preliminary Diagnostic Review

Initially, to refine the scope and focus of our assessment, we completed a preliminary diagnostic review of the Medical Board's expenditures and Enforcement Program performance during the past five (5) years. The results of this review indicated that, subsequent to implementation of Vertical Enforcement during 2006, costs for legal services provided by the Attorney General escalated rapidly while other legal service costs declined. Concurrently, the number of cases referred for investigation, the number of completed investigations referred for prosecution, the number of accusations filed, the number of stipulated settlements and proposed decisions submitted, and the number of disciplinary actions all declined. Additionally, the average elapsed time to complete investigations increased while the average elapsed time to complete prosecutions declined.

Given the amount of funding utilized for legal services provided by the Attorney General (currently more than \$1 million per month) and these performance trends, it was jointly determined, in consultation with Medical Board management, that the primary focus of this assessment should be on (1) identifying and assessing the impacts of the VE Pilot Project on the Enforcement Program, (2) identifying and assessing the benefits provided from increased expenditures for VE-related legal services, (3) identifying and assessing other factors contributing to deteriorating Enforcement Program performance, and (4) developing an *Enforcement Program Performance Improvement Plan*.

Governing Board Structure and Composition

We prepared and disseminated a survey of board members to obtain members' input regarding the structure and composition of the Medical Board's governing board, board capabilities and effectiveness, and the effectiveness of training provided to board members. As of June 30, 2010, a sufficient number of completed surveys had not been returned to enable development of findings, conclusions, or recommendations for improvement in these areas.

License Fees and Fund Condition

Since increasing initial and biennial renewal fees for physicians and surgeons from \$600 to \$790, effective January 1, 2006, there have been continuing concerns regarding whether the higher fees are justified. Section 2435(h) of Article 20 of the *Medical Practice Act*, adopted in conjunction with the January 2006 fee increase, placed a statutory cap on the amount of reserves that the Medical Board could accumulate in its Contingent Fund. Section 2435(h) stated that "It is the intent of the Legislature that, in setting fees pursuant to this section, the board shall seek to maintain a reserve in the Contingent Fund of the Medical Board of California equal to approximately two months' operating expenditures." Subsequently, during 2009, Section 2435(h) was modified (AB 501, Emmerson) to enable the Medical Board to maintain a higher reserve fund balance equal to 2 to 4 months' operating expenditures.

Our assessment of the Medical Board's fiscal circumstances focused on compliance with Section 2435(h) of the *Medical Practice Act*. Results of our review show that, within 2 to 3 years, the Medical Board's reserves are likely to decrease to a level equivalent to less than four (4) months' operating expenditures. Consequently, an adjustment to the Medical Board's license fees, currently set at \$783, would not be supported.

Licensing Program

During 2009 the Medical Board contracted with Hubbert Systems Consulting, Inc. (HSC) to conduct an assessment of the Licensing Program to identify effectiveness, efficiency, and other improvements that would facilitate compliance with governing statutes and regulations and improve customer service. The focus of HSC's study was on the license application process. We completed a critical review of HSC's report. We also incorporated results of analyses we performed in other related areas.

In addition to recommending various improvements to licensing-related business processes and technology support systems, HSC recommended increasing the number of authorized permanent Licensing Section positions by 54 percent (from 26 positions to 41 positions, an increase of 15 positions). Partially offsetting this proposed increase, HSC also proposed eliminating four (4) half-time retired annuitant positions (equivalent to 2 full-time positions) and eight (8) part-time student assistant positions (equivalent to 6 full-time positions, assuming all of the student assistants work a maximum of 30 hours per week). With these offsets, a net increase of at least seven (7) full-time-equivalent positions was recommended, representing a 27 percent increase in authorized staffing for the Licensing Section. With these recommendations, total authorized positions for the Licensing Program would increase by 33 percent (from about 45 to 60 positions, excluding offsets for the elimination of retired annuitants and student assistants).

As noted by HSC, during 2009/10 the Medical Board began filling eight (8) new positions proposed in a 2010/11 BCP that was not yet approved. The Department of Consumer Affairs (DCA) provided the Medical Board with a special authorization to fill these positions on an accelerated basis. At the time of HSC's study, four (4) of the positions had already been filled. As of early-July 2010, seven (7) of the positions were filled, including one (1) new SSM I position. With these eight (8) additional positions, authorized staffing for the Licensing Program now exceeds 52 total positions, excluding retired annuitants and student assistants. These additional resources fully restore positions lost earlier during the decade and would actually exceed, by 10 to 20 percent, the total number of positions authorized for the Licensing Division at any point during the 8-year period from 2000/01 through 2007/08. During this period, Licensing Division workload grew modestly (e.g., from 2004/05 through 2008/09, the number of license applications increased by about 10 percent).

Results of our analyses support the need for the additional eight (8) positions included in the 2010/11 BCP. However, there is not a clear rationale for HSC's recommendation to seek authorization for seven (7) additional positions beyond the additional positions included in the 2010/11 BCP. Also, HSC provided no analysis of the cost-benefit trade-offs of using permanent intermittent positions, temporary help, such as retired annuitants and student assistants, and overtime, in lieu of additional full-time permanent positions, to address recurring seasonal workload peaks. Additionally, HSC's recommendation to upgrade two (2) of the Licensing Section's remaining three (3) Office Technician positions, and to completely eliminate the use of student assistants, would shift clerical and administrative support activities and workload to higher level staff.

Enforcement Program

Our assessment of the Enforcement Program's business processes and performance, and related organizational, management, and staffing capabilities, focused on impacts of the Vertical Enforcement Pilot Project which the Medical Board and Health Quality Enforcement Section (HQES) jointly implemented beginning during 2006. Our analyses included collection and review of historical data, interviews with management and staff at both the Medical Board and HQES, and research of several dozen individual case histories.

To support our assessment, Medical Board staff produced several dozen sets of data pertaining to the intake, screening, investigation, and prosecution of complaints, disciplinary outcomes, and other related activities and events. We filtered, compiled, summarized, and analyzed the data provided as needed for purposes of this assessment. Where required, replacement or supplemental sets of data were requested and provided. Some statistical data was also provided by HQES, including data regarding time charges for investigation and prosecution-related services. Where appropriate, we incorporated HQES' data into our analyses, but much of the data provided by HQES was not provided until near the conclusion of the assessment. Also, much of the data provided was incomplete and of limited utility.

Overall, results of our assessment of the Enforcement Program show that Vertical Enforcement was implemented very differently in different geographic regions of the State, with differing impacts in terms of cost-effectiveness, service levels, and outcomes achieved. These differences provide an opportunity to identify best practices, reverse the deterioration in Enforcement Program performance that has occurred, and enhance consumer protection by instituting a more uniform and effective statewide approach to investigating and prosecuting complaints.

Impacts on Investigations

Results of our analyses show that fewer investigations are being completed by the District offices, the investigations are taking significantly longer to complete, and fewer cases are being referred for prosecution. Most concerning, is the increase in the time needed to complete quality of care case investigations, which already take an average of more than 18 months to complete for cases that are referred for prosecution. Also, performance levels have declined as much, or more, in the Los Angeles Metro region than in other regions of the State even though Los Angeles Metro region Attorneys are significantly more involved with investigations (2 to 3 times higher level of involvement than Attorneys in other regions of the State). Notwithstanding the much higher level of Attorney involvement in Los Angeles Metro area investigations, during 2008/09, and also during 2007/08, only about 75 cases per year were referred for prosecution. This compares to about 72 cases per year referred for prosecution in the Other Southern California region and more than 100 cases per year referred for prosecution in the Northern California region. Of particular concern, during the past two (2) years, only 25 percent of completed Los Angeles Metro region investigations were referred for prosecution. In contrast, in the Northern California region, 28 percent of completed investigations were referred for prosecution and, in the Other Southern California region, 32 percent of completed investigations were referred for prosecution.

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During the 4-year period from 2003/04 through 2006/07, 312 disciplinary actions were taken per year. During the next two years (2007/08 and 2008/09), 292 disciplinary actions were taken per year. The decrease in number of disciplinary actions is greater if Out-of-State cases, which are rarely handled by the District offices, are excluded. During the past two (2) years, there were significant variations in disciplinary outcomes among the different geographic regions of the State. In the Northern California region, the total number of disciplinary actions decreased by about 9 percent, but the proportion of disciplinary actions involving license revocation,

surrender, suspension, or probation increased marginally (from 72 to 74 percent). In the Other Southern California region, the number of disciplinary actions increased by about 10 percent, due to a significant increase in the number of public reprimands – there was no change in the number of disciplinary actions involving license revocation, surrender, suspension, or probation. As a result, for the Other Southern California region, the proportion of disciplinary actions involving license revocation, surrender, suspension, or probation decreased (from 75 percent to 66 percent). In the Los Angeles Metro region, the total number of disciplinary actions decreased by 13 percent *and* the number of disciplinary actions involving license revocation, surrender, suspension, or probation decreased by 20 percent. As a result, in the Los Angeles Metro region, the proportion of disciplinary actions involving license revocation, surrender, suspension, or probation decreased from 74 percent to 67 percent. The changes in the number and composition of Los Angeles Metro region disciplinary actions were the largest contributors to the decreases that recently occurred in (1) the overall number of disciplinary actions taken, and (2) the number of disciplinary actions taken involving license revocation, surrender, suspension, or probation.

Impacts on Overall Enforcement Process Performance

Since implementation of VE there has been a marked deterioration in several overall indicators of enforcement process performance. For example, significantly fewer, rather than more, interim suspension actions are taken. Also, it was expected that, with HQES Attorneys more involved with investigations, the elapsed time from referral of a case for investigation to filing of the accusation would decrease. In fact, the average elapsed time from referral for investigation to accusation filed has increased by two (2) months during the past several years. The average elapsed times from referral for investigation to accusation filed increased in all three (3) geographic regions. However, there were significant performance variances among the regions. The Northern California and Other Southern California regions had much shorter average elapsed times than the Los Angeles Metro region (17 to 19 months for the Northern California and Other Southern California regions compared to 22 to 23 months for the Los Angeles Metro region, a difference of 5 to 6 months). From this data it is abundantly clear that the much higher level of involvement of Attorneys in Los Angeles Metro region investigations has not provided any differential benefit in terms of reducing average elapsed times from referral of a case for investigation to filing of the accusation, which provides notice to the public of alleged negligence or misconduct by a licensee.

Implementation of VE was also expected to reduce average elapsed times from referral of cases for investigation to stipulation received which, for most cases, effectively represents completion of the prosecution phase of the enforcement process. It was anticipated, for example, that in addition to reducing the average elapsed time to complete investigations and the average elapsed time to file accusations, that implementation of VE might (1) marginally increase the proportion of cases that settle without a hearing, and (2) reduce the average elapsed time to negotiate a settlement and prepare the stipulation.

With respect to increasing the proportion of cases that settle rather than proceed to hearing, about 80 to 85 percent of cases usually settle without a hearing. Thus, it was considered unlikely that implementation of VE would significantly increase the proportion of cases that settle without a hearing. On an annual basis for the past six (6) years, the proportion of cases that did not settle, and proceeded to hearing, fluctuated between 15 and 20 percent. There is no evidence that implementation of VE had any significant beneficial impact in terms of increasing the proportion of cases that settle without a hearing. With respect to reducing the average elapsed time from referral for investigation to stipulation received, for cases with District office Identifiers the average elapsed times changed very little in recent years and, for all regions, this performance measure was only marginally lower during the past three (3)

years than during the preceding three (3) years. However, as aged cases migrate from the Investigation Stage to the Prosecution Stage during 2009/10 and subsequent years, it is likely that the average elapsed time from referral for investigation to stipulation received will increase.

Finally, with respect to this key performance metric, there are significant performance variations among the regions. For example, the Los Angeles Metro region consistently had significantly higher average elapsed times from referral for investigation to stipulation received than the other regions. During the past two (2) years the average elapsed time for the Los Angeles Metro region was about seven (7) months longer than the average elapsed time for the Northern California region, and about three (3) months longer than the average elapsed time for the Other Southern California region.

Organizational and Workforce Development Impacts

There are a number of factors over the past several years that have contributed to the Enforcement Program's inability to meet its goals. The loss of Investigators to a number of state agencies is likely to have contributed, although it is not possible to know whether or to what extent goals would have been met if fewer Investigators had separated from the Board. It is, however a fact that the Board has experienced a number of lateral transfers (non-promotional) to other State agencies subsequent to implementation of Vertical Enforcement. Some staff were disappointed that pay raises did not materialize, case levels did not decline as hoped, and the Investigators were not transferred to the Department of Justice. It is also a fact that there are tensions between Medical Board and HQES management, and a lack of consistency of VE implementation among regions. All parties involved are jointly responsible for ensuring stability and an employment environment conducive to productivity, and it would appear that significant and continuing problems in this area have not been sufficiently addressed. Although current Enforcement Program staffing levels are higher than they have been in several years and the workforce is stable, likely due to current economic conditions, as the economy improves the Medical Board may again experience high attrition and vacancy rates if improvements are not made.

Fiscal Impacts

In recent years the Medical Board's costs for HQES legal services increased by \$3.6 million (43 percent) due to rate increases and a 20 percent increase in Attorney staffing authorized to support implementation of VE. HQES currently charges the Medical Board more than \$1 million per month for legal services (\$13 million per year) and these charges now account for more than 25 percent of the Medical Board's entire budget. HQES' Los Angeles Metro office accounts for about two-thirds of HQES' increased costs. Some increased expenditures for additional Investigators also were incurred (about \$0.7 million per year), but the Furlough Friday Program during 2009/10 temporarily offset these additional costs. The increased resources now being used to support the Enforcement Program are producing increasingly lower levels of output. Expectations that implementation of VE would improve efficiency have not been fully realized.

Enforcement Program Improvement Plan

Nineteen (19) recommendations are presented in the *Final Report* addressing improvement needs involving complaint intake and screening, investigations, prosecutions, probation monitoring, and related organizational and management structures. These recommendations for improvement include:

- ✓ Augmenting CCU's Specialist Reviewer pool in targeted medical specialties or providing flexibility to waive the requirement for review by a Medical Specialist
- ✓ Augmenting CCU workforce capabilities and training
- ✓ Augmenting Medical Consultant staffing
- ✓ Augmenting the Medical Expert pool
- ✓ Strengthening management and administration of the Medical Expert Program
- ✓ Conducting a structured diagnostic review of the factors contributing to excessive Investigator turnover and developing and implementing plans to minimize attrition
- ✓ Establishing independent panels to review all requests for supplemental investigations and decline to file cases
- ✓ Restructuring the processes used for preparing accusations and surrender stipulations for Out-of-State cases
- ✓ Restructuring the handling of petitions for modification or termination of probation
- ✓ Restructuring the handling of Section 801 (medical malpractice) cases
- ✓ Amending the statutes to clarify the Medical Board's sole authority to determine whether to continue an investigation
- ✓ Scaling back and optimizing Attorney involvement in investigations, and increasing uniformity among regions
- ✓ Establishing new processes for tracking the status of cases following referral to HQES for prosecution and reviewing charges for legal services
- ✓ Establishing a new position within the Medical Board to monitor spending, review HQES costs, and identify inconsistencies or anomalies
- ✓ Developing new monthly management reports and new quarterly reports for the Board
- ✓ Developing systems for tracking and reporting key probation monitoring activities.

* * * * *

We are grateful for all of the assistance provided to us by both Medical Board and HQES staff. In particular, we want to acknowledge the efforts of Janie Cordray, Nancy Smith, Sean Eichelkraut, Susan Cady, John Harai, Laura Guardhouse, Marianne Eckhoff, Debbie Titus, Jill Johnson, Carlos Ramirez, Gail Heppell, Jose Guerrero, Tom Lazar, and Liana Ashley. Without the support of these and many other Medical Board and HQES staff, completion of this assessment would have been substantially more difficult.

We appreciate the opportunity to be of service to the Medical Board. If you have any questions or need additional information, please contact me at 916.425.1475.

Very truly yours,
BENJAMIN FRANK, LLC

Ben Frank

Benjamin Frank
Chief Executive Officer

Summary Listing of Recommendations for Improvements

Section III. License Fees, Expenditures, and Fund Condition

Recommendation No. III-1. Closely review each of the Attorney General's monthly Invoice Reports for the past three (3) fiscal years (2007/08 through 2009/10) to identify case billing inconsistencies by regions or billing anomalies that may have occurred. If significant over-charges are identified, request an adjustment in future billing periods.

Recommendation No. III-2. Maintain the current \$783 initial and biennial fee structure. Reserves will likely fall below the 4-month ceiling set forth in statute within the next two to three years.

Section V. Complaint Intake and Screening

Recommendation No. V-1. Augment the Specialist Reviewer pool in targeted medical specialties and counsel or replace current Medical Specialists who consistently fail to complete reviews on a timely basis, or amend the governing statutes to provide flexibility to refer complaints for investigation without review by a Medical Specialist.

Recommendation No. V-2. Augment CCU's workforce capabilities. When authorized, fill the new CCU and OST positions. Develop a specific plan detailing the program development and performance improvement goals and objectives that will be achieved by increasing authorized CCU and OST staffing levels. Track progress relative to the plan and provide periodic reports to the Medical Board showing progress in achieving each of the plan's goals and objectives.

Recommendation No. V-3. Resume surveys of CCU customer satisfaction levels and compile and publish the results of the surveys.

Section VI. Investigations

Recommendation No. VI-1. Augment Medical Consultant staffing. Medical Consultants should be available to all District offices all of the time (e.g., the equivalent of at least one full-time position per office, although actual availability will be less than full time due to vacations, sick leave and other time off). Because the Medical Consultant positions are classified as Permanent Intermittent, work hours can be adjusted to accommodate fluctuating workload demands, assuming a sufficient pool of resources is available to provide the services and the physicians are willing to work the number of hours needed. Offset costs for additional Medical Consultant positions by reducing expenditures for HQES investigation-related services (e.g., in the Los Angeles region).

Recommendation No. VI-2. Eliminate the limitation on reutilization of Medical Experts and augment the Medical Expert pool and enhance capabilities. In addition to strengthening Medical Expert oversight and overall Expert Reviewer Program management and administration, consider redirecting some funding currently used for HQES investigation-related services toward establishing a new program under which the Medical Board would contract for the services of a pool of physicians to provide Expert Review services (e.g., through an Interagency Agreement with one or more University of California Medical Centers, although this model may have its own problems relating to conflicts of interest).

Recommendation No. VI-3. Develop and implement an Immediate Action Improvement Plan to address critical District office workload and work environment issues. Meet with District office staff at each office to present the Improvement Plan and to outline a process for identifying and implementing further improvements. Conduct a structured diagnostic review of factors contributing to excessive Investigator turnover during the past several years, and develop and implement a Longer-Term Improvement Plan to reduce Investigator attrition and rebuild the Enforcement Program's field investigation workforce capabilities and competencies.

Summary Listing of Recommendations for Improvements

Section VII – Prosecutions and Disciplinary Actions

Recommendation No. VII-1. Establish independent panels to review all requests for supplemental investigations and all decline to file cases. The reviews should be completed expeditiously (e.g., within 1 to 2 days of issuance of the request for supplemental investigation or Decline to File Memorandum). For Northern California cases, the panel members should include a Regional Manager and Supervising DAG from the Southern California region, plus the Medical Board's HQES Services Monitor (see Recommendation No. X-6). For Southern California cases, the panel members should include a Regional Manager and Supervising DAG from the Northern California region, plus the Medical Board's HQES Services Monitor. The panels should review all decline to file cases and all requests for supplemental investigations for any cases where preparation of the pleading will be delayed pending completion of the supplemental investigation, and then advise the Chief of Enforcement, the Senior Assistant Attorney General, and all Medical Board and HQES managers and supervisors involved in the matter as to the results of their review, including recommended disposition of the matter.

Recommendation No. VII-2. Restructure the processes used for preparing accusations for Out-of-State cases to reduce the number of cases referred to HQES. Utilize DCU staffing resources to draft accusations and license surrender stipulations for Out-of-State cases.

Section VIII – Probation Program

Recommendation No. VIII-1. Develop systems for tracking and reporting completion of quarterly reviews, random office visits, and other key probation monitoring activities.

Recommendation No. VIII-2. Restructure the processes used for investigating petitions for modification or termination of probation. Exclude cases referred to the District offices from the VE Program, and screen out petitions from referral to HQES that do not need a hearing before an ALJ.

Section X – Organizational and Management Structures

Recommendation No. X-1. Restructure the handling of Section 801 cases by establishing a centralized unit comprised of non-sworn staff to investigate Section 801 and selected other cases.

Recommendation No. X-2. Amend the statutes governing Vertical Enforcement to clarify the Medical Board's sole authority to determine whether to continue an investigation.

Summary Listing of Recommendations for Improvements

Section X – Organizational and Management Structures *(continued)*

Recommendation No. X-3. Implement the best practices, identified and as implemented in the Northern and Other Southern California regions, statewide to optimize effective HQES Attorney involvement in investigations. Amend the statutes and policies governing Vertical Enforcement to establish the best practices identified in the Northern and Other Southern California regions. It would be helpful to amend the statute to make primary DAG assignments permissive, allowing Medical Board and HQES supervisors to jointly review incoming investigations to identify which cases would benefit from VE. Clarifying the statute as to the agencies' roles, responsibilities, and authority over investigations would help assure greater uniformity of investigations among regions.

Recommendation No. X-4. Require HQES to inform the Medical Board Regional Manager, District office and HQES Services Monitor of the scheduled date for completing a pleading. The notice should be required to be provided within five (5) business days of referral of any case for prosecution. Also, require that all Medical Board Regional Managers meet (or conference) on a monthly basis with their HQES counterparts to review the status of all previously referred cases for which an accusation has not yet been filed.

Recommendation No. X-5. Develop and implement an HQES Invoice Report review and approval process that provides for review of the reasonableness of HQES time charges. As necessary, require that HQES create new summary templates that display time charge data in a summary format that facilitates completion of these reviews.

Recommendation No. X-6. Establish a new HQES Services Monitor position within the Medical Board's Enforcement Program to coordinate the provision of services to the Medical Board by HQES, continuously monitor and evaluate HQES performance and costs, resolve conflicts that arise between the agencies, and prepare and provide regular reports to Executive Management, the Medical Board, and oversight and control agencies.

Recommendation No. X-7. Develop new monthly management reports showing key output and performance measures by business unit and for the State as a whole. (Presently, data is provided to the Board on a statewide basis only). Provide the monthly reports to all Enforcement Program and HQES Managers and Supervisors and to designated Medical Board Executive Office Managers and staff. Develop and provide the Board with quarterly Enforcement Program Output and Performance Summary reports that include data for the most recently completed quarter and time series data for the preceding three (3) fiscal years.

Recommendation No. X-8. Amend or repeal Subsection(e) of Section 12529.6 of the Government Code. The Medical Board should not invest in CAS to make it more compatible with HQES' ProLaw System and should not permanently co-locate Medical Board Investigators and HQES Attorneys.

Recommendation No. X-9. Conduct periodic performance reviews of the services, costs, and performance of HQES, including the performance of each HQES office. Provide results of the reviews to Department of Justice and Medical Board management and to oversight and control agencies.

Summary Listing of Recommendations for Improvements

Section XI – Licensing Program

Recommendation No. XI-1. Implement HCS' recommended business process improvements.

Recommendation No. XI-2. Conduct a limited, high level business case analysis of potential benefits, costs, and risks of a Document Management System (DMS).

Recommendation No. XI-3. Obtain authorization to convert recently established limited-term positions to permanent status.

Recommendation No. XI-4. Scale back the use of retired annuitants, student assistants, and overtime, if furloughs are discontinued.

Recommendation No. XI-5. Conduct a detailed analysis of Licensing Program workload and staffing requirements after a new Licensing Program Chief is appointed.

Recommendation No. XI-6. Develop an integrated framework for planning and managing Licensing Program performance.

Recommendation No. XI-7. Resume audits of licensee compliance with CME requirements.



Medical Board of California

Program Evaluation

Volume I Summary Report

August 31, 2010

**BENJAMIN
FRANK** LLC
MANAGEMENT
CONSULTANTS

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August 31, 2010

Ms. Linda Whitney, Executive Director
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, California 95815

**Program Evaluation
Volume I – Summary Report**

Dear Ms. Whitney,

We are pleased to present this *Summary Report* which documents the major findings, conclusions, and recommendations resulting from our review of the Medical Board's programs. The report presents results of extensive analyses we performed of the Medical Board's complaint intake and screening, investigation, and prosecution processes, including numerous analyses targeted specifically on assessing fiscal and program performance impacts resulting from implementation of Vertical Enforcement (VE) during 2006. Additionally, we completed assessments of other aspects of the Board's programs as required pursuant to our contract with the Board.

Preliminary Diagnostic Review

Initially, to refine the scope and focus of our assessment, we completed a preliminary diagnostic review of the Medical Board's expenditures and Enforcement Program performance during the past five (5) years. The results of this review indicated that, subsequent to implementation of Vertical Enforcement during 2006, costs for legal services provided by the Attorney General escalated rapidly while other legal service costs declined. Concurrently, the number of cases referred for investigation, the number of completed investigations referred for prosecution, the number of accusations filed, the number of stipulated settlements and proposed decisions submitted, and the number of disciplinary actions all declined. Additionally, the average elapsed time to complete investigations increased while the average elapsed time to complete prosecutions declined.

Given the amount of funding utilized for legal services provided by the Attorney General (currently more than \$1 million per month) and these performance trends, it was jointly determined, in consultation with Medical Board management, that the primary focus of this assessment should be on (1) identifying and assessing the impacts of the VE Pilot Project on the Enforcement Program, (2) identifying and assessing the benefits provided from increased expenditures for VE-related legal services, (3) identifying and assessing other factors contributing to deteriorating Enforcement Program performance, and (4) developing an *Enforcement Program Performance Improvement Plan*.

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Governing Board Structure and Composition

We prepared and disseminated a survey of board members to obtain members' input regarding the structure and composition of the Medical Board's governing board, board capabilities and effectiveness, and the effectiveness of training provided to board members. As of June 30, 2010, a sufficient number of completed surveys had not been returned to enable development of findings, conclusions, or recommendations for improvement in these areas.

License Fees and Fund Condition

Since increasing initial and biennial renewal fees for physicians and surgeons from \$600 to \$790, effective January 1, 2006, there have been continuing concerns regarding whether the higher fees are justified. Section 2435(h) of Article 20 of the *Medical Practice Act*, adopted in conjunction with the January 2006 fee increase, placed a statutory cap on the amount of reserves that the Medical Board could accumulate in its Contingent Fund. Section 2435(h) stated that "It is the intent of the Legislature that, in setting fees pursuant to this section, the board shall seek to maintain a reserve in the Contingent Fund of the Medical Board of California equal to approximately two months' operating expenditures." Subsequently, during 2009, Section 2435(h) was modified (AB 501, Emmerson) to enable the Medical Board to maintain a higher reserve fund balance equal to 2 to 4 months' operating expenditures.

Our assessment of the Medical Board's fiscal circumstances focused on compliance with Section 2435(h) of the *Medical Practice Act*. Results of our review show that, within 2 to 3 years, the Medical Board's reserves are likely to decrease to a level equivalent to less than four (4) months' operating expenditures. Consequently, an adjustment to the Medical Board's license fees, currently set at \$783, would not be supported.

Licensing Program

During 2009 the Medical Board contracted with Hubbert Systems Consulting, Inc. (HSC) to conduct an assessment of the Licensing Program to identify effectiveness, efficiency, and other improvements that would facilitate compliance with governing statutes and regulations and improve customer service. The focus of HSC's study was on the license application process. We completed a critical review of HSC's report. We also incorporated results of analyses we performed in other related areas.

In addition to recommending various improvements to licensing-related business processes and technology support systems, HSC recommended increasing the number of authorized permanent Licensing Section positions by 54 percent (from 26 positions to 41 positions, an increase of 15 positions). Partially offsetting this proposed increase, HSC also proposed eliminating four (4) half-time retired annuitant positions (equivalent to 2 full-time positions) and eight (8) part-time student assistant positions (equivalent to 6 full-time positions, assuming all of the student assistants work a maximum of 30 hours per week). With these offsets, a net increase of at least seven (7) full-time-equivalent positions was recommended, representing a 27 percent increase in authorized staffing for the Licensing Section. With these recommendations, total authorized positions for the Licensing Program would increase by 33 percent (from about 45 to 60 positions, excluding offsets for the elimination of retired annuitants and student assistants).

As noted by HSC, during 2009/10 the Medical Board began filling eight (8) new positions proposed in a 2010/11 BCP that was not yet approved. The Department of Consumer Affairs (DCA) provided the Medical Board with a special authorization to fill these positions on an accelerated basis. At the time of HSC's study, four (4) of the positions had already been filled. As of early-July 2010, seven (7) of the positions were filled, including one (1) new SSM I position. With these eight (8) additional positions, authorized staffing for the Licensing Program now exceeds 52 total positions, excluding retired annuitants and student assistants. These additional resources fully restore positions lost earlier during the decade and would actually exceed, by 10 to 20 percent, the total number of positions authorized for the Licensing Division at any point during the 8-year period from 2000/01 through 2007/08. During this period, Licensing Division workload grew modestly (e.g., from 2004/05 through 2008/09, the number of license applications increased by about 10 percent).

Results of our analyses support the need for the additional eight (8) positions included in the 2010/11 BCP. However, there is not a clear rationale for HSC's recommendation to seek authorization for seven (7) additional positions beyond the additional positions included in the 2010/11 BCP. Also, HSC provided no analysis of the cost-benefit trade-offs of using permanent intermittent positions, temporary help, such as retired annuitants and student assistants, and overtime, in lieu of additional full-time permanent positions, to address recurring seasonal workload peaks. Additionally, HSC's recommendation to upgrade two (2) of the Licensing Section's remaining three (3) Office Technician positions, and to completely eliminate the use of student assistants, would shift clerical and administrative support activities and workload to higher level staff.

Enforcement Program

Our assessment of the Enforcement Program's business processes and performance, and related organizational, management, and staffing capabilities, focused on impacts of the Vertical Enforcement Pilot Project which the Medical Board and Health Quality Enforcement Section (HQES) jointly implemented beginning during 2006. Our analyses included collection and review of historical data, interviews with management and staff at both the Medical Board and HQES, and research of several dozen individual case histories.

To support our assessment, Medical Board staff produced several dozen sets of data pertaining to the intake, screening, investigation, and prosecution of complaints, disciplinary outcomes, and other related activities and events. We filtered, compiled, summarized, and analyzed the data provided as needed for purposes of this assessment. Where required, replacement or supplemental sets of data were requested and provided. Some statistical data was also provided by HQES, including data regarding time charges for investigation and prosecution-related services. Where appropriate, we incorporated HQES' data into our analyses, but much of the data provided by HQES was not provided until near the conclusion of the assessment. Also, much of the data provided was incomplete and of limited utility.

Overall, results of our assessment of the Enforcement Program show that Vertical Enforcement was implemented very differently in different geographic regions of the State, with differing impacts in terms of cost-effectiveness, service levels, and outcomes achieved. These differences provide an opportunity to identify best practices, reverse the deterioration in Enforcement Program performance that has occurred, and enhance consumer protection by instituting a more uniform and effective statewide approach to investigating and prosecuting complaints.

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Results of our analyses show that fewer investigations are being completed by the District offices, the investigations are taking significantly longer to complete, and fewer cases are being referred for prosecution. Most concerning, is the increase in the time needed to complete quality of care case investigations, which already take an average of more than 18 months to complete for cases that are referred for prosecution. Also, performance levels have declined as much, or more, in the Los Angeles Metro region than in other regions of the State even though Los Angeles Metro region Attorneys are significantly more involved with investigations (2 to 3 times higher level of involvement than Attorneys in other regions of the State). Notwithstanding the much higher level of Attorney involvement in Los Angeles Metro area investigations, during 2008/09, and also during 2007/08, only about 75 cases per year were referred for prosecution. This compares to about 72 cases per year referred for prosecution in the Other Southern California region and more than 100 cases per year referred for prosecution in the Northern California region. Of particular concern, during the past two (2) years, only 25 percent of completed Los Angeles Metro region investigations were referred for prosecution. In contrast, in the Northern California region, 28 percent of completed investigations were referred for prosecution and, in the Other Southern California region, 32 percent of completed investigations were referred for prosecution.

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Since implementation of VE there has been a marked deterioration in several overall indicators of enforcement process performance. For example, significantly fewer, rather than more, interim suspension actions are taken. Also, it was expected that, with HQES Attorneys more involved with investigations, the elapsed time from referral of a case for investigation to filing of the accusation would decrease. In fact, the average elapsed time from referral for investigation to accusation filed has increased by two (2) months during the past several years. The average elapsed times from referral for investigation to accusation filed increased in all three (3) geographic regions. However, there were significant performance variances among the regions. The Northern California and Other Southern California regions had much shorter average elapsed times than the Los Angeles Metro region (17 to 19 months for the Northern California and Other Southern California regions compared to 22 to 23 months for the Los Angeles Metro region, a difference of 5 to 6 months). From this data it is abundantly clear that the much higher level of involvement of Attorneys in Los Angeles Metro region investigations has not provided any differential benefit in terms of reducing average elapsed times from referral of a case for investigation to filing of the accusation, which provides notice to the public of alleged negligence or misconduct by a licensee.

Implementation of VE was also expected to reduce average elapsed times from referral of cases for investigation to stipulation received which, for most cases, effectively represents completion of the prosecution phase of the enforcement process. It was anticipated, for example, that in addition to reducing the average elapsed time to complete investigations and the average elapsed time to file accusations, that implementation of VE might (1) marginally increase the proportion of cases that settle without a hearing, and (2) reduce the average elapsed time to negotiate a settlement and prepare the stipulation.

With respect to increasing the proportion of cases that settle rather than proceed to hearing, about 80 to 85 percent of cases usually settle without a hearing. Thus, it was considered unlikely that implementation of VE would significantly increase the proportion of cases that settle without a hearing. On an annual basis for the past six (6) years, the proportion of cases that did not settle, and proceeded to hearing, fluctuated between 15 and 20 percent. There is no evidence that implementation of VE had any significant beneficial impact in terms of increasing the proportion of cases that settle without a hearing. With respect to reducing the average elapsed time from referral for investigation to stipulation received, for cases with District office Identifiers the average elapsed times changed very little in recent years and, for all regions, this performance measure was only marginally lower during the past three (3)

years than during the preceding three (3) years. However, as aged cases migrate from the Investigation Stage to the Prosecution Stage during 2009/10 and subsequent years, it is likely that the average elapsed time from referral for investigation to stipulation received will increase.

Finally, with respect to this key performance metric, there are significant performance variations among the regions. For example, the Los Angeles Metro region consistently had significantly higher average elapsed times from referral for investigation to stipulation received than the other regions. During the past two (2) years the average elapsed time for the Los Angeles Metro region was about seven (7) months longer than the average elapsed time for the Northern California region, and about three (3) months longer than the average elapsed time for the Other Southern California region.

Organizational and Workforce Development Impacts

There are a number of factors over the past several years that have contributed to the Enforcement Program's inability to meet its goals. The loss of Investigators to a number of state agencies is likely to have contributed, although it is not possible to know whether or to what extent goals would have been met if fewer Investigators had separated from the Board. It is, however a fact that the Board has experienced a number of lateral transfers (non-promotional) to other State agencies subsequent to implementation of Vertical Enforcement. Some staff were disappointed that pay raises did not materialize, case levels did not decline as hoped, and the Investigators were not transferred to the Department of Justice. It is also a fact that there are tensions between Medical Board and HQES management, and a lack of consistency of VE implementation among regions. All parties involved are jointly responsible for ensuring stability and an employment environment conducive to productivity, and it would appear that significant and continuing problems in this area have not been sufficiently addressed. Although current Enforcement Program staffing levels are higher than they have been in several years and the workforce is stable, likely due to current economic conditions, as the economy improves the Medical Board may again experience high attrition and vacancy rates if improvements are not made.

Fiscal Impacts

In recent years the Medical Board's costs for HQES legal services increased by \$3.6 million (43 percent) due to rate increases and a 20 percent increase in Attorney staffing authorized to support implementation of VE. HQES currently charges the Medical Board more than \$1 million per month for legal services (\$13 million per year) and these charges now account for more than 25 percent of the Medical Board's entire budget. HQES' Los Angeles Metro office accounts for about two-thirds of HQES' increased costs. Some increased expenditures for additional Investigators also were incurred (about \$0.7 million per year), but the Furlough Friday Program during 2009/10 temporarily offset these additional costs. The increased resources now being used to support the Enforcement Program are producing increasingly lower levels of output. Expectations that implementation of VE would improve efficiency have not been fully realized.

Enforcement Program Improvement Plan

Nineteen (19) recommendations are presented in the *Final Report* addressing improvement needs involving complaint intake and screening, investigations, prosecutions, probation monitoring, and related organizational and management structures. These recommendations for improvement include:

- ✓ Augmenting CCU's Specialist Reviewer pool in targeted medical specialties or providing flexibility to waive the requirement for review by a Medical Specialist
- ✓ Augmenting CCU workforce capabilities and training
- ✓ Augmenting Medical Consultant staffing
- ✓ Augmenting the Medical Expert pool
- ✓ Strengthening management and administration of the Medical Expert Program
- ✓ Conducting a structured diagnostic review of the factors contributing to excessive Investigator turnover and developing and implementing plans to minimize attrition
- ✓ Establishing independent panels to review all requests for supplemental investigations and decline to file cases
- ✓ Restructuring the processes used for preparing accusations and surrender stipulations for Out-of-State cases
- ✓ Restructuring the handling of petitions for modification or termination of probation
- ✓ Restructuring the handling of Section 801 (medical malpractice) cases
- ✓ Amending the statutes to clarify the Medical Board's sole authority to determine whether to continue an investigation
- ✓ Scaling back and optimizing Attorney involvement in investigations, and increasing uniformity among regions
- ✓ Establishing new processes for tracking the status of cases following referral to HQES for prosecution and reviewing charges for legal services
- ✓ Establishing a new position within the Medical Board to monitor spending, review HQES costs, and identify inconsistencies or anomalies
- ✓ Developing new monthly management reports and new quarterly reports for the Board
- ✓ Developing systems for tracking and reporting key probation monitoring activities.

* * * * *

We are grateful for all of the assistance provided to us by both Medical Board and HQES staff. In particular, we want to acknowledge the efforts of Janie Cordray, Nancy Smith, Sean Eichelkraut, Susan Cady, John Harai, Laura Guardhouse, Marianne Eckhoff, Debbie Titus, Jill Johnson, Carlos Ramirez, Gail Heppell, Jose Guerrero, Tom Lazar, and Liana Ashley. Without the support of these and many other Medical Board and HQES staff, completion of this assessment would have been substantially more difficult.

We appreciate the opportunity to be of service to the Medical Board. If you have any questions or need additional information, please contact me at 916.425.1475.

Very truly yours,

BENJAMIN FRANK, LLC



Benjamin Frank
Chief Executive Officer

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I. Introduction

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I. Introduction

During 2009 the Medical Board, along with all of the State’s other health profession licensing programs, were the subject of a series of critical reports in the Los Angeles Times and other newspapers that highlighted the extended timeframes needed to complete investigations and initiate disciplinary actions against regulated professionals. These reports also highlighted related problems with large, and growing, workloads and backlogs at these agencies. In response to this publicity, a series of organizational changes were implemented at the Board of Registered Nursing, which was the primary focus of these reports. Additionally, the Governor and the newly-appointed Director of Consumer Affairs pledged to implement broad reforms to improve patient safety by reducing backlogs of work at all of the health profession licensing boards, and initiating administrative and program oversight improvements. Concurrently, at its July Quarterly Meeting, the members of the Medical Board’s Governing Board expressed concerns about the newspaper reports, and about growing backlogs of work in the Licensing and Enforcement programs, increased turnover of staff, the impacts of work furloughs, and management’s plans to achieve meaningful effectiveness and efficiency improvements.

To address the above concerns, the Board directed the Executive Director to undertake a comprehensive, independent evaluation of the Medical Board. A Request for Offers was issued on August 25, 2009, the Medical Board completed its evaluation September 2009, and Benjamin Frank, LLC was awarded the contract on October 26, 2009 (extending to August 31, 2010). Work commenced on November 4, 2009.

This *Summary Report* is a condensed version of the *Final Report* which more fully documents the results of our assessment. The *Summary Report* is organized as follows:

Section	Title	Section	Title
I.	Introduction	VI.	Investigations
II.	Overview of the Evolution of the Medical Board’s Governance Structure, Licensing Fees, and Enforcement Program	VII.	Prosecutions and Disciplinary Action
III.	License Fees, Expenditures, and Fund Condition	VIII.	Probation Program
IV.	Overview of Complaint Workload, Workflows, and Performance	IX.	Integrated Assessment of Enforcement Program Performance
V.	CCU Complaint Intake and Screening	X.	Organizational and Management Structures
		XI.	Licensing Program.

A listing of all recommendations for improvement is provided in Appendix A. Additional technical information and analyses are presented in Volume II (*Final Report*).

I. Introduction

A. Project Purpose and Scope

The purpose of this study was to conduct an independent and unbiased review of the Medical Board's organizational structure and core programs to identify strengths and weaknesses of current operations and develop recommendations for improvements. The scope of the review encompassed assessment of the Medical Board's governance structure and a review of the Medical Board's internal organizational and management structure. Additionally, the study scope included assessment of:

- ❖ The sufficiency of fees to meet legislative goals and mandates
- ❖ Identification of laws, regulations, policies, and procedures that may hinder effectiveness
- ❖ The value of services provided by external agencies
- ❖ The value of services provided by contractors
- ❖ The uses and effectiveness of major equipment purchases
- ❖ The effectiveness of IT applications used for enforcement and licensing.

Initially, we completed a preliminary diagnostic review of the Medical Board's expenditures and Enforcement Program performance during the past five (5) years to refine the scope and focus of our assessment efforts. The results of this review indicated that, subsequent to implementation of the Vertical Enforcement (VE) Pilot Project during 2006, costs for legal services provided by the Attorney General had escalated rapidly while other legal service costs declined. Concurrently, the number of cases referred for investigation, the number of completed investigations referred for prosecution, the number of accusations filed, the number of stipulated settlements and proposed decisions submitted, and the number of disciplinary actions all declined. Additionally, the average elapsed time to complete investigations increased while the average elapsed time to complete prosecutions declined.

Given the amount of funding utilized for legal services provided by the Attorney General (currently more than \$1 million per month) and these performance trends, it was jointly determined, in consultation with Medical Board management, that the primary focus of this assessment should be on (1) identifying and assessing the impacts of the VE Pilot Project on the Enforcement Program, (2) identifying and assessing the benefits provided from increased expenditures for VE-related legal services, (3) identifying and assessing other factors contributing to deteriorating Enforcement Program performance, and (4) developing an *Enforcement Program Performance Improvement Plan*.

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B. Medical Board Data Constraints and Effects

As part of this assessment Medical Board staff produced several dozen sets of data pertaining to the intake, screening, investigation, and prosecution of complaints, disciplinary outcomes, and other related activities and events. The data provided also included mandated reports submitted by licensees, insurers, and other government agencies, reports submitted by medical/osteopathic boards in other states, Medical Board-originated complaint records, petitions for modification or termination of probation, petitions for reinstatement, and other matters that are tracked using the Medical Board's Complaint Tracking System (CAS), such as statements of issues (SOIs) and probationary license certificates issued to some new licensees in lieu of full licensure. We filtered, compiled, summarized, and analyzed the data provided as needed for purposes of this study. Where required, replacement or supplemental sets of data were requested and provided. To the extent practicable we corrected significant anomalies in the data and, where appropriate, excluded some records from our analyses.

In the past, and currently, a major area of contention between the Medical Board and the Health Quality Enforcement Section (HQES) involves differences in how the two agencies account for the time that elapses between referral (or transmittal) of a case to HQES for prosecution and filing of an accusation. The Medical Board generally measures the elapsed time from transmittal of a case to HQES to the filing of an accusation. HQES generally measures the elapsed time from its acceptance of a case for prosecution to completion of its preparation of a pleading. These alternative measurement approaches can result in significant differences in resulting performance measures. Factors which contribute to the differences include the following:

- ❖ The Medical Board's measurement approach includes the elapsed time from transmittal of the case to HQES to HQES' acceptance of the case for prosecution. Generally, the difference between these two events should be limited to a period of just a few days, but can extend for somewhat longer periods as a result of delays due to the unavailability of staff to promptly review the case, case reassignments, or internal deliberations about whether or not to accept the case for prosecution. Additionally, HQES sometimes requests a supplemental investigation, and does not accept the case for prosecution until the supplemental investigation is completed and accepted. In some cases multiple supplemental investigations are requested. In these circumstances the elapsed time between transmittal of the case and filing of the accusation can include extended periods of additional time. This additional time is included in the Medical Board's elapsed time measures, but not in HQES' elapsed time measures.
- ❖ The Medical Board's measurement approach includes elapsed time from HQES' submittal of the accusation to the Medical Board to the filing of the accusation. In some cases the Medical Board may request that HQES amend the accusation which can delay the filing. This additional elapsed time is included in the Medical Board's elapsed time measures, but not in HQES' elapsed time measures.

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While the data maintained in CAS appears to be reasonably complete and accurate for most data elements, it appears that some updates to CAS are not always consistently posted by District office staff for various interim investigation activities, including activities involving (1) medical records requests, (2) Complainant and Subject interviews, and (3) Medical Consultant case reviews. The output and performance measures related to obtaining medical records are especially limited. Medical records are sometimes requested from multiple sources for the same case, but the Medical Board's performance measures typically only account for one records request for each case. Also, in some cases the records submitted are incomplete or overly redacted and are re-requested. The Medical Board's measures count the records as received irrespective of the completeness or quality of the records provided, and do not account for supplemental submissions. Problems with obtaining complete records quickly have been ongoing over the years and are likely to continue as poor performers are also more likely to keep poor records or engage in maneuvers to avoid producing them. These problems may be addressed in the future by the universal use of electronic medical records.

In the past concerns have surfaced about the extent to which measures of Enforcement Program performance focus on outputs without consideration of the quality of the outputs (e.g., measures of the number of cases referred for prosecution, without consideration of the quality of the completed investigations). Our analyses included assessment of the following measures which potentially reflect the quality of completed investigations, but which also have various inherent limitations:

Supplemental Investigations – If there is insufficient evidence to meet the burden of proof in a completed investigation, HQES can request a supplemental investigation to address the deficiencies. However, HQES Attorneys sometimes request supplemental investigations to strengthen a case even though another HQES Attorney might consider the initial submission sufficient without further investigation.

HQES Decline to File – If an investigation does not contain sufficient evidence to meet the burden of proof that cannot reasonably be corrected with a supplemental investigation, HQES can decline to file the case. However, HQES Attorneys sometimes reject cases that other HQES Attorneys accept for prosecution. Also, HQES may decline to file a case for reasons unrelated to the quality of the completed investigation.

Accusations Withdrawn or Dismissed – If after an accusation is filed, there is insufficient evidence to meet the burden of proof, HQES can, with the permission of the Board, withdraw the accusation or, if the case proceeds to hearing, the Hearing Officer can dismiss the case. However, accusations can be, and oftentimes are, withdrawn or dismissed for reasons completely unrelated to the quality of the completed investigation (e.g., death of the physician, cancellation of the license, modified Expert opinion, etc.).

A final area of concern about statistical measures of Enforcement Program performance involves consideration of not just the number of disciplinary actions taken by the Medical Board, but also the level of discipline imposed. To address this concern, our assessment includes analysis, where appropriate, of the number and proportion of public reprimands compared to other types of discipline imposed (license revocation, surrender, suspension, or probation). Additionally, where appropriate, we segregated disciplinary actions taken related to complaints investigated by the Medical Board's District offices from disciplinary actions taken related to other types of cases (e.g., license surrenders resulting from disciplinary actions taken by medical/osteopathic boards in other states).

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C. HQES Data Constraints and Effects

In the past, concerns have been expressed about the failure to include HQES data in prior analyses of Enforcement Program performance. Accordingly, as part of this assessment, in mid-January 2010 we asked HQES' Senior Assistant Attorney General to provide us with detailed organization charts and staffing rosters for HQES, to disclose to us the availability of any workload, workflow, or performance data showing how VE had impacted investigation or prosecution processes, and to provide us with any general background information that would be helpful to us in performing our assessment. HQES provided us with staff rosters showing HQES positions, by office, but provided no other information to us in response to this request.

During February 2010 we met with the HQES' Supervising DAGs and selected Attorneys at HQES' offices in San Diego, Los Angeles, Sacramento, and San Francisco. At each of these meetings we requested copies of any background documents or statistical data that HQES thought might be helpful to us for purposes of our assessment of the impacts of VE on the investigation and prosecution processes. At these meetings we were told that Los Angeles-based HQES technical support staff could potentially provide us with workload, workflow, and performance data that was available from HQES' ProLaw System. With the exception of a one-page spreadsheet summarizing the number of Investigation and Administrative matters opened and closed by HQES during 2009, no other data or other background information was provided to us following these meetings.

On March 3, 2010, we submitted to HQES' Senior Assistant Attorney General a draft data request listing about 20 specific sets of data. The draft Data Request included requests for time series data for the past 4 to 5 years regarding:

- | | |
|--|--|
| ❖ Numbers of hours charged to Investigation matters | ❖ Numbers of hours charged to Administrative matters |
| ❖ Numbers of Investigation matters opened and closed | ❖ Number of Administrative matters opened and closed |
| ❖ Numbers of Subject interviews attended | ❖ Numbers of accusations and SOIs prepared |
| ❖ Numbers of Expert opinions reviewed | ❖ Numbers of petitions to revoke probation prepared |
| ❖ Numbers of Final Reports of Investigation reviewed | ❖ Numbers of stipulations prepared |
| ❖ Numbers of ISOs, TROs, and PC 23s | ❖ Number of administrative hearings attended. |

We also requested extracts of data showing the migration of cases, by milestone, through the investigation and prosecution processes, and the hours charged to each completed case. We reviewed the draft data request with HQES' Senior Assistant Attorney General and HQES' technical support specialist to identify items for which sufficiently complete and reliable data were not available and to identify ways to better align the data request with the specific data elements captured within the ProLaw System. Finally, HQES agreed to provide us with the requested data on a flow basis as it was prepared, with a goal of providing all of the requested data by March 31, 2010. A

I. Introduction

revised data request was transmitted to HQES' Senior Assistant Attorney General on March 9, 2010. The revised data request excluded nearly one-half of the items included in the draft data request because:

- ❖ The data is captured in ProLaw, but is substantially incomplete or unreliable (e.g., numbers of investigation and Administrative cases closed)
- ❖ The data is only captured in ProLaw in non-standardized "case notes" (e.g., numbers of Subject interviews, Expert report reviews, and Report of Investigation reviews)
- ❖ More reliable data was believed to be available from the Medical Board (e.g., numbers of ISOs, TROs, and PC 23s).

We also consolidated data elements to make it simpler and easier for HQES to provide the requested data.

After a period of nearly a month, HQES provided a partial response to the revised data request. However, in terms of completeness and quality, there appeared to be some significant deficiencies with some of the data provided. We requested additional information from HQES regarding these deficiencies. HQES was non-responsive to this request.

On April 22, 2010, the Medical Board re-submitted the revised data request to HQES. Additionally, the Medical Board again requested an explanation of the completeness and quality deficiencies identified with some of the previously provided data. The Medical Board also requested additional data regarding hours charged for Investigation Stage-related activities that would supplement data previously provided by HQES regarding hours charged to specific Investigation matters. Finally, the Medical Board requested that HQES submit a schedule indicating when the requested data would be provided.

As of June 20, 2010, the following three (3) sets of statistical data had been provided by HQES:

- ❖ Numbers of Investigation matters opened, by HQES office, by year (CY2006 through CY2009)
- ❖ Numbers of hours charged to Investigation matters, by classification level, by HQES office, by year (CY2006 through CY2009)
- ❖ Numbers of hours charged to Administrative matters, by classification level, by HQES office, by year (CY2005 through CY2009).

During late-June, HQES provided data showing the number of Administrative matters opened by HQES office by year (CY2005 through CY2009). This data set also included information showing the completion of pleadings, settlement agreements, and other milestones for these matters. However, the data is incomplete because it does not include pleadings, settlement agreements, and other milestones completed during 2005, and subsequent years, related to Administrative matters opened by HQES during 2004 and prior years. Thus, the data was of limited utility for purposes of this analysis.

I. Introduction

Finally, in mid-July HQES provided data showing Investigation matters opened by HQES office by year (CY2006 through CY2009). This data set also included information showing the assignment of an Attorney to each case and acceptance of the case for prosecution. However, because HQES only began tracking cases referred for investigation after January 1, 2006, the data provided for the first several years following implementation of Vertical Enforcement is incomplete and not representative of all completed investigations. For example, the cases shown as referred for prosecution during 2006 only includes cases referred for investigation after 2005 and, hence, only includes a small number of investigations that were completed in less than one (1) year. The data provided for cases referred for prosecution during 2009 (and possibly the latter part of 2008) is the only data that appears reasonably complete. The data provided for these cases is not completely consistent with comparable data separately provided by the Medical Board. For example, HQES' data shows somewhat fewer cases referred for prosecution, possibly due to failure to open separate Investigation matters for each complaint referred for investigation. On a statewide basis, the average elapsed timeframes to complete the investigations, as shown by HQES' data for cases referred for prosecution during 2008 and 2009, were similar to comparable data obtained from the Medical Board (e.g., an average elapsed time of about 15 to 16 months). However, because of the limitations mentioned above, the data provided by HQES for cases referred for prosecution during 2009 is not comparable to HQES' data for prior years (2006 through 2008). For 2009, HQES' data shows significantly longer average elapsed times to complete investigations of cases referred for prosecution in the Los Angeles Metro region than for other geographic regions of the State (an average of 16.8 months for the Los Angeles Metro region compared to an average of 15.3 months in the Other Southern California region and an average of 14.3 months in the Northern California region).

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II. Overview of the Evolution of the Medical Board's Governance Structure, License Fees, and Enforcement Program

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II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

This section presents an overview of the history and evolution of the Medical Board's governance structure, licensing fees, and Enforcement Program. The overview of the Enforcement Program highlights a 35-year history of efforts to strengthen discipline and reduce the time required to complete complaint intake/screening, investigation, and prosecution processes. A more detailed chronicle of the history of the Medical Board from the mid-1970s through 2004/05 is included in Volume II (*Final Report*) and in the *Initial* and *Final Reports* prepared by the Medical Board Enforcement Monitor (dated November 1, 2004 and November 1, 2005, respectively).

A. Governing Board Structure and Composition

Prior to 1975, the Medical Board, known then as the Board of Medical Examiners (BME), had 11 members, of which 10 were physicians. During this period responsibility for physician discipline was largely delegated to physician-dominated regional Medical Quality Review Committees (MQRCs). The MQRCs were five-member panels that held medical disciplinary hearings and made recommendations to BME. BME rarely disciplined physicians for incompetence or gross negligence and nearly all disciplinary actions took two (2) to three (3) years to complete.

Concurrently, during the early-1970s, medical malpractice Insurance premiums in the State skyrocketed due to increased costs associated with medical malpractice litigation. The insurance premium increases threatened to disrupt delivery of physician services, particularly to economically disadvantaged segments of the population. In response, the *Medical Injury Compensation Reform Act* (MICRA) was enacted (AB 1, Keene) during a 1975 Special Session of the Legislature. AB 1 (Keene) established a \$250,000 cap on non-economic damages in medical malpractice actions, such as damages for pain and suffering, and limited the contingency fees that could be charged by the plaintiff's counsel. Additionally, MICRA abolished the Board of Medical Examiners and created a new Board of Medical Quality Assurance (BMQA) consisting of 12 physician members and seven (7) public members. BMQA was organized into three divisions:

- ❖ A 7-member Division of Licensing (DOL) responsible for licensing examinations, issuing licenses, and administering a new Continuing Medical Education (CME) program
- ❖ A 7-member Division of Medical Quality (DMQ) responsible for overseeing the Enforcement Program and disciplinary actions
- ❖ A 5-member Division of Allied Health Professions (DAHP) responsible for overseeing non-physician Allied Health Licensing Programs (AHLPs) that were placed under BMQA's jurisdiction.

MICRA also transferred responsibility for investigating complaints against physicians from the Department of Consumer Affairs (DCA) to BMQA, and added public members to the MQRCs which continued to be responsible for conducting disciplinary hearings. Finally, MICRA added several mandatory reporting requirements, including requirements that:

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

- ❖ Insurers and the insured report to BMQA the payment of judgments, settlements, and arbitration awards in medical malpractice actions (Sections 801 and 802 of the Business and Professions Code)
- ❖ Court clerks report to BMQA criminal charges and convictions against physicians (Section 803 of the Business and Professions Code)
- ❖ Hospitals and health care institutions report to BMQA adverse peer review actions taken against physicians (Section 805 of the Business and Professions Code).

During 1990 BMQA was renamed the Medical Board of California (AB 184, Speier) and, in 1993, the DAHP was abolished and its members were combined with the DMQ (SB 916, Presley). SB 916 also abolished the MQRCs and assigned responsibility for conducting medical disciplinary hearings to the Office of Administrative Hearings (OAH). SB 916 preserved the DMQ's authority to review disciplinary actions, but divided the DMQ into two panels for purposes of reviewing (1) stipulated settlement agreements (STIPs) that are oftentimes entered into in lieu of proceeding to an administrative hearing, and (2) proposed decisions (PDs) prepared by Administrative Law Judges (ALJs) for cases where a hearing is held.

Effective January 1, 2003, two (2) additional public members were added to the DMQ (SB 1950, Figueroa), thereby increasing the size of the Medical Board to 21 total members, including 12 physicians and nine (9) public members. With these additions, the DOL had seven (7) members (4 physicians and 3 public members) and the DMQ had 14 members (8 physicians and 6 public members). For purposes of reviewing STIPs and PDs, each DMQ panel was allocated seven (7) members (4 physicians and 3 public members).

Effective January 1, 2008, the DOL and DMQ were consolidated into a single 15-member governing Board, including eight (8) physicians and seven (7) public members (AB 253, Eng). This is the fewest physician members that the Medical Board has ever had. Additionally, AB 253 mandated that the Medical Board delegate to the Executive Director authority to adopt default decisions and specified types of STIPs. To carry out its responsibilities, the Medical Board subsequently established 15 Standing Committees.

B. License Fees and Expenditures

During 1992, initial and biennial renewal fees for physicians and surgeons were increased to \$480 (\$240 per year) from \$400 previously (\$200 per year). Subsequently, during November 1993 the Medical Board adopted Emergency Regulations increasing initial and biennial renewal fees to \$600 (\$300 per year). The primary purpose of the higher fees was to fund a 100 percent increase in staffing for the Health Quality Enforcement Section (HQES) within the Office of the Attorney General (from 22 Attorney positions, to 44 Attorney positions). At the time, HQES Attorneys were carrying an average of 30 cases per position and taking an average of 16 months to file accusations. Initial and biennial renewal fees remained at the \$600 level until 2003 when they were increased marginally to \$610 (\$305 per year).

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

Effective January 1, 2006, initial and biennial fees were statutorily increased to \$790 (\$395 per year). This increase was needed to replenish the Medical Board's depleted reserves and to fund general cost increases and additional Investigator and HQES Attorney positions to support of implementation of the VE Pilot Project. By May 1 of each year, the Medical Board is required to set the fee for the next subsequent fiscal year, subject to the ceiling set in statute. The fee is required to be sufficient to recover actual costs of operating the Medical Board's Licensing Program as projected for the fiscal year commencing on the date that the fees become effective. Provisions also were included in the statutes stating that it was the intent of the Legislature that the Medical Board maintain a reserve fund equal to two months' operating expenditures.

In conjunction with the 2006 fee increase, the statutory provisions governing the reimbursement of investigative and enforcement costs by licensees subject to disciplinary action by the Medical Board (cost recovery) were repealed. Subject to several limiting provisions set forth in statute, the maximum initial and biennial licensee fees may be increased above the current \$790 ceiling to recover the difference, if any, between (1) the average amount of reimbursements (cost recovery) paid for investigation and enforcement costs during the three fiscal years preceding July 1, 2006, and (2) any increase in investigation and enforcement costs incurred following July 1, 2006, as compared to average costs during the three fiscal years preceding July 1, 2006. The purpose for incorporating these provisions was to enable the Medical Board to potentially recover some of the increased costs of investigation and enforcement that would otherwise have been paid by licensees subject to disciplinary action if the provisions governing cost recovery had not been repealed.

During 2007, initial and biennial renewal fees were increased by \$15 to \$805. Then, following termination of the Diversion Program, these fees were reduced by \$22 to \$783. Additionally, during 2010/11, some licensees have or will receive a \$22 renewal credit reflecting their prior over-payment of Diversion Program costs when they renewed their license.

Exhibit II-1, on the next page, shows actual personal services and operating expenditures by year for the past five (5) years, and projected expenditures for 2009/10. As shown by Exhibit II-1, total expenditures peaked at a level of about \$49.5 million during 2007/08, and then declined by \$1.75 million (4 percent) during 2008/09. The recent decrease in expenditures was due to (1) a decrease in salaries and benefits paid to Medical Board staff, (2) reductions in major and minor equipment purchases, and (3) decreases in general administrative and operating expenses, including reduced expenditures for professional services and lower costs for support services provided by DCA. These expenditure reductions resulted primarily from spending controls implemented during 2008/09 in response to the State's General Fund fiscal crisis. Additionally, charges during 2008/09 for legal services provided by the Attorney General and OAH were more than \$600,000 lower than the amounts charged during the prior fiscal year.

Historical and Budgeted Medical Board Expenditures

Personal Service and Operating Expenditures		Actual					2009/10 Budget ³
		2004/05	2005/06	2006/07 ¹	2007/08	2008/09 ²	
Personal Services	Salaries/Wages, Including Fitness Incentive Pay	\$12,688	\$12,647	\$13,253	\$13,527	\$13,425	\$13,336
	Staff Benefits	5,620	4,719	5,067	5,340	5,327	6,005
	Temporary Help (Medical Consultants, Retired Annuitants, and Student Assistants)	1,154	1,143	1,270	1,742	1,321	1,144
	Board Members	33	32	34	24	24	31
	Overtime (Primarily for the Licensing Program)	21	31	77	86	196	12
	DEC	21	32	27	22	0	0
	Salary Savings	0	0	0	0	0	(836)
	Total Personal Services Expenses	\$19,537	\$18,604	\$19,728	\$20,741	\$20,293	\$19,692
General Expenses	Printing, Communications, and Postage	\$1,413	\$1,050	\$1,121	\$1,350	\$1,475	\$1,603
	General Expense, Minor Equipment, and Insurance	535	626	716	928	721	472
	Travel	291	314	380	403	379	397
	Vehicle Operation/Other Items	273	269	350	446	300	262
	Training	57	45	79	74	89	66
		Total General Expenses	\$2,569	\$2,304	\$2,646	\$3,201	\$2,964
	Facilities Operation (Rent)	\$1,851	\$1,963	\$2,814	\$2,235	\$2,173	\$2,702
	Professional Services	\$605	\$788	\$1,397	\$1,386	\$870	\$983
	Fingerprint Reports	\$358	\$382	\$380	\$334	\$332	\$492
	Major Equipment (Items greater than \$5,000)	\$295	\$370	\$375	\$192	(\$9)	\$333
Legal Services	Attorney General Services	\$8,292	\$8,596	\$11,247	\$12,316	\$11,881	\$13,347
	Evidence/Witness Fees	1,563	1,367	1,215	1,391	1,519	1,893
	Office of Administrative Hearings	1,248	915	1,200	1,344	1,099	1,863
	Court Reporter Services	69	113	143	158	128	175
		Total Legal Services	\$11,172	\$10,991	\$13,805	\$15,209	\$14,627
Allocated Administrative & Data Processing	Department Prorata	\$3,296	\$3,395	\$3,670	\$3,906	\$3,671	\$3,882
	Statewide Prorata	1,185	1,315	1,376	1,794	2,323	1,699
	Consolidated Data Center (Teale)	304	293	238	259	300	647
	Data Processing	289	321	128	232	224	125
		Total Administrative and Data Processing Services	\$5,074	\$5,324	\$5,412	\$6,191	\$6,518
Other Expenses	DOI Investigations	\$0	\$0	\$0	\$2	\$0	\$0
	State Controller's Office (Including 21st Century Project)	0	0	0	38	2	0
	Special Adjustment	(24)	0	0	(1)	10	0
	Court-Ordered and Tort Payments	7	2	13	3	0	0
		Total Miscellaneous Expenses	(\$17)	\$2	\$13	\$42	\$12
	Total Operating Expenses	\$21,907	\$22,124	\$26,842	\$28,790	\$27,487	\$30,941
	Total Personal Services and Operating Expenses	\$41,444	\$40,728	\$46,570	\$49,531	\$47,780	\$50,633

¹ In 2006/07, authorized staffing levels increased by 12.50 positions (2.0 Diversion Program, 4.0 Investigators, 4.0 Investigative Assistants, 2.0 Information System Analysts, and 0.5 Staff Services Analyst).

² In 2008/09, authorized staffing levels decreased by 12.40 positions due to termination of the Diversion Program.

³ The 2009/10 budget incorporates cost-savings related to the Furlough Friday Program and includes unfunded allocations for six (6) new Operation Safe Medicine positions (**\$500,000**), four (4) new Probation Program positions (**\$300,000**), and contracts for Telemedicine (\$399,734 for the first year), an evaluation of Medical Board programs (\$159,300), and an analysis of Licensing Program business processes (\$40,350).

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

Over the 5-year period from 2004/05 through 2008/09, total expenditures increased by about \$6.3 million (15 percent). **Table II-1**, below, shows the expenses that contributed most to these increased costs.

Table II-1. Expenditure Increases - 2004/05 through 2008/09

Category	Amount	Percent Increase
Attorney General Services	\$3.6 million	43%
State Prorata	\$1.1 million	96%
Personal Services	\$0.8 million	4%
Department Prorata	\$0.4 million	11%
Facilities (Rent)	\$0.3 million	17%
Total	\$6.2 million	18%

As shown by Table II-1, costs for legal services provided by the Attorney General increased significantly on both an absolute and percentage basis, and accounted for more than one-half of the total increase in expenditures during this period. In contrast, costs for services provided by OAH fluctuated between \$0.9 million and \$1.4 million during this same period, and the most recent year's costs for OAH services were about average for the period (\$1.1 million). The increased costs for Attorney General services reflect the combined impacts of rate increases and the authorization of 10 additional Attorney positions to support implementation of the VE Pilot Project.

C. Complaint Intake and Screening

During the 1980s complaint intake and screening were handled by a handful of Customer Service Representatives (CSRs) dispersed across regional offices in Sacramento, San Francisco, Los Angeles, and San Bernardino/San Diego. Each regional office also had 1 to 2 full-time Medical Consultants who assisted the CSRs in determining which complaints should be referred for field investigation. During this period the Medical Board received fewer than 5,000 complaints per year, of which about one-half involved negligence/competency (quality of care) issues. About one-half of complaints received were referred to the District offices for investigation (2,500 per year).

During the early-1990s the Medical Board consolidated responsibility for complaint intake and screening in the Sacramento Headquarters Central Complaint Unit (CCU). Since that time the number of positions authorized for the CCU has grown. CCU is currently authorized 24 positions, about the same number as authorized at the beginning of the decade. About two-thirds of CCU staff are classified at the SSA or AGPA levels. AGPA is a higher classification level than CSR positions. In the early-2000s, CCU was reorganized into two specialized sections based on the type of complaint handled (Quality of Care and Physician Conduct). Most staff within the Quality of Care

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

Section are assigned to specific geographic regions of the State. Most staff within the Physician Conduct Section are assigned to specific types of complaints.

In the early 1990s, HQES Attorneys were assigned to work at CCU on a part-time basis to assist in evaluating and screening complaints. In October 2003 the assignment of this position was formalized in response to legislative requirements enacted 12 years earlier during 1991 (SB 2375, Presley). Also during 2003, CCU began implementing a new Specialty Reviewer process pursuant to requirements set forth in SB 1950 (Figueroa). The Specialty Reviewer requirement was enacted to help reduce the number of complaints referred for investigation, and related needs to conduct field investigations in cases where it might not be warranted. Prior to implementation of the Specialty Reviewer process, a physician not specializing in the subject physician's case may have reviewed the complaints, and, in some cases, were unable to make a preliminary determination regarding the merits of the complaint because they lacked knowledge of, and experience with, the medical specialty involved. In these circumstances the cases were referred for investigation where a more specialized medical professional would make a determination on the merits of the case as a part of the field investigation process.

CCU currently handles about 7,200 complaints per year involving physicians and surgeons, or about 50 percent more complaints than were handled during the 1980s. These complaints include about 1,000 mandated reports that are submitted to the Medical Board pursuant to statutory requirements that were not in effect prior to 1990. The number of complaints received by the Medical Board has grown modestly over time, but more slowly than the growth rate of the industry during this period. CCU now performs a much more rigorous review of complaints than was previously performed and, except for disputes involving the release of the patients records, does not attempt to mediate complaints. CCU currently refers fewer than 20 percent of complaints for investigation, including some high-priority complaints that are referred for investigation with only limited screening (e.g., Section 805 reports).

For some types of cases CCU works collaboratively with the Discipline Coordination Unit (DCU). For example, CCU receives a significant number of reports of physician discipline from licensing boards in other states. Following intake by CCU, these cases are forwarded directly to DCU which reviews each case and, if needed, requests additional records. DCU may then close the case, prepare a proposed settlement agreement with the licensee (referred to as a pre-filing stipulation), or refer the case to HQES' San Francisco office for prosecution. District offices are rarely involved with these cases, unless the licensee is practicing in California.

D. Investigations and Prosecutions

During the past 30 years several major comprehensive reform initiatives and numerous targeted changes and improvements have been implemented to strengthen discipline and reduce the time required to complete complaint intake/screening, investigation, and prosecutorial processes. These efforts included creating a new Health Quality Enforcement Section (HQES) within the Attorney General's office, organizationally separate from the Licensing Section, transferring responsibility for disciplinary hearings to the Office of Administrative Hearings (OAH) and then creating a new Medical Quality Hearing Panel (MQHP) within OAH to hear medical discipline cases, and restructuring the Medical Board's governance structure. These efforts had some success. For example, while the number of

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

cases referred for investigation decreased, the number of cases resulting in disciplinary action increased. However, concerns were raised nearly continuously throughout this period about the extended 2 to 3-year timeframes needed to complete investigations and prosecutions.

Most recently, during 2006 the VE Pilot Project was implemented, representing the third major restructuring of the Enforcement Program within a period of 20 years. VE was intended to address long-standing problems that contributed to the extended timeframes needed to complete investigations and prosecutions, and was expected to provide significant benefits, including all of the following:

- ✓ Improved efficiency and effectiveness
- ✓ Reduced case cycle times
- ✓ Improved Investigator and Prosecutor morale, recruitment, and retention
- ✓ Improved training for Investigators and Prosecutors
- ✓ Improved commitment to cases
- ✓ Improved perception of the fairness of the process (*this benefit would only accrue if Medical Board Investigators were transferred to the Department of Justice, which did not occur*).

To support implementation of VE, 10 additional Attorney positions were authorized for HQES, which fully restored six (6) HQES Attorney positions previously eliminated. Additionally, eight (8) new positions were authorized for the Enforcement Program (4 Investigators and 4 Assistant Investigators). The additional Investigator positions were authorized beginning with the 2006/07 fiscal year (6 months after implementation of VE commenced). The new Investigator positions only partially restored the 35 District office positions that had been eliminated since the beginning of the decade. Given the extended lead times to hire and train new staff, these additional resources were largely unavailable to support implementation of VE for the first full year following implementation of this new approach to conducting investigations. Subsequently, the Medical Board reclassified the four (4) new Assistant Investigator positions to Inspectors and assigned the positions to the Probation Units. Concurrently, a comparable number of Investigator positions assigned to the Probation Units were reassigned to the District offices along with a responsibility for investigating cases previously handled by the Probation Units.

At the time that VE was implemented (2006), staffing levels at the District offices were 25 percent lower than existed earlier in the decade. Additionally, Investigator caseloads were growing and the average time to complete investigations had been steadily increasing for several years. The Medical Board's District offices were not initially provided with any additional resources to assist them in responding to the additional workload demands associated with coordinating their investigation activities with HQES Attorneys and responding to the Attorneys' directions regarding the conduct of investigations.

To guide implementation of VE, the Medical Board and HQES jointly developed a *Vertical Prosecution Manual* that defined the roles and responsibilities of the members of the VE Team. Additionally, HQES created a new Lead Prosecutor (LP) designation for selected DAGs

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to support implementation of VE. HQES assigned one (1) LP to each Medical Board District office to act as HQES' principal liaison to that office. The LP is jointly assigned to each case along with a second DAG. The LP is required to review all incoming complaints and determine whether the complaints warrant an investigation or should be closed without investigation. The determination of whether to close a complaint without investigation is required to be made in consultation with the District office Supervisor. If the LP determines that an investigation is warranted, they are required to inform the assigned Investigator and then review and approve the Investigator's Investigation Plan.

The LP is also required to identify cases in which an Interim Suspension Order (ISO) or Penal Code Section 23 (PC 23) appearance is necessary, and notify the Supervising DAG (SDAG). In such cases the SDAG is required to designate the second DAG as the Primary DAG responsible for the ISO or PC 23 appearance. The SDAG is also required to designate the second DAG as the Primary DAG for cases involving sexual abuse or misconduct, mental or physical illness, and complex criminal conviction cases. Finally, whenever the LP determines that it is likely a violation of law may be found, the second DAG is required to replace the LP as the Primary DAG on the case for all purposes. If the second DAG is assigned as Primary DAG, then the LP is required to monitor the progress of the investigation and the appropriateness of the direction provided by the Primary DAG. If the second DAG is not assigned by the SDAG as the Primary DAG, then the LP is required to act as the Primary DAG throughout the investigation and prosecution of the case. LPs are required to be physically present at their assigned District office to the extent necessary to fully discharge their responsibilities.

Subsequently, in April 2008 the Medical Board and HQES issued a set of *Joint Vertical Enforcement Guidelines* which supplement the policies and guidelines set forth in the *Vertical Prosecution Manual*. However, there are some disparities between the policies and guidelines established for the VE Pilot Project and actual case investigation practices, and considerable variability in how VE has been implemented in different regions throughout the State. For example:

Lead Prosecutor Assignments – For some District offices an SDAG rather than a DAG serves as LP. At some District offices the assigned LP rarely changes while, at other District offices, the LP is changed on a rotational basis. At some District offices where Primary DAGs are assigned to most cases, the LP serves as an intermediary or liaison between the Investigator and the Primary DAG and the Investigator and Primary DAG directly interface only on an exception basis. At other District offices where Primary DAGs are assigned to most cases, the Investigator and Primary DAG usually interface directly, and the LP only becomes involved when there are disagreements or problems between the Investigator and Primary DAG. Depending on the location of the District office and other factors, LPs usually have either one (1) or two (2) regularly scheduled days each week where they are expected to physically visit their assigned District office (not necessarily for the full day).

Case Intake and Investigator Assignments – For most District offices incoming complaints are accepted by the District office Supervisor and assigned to an Investigator without any involvement or consultation with the LP. Concurrently, the case file is transmitted to the LP. At some District offices a physical copy of the entire case file is staged for the LP's review on their next regular duty day at the District office. At other District offices a soft copy of the case file is created and emailed to the LP but, if there are a large number of supporting documents, copies of all of the documents may not always be provided.

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Generally, the LP's review of a new complaint and their opening of a new Investigation matter in HQES' ProLaw System occur at some point after the opening of the investigation by the District office, after the District office Supervisor's assignment of an Investigator to the case, and, in some cases, after the initiation of investigation activities.

Primary DAG Assignments – For some District offices a Primary DAG is usually assigned by the SDAG to each new investigation following the LP's opening of the new investigation matter in HQES' ProLaw System. For District offices where the SDAG serves as the LP, the assignment of a Primary DAG can occur concurrent with the SDAG's case intake review. For some District offices a Primary DAG is only assigned to an investigation on an exception basis (e.g., cases involving sexual misconduct or if requested by the District office) or the assignment of a Primary DAG is usually deferred until much later during the investigation process (e.g., when the case is ready to be transmitted to an Expert Reviewer or following completion of the investigation when the case is ready to be referred for prosecution).

Initial Investigation Plan Preparation and Review – For most District offices the assigned Investigator prepares the initial Investigation Plan, submits it to the District office Supervisor, LP, Primary DAG (if assigned), and others, as required (which varies among the District offices), and commences the investigation. HQES Attorneys rarely suggest any changes to the initial Investigation Plan. At some District offices the Investigators do not commence their Investigation until either the LP or Primary DAG approves the initial Investigation Plan (which is required to be provided within 5 business days, but can take longer due to absences, vacations, or other factors).

Medical and Other Records – For some District offices complete copies of all medical and other records collected during the investigation are forwarded to the Primary DAG as they are obtained. In other District offices copies of these records are forwarded on an as-needed basis or are always forwarded to only some of the Primary DAGs assigned to the office's cases.

Subject Interviews – At some District offices the Primary DAG is expected to attend all Subject interviews. At other District offices either the LP attends most Subject interviews on behalf of the Primary DAGs or an HQES Attorney (usually either the LP or Primary DAG) only attends Subject interviews on an exception basis (e.g., cases involving sexual misconduct or if requested by the District office). At some District offices the LP rarely attends Subject interviews. Attorney practices regarding completion of pre-interview case file reviews, attendance at pre-interview planning meetings, and the extent of their participation during the interview vary greatly depending on individual Attorney personal preferences. Primary DAGs sometimes fail to show for Subject interviews that they were scheduled to attend.

Expert Reviewer Selection and Expert Package Review – For some District offices the Primary DAG is usually substantively involved in selecting an Expert Reviewer and reviewing Expert packages. At other District offices the Primary DAG is not usually substantively involved in the investigation until this point in the process. At other District offices the Primary DAG usually declines to review the Expert Package. In some cases the Primary DAGs are not substantively involved in reviewing the Expert package because were previously substantively involved in the case during earlier stages of the investigation. At some District offices an HQES Attorney (Primary DAG or LP) is only involved in Expert Reviewer-related activities on an

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

exception basis. There is considerable variability in Medical Board and HQES practices related to the preparation and review of Expert packages.

Completed Investigation Case Reviews – For some District offices most completed cases are regularly reviewed and accepted for closure or prosecution within required timeframes (5 business days for cases recommended for prosecution and 10 business days for cases recommended for closure). For other District offices the completed cases oftentimes are not reviewed and approved within the required timeframes. At some District offices there appear to be chronic problems with these processes with HQES either (1) delaying the closure or transmittal of cases by requesting completion of additional investigation activity, or (2) not informing the District office regarding its approval or disapproval of the recommended case disposition, or not doing so on a timely basis. According to Medical Board staff, there is considerable variability in HQES practices related to acceptance of cases for prosecution.

Investigator Attendance at Hearings – Investigators attend hearings to assist the DAGs prosecuting the cases, however, hearings are rarely conducted (fewer than 50 per year for cases investigated by District offices). When hearings are held, it is a major drain of resources as the hearing may extend over a period of weeks. The experience, however, is valuable and essential for the growth and development of seasoned Investigators.

Finally, ambiguities in the statutes mandating use of the VE Model appear to underlie some of variability that exists is how VE was implemented in different regions of the State. Additionally, there is great deal of variability in the relationships between Medical Board Investigators and HQES Attorneys. Generally, there is a fairly high level of friction between the Investigators and Attorneys throughout the State. However, the relationships are particularly poor in the Los Angeles region. One source of the friction and conflict between Medical Board and HQES staff is variability in the perceptions of different individuals regarding the Legislative intent in mandating use of the VE Model, and ambiguities in the statutes requiring its use.

Following implementation of VE, during 2007/08 and 2008/09, there were some minor shifts in authorized positions between various programs and business units within the Medical Board. Collectively these shifts increased authorized staffing for the Licensing program by eight (8) positions (21 percent), but most of this increase is attributable to a concurrent transfer of the Cashiering Unit to the Licensing Program. Subsequently, during 2009/10, 10 additional positions were authorized for the Enforcement Program, the first increases since the addition of eight (8) Investigator and Assistant Investigator positions in 2006/07. Six (6) additional positions were authorized to re-establish the Operation Safe Medicine (OSM) Unit (1 Supervising Investigator, 4 Investigators, and 1 Office Technician) and four (4) additional positions were authorized for the Probation Program (3 Inspectors and 1 Office Technician). No additional positions were authorized for the District offices to support implementation of VE and investigate growing backlogs of complaints against licensed physicians.

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E. HQES Staffing Resource Allocations

For the past several years, excluding temporary help (retired annuitants) and Secretaries (7 positions), 58 full-time, permanent positions were authorized for the HQES, including 1 Senior Assistant Attorney General, 6 Supervising Deputy Attorneys, 47 Deputy Attorneys (all levels), 3 Senior Legal Analysts, and 1 Associate Government Program Analyst (AGPA). Prior to implementation of Vertical Enforcement, HQES did not have an AGPA position and had nine (9) fewer Attorney positions. The Secretary positions are not shown as budgeted to HQES in the *Wage and Salary Supplements to the Governor's Budgets*.

Table II-2, below, shows allocations of authorized SDAG, DAG, and Senior Legal Analyst positions by HQES office during 2008/09 and 2009/10. The position allocations shown for 2009/10 reflect a reduction of four (4) authorized DAG positions. As shown by Table II-2, nearly one-half of authorized DAG positions are assigned to the Los Angeles Metro office, 30 percent are assigned to Northern California offices (Sacramento and San Francisco), and less than one-quarter are assigned to the San Diego office. During 2009/10, authorized DAG staffing for HQES was reduced by four (4) positions. All of the reductions were absorbed by the smaller Sacramento, San Francisco, and San Diego offices. Additionally, one (1) vacant DAG position was shifted to the Los Angeles Metro office to accommodate unrelated personnel placement needs at that location. To better balance workload between the various HQES offices, the geographic boundaries of the Los Angeles Metro office were recently extended, both North and South, to encompass portions of the areas served previously by HQES' Sacramento and San Diego offices.

Table II-2. Health Quality Enforcement Section Staff Allocations by Office

Fiscal Year	HQES Office Location	Position Classification			Total ¹		Percent of DAGs
		Supervising Deputy Attorney General (SDAG)	Deputy Attorney General (DAG)	Senior Legal Analyst	Number	Percent	
2008/09	Sacramento, San Francisco, and Oakland	2	16	1	19	33%	33%
	Los Angeles Metro	2	20	1	23	40%	42%
	San Diego (Other Southern California)	2	12	1	15	26%	25%
	Total Allocated Positions¹	6	48	3	57	100%	100%
2009/10	Sacramento and San Francisco	2	13	1	16	30%	30%
	Los Angeles Metro	2	21	1	24	45%	48%
	San Diego (Other Southern California)	2	10	1	13	25%	23%
	Total Allocated Positions¹	6	44	3	53	100%	100%

¹ Excludes one (1) Senior Assistant Attorney General position, one (1) Associate Government Program Analyst (AGPA) position based in HQES' Los Angeles office, and seven (7) Secretary positions.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

Table II-3, below, shows the significant shift that has occurred during the past several years in the number of Attorney hours charged by HQES to Medical Board investigations. As shown by Table II-3, the number of hours charged by HQES Attorneys to Medical Board investigations increased significantly during the past three (3) years, and virtually all of the additional hours were charged by Attorneys based in HQES' Los Angeles Metro office. During 2009, Los Angeles Metro office Attorneys charged more than 17,000 hours to Medical Board investigations compared to fewer than 6,000 hours charged to investigations by Attorneys in each of the other geographic regions of the State. The hours charged to investigations by Los Angeles Metro office Attorneys during 2009 accounted for 60 percent of all HQES Attorney hours charged to investigations.

Table II-3. Hours Charged by HQES Attorneys to Investigation Matters
Includes Hours Charged to Investigation Matters, Section-Specific Tracking and Client Service

HQES Office(s)	2006	2007	2008	2009
Northern California ¹	6,610	6,085	5,007	5,168
Los Angeles Metro	6,349	6,388	13,528	17,084
San Diego (Other Southern California)	4,536	3,778	5,626	5,989
Total²	17,495	16,250	24,161	28,240

¹ Includes San Francisco, Oakland, Sacramento, and Fresno offices.

² Excludes Supervising Deputy Attorneys (SDAGs).

In contrast with the distribution of Attorney billings shown in Table II-3, **Table II-4**, on the next page, shows much smaller differences between geographic regions in the number of hours charged by HQES Attorneys to prosecutions. Generally, more hours are charged for prosecutions by HQES' Northern Region offices than are charged by HQES' other two regional offices. However, the San Francisco and Sacramento offices handle nearly all Out-of-State and SOI cases. In the Northern California and Other Southern California regions, HQES Attorneys charge significantly more hours to prosecutions than charged to investigations. In contrast, in the Los Angeles Metro region, the proportions of time charged to investigations and prosecutions are reversed, with significantly fewer hours charged to prosecutions during 2009 (9,823) than charged to investigations (17,084).

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

Table II-4. Hours Charged by HQES Attorneys to Administrative Matters
Excludes Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort Matters

HQES Office(s)	2005	2006	2007	2008	2009
Northern California ¹	11,333	11,718	12,960	12,231	13,026
Los Angeles Metro	10,150	9,696	12,937	11,820	9,823
San Diego (Other Southern California)	9,220	8,290	11,265	8,144	8,923
Total	30,703	29,704	37,161	32,195	31,772

¹ Includes San Francisco, Oakland, Sacramento, and Fresno offices.

² Excludes Supervising Deputy Attorneys (SDAGs).

The time charges by Los Angeles Metro office Attorneys are disproportionate to the geographic distribution of licensees. Only about 30 percent of active licensees are based in counties served by HQES' Los Angeles Metro office. Counties served by HQES' Northern California offices account for 44 percent of active licensees while counties served by HQES' San Diego office account for 25 percent of active licensees. The time charges by Los Angeles Metro office Attorneys are also disproportionate to the geographic distribution of investigations opened and cases referred for prosecution, which generally parallel the geographic distribution of licensees. The time charges are also inconsistent with data provided to us by HQES showing the number of Investigation matters opened by HQES. As shown by **Table II-5**, below, Investigation matters opened for Los Angeles Metro cases account for about one-third of all Investigation matters opened by HQES.

Table II-5. Investigation Matters Opened by HQES

HQES Office(s)	2006	2007	2008	2009	Total	
					Number	Percent
Northern California ¹	374	387	392	340	1,493	38%
Los Angeles Metro ²	306	350	365	340	1,361	34%
San Diego ³ (Other Southern California)	339	287	232	264	1,122	28%
Total	1,019	1,024	989	944	3,976	100%

¹ Includes HQES' San Francisco, Oakland, Sacramento, and Fresno offices.

² Data shown for 2009 includes 47 Fresno cases.

³ Data shown for 2006 excludes 39 pre-2006 cases.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

Finally, as shown by **Table II-6**, below, the total hours charged by Attorneys assigned to HQES' offices in Northern California and San Diego (Other Southern California) offices for investigations and prosecutions have changed little during the past several years (18,000 hours and 15,000 hours per year, respectively). In contrast, the total hours charged by Los Angeles Metro office Attorneys increased by nearly 70 percent and, in 2009, exceeded the number of hours charged in each of the other two geographic regions by 50 to 80 percent.

Table II-6. Hours Charged by HQES Attorneys to Investigations and Prosecutions

Matter	HQES Office(s)	2006	2007	2008	2009
Investigations ²	Northern California ¹	6,610	6,085	5,007	5,168
	Los Angeles Metro	6,349	6,388	13,528	17,084
	San Diego (Other Southern California)	4,536	3,778	5,626	5,989
	Total - Investigations	17,495	16,250	24,161	28,240
Prosecutions	Northern California ¹	11,718	12,960	12,231	13,026
	Los Angeles Metro	9,696	12,937	11,820	9,823
	San Diego (Other Southern California)	8,290	11,265	8,144	8,923
	Total - Prosecutions	29,704	37,161	32,195	31,772
Total ³	Northern California ¹	18,328	19,045	17,238	18,194
	Los Angeles Metro	16,045	19,325	25,348	26,907
	San Diego (Other Southern California)	12,826	15,042	13,770	14,912
	Total - Investigations and Prosecutions	47,198	53,411	56,356	60,012

¹ Includes San Francisco, Oakland, Sacramento, and Fresno offices.

² Includes Section-Specific Tracking and Client Service hours.

³ Excludes Supervising Deputy Attorneys (SDAGs).

The differences in hours charged by HQES Attorneys in each of the three major geographic regions of the State reflect significant differences in their level of involvement in Medical Board investigations, and substantive differences in the way that VE has been implemented. Since 2006, Los Angeles Metro office Attorneys have become increasingly involved in Medical Board investigations and have, for several years, been much more intensively involved in investigations than Attorneys based in HQES' other offices. As a result, expenditures for Attorney services provided by HQES' Los Angeles Metro office during 2009 were more than \$1.4 million greater than expenditures for Attorney services provided by HQES' Northern California offices, and more than \$2.0 million greater than expenditures for Attorney services provided by HQES' San Diego office.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

F. Enforcement Program Attrition History

During the two (2) years prior to implementation of VE (2004 and 2005), the Enforcement Program lost thirteen (13) Investigators, Senior Investigators, and Supervising Investigators, including, nine (9) employees who retired from State service, one (1) employee who transferred to DCA's Division of Investigation, and three (3) employees who left State service. Beginning during 2006, concurrent with implementation of VE, there was a sharp acceleration in staff turnover within the Enforcement Program. Ten (10) Investigators, Senior Investigators, and Supervising Investigators retired from State service during 2006 and 2007. This is about the same number of staff with these classifications as retired during the preceding two (2) years. However, in contrast with prior years, 17 other Investigators, Senior Investigators, and Supervising Investigators separated from the Medical Board, including:

- ❖ 8 employees who transferred to DCA's Division of Investigation
- ❖ 3 employees who transferred to the Department of Justice
- ❖ 5 employees who transferred to other State agencies
- ❖ 1 employee that left State service.

Similarly, during the next two (2) years (2008 and 2009), nine (9) Investigators, Senior Investigators, and Supervising Investigators retired from State service. Concurrently, 17 others in these same classifications separated from the Medical Board, including:

- ❖ 7 employees who transferred to DCA's Division of Investigation
- ❖ 3 employees who transferred to the Department of Justice
- ❖ 4 employees who transferred to other State agencies
- ❖ 3 employees who left State service.

In summary, during the past four (4) years more than one-half of the Enforcement Program's Investigators, Senior Investigators, and Supervising Investigators separated from the Medical Board. Only about one-third of the separations were due to retirements (fewer than 5 positions per year). Thirty (30) Investigators, Senior Investigators, and Supervising Investigators (7.5 positions per year) transferred to other State agencies, including 14 who transferred to DCA's Division of Investigations. The staff that separated during this period were highly experienced, with an average of eight (8) years experience with the Medical Board prior to their separation. Geographically, a disproportionate share of the separations was from Northern Region District offices.

High Investigator turnover over the past four (4) years compounded performance problems that the Medical Board was already experiencing as a result of staffing reductions imposed on the District offices earlier in the decade. Additionally, the smaller pool of remaining seasoned Investigators was increasingly used during this period to help train and mentor newly hired and less experienced staff.

As of late-2009 the Medical Board had 13 vacant Investigator-series positions, representing 16 percent of total authorized Investigator positions. Typically, California State Government agencies operate with only about 5 percent of their positions vacant. The

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

relatively high Investigator vacancy rate is partially attributable to the recent creation of five (5) new Investigator series positions for the Rancho Cucamonga-based OSM Unit. In late-2009, Los Angeles Metro District offices accounted for a disproportionate share of vacant Investigator positions due, in part, to the recent transfer of four (4) Investigator series positions from Los Angeles Metro District offices to the OSM Unit. As with the lateral transfers of Medical Board staff to DCA's Division of Investigation, the Investigators that transferred to the OSM Unit did not receive a salary increase and are now no longer required to work under the direction of HQES Attorneys. As of May 2010, the Investigator vacancy rate was reduced to 5 percent (with positions in background accounted for as filled).

G. Prior Analyses of the Impacts of Vertical Enforcement

Analyses of the impacts of Vertical Enforcement were previously completed during 2007 and 2009. Additionally, a one-page summary statistical report is provided on a quarterly basis to the Medical Board's Governing Board.

1. November 2007 Medical Board Analysis

In November 2007, the Medical Board reported to the Legislature that implementation of VE had (1) reduced the average time to complete investigations by 10 days, (2) reduced the average time to close cases without prosecution by six (6) days, and (3) reduced the average time for HQES to file accusations by 29 days.

2. June 2009 Integrated Solutions for Business and Government, Inc. Analysis

During 2009 an independent consultant was retained to review Enforcement Program statistical data provided by the Medical Board from 2005 through 2008. In June 2009, the consultant reported that (1) significantly fewer investigations were completed during 2008 as compared to 2005, and (2) significantly fewer accusations were filed during 2008 as compared to 2005. The consultant also reported that (1) the average elapsed time to complete investigations that were not referred for prosecution had increased by more than three (3) months, (2) the average elapsed time to complete investigations that were referred for prosecution had increased by more than two (2) months, and (3) for cases with an accusation filed, the average elapsed time from assigned for investigation to filing of the accusation had increased by more than a month.

3. Quarterly Board Reports

These reports have been provided to the Medical Board since mid-2008. Recent reports show significant decreases, since implementation of VE, in (1) the number of suspension orders granted, and (2) the number of investigations completed. The reports show a significant increase in recent years in the average elapsed time to complete "All" investigations. The reports also show no significant change in the number of cases with a disciplinary outcome, and a limited (10 percent) decrease in the average elapsed time to investigate and prosecute these cases (from 38 months to 34 to 35 months).

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

H. Probation Program

Since the early-1990s the Medical Board has maintained regional probation offices in Sacramento and the Los Angeles Metro area (e.g., Cerritos and Rancho Cucamonga). In addition to completing intake interviews of new probationers and monitoring Probationer compliance with the terms and condition of their probation, Investigators assigned to these offices also were responsible for investigating (1) complaints involving Probationers, (2) petitions of modification or termination of probation, and (3) petitions for reinstatement.

During the early-2000s, about 500 probationers were assigned to the Probation program, including about 100 cases that were inactive because the Probationer was practicing outside the State. During 2003/04 the total number of Probationers increased by about 10 percent to 547 cases. Since that time the number of Probationers has fluctuated between 510 and 550 cases. As of June 30, 2009, there were a total of 545 probation cases, including 109 inactive cases. Probation Program Investigators typically carry an average caseload of about 36 cases per position.

In recent years the Medical Board referred for investigation an average of 48 complaints involving Probationers per year. Many of these cases were actually originated by Probation Program Investigators. On average, about two-thirds of these cases were closed following investigation and about one-third were referred to HQES for prosecution. The proportion of cases referred for prosecution is comparable to that for cases involving Non-Probationers. Additionally, over the past 10 years the Medical Board received an average of about 40 petitions for modification or termination of probation per year. The number of petitions for modification or termination of probation received fluctuated within a range of 30 to 50 petitions per year. Variations in the number of petitions for modification or termination of probation received appear to be correlated with the number of Probationers. During 2008/09, 40 petitions for modification or termination of probation were received. A portion of this workload is now handled by the District offices. Finally, over the past 10 years, the Medical Board received an average of about 16 petitions for reinstatement per year. The number of petitions for reinstatement received fluctuated within a range of 10 and 25 petitions per year. During 2008/09, 18 petitions for reinstatement were received. Over the past six (6) years, the total number of all petitions received fluctuated within a fairly narrow range (50 to 65 per year).

Until recently, authorized staffing for the Probation Program typically consisted of about 24 total positions, including:

- ❖ 1 Supervising Investigator II (based in Sacramento)
- ❖ 3 Investigator Assistant (1 per office)
- ❖ 3 Supervising Investigator I (1 per office)
- ❖ 3 Clerical Support staff (1 per office).
- ❖ 14 Senior Investigator/Investigator (4 to 5 per office)

However, during 2008/09 the Medical Board transferred all of its Assistant Investigator positions to the Probation Program and reclassified the positions to Inspector I/II. Concurrently, the Probation Program's Supervisory and Management positions were reclassified to non-sworn classifications (i.e., the 3 Supervising Investigator positions were reclassified to Inspector III and the Supervising Investigator II position was reclassified to Staff Services Manager I). Subsequently, during 2009/10 three (3) new Inspector positions and one (1) new

II. Overview of the Evolution of the Medical Board’s Governance Structure, Licensing Fees, and Enforcement Program

support position were authorized for the Probation Program. Currently, the Probation Program is authorized a total of 26 positions, including, one (1) Staff Services Manager I, three (3) Inspector III, 16 Inspector I/II, and five (5) technical/clerical support staff.

Concurrent with the organizational restructuring of the Probation Program, responsibility for investigating complaints involving Probationers and petitions for reinstatement was transferred to the District offices. Also, petitions for modification or termination of probation were transferred to the District offices, except in cases where the Petitioner has generally been complying with the terms and conditions of their probation and there are not any pending investigations involving the Petitioner. The workload restructuring will enable Probation Program staff to focus their efforts on monitoring Probationer compliance with the terms and conditions of their probation.

I. Current Enforcement Program Organization and Staffing Resource Allocations

The Medical Board currently has 76 authorized Investigator and Senior Investigator positions, plus 19 Supervising Investigators (I or II). As shown by **Table II-7**, below, 10 of these positions are allocated to various Headquarters Units.

Table II-7. Investigator Positions Assigned to Headquarters Units

Headquarters Unit	Supervising Investigator I/II	Investigator/ Senior Investigator
Operation Safe Medicine (OSM)	1	4
Office of Standards and Training	3	2
Total Investigator Positions	4	6

The Medical Board’s District offices are organized into three (3) regional groups (Northern California, Los Angeles Metropolitan, and Other Southern California). Four (4) District offices are assigned to each region. A Regional Manager (Supervising Investigator II) oversees the operations of each region. Including the Regional Area Managers, District office Supervisors, Investigators and Senior Investigators, and clerical support staff, each of the three (3) regions is allocated 30 to 35 percent of total available staffing resources, with the fewest positions allocated to the Other Southern California region. These allocations are reasonably consistent with the geographic distribution of cases referred for investigation.

Within each District office, first level supervision is provided by a Supervising Investigator I. Subordinate staffing at each District office typically consists of six (6) full-time Investigator positions (Investigator or Senior Investigator) and 1 to 2 full-time clerical support positions (Office Technician or Office Assistant). A few offices have only five (5) Investigator positions. In total, 96 permanent, full-time positions are currently authorized for the District offices, including 12 Supervising Investigators, 70 Investigators or Senior Investigators, and 14 Office Technicians or Office Assistants.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

Some District offices supplement their Investigator staffing with part-time Retired Annuitant Investigators and about one-half of the offices supplement their clerical support staffing with part-time Retired Annuitant Office Technicians or Office Assistants. Additionally, each District office is authorized 2 to 3 Part-Time Medical Consultant positions. While Investigator positions are allocated equally among District offices, Medical Consultant staffing levels vary considerably. For example, during 2008/09 the Medical Consultants at some District offices were paid a combined total of more than 1,500 hours (the equivalent of about 0.7 positions). At other District offices the Medical Consultants were paid a combined total of less than 800 hours (the equivalent of less than 0.4 positions). Due to holidays, vacation, sick leave, and other paid time off, the hours actually worked by Medical Consultants are less than the hours paid.

J. Pending 2010/11 Budget Change Proposals

A currently pending Budget Change Proposal (BCP), if adopted, would increase authorized Enforcement Program staffing by 22.50 positions. The BCP would provide:

- ❖ 2 positions to strengthen and enhance management and administration of the Expert Reviewer Program (e.g., Expert recruitment and training)
- ❖ 2 positions for the Office of Standards and Training (OST), primarily to enhance CCU staff training
- ❖ 1 position for the Discipline Coordination Unit (DCU) to provide closer monitoring of disciplinary action cases
- ❖ 1 position to serve as an Assistant to the Chief of Enforcement
- ❖ 2 positions for CCU to be used primarily to enhance screening of AHLP cases
- ❖ 5.5 positions for CCU to be used primarily to enhance intake, screening, and specialty reviews of physician and surgeon quality of care cases
- ❖ 9 positions to perform investigations, including six (6) "non-sworn" staff, with two (2) of the positions designated for AHLP cases.

It is anticipated that the new "non-sworn" positions will be based at Headquarters and that the positions will be used to investigate Section 801 (medical malpractice) cases, plus possibly some petitions for modification or termination of probation, petitions for reinstatement, criminal conviction reports, and probation violation cases.

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III. License Fees, Expenditures, and Fund Condition

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III. License Fees, Expenditures, and Fund Condition

Since increasing initial and biennial renewal fees for physicians and surgeons from \$600 to \$790, effective January 1, 2006, there have been continuing concerns regarding whether the higher fees are justified. Section 2435(h) of Article 20 of the *Medical Practice Act*, adopted in conjunction with the January 2006 fee increase, placed a statutory cap on the amount of reserves that the Medical Board could accumulate in its Contingent Fund. Section 2435(h) stated that "It is the intent of the Legislature that, in setting fees pursuant to this section, the board shall seek to maintain a reserve in the Contingent Fund of the Medical Board of California equal to approximately two months' operating expenditures." Subsequently, during 2009, Section 2435(h) was modified to enable the Medical Board to maintain a higher reserve fund balance equal to two (2) to four (4) months operating expenditures (AB 501, Emmerson).

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

Exhibit III-1, on the next page, shows the amount of the surplus/(deficit) for the Medical Board Contingent Fund by year for the past five (5) years, and the projected surplus for 2009/10. Exhibit III-1 also shows end-of-year reserves for each year. As shown by Exhibit III-1, surpluses have been generated each year since implementation of the last fee increase during 2006. The amount of the surpluses ranged from \$4.7 million during 2005/06 to \$6.5 million during 2008/09. For 2009/10 a surplus of \$1.9 million was projected. However, it is likely that the surplus for 2009/10 will be greater than \$1.9 million due to:

- ✓ Higher than projected renewal fees
- ✓ Lower than projected expenditures for general expenses, rent, and major equipment
- ✓ Lower than projected expenditures for legal services, except services provided by the Attorney General
- ✓ Higher than projected probation monitoring reimbursements.

The total amount of these additional revenues and cost-savings are unlikely to be completely offset by lower than projected revenues, or greater than projected expenditures, in other areas (e.g., lower than projected interest earnings, higher than projected expenditures for temporary help and overtime for the Licensing Program

Historical and Budgeted Medical Board Revenues, Expenditures, and Fund Reserves

Fund Condition Summary		Actual					2009/10 Budget ⁴
		2004/05	2005/06 ¹	2006/07 ²	2007/08	2008/09 ³	
Total Revenues		\$36,544	\$42,297	\$49,688	\$52,091	\$51,313	\$50,286
Personal Services Expenses		\$19,537	\$18,604	\$19,728	\$20,741	\$20,293	\$19,692
Operating Expenses		21,907	22,124	26,842	28,790	27,487	30,941
Total Personal Services and Operating Expenses		\$41,444	\$40,728	\$46,570	\$49,531	\$47,780	\$50,633
Adjustments	Reimbursements - Scheduled (Fingerprinting and Criminal Cost Recovery)	\$378	\$408	\$393	\$347	\$330	\$384
	Reimbursements - Unscheduled (Probation Monitoring)	2,120	1,819	1,495	1,498	1,215	1,000
	Distributed Costs (Budgeted AHLP Reimbursements)	646	791	711	691	677	677
	Internal Cost Recovery (Additional AHLP Reimbursement)	0	0	0	151	145	150
	Prior Year Reserve Adjustments	(1)	150	551	152	613	Unknown
Total Expenditures, Including Adjustments		\$38,301	\$37,560	\$43,420	\$46,692	\$44,800	\$48,422
Surplus/(Deficit)		(\$1,757)	\$4,737	\$6,268	\$5,399	\$6,513	\$1,864
Physician Loan Repayment Program		(\$1,150)	(\$1,150)	\$0	\$0	\$0	\$0
Teale Data Center Adjustment		78	0	0	0	0	0
Loan to General Fund		0	0	0	0	(6,000)	0
End of Year Reserves		\$8,540	\$12,127	\$18,395	\$23,794	\$24,307	\$26,171
Estimated Months Reserve (based on subsequent year expenditures)		2.7	3.4	5.1	6.4	6.0	6.0
Authorized Positions, Including Diversion Program		263.1	263.1	275.6	275.6	262.2	272.2

¹ Initial and biennial renewal fees increased \$790 effective January 1, 2006.

² In 2006/07 authorized staffing levels increased by 12.50 positions (2.0 Diversion Program, 4.0 Investigators, 4.0 Investigative Assistants, 2.0 Information System Analysts, and 0.5 Staff Services Analyst).

³ In 2008/09 authorized staffing levels decreased by 12.40 positions due to termination of the Diversion Program.

⁴ The 2009/10 budget incorporates cost-savings related to the Furlough Friday Program and includes unfunded allocations for six (6) new Operation Safe Medicine positions (**\$500,000**), four (4) new Probation Program positions (**\$300,000**), and contracts for the Telemedicine Pilot Program (\$399,734 for the first year), an evaluation of Medical Board programs (\$159,300), and an analysis of Licensing Program business processes (\$40,350).

III. License Fees, Expenditures, and Fund Condition

As shown by Exhibit III-1, end-of-year reserves were about \$24 million for the last two (2) years, after excluding a \$6 million loan to the General Fund, and reserves were projected to increase to \$26.2 million at the end of 2009/10, assuming a \$1.9 million surplus for that year. It is likely that reserves at the end of 2009/10 will be greater than \$26.2 million because it is likely that the 2009/10 surplus will be greater than the \$1.9 amount budgeted. An end-of-year reserve of \$26.2 million would be equivalent to nearly six (6) months of projected 2010/11 expenditures, assuming:

- ❖ Total fee and revenue collections are the same as budgeted for 2009/10 (\$50.3 million)
- ❖ \$3.2 million in additional salary and benefit costs related to the expected elimination of the Furlough Friday Program (assumes 17 percent higher salary and benefit costs than budgeted for 2009/10)
- ❖ \$0.9 million in additional salary and benefit costs for 17 new Enforcement Program positions included in DCA's Consumer Protection Enforcement Initiative BCP (assumes all positions start work on October 1, 2010, and an average annual cost of \$70,000 per position)
- ❖ \$0.5 million in additional salary and benefit costs for 7 new Licensing Program positions recently authorized by DCA (assumes all positions start work by July 1, 2010, and an average annual cost of \$70,000 per position)
- ❖ \$0.5 million in additional operating expenditures (e.g., major equipment replacements, service contracts, etc.)
- ❖ \$1.1 million in cost-savings related to adoption of new salary and benefit cost containment programs (e.g., pay rate reductions)
- ❖ No offsetting reductions in expenditures for overtime or temporary help
- ❖ No new funding for six (6) new Operation Safe Medicine Unit positions and four (4) new Probation Program positions authorized during 2009/10.

With these assumptions total projected 2010/11 expenditures, net of reimbursement and cost recovery adjustments, would be about \$52.4 million (\$4.4 million per month). As has been the case for the past five (5) years, this level of reserves (\$26.2 million) significantly exceeds the maximum amount current set forth in Section 2435(h) of the *Medical Practice Act*. It is likely that reserves at the end of 2009/10 will be greater than \$26.2 million, and could approach a level equivalent to about 6.5 months of projected 2010/11 expenditures (\$28.6 million). At 2009/10 budgeted expenditure levels, a two-month reserve would be about \$8 million, or \$18 million less than current reserves, excluding \$6 million loaned to the General Fund. However, results of our review show that, within 2 to 3 years, the Medical Board's reserves are likely to decrease to a level equivalent to less than four (4) months' operating expenditures.

III. License Fees, Expenditures, and Fund Condition

As shown by **Table III-1**, below, if total expenditures increase by about 8 percent during 2010/11 (to \$52.4 million), and increase by an additional \$1.6 million per year (3 percent) for the next several years, reserves at the end of 2012/13 will still exceed the minimum set forth in statute, excluding the \$6 million loan to the General Fund. The Medical Board’s proposed budget for 2010/11 assumes a similar \$4 million increase in total expenditures to \$52.4 million.

Table III-1. Projected End-of-Year Reserves

	2009/10	2010/11	2011/12	2012/13	2013/14
Total Fees and Revenues	\$50.3	\$50.3	\$50.3	\$50.3	\$50.3
Total Expenditures, Including Adjustments and Cost Recovery	48.4	52.4	54.0	55.6	57.0
Surplus/(Deficit)	\$1.9	(\$2.1)	(\$3.7)	(\$5.3)	(\$6.7)
End-of-Year Reserves	\$26.2	\$24.1	\$20.4	\$15.1	\$8.4
Estimated Months Reserve (based on subsequent year expenditures)	6.0	5.4	4.4	3.2	1.7

Irrespective of whether expenditures increase by \$4.0 million in 2010/11, or a somewhat smaller amount, projected expenditures will likely exceed revenue collections during the year, and the resultant operating deficit will begin to deplete accumulated reserves. In subsequent years accumulated reserves will decrease further, assuming costs increase by several percent per year. It is likely that, at some point within the next two (2) to three (3) years, reserves will fall below the 4-month ceiling set forth in statute. However, in the absence of significant additional cost increases, reserves are unlikely to fall below the minimum 2-month level set forth in statute for at least several years. The \$6 million loan outstanding to the State’s General Fund is not expected to be repaid in the near future but, even if repaid, would not significantly impact the Medical Board’s fund condition because the amount is equivalent to less than 1.5 months’ expenditures.

Finally, we critically reviewed each major category of expenditures. Expenditures for HQES legal services have escalated rapidly in recent years, while other legal service costs declined. Costs for HQES legal services now exceed \$1 million per month and account for more than 25 percent of total expenditures. We also identified potential internal control issues involving HQES’ billings to the Medical Board, and potential overcharges for HQES’ services.

Recommendation No. III-1. *Closely review each of the Attorney General’s monthly Invoice Reports for the past three (3) fiscal years (2007/08 through 2009/10) to identify case billing inconsistencies by regions or billing anomalies that may have occurred. If significant over-charges are identified, request an adjustment in future billing periods.*

Recommendation No. III-2. *Maintain the current \$783 initial and biennial fee structure. Reserves will likely fall below the 4-month ceiling set forth in statute within the next two to three years.*

IV. Overview of Complaint Workload, Workflows, and Performance

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IV. Overview of Complaint Workload, Workflows, and Performance

Over the past eight (8) years, the number of complaints opened by the Medical Board declined by about 10 percent from an average of more than 8,000 complaints per year to about 7,200 complaints per year, excluding decreases attributable to changes implemented by the Medical Board to discontinue counting certain categories of complaints. Specifically, effective January 1, 2005, the Medical Board stopped counting complaints created when initiating change of address citations which, until recently, typically accounted for 250 to 350 complaints per year. Additionally, beginning in 2008/09 the Medical Board stopped opening complaints received that are determined during intake to be outside of the Board's jurisdiction. During 2008/09 about 800 non-jurisdictional complaints were not counted as received or closed. Excluding change of address citations and non-jurisdictional complaints identified during CCU's initial intake process, 6,442 complaints were opened during 2008/09. This figure compares to an average of more than 7,400 complaints received per year during the early part of the decade, adjusted to exclude change of address citations and a comparable number of non-jurisdictional complaints.

Exhibit IV-1, on the next page, shows the number of complaints opened from 2000/01 through 2008/09 for each of the following 10 categories of matters:

- ❖ Mandated Section 800 and 2240(a) reports
- ❖ Disciplinary Action Reports Submitted by Other States
- ❖ Medical Board-Originated Complaints with District Office Identifiers
- ❖ Medical Board-Originated Complaints with Headquarters Unit Identifiers
- ❖ Medical Board-Originated Cases with CME Audit Failure Citation Identifier
- ❖ Medical Board-Originated Complaints with Probationer Identifier
- ❖ Medical Board-Originated Complaints with Other Identifiers
- ❖ Petitions for Modification or Termination of Probation
- ❖ Petitions for Reinstatement
- ❖ Other Complaints and Reports.

Exhibit IV-1 also shows, by year, the following aggregate output and performance measures:

- ❖ Number of complaints closed with no further action
- ❖ Number of complaints referred for investigation or prosecution
- ❖ Percent of cases referred for investigation or prosecution
- ❖ Average elapsed time to close or refer cases for investigation or prosecution.

Overview of Complaints Opened and Dispositions - 2000/01 through 2008/09

Category of Complaints		2000/01 through 2002/03 (3-Year Avg.)	2003/04	2004/05 ¹	2005/06	2006/07	2007/08	2008/09 ²
Mandated Reports	Malpractice Reports from Insurers (Section 801 & 801.1)	888	787	722	726	676	597	605
	Malpractice Self-Reports (Section 801(c), 802, and 803.2)	328	228	212	185	187	150	204
	Malpractice Reports from Others (Section 803)	24	3	9	6	10	6	2
	Coroner Reports (Section 802.5)	32	18	23	11	22	16	16
	Health Care Facility Reports (Section 805)	146	157	110	138	127	138	122
	Surgical Death/Complication Self-Reports (Section 2240(a))	8	14	11	2	10	7	6
	Criminal Charge and Conviction Self-Reports (Section 802.1 and 803.5)	33	33	20	16	29	76	91
Total Mandated Reports	1,459	1,240	1,107	1,084	1,061	990	1,046	
Disciplinary Action Reports Submitted by Other States (IDENT 16)		323	371	448	385	279	288	258
Medical Board Originated Complaints with District Office Identifiers		286	212	202	216	216	161	113
Medical Board Originated Complaints with Headquarters Identifier ^{1 3} (IDENT 20, Excluding Petitions)		375	377	281	133	31	65	102
Medical Board Originated Complaints with CME Audit Failure Identifier (IDENT 21)		66	0	0	1	140	75	0
Medical Board Originated Complaints with Probationer Identifiers (IDENT 19)		6	13	22	23	9	11	34
Medical Board Originated Complaints with Other Identifiers ⁴ (IDENTs 22, 23, and 25)		32	12	7	9	10	6	10
Petitions for Modification or Termination of Probation (IDENT 26)		29	37	42	50	47	37	40
Petitions for Reinstatement (IDENT 27)		14	25	19	13	21	9	18
Other Complaints and Reports ^{1 2} Includes NPDB (26 in 2008/09)		5,968	5,953	5,375	5,749	5,445	5,197	4,821
Total Complaints and Other Matters Opened^{1 2}		8,558	8,240	7,503	7,663	7,259	6,839	6,442
Complaints and Other Matters Closed		5,967	6,837	6,603	6,349	6,105	5,608	5,303
Complaints and Other Matters Referred for Investigation or Prosecution ^{1 3} Incl. PLRs (31 in 2008/09)		2,355	1,887	1,443	1,331	1,182	1,133	1,123
Total Complaints and Other Matters Closed or Referred for Investigation or Prosecution^{1 2 3}		8,322	8,724	8,046	7,680	7,287	6,741	6,426
Percent of Cases Referred for Investigation or Prosecution^{1 3}		28%	22%	18%	17%	16%	17%	17%
Reported Average Days to Close or Refer Cases for Investigation or Prosecution ^{1 2 3}		55 Days	76 Days	66 Days	54 Days	54 Days	61 Days	75 Days
Reported Open Complaints and Petitions (End of Period)		2,019	1,566	1,011	1,086	1,133	1,283	1,323

¹ Effective in January 2005, change of address citations were no longer counted as complaints or investigations.

² Effective in 2008/09, some complaints received and determined by CCU to be outside of the Medical Board's jurisdiction were no longer counted as received or closed, thereby increasing CCU's reported average elapsed time to process complaints.

³ Includes probationary license certificates, SOIs, and criminal conviction notifications, advertising violations, and cite and fine non-compliance cases. Also includes change of address citation cases (through December 2004),

⁴ Includes Operation Safe Medicine, Internet Crimes Unit, and probation violation citation cases.

IV. Overview of Complaint Workload, Workflows, and Performance

Since the early part of the decade the number of complaints opened decreased significantly in both of the following areas:

Medical Malpractice Reports – The number of Medical Malpractice Reports submitted to the Medical Board decreased by 37 percent from an average of 1,240 reports per year during the early part of the decade to an average of 782 reports per year during the past two (2) years.

Out-of-State Disciplinary Action Reports – The number of Disciplinary Action Reports submitted to the Medical Board by medical/osteopathic boards in other states decreased by 27 percent from an average of about 350 reports per year during the early part of the decade to an average of 273 reports per year during the past two (2) years.

All complaints are opened by the CCU, but are assigned different Identifiers to distinguish the District office to which they are assigned. Additionally, CCU opens complaints on behalf of other Medical Board business units to track various matters that are not usually assigned to the District offices for investigation, including:

- ❖ Probationary License Certificates (issued in lieu of full licensure)
- ❖ Appeals of license application denials, referred to as statements of issues (SOIs)
- ❖ Continuing Medical Education (CME) audit failure citations
- ❖ Operation Safe Medicine (OSM) investigations
- ❖ Internet crime investigations
- ❖ Probation violation citations
- ❖ Advertising violation citations
- ❖ Cite and fine non-compliance cases
- ❖ Petitions for modification or termination of probation
- ❖ Petitions for reinstatement.

In some years there have been significant changes in the number of complaint records opened by CCU for these matters. Since the early part of the decade the total number of complaint records opened for these matters has decreased by 60 percent (from more than 500 “records” opened per year to about 200 “records” opened per year).

Since the beginning of the decade the number of complaints submitted by patients, family members, other licensees, and numerous other similar external referral sources has fluctuated within a relatively narrow range (5,200 to 5,800 per year). Also, there has been a significant increase in the number of complaints received since the beginning of the decade in only one category of complaints (Criminal Charge and Conviction Self-Reports). The number of these complaints recently increased primarily as a result of new requirements that licensees self-report misdemeanor charges and convictions in addition to previously required self-reporting of felony charges and convictions. This requirement became effective in January 2006 (SB 231, Figueroa).

IV. Overview of Complaint Workload, Workflows, and Performance

Various changes have occurred in the composition of complaints received since the early part of the decade (e.g., fewer medical malpractice reports, fewer Out-of-State reports, and fewer Medical Board-originated complaints). These changes appear to have had offsetting impacts on some aggregate complaint-handling performance measures. For example, over the past five (5) years the Medical Board has consistently closed about 83 to 84 percent of all complaints, and referred the remaining 16 to 17 percent for investigation or prosecution.

Since 2004/05, the number of complaints closed, adjusted for recent changes in the reporting of change of address citations and non-jurisdictional complaints, decreased by about 10 percent. Concurrently, the number of complaints referred for investigation or prosecution decreased by about 15 percent, after adjustment for changes in the reporting of change of address citation cases. During the past two (2) years an average of 1,128 complaints was referred for investigation or prosecution – about 200 fewer complaints than were referred during 2004/05, after adjustment for changes in the reporting of change of address citations.

From 2004/05 through 2007/08, the Medical Board maintained an average processing timeframe for all complaints of about two (2) months (60 days). The recent increase in the average complaint processing time to 75 days in 2008/09 is partially attributable to elimination of about 800 non-jurisdictional complaints from the calculation of this performance measure.

Finally, during the early part of the decade Medical Board closed or referred for investigation or prosecution significantly more complaints than were opened, and reduced the backlog of open complaints by 50 percent (from 2,000 open complaints to 1,000 open complaints). However, in recent years fewer complaints have been closed or referred for investigation or prosecution than have been opened. This has resulted in continuous increases in the number of pending complaints. At the end of 2008/09 there were 1,323 pending complaints. This is 300 (30 percent) more pending complaints than existed at the end of 2004/05. Inevitably, the growing number of open complaints will soon translate into longer average processing times, particularly given the continuation of the Furlough Friday Program through June 2010. Ultimately, over a period of several years, these complaint-handling delays will adversely impact aggregate Enforcement Program performance measures (e.g., total elapsed time from receipt of complaint to disciplinary outcome).

V. Complaint Intake and Screening

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V. Complaint Intake and Screening

A. Overview of Complaint Intake and Screening Outputs and Performance

CCU continues to do an outstanding job of administering and operating the Medical Board's complaint intake and screening processes. However, in recent years CCU has struggled to prevent growth in the number of pending complaints, which is beginning to adversely impact elapsed timeframes to close or refer complaints for investigation or prosecution. **Exhibit V-1**, on the next page, shows the total number of complaints closed and referred to investigation or prosecution during 2008/09, and the average elapsed time to close or refer the complaints. As shown by Exhibit V-1, during 2008/09:

- ❖ More than 6,100 complaints were either closed or referred for investigation or prosecution by CCU. About 30 percent of these complaints were reviewed by an outside Medical Specialist prior to closure or referral for investigation or prosecution. About 85 percent of the complaints handled by CCU were closed.
- ❖ The average elapsed time for CCU to close or refer complaints for investigation or prosecution was 78 days (about 2.5 months), after excluding more than 800 closed non-jurisdictional complaints. If all non-jurisdictional complaints were included, CCU's average processing time would be about 67 days. Prior to 2008/09, the average processing time for complaints, including all non-jurisdictional complaints, was about 60 days (1 week less).
- ❖ The average elapsed time to close or refer complaints not reviewed by a Medical Specialist was about two (2) months (54 days). This compares to an average time of more than four (4) months (127 days) to close or refer complaints that were reviewed by a Medical Specialist.
- ❖ The average time to refer complaints for investigation or prosecution for cases not reviewed by a Medical Specialist was about one (1) month (33 days), reflecting both the expedited referral of selected, high-priority cases to investigation and also the accelerated processing timeframes associated with DCU's handling of Out-of-State cases, most of which are referred directly to HQES for prosecution.

CCU's overall average processing time to close or refer complaints reflects the impacts of efforts to complete a substantive screening of all complaints to identify those that require a field investigation. These processes, including independent review of nearly all quality of care complaints by a Medical Specialist, increase the amount of time needed to complete screening, but reduce the number of complaints referred to the District offices for investigation. It is much more effective and efficient for CCU to screen complaints than to have District office staff investigate and close the cases, and the case dispositions are determined within an average of about 2.5 months. Nearly 95 percent of the cases handled by CCU are either closed or referred for investigation within a maximum of six (6) months.

Summary of 2008/09 CCU Processing Timeframes for All Complaints

Disposition	Months	Not Reviewed by Medical Consultant ¹		Reviewed by Medical Consultant		Total	
		Number	Percent	Number	Percent	Number	Percent
Closed	Less than 1 Month	1,479	41%	6	0%	1,485	29%
	1 to 2 Months	720	20%	107	7%	827	16%
	2 to 3 Months	598	17%	304	19%	902	17%
	3 to 4 Months	366	10%	415	26%	781	15%
	4 to 6 Months	315	9%	510	32%	825	16%
	Longer than 6 Months	112	3%	237	15%	349	7%
	Total	3,590	100%	1,579	100%	5,169	100%
	Average Days	58 Days		129 Days		80 Days	
Referred to Investigation or Prosecution ²	Less than 1 Month	391	62%	8	2%	399	41%
	1 to 2 Months	139	22%	43	12%	182	19%
	2 to 3 Months	37	6%	70	20%	107	11%
	3 to 4 Months	29	5%	82	24%	111	11%
	4 to 6 Months	23	4%	97	28%	120	12%
	Longer than 6 Months	8	1%	48	14%	56	6%
	Total	627	100%	348	100%	975	100%
	Average Days	33 Days		120 Days		65 Days	
Total	Less than 1 Month	1,870	44%	14	1%	1,884	31%
	1 to 2 Months	859	20%	150	8%	1,009	16%
	2 to 3 Months	635	15%	374	19%	1,009	16%
	3 to 4 Months	395	9%	497	26%	892	15%
	4 to 6 Months	338	8%	607	31%	945	15%
	Longer than 6 Months	120	3%	285	15%	405	7%
	Total	4,217	100%	1,927	100%	6,144	100%
	Average Days	54 Days		127 Days		78 Days	

¹ Excludes 13 closed records and 145 records referred by Medical Board Headquarters or Probation Units directly to the District offices or HQES. Nearly all of the excluded records were SOIs, petitions for modification or termination of probation, petitions for reinstatement or probation violation matters originated by Medical Board Headquarters or Probation Units.

² Includes all Out-of-State (IDENT 16) cases, most of which are referred directly to HQES rather than to the District offices for investigation.

V. Complaint Intake and Screening

Only about 15 percent of all complaints handled by CCU, those considered most likely to involve a violation of the *Medical Practice Act*, are referred for investigation, and about one-third of these cases are subsequently referred for prosecution. Because of the filtering performed by CCU, the District offices receive few complaints that do not require a substantive investigation. The District offices, in turn, are expected to perform substantive investigations of most of these cases, and not simply re-screen and re-triage the cases to limit the number of investigations performed.

The specialist reviews and CCU's post-closure review processes help to ensure that cases requiring investigation are not improperly closed. Conversely, only a small percent of cases referred by CCU to the District offices are rejected and returned to CCU. Returns are usually due to either (1) referral of a complaint that is redundant to a currently pending investigation, or (2) referral of a complaint related to a pending multiple patient case investigation where the new patient would not strengthen the case if added to it. These cases are properly referred to the District offices for these determinations and, if returned, are properly accounted for as a CCU rather than District office closure.

Quality of care complaints represent about one-half of all complaints closed or referred for prosecution, and the average time to close or refer these complaints during 2008/09 was about three (3) months (96 days) compared to about 2 months (56 days) for other complaints. Quality of care complaints reviewed by a Medical Specialist took an average of more than four (4) months to close or refer for investigation or prosecution. Of more than 400 complaints that CCU took longer than six (6) months to close or refer, nearly three quarters were quality of care complaints, and nearly all of these complaints were reviewed by a Medical Specialist.

The most common sources of delay in referring cases for investigation are related to obtaining and reviewing medical records. The delays become extended when problems surface at different points during the screening process (e.g., delayed getting patient cooperation and release of the records, then further delayed obtaining the records, then further delayed identifying a Medical Specialist to review the records, and then further delayed getting the completed review from the Medical Specialist). Some of these delays are within CCU's control, or CCU could more effectively manage the process to reduce the delays. In other cases the cause of the delay is outside CCU's control and CCU has limited capability to reduce the delay (e.g., waiting for a recovering patient to provide a release).

The number of pending complaints recently increased, from about 1,308 open complaints at the end of June 2009, to 1,443 at the end of the year. The 10 percent increase in open complaints during this brief period is primarily attributable to staffing reductions resulting from implementation of the closure of the Medical Board's offices during the first three (3) Fridays of each month (Furlough Fridays). Since 2004/05, the number of pending CCU complaints has increased by more than 40 percent (from fewer than 1,000 complaints at the end of 2004/05 to more than 1,400 complaints at the end of the 2009).

V. Complaint Intake and Screening

B. Specialist Reviews

The average elapsed times to complete Medical Specialist reviews vary by specialty. For six (6) high volume specialties, which collectively account for nearly two-thirds of all reviews, the average elapsed time to complete the reviews is about one (1) month (31 days). This compares to an average elapsed time of about two (2) months for 14 moderate volume medical specialties that collectively account for most of the remaining reviews.

For nearly all of the moderate volume specialties, the Medical Board has available a pool of fewer than 10 Medical Specialists to perform the reviews. For nine (9) of the 14 moderate volume specialties, a pool of five (5) or fewer Medical Specialists is available to review the complaints. The small number of Medical Specialists available to perform reviews of moderate volume specialty complaints contributes to the longer time needed to complete the reviews. However, the moderate volume specialties represent less than one-third of all reviewed complaints, and the Medical Specialist review accounts for only about one-half of the total elapsed time to process these complaints. Therefore, significantly reducing the average elapsed time to complete the reviews (e.g., to the same one-month average timeframe achieved for high volume specialties), will only marginally improve the Medical Board's overall average complaint processing performance.

Table V-1, on the next page, provides a profile of the dispositions of complaints following Medical Specialist review for periods immediate prior to, and concurrent with, implementation of Medical Specialist reviews. Additionally, a profile of the dispositions of complaints following Medical Specialist review is provided for 2008/09. As shown by Table V-1, 17 percent of complaints were referred for investigation during 2008/09 compared to 20 to 21 percent referred to investigation previously. Additionally, a higher proportion of complaints are Closed-Insufficient Evidence (which usually refers to cases involving a simple or minor departure) and a lower percent of complaints are Closed-No Violation (which usually refers to cases where no departure is identified).

The primary purpose of enacting the Specialist Review requirements was to reduce unnecessary referrals of complaints for field investigation that occurred due to competency limitations of the assigned reviewer. The data presented in Table V-1 indicate that the Medical Specialist review requirement is marginally reducing the number of complaints referred for investigation (i.e., by about 50 complaints per year, assuming 20 percent of 1,999 complaints would otherwise have been referred to investigation). Additionally, significantly more complaints are now being closed with an "Insufficient Evidence" designation. These complaints can potentially serve to support future disciplinary actions against the licensee on the basis that the licensee performed repeated negligent acts.

V. Complaint Intake and Screening

Table V-1. Disposition of Complaints Following Medical Specialist Review

Disposition	CY2000 to CY2002		CY2003 to CY2004		FY2008/09	
	Average Number	Percent	Average Number	Percent	Number	Percent
Closed - No Violation (i.e., No Departure)	1,852	61%	1,331	59%	1,082	54%
Closed - Insufficient Evidence (i.e., Simple/Minor Departure)	486	16%	348	16%	456	23%
Closed - Information on File	49	2%	72	3%	80	4%
Closed - Other	29	1%	22	1%	33	2%
Total	2,416	80%	1,773	79%	1,651	83%
Referred to Investigation	596	20%	468	21%	348	17%
Total	3,012	100%	2,241	100%	1,999	100%

C. Recommendations for Improvement

The following recommendations are structured to enhance CCU's performance.

1. Medical Specialist Reviews

There are only a relatively small number of Medical Specialists available to review complaints in a number of moderate volume specialty areas, and some of the specialty areas are the same as those that have some of the longest average elapsed times to complete complaint reviews. On average, these reviews take only a few hours of labor time, but a few months of calendar time, to complete. For example, there are only four (4) neurologists available to review more than two (2) dozen complaints per year and the average time to review these complaints is nearly three (3) months. Similar situations exist with:

- ❖ Urologists (2 Specialists, 54 complaints, 61-day average review time)
- ❖ Radiologists (5 Specialist, 53 complaints, 80-day average review time)
- ❖ Pediatrics (8 Specialists, 38 complaints, 76-day average review time)
- ❖ Anesthesiologists (9 Specialists, 30 complaints, 66-day average review time)
- ❖ Neurological Surgeons (3 Specialists, 25 complaints, 76-day average review time)
- ❖ Oncologists (5 Specialists, 21 complaints, 75-day average review time).

V. Complaint Intake and Screening

It would be beneficial to increase the number of Medical Specialists available to CCU in these and other moderate volume specialty areas.

Recommendation No. V-1. *Augment the Specialist Reviewer pool in targeted medical specialties and counsel or replace current Medical Specialists who consistently fail to complete reviews on a timely basis, or amend the governing statutes to provide flexibility to refer complaints for investigation without review by a Medical Specialist.*

2. CCU Workforce Capability and Competency

Seven and one-half (7.5) new CCU positions, including one (1) SSM I position, five (5) AGPA positions, and 1.5 MST/OT positions, are expected to be authorized in the 2010/11 Budget. These positions will be used primarily to enhance intake and screening of physician and surgeon and AHLF cases, and to enhance management and administration of the Specialty Review process. Additionally, two (2) new AGPA positions are expected to be authorized for the Office of Standards and Training (OST). These positions are expected to focus their efforts on training programs for CCU staff. These additional positions would significantly enhance CCU workforce capabilities. To ensure anticipated benefits are actually realized, CCU management should develop a specific plan detailing the program development and performance improvement goals and objectives that will be achieved as a result of these significant increases in authorized CCU and OST staffing levels. As much as possible the program development and performance improvement goals and objectives should be stated in terms that will enable assessment of the extent to which the objectives are actually achieved.

Recommendation No. V-2. *Augment CCU's workforce capability. When authorized, fill the new CCU and OST positions. Develop a specific plan detailing the program development and performance improvement goals and objectives that will be achieved by increasing authorized CCU and OST staffing levels. Track progress relative to the plan and provide periodic reports to the Medical Board showing progress in achieving each of the plan's goals and objectives.*

3. Customer Satisfaction Metrics

CCU has not surveyed customers regarding the level of satisfaction with CCU services since the late-1990s. Monitoring customer satisfaction levels helps to maintain and improve the level of service provided to the public by linking changes in policies and procedures with measures of the impacts of these changes on the customer community. Other DCA-affiliated regulatory programs utilize a simple postcard survey for this purpose.

Recommendation No. V-3. *Resume surveys of CCU customer satisfaction levels and compile and publish the results of the surveys.*

VI. Investigations

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VI. Investigations

Our assessment of investigation process performance focused on determination of the numbers of investigations completed by the District offices concurrent with and following implementation of the VE during 2006, the disposition of the cases, and the elapsed time to complete the investigations. The assessment also encompassed analysis of time spent by HQES Attorneys on investigations and in-depth reviews of more than two (2) dozen cases with more than 40 hours of time charged by HQES Attorneys during 2008/09. Additionally, we completed analyses of Medical Consultant and Medical Expert services and expenditures.

Results of these analyses show that fewer investigations are being completed by the District offices, the investigations are taking significantly longer to complete, and fewer cases are being referred for prosecution. Also, performance levels have declined as much, or more, in the Los Angeles Metro region than in other regions of the State even though Los Angeles Metro region Attorneys are significantly more involved with investigations. For example, during 2008/09 Los Angeles Metro region Attorneys billed the Medical Board about 50 hours of time per completed investigation, compared to about 31 hours of Attorney time billed per completed investigation in the Other Southern California region, and 15 hours of Attorney time billed per completed investigation in the Northern California region. Yet, notwithstanding this much higher level of Attorney involvement in investigations, during 2008/09, and also during 2007/08, only about 75 cases per year were referred for prosecution by Los Angeles Metro region District offices. This compares to about 72 cases per year referred for prosecution in the Other Southern California region and more than 100 cases per year referred for prosecution in the Northern California region. During the past two (2) years 25 percent of completed Los Angeles Metro region investigations were referred for prosecution. In the Northern California region, 28 percent of completed investigations were referred for prosecution and, in the Other Southern California region, 32 percent of completed investigations were referred for prosecution.

A. Investigations Opened and Completed by Identifier

Exhibit VI-1, on the next page, shows the number of investigations opened and completed by Identifier, by fiscal year. As shown by Exhibit VI-1, in recent years the number of investigations with District office Identifiers that were opened, closed, and referred for prosecution decreased significantly. During this period there was little change in the overall percentage of cases referred for prosecution, which averaged 29 percent during this period. However, there were significant differences in performance between the three (3) regions to which District offices are assigned. For example:

- ❖ The number of cases referred for prosecution decreased significantly in the Los Angeles Metro and Other Southern California regions. In contrast, there was no decrease in the number of cases referred for prosecution by the Northern California region.
- ❖ During the past several years the Northern and Other Southern California regions both closed or referred more cases than were opened. In contrast, in the Los Angeles Metro region, fewer cases were closed or referred than were opened. However, during 2008/09 none of the three (3) regions closed or referred more cases than were opened.

Summary of Investigations Opened and Completed, by Identifier
2005/06 through 2008/09¹

Cases with District Office Identifiers		2005/06	2006/07	2007/08	2008/09	Cases with Other Identifiers		2005/06	2006/07	2007/08	2008/09
Opened	Northern California	398	379	324	344	Opened	Out of State (IDENT 16)	105	50	132	93
	Los Angeles Metro	343	338	350	306		Probation (IDENT 19)	39	48	50	54
	Other Southern California	382	246	193	222		Headquarters (IDENTs 20, 21, 22, 26, and 27)	72	88	61	108
	Total Investigations Opened	1,123	963	867	872		Internet (IDENT 23)	15	8	15	8
Closed or Referred for Prosecution	Northern California	399	389	383	330		Total Investigations Opened	231	194	258	263
	Los Angeles Metro	343	308	302	305	Closed or Referred for Prosecution	Out of State (IDENT 16)	18	13	13	9
	Other Southern California	325	257	258	190		Probation (IDENT 19)	48	34	49	51
	Total Investigations Closed or Referred	1,067	954	943	825		Headquarters (IDENTs 20, 21, 26, and 27)	41	50	55	56
Difference	Northern California	(1)	(10)	(59)	14		Internet (IDENT 23)	5	9	6	19
	Los Angeles Metro	0	30	48	1		Direct Referrals and Same-Day Closures (IDENTs 16 and 19 through 27)	102	65	105	132
	Other Southern California	57	(11)	(65)	32	Total Investigations Closed or Referred	214	171	228	267	
	Difference: Opened Less Closed or Referred	56	9	(76)	47	Difference: Opened Less Closed or Referred	17	23	30	(4)	
Referred for Prosecution	Northern California	89	107	100	103	Referred for Prosecution	Out of State (IDENT 16)	6	7	9	1
	Los Angeles Metro	112	86	76	75		Probation (IDENT 19)	17	14	17	22
	Other Southern California	104	101	71	74		Headquarters (IDENTs 20, 21, 26, and 27)	39	45	53	51
	Total District Office Legal Closures	305	294	247	252		Internet (IDENT 23)	1	1	2	10
Percent Referred for Prosecution	Northern California	22%	28%	26%	31%		Direct Referrals to AG or DA (IDENTs 16, 19, 20, and 21)	100	65	89	122
	Los Angeles Metro	33%	28%	25%	25%	Total Legal Closures - Other Identifiers	163	132	170	206	
	Other Southern California	32%	39%	28%	39%	Percent Referred for Prosecution - Other Identifiers	76%	77%	75%	77%	
	Total - District Office Identifiers	29%	31%	26%	31%						

¹ Excludes re-opened cases. Statewide, an average of about 30 cases are re-opened per year.

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- ❖ In the Los Angeles region, the proportion of cases referred for prosecution decreased from 33 percent during 2005/06 to 25 percent during each of the past two (2) fiscal years. In contrast, the proportion of cases referred for prosecution by the Northern California region increased from 22 percent during 2005/06 to an average of 28 percent during the past several years. For the Other Southern California region, the proportion of cases referred for prosecution averaged about 35 percent during the past several years, a higher proportion than achieved by either of the other two regions.

In contrast to the workload trends at the District offices, the number of cases with Out-of-State, Probationer, and Headquarters Unit Identifiers that were opened, closed, and referred for prosecution increased during the past several years. About 76 percent of these cases were consistently referred for prosecution. These cases consistently have a comparatively high 76 percent referral rate, and typically account for 20 to 25 percent of all case closures and referrals. The consolidation of these cases, for performance reporting purposes, with cases handled by the District offices, obscures changes occurring in District office performance.

B. Elapsed Time to Complete Investigations

Exhibit VI-2, on the next page, shows average elapsed times to investigate cases, by fiscal year, for quality of care and other cases. The data shown excludes cases closed or referred directly for prosecution by the originating Headquarters or Probation Unit without involvement of the District offices. During the past several years the average elapsed time to complete quality of care case investigations increased by 35 percent (from 11.3 months during 2005/06 to 15.2 months during 2008/09). For other cases, the average elapsed time to investigate the cases increased by 42 percent (from 7.4 months during 2005/06 to 10.5 months during 2008/09). The 35 percent increase over the past several years in the average elapsed time to complete quality of care case investigations is particularly surprising given the impacts that VE was expected to have on these types of cases. For example, HQES Attorney involvement was expected to significantly reduce the amount of time needed to obtain patient medical records needed to determine the viability of the cases, and that cases that were not viable would be closed more quickly, thereby enabling redeployment of Investigators to accelerate the processing of other cases.

Exhibit VI-3, following Exhibit VI-2, shows average elapsed times to investigate cases by District office Identifier, by fiscal year. The average elapsed time to investigate cases with District office Identifiers increased by 35 percent (from 10.2 months during 2005/06 to 13.7 months during 2008/09). Average elapsed times to complete investigations increased significantly in all three (3) regions. In the Other Southern California region the average elapsed time to complete investigations reached nearly 16 months and the number of cases closed or referred for prosecution decreased by 42 percent (to fewer than 200 completed investigations compared to more than 300 investigations completed in both of the other regions). For cases with other Identifiers, the number of completed investigations decreased during the past several years and the average elapsed time to investigate these cases increased significantly. Some of these cases were handled by Headquarters Units, some were handled by Probation Units, and some were handled by the District offices.

**Summary of Completed Investigations, By Type of Case
2005/06 through 2008/09**

Case Type	Elapsed Time to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	6 Months or Less	128	17%	85	14%	90	15%	78	14%
	9 to 12 Months	323	43%	227	36%	212	35%	149	27%
	12 to 18 Months	213	28%	193	31%	161	26%	140	25%
	18 to 24 Months	59	8%	86	14%	102	17%	97	18%
	More than 24 Months	25	3%	31	5%	47	8%	86	16%
	Total	748	100%	622	100%	612	100%	550	100%
	Average Number of Months	11.3 Months		12.5 Months		13.1 Months		15.2 Months	
Other Cases	6 Months or Less ¹	206	48%	183	42%	162	36%	139	34%
	9 to 12 Months	145	34%	145	33%	139	31%	133	33%
	12 to 18 Months	63	15%	78	18%	74	16%	64	16%
	18 to 24 Months	13	3%	21	5%	54	12%	33	8%
	More than 24 Months	2	0%	10	2%	25	6%	35	9%
	Total	429	100%	437	100%	454	100%	404	100%
	Average Number of Months	7.4 Months		8.4 Months		10.3 Months		10.5 Months	
All Cases	6 Months or Less ¹	334	28%	268	25%	252	24%	217	23%
	9 to 12 Months	468	40%	372	35%	351	33%	282	30%
	12 to 18 Months	276	23%	271	26%	235	22%	204	21%
	18 to 24 Months	72	6%	107	10%	156	15%	130	14%
	More than 24 Months	27	2%	41	4%	72	7%	121	13%
	Total	1,177	100%	1,059	100%	1,066	100%	954	100%
	Average Number of Months	9.9 Months		10.8 Months		11.9 Months		13.1 Months	

¹ Data shown excludes cases closed by Headquarters and Probation Units, cases closed with a citation issued by DCU or Probation Units, and cases referred directly for prosecution without District office investigation, including nearly all Out-of-State (IDENT 16) cases, cases involving probation violations (IDENT 19), originated by the Medical Board), and SOI, CME audit failure, and citation non-compliance cases (IDENT 20 or 21, originated by the Medical Board).

Cases Closed or Referred Directly for Prosecution	Quality of Care Cases	3	3%	12	18%	47	34%	20	14%
	Other Cases	101	97%	54	82%	93	66%	118	86%
	Total	104	100%	66	100%	140	100%	138	100%

**Summary of Completed Investigations, By Identifier
2005/06 through 2008/09**

Business Unit		Investigations Completed				Average Elapsed Time to Complete (Months)				Comments
		2005/06	2006/07	2007/08	2008/09	2005/06	2006/07	2007/08	2008/09	
Cases with District Office Identifiers	Fresno	72	67	87	55	12.3	13.1	15.1	18.6	Includes several aged Section 805 cases.
	Pleasant Hill	120	93	99	102	10.1	10.4	13.5	13.9	
	Sacramento	117	139	116	97	12.8	13.1	10.7	9.8	
	San Jose	90	90	81	76	9.8	10.8	11.1	12.6	
	Total - Northern California	399	389	383	330	11.2	11.9	12.5	13.2	
	Cerritos	100	86	115	118	10.2	8.7	10.1	10.9	
	Diamond Bar	83	54	60	64	8.6	11.9	12.7	17.0	
	Glendale	82	67	40	72	11.0	11.6	12.2	13.5	
	Valencia	78	101	87	51	11.1	8.9	10.9	12.2	
	Total - Los Angeles Metro Area	343	308	302	305	10.2	9.9	11.1	13.0	
	Rancho Cucamonga	N/A	N/A	N/A	6	N/A	N/A	N/A	8.6	Prior to 2008/09, Rancho Cucamonga was a Regional Probation Unit.
	San Bernardino	119	105	87	61	9.4	11.3	15.0	16.9	
	San Diego	102	68	106	69	9.6	12.6	12.8	15.1	
	Tustin	104	84	65	54	8.3	10.4	13.6	16.6	
	Total - Other Southern California	325	257	258	190	9.1	11.3	13.8	15.9	
	Total - District Offices	1,067	954	943	825	10.2	11.1	12.4	13.7	
Cases with Other Identifiers †	Out of State (IDENT 16)	16	12	13	3	3.6	8.0	6.3	11.7	These cases are nearly always referred from DCU directly to HOES. They are only assigned to District offices when the licensee is practicing in California.
	Probation (IDENT 19)	48	34	49	51	9.7	10.1	9.9	10.9	Prior to 2008/09 these cases were investigated by regional Probation Units. Subsequently, the investigations were performed by District offices.
	Headquarters (IDENT 20)	41	50	55	17	3.8	6.3	7.1	7.1	Includes SOIs and probationary license certificates which are not handled by the District offices.
	Petition for Modification/Termination of Probation (IDENT 26)	Included with Headquarters Cases			31	Included with Headquarters Cases			6.7	Prior to 2008/09, petitions were handled by regional Probation Units. Subsequently, petitions for modification/termination of probation were handled by Probation Monitoring Units and the District offices and petitions for reinstatement were handled exclusively by the District offices.
	Petition for Reinstatement (IDENT 27)	Included with Headquarters Cases			8	Included with Headquarters Cases			9.3	
	Internet (IDENT 23)	5	9	6	19	7.6	8.3	12.1	13.2	These cases are handled by a specialized Headquarters Unit. They are usually referred to DAs for prosecution without involvement of the District offices.
	Total - Other Identifiers	110	105	123	129	6.5	7.9	8.4	9.6	
Total	1,177	1,059	1,066	954	9.9	10.8	12.0	13.2		

† Data shown excludes closed Headquarters and Probation Unit cases, cases closed with a citation issued by DCU or Probation Units, and cases referred directly for prosecution without District office investigation, including nearly all Out-of-State (IDENT 16) cases, cases involving probation violations (IDENT 19, originated by the Medical Board), and all SOI, CME audit failure, and citation non-compliance cases (IDENT 20 or 21, originated by the Medical Board).

Cases Closed or Referred Directly for Prosecution by the Originating Headquarters or Probation Unit	104	66	140	138	Not Applicable			
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C. Elapsed Time to Refer Cases for Prosecution

Exhibit VI-4, on the next page, shows average elapsed times to complete investigations for cases referred for prosecution, by fiscal year, for quality of care and other cases. As shown by Exhibit VI-4, during the past several years the average elapsed time to complete quality of care case investigations increased by 34 percent (from 13.7 months during 2005/06 to 18.4 months during 2008/09). During 2008/09 it took longer than 18 months to investigate nearly 50 percent of these cases. For cases with other Identifiers, the average elapsed time to complete the investigations increased by 16 percent (from 7.5 months during 2005/06 to 8.7 months during 2008/09). Overall, the average elapsed time to investigate cases referred for prosecution increased by 23 percent (from 10.9 months during 2005/06 to 13.4 months during 2008/09). Concurrently, the number of cases referred for prosecution decreased by 9 percent (from 368 cases during 2005/06 to 336 cases during 2008/09).

Exhibit VI-5, following Exhibit VI-4, shows average elapsed times to investigate cases referred for prosecution, by Identifier, by fiscal year. As shown by Exhibit VI-5, the average elapsed time to investigate cases with District office Identifiers increased by 27 percent (from 11.9 months during 2005/06 to 15.1 months during 2008/09). The average elapsed time to investigate these cases increased significantly in all three (3) regions. During 2008/09 the average elapsed time to investigate cases in the Other Southern California region reached 15 months for cases referred for prosecution. This region also experienced a relatively large 29 percent decrease in the number of cases referred for prosecution. In contrast, in the Northern California region, the number of cases referred for prosecution, and the average elapsed time to complete these investigations, increased by 10 percent. In each of the last two fiscal years the Northern California region referred at least 30 percent more cases for prosecution than either the Los Angeles Metro or Other Southern California regions (100 cases referred for prosecution by the Northern California region compared to 76 or fewer cases in each of the other regions). For cases with other Identifiers, the number of cases referred for prosecution and the average elapsed time to complete the investigations increased during the past several years. Some of these cases were handled by Headquarters Units, some were handled by Probation Units, and some were handled by the District offices.

D. HQES Decline to File Cases

With a greater level of HQES Attorney involvement in investigations, it might be expected that the number of cases that HQES declined to file would decrease. During the past several years there were not any sustained changes in the number of cases that HQES declined to file. The average number of cases that HQES declined to file during the past two (2) years (20 cases per year) was about the same as the average number of cases that HQES declined to file during the preceding three (3) years (21 cases per year).

Implementation of VE has not reduced the number of cases that HQES declines to file, notwithstanding HQES' higher level of involvement in the investigation of the cases. During the past two (2) years there was little difference between geographic regions in the average number of cases that HQES declined to file. HQES' Los Angeles Metro office continues to decline to file as many, or more, cases than offices in other regions, notwithstanding the Los Angeles Metro office's much higher level of Attorney involvement in the investigation of cases in that region.

**Summary of Investigations Referred for Prosecution, By Type of Case
2005/06 through 2008/09**

Case Type	Timeframe to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	6 Months or Less ¹	20	10%	21	10%	17	10%	14	9%
	6 to 12 Months	72	35%	76	36%	47	28%	26	16%
	12 to 18 Months	71	35%	65	31%	44	26%	44	27%
	18 to 24 Months	27	13%	35	17%	36	21%	34	21%
	More than 24 Months	15	7%	14	7%	26	15%	46	28%
	Total	205	100%	211	100%	170	100%	164	100%
	Average Number of Months	13.7 Months		13.4 Months		15.6 Months		18.4 Months	
Other Cases	6 Months or Less ¹	84	52%	72	48%	66	42%	75	44%
	6 to 12 Months	43	26%	46	31%	54	34%	54	31%
	12 to 18 Months	29	18%	16	11%	17	11%	23	13%
	18 to 24 Months	5	3%	14	9%	17	11%	13	8%
	More than 24 Months	2	1%	2	1%	4	3%	7	4%
	Total	163	100%	150	100%	158	100%	172	100%
	Average Number of Months	7.5 Months		8.0 Months		9.0 Months		8.7 Months	
All Cases	6 Months or Less ¹	104	28%	93	26%	83	25%	89	26%
	6 to 12 Months	115	31%	122	34%	101	31%	80	24%
	12 to 18 Months	100	27%	81	22%	61	19%	67	20%
	18 to 24 Months	32	9%	49	14%	53	16%	47	14%
	More than 24 Months	17	5%	16	4%	30	9%	53	16%
	Total	368	100%	361	100%	328	100%	336	100%
	Average Number of Months	10.9 Months		11.1 Months		12.4 Months		13.4 Months	

¹ Data shown excludes cases referred directly to the Attorney General or a District Attorney without District office investigation, including nearly all Out of State (IDENT 16) cases, cases involving probation violations (IDENT 19, originated by the Medical Board), and SOI, CME Audit Failure, and Citation Non-Compliance cases (IDENT 20 or 21, originated by the Medical Board).

Direct Referrals for Prosecution	Quality of Care Cases	3	3%	12	18%	47	38%	20	16%
	Other Cases	99	97%	54	82%	77	62%	108	84%
	Total	102	100%	66	100%	124	100%	128	100%

**Summary of Investigations Referred for Prosecution, By Identifier
2005/06 through 2008/09**

Business Unit		Cases Referred for Prosecution				Average Elapsed Time to Refer (Months)				Comments
		2005/06	2006/07	2007/08	2008/09	2005/06	2006/07	2007/08	2008/09	
Cases with District Office Identifiers	Fresno	25	29	25	12	13.5	12.0	17.2	21.3	Includes several aged Section 805 cases.
	Pleasant Hill	26	18	27	33	12.1	11.1	15.6	16.9	
	Sacramento	24	38	20	34	14.6	11.1	12.4	10.4	
	San Jose	14	22	28	24	12.6	13.7	12.2	13.8	
	Total - Northern California	89	107	100	103	13.2	11.9	14.4	14.5	
	Cerritos	35	18	33	26	12.0	11.8	13.0	11.8	
	Diamond Bar	26	16	10	12	10.2	14.6	18.1	18.7	
	Glendale	27	28	14	26	15.2	13.6	14.4	15.8	
	Valencia	24	24	19	11	13.1	8.9	12.4	12.9	Includes several 3-week HQES cases.
	Total - Los Angeles Metro Area	112	86	76	75	12.6	12.1	13.8	14.5	
	Rancho Cucamonga	N/A	N/A	N/A	2	N/A	N/A	N/A	8.1	Prior to 2008/09, Rancho Cucamonga was a Regional Probation Unit.
	San Bernardino	44	39	19	15	10.0	12.6	15.0	18.5	
	San Diego	25	29	34	34	11.4	13.0	14.5	16.5	
	Tustin	35	33	18	23	9.0	10.3	10.8	16.1	
	Total - Other Southern California	104	101	71	74	10.0	12.0	13.7	16.6	
Total - District Offices	305	294	247	252	11.9	12.0	14.0	15.1		
Cases with Other Identifiers ¹	Out of State (16)	6	7	9	1	2.2	8.0	7.5	3.6	These cases are nearly always referred from the Disciplinary Unit directly to the AG. They are only assigned to District offices when the licensee is practicing in California.
	Probation (19)	17	14	17	22	12.1	11.2	8.7	10.3	Prior to 2008/09, these cases were investigated by Regional Probation Units. Subsequently, the investigations were performed by District offices.
	Headquarters (20)	39	45	53	14	3.9	6.2	7.0	5.9	Includes Statement of Issue (SOI) cases and Probation Certifications which are not handled by the District Offices.
	Petitions for Modification/Termination of Probation (26)	Included with Headquarters Cases			29	Included with Headquarters Cases			6.1	Prior to 2008/09 petitions were handled by regional Probation Units. Subsequently, petitions for modification/termination of probation were handled by Probation Monitoring Units and the District offices and petitions for reinstatement were handled exclusively by the District offices.
	Petitions for Reinstatement (27)	Included with Headquarters Cases			8	Included with Headquarters Cases			9.3	
	Internet (23)	1	1	2	10	9.4	10.6	17.6	14.5	These cases are handled by a specialized Headquarters Unit. They are usually referred to DAs for prosecution without involvement of the District offices.
	Total - Other Identifiers¹	63	67	81	84	6.0	7.5	7.7	8.4	
Total, Excluding Direct Referrals¹	368	361	328	336	10.9	11.1	12.4	13.4		

¹ Data shown excludes closed Headquarters and Probation Unit cases, cases closed with a citation issued by DCU or Probation Units, and cases referred directly for prosecution without District office investigation, including nearly all Out-of-State (IDENT 16) cases, cases involving probation violations (IDENT 19, originated by the Medical Board), and all SOI, CME audit failure, and citation non-compliance cases (IDENT 20 or 21, originated by the Medical Board).

Cases Referred Directly for Prosecution from Headquarters or Probation Units	102	66	124	128	Not Applicable			
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VI. Investigations

E. Expenditures for HQES Investigation Services

Concurrent with implementation of VE during 2006, HQES began opening “Investigation Matters” for specific cases during the Investigation Stage, and HQES Attorneys began charging time to these matters when they worked on these cases. Additionally, many HQES Attorneys, and Lead Prosecutors in particular, began charging additional time to general “Client Service” matters reflecting time spent assisting with Investigations that was not charged to specific cases. In some cases the HQES Attorneys charged their time to “Section-Specific Tracking” matters rather than to general “Client Service” matters. Based on a review of individual Attorney time charges during 2008/09, most of the time charged by HQES Attorneys to general Client Service and Section-Specific Tracking matters, excluding time charged by Supervising DAGs, was for time worked on investigation-related activities. Additionally, in the Northern California region, these charges include time providing assistance to CCU (i.e., several hours per week).

Exhibit VI-6, on the next page, summarizes HQES time charges to Investigation, Client Service, and Section-Specific Tracking matters by year from 2006 through 2009, excluding time charged by Supervising DAGs and HQES’ Senior Assistant Attorney General. As shown by Exhibit VI-6, during the past two years the number of hours charged by HQES DAGs to these matters increased by nearly 70 percent, from an average of 16,872 hours during 2006 and 2007 to more than 28,000 hours during 2009. Exhibit VI-6 also shows that time charges by Los Angeles Metro office Attorneys accounted for nearly all of this increase. During 2009, Los Angeles Metro office Attorneys charged more than 17,000 hours to Medical Board investigations, compared to fewer than 6,400 hours charged during 2006 and 2007. Additionally, during 2009 Los Angeles Metro office Attorneys charged about 11,000 more hours to Medical Board investigations than HQES’ San Diego office Attorneys, and nearly 12,000 more hours than charged by HQES’ Northern California offices.

HQES’ hourly billing rates for Attorney services during 2008/09 and 2009/10 were \$158 and \$170, respectively, or an average of \$164 per hour. Assuming a \$164 hourly billing rate for Attorney services, estimated billings during 2009 for investigation-related services for cases assigned to the Northern and Southern California regions were less than \$1 million each during 2009, compared to more than \$2.8 million for cases assigned to the Los Angeles Metro office.

As discussed previously, there are significant variations between regions in the number of investigations completed, as well as variations in other output and performance measures, such as the proportion of completed investigations referred for prosecution. **Table VI-1**, on page VI-11, shows the number of investigations completed by year, by region. Also shown are corresponding ratios of the number of HQES Attorney hours charged per completed investigation based on the Attorney hours charged during each fiscal year as shown in Exhibit VI-6.

**Hours Charged by HQES Staff to Investigation Matters - 2006 through 2009
Including Hours Charged to Section-Specific Tracking and Client Service Matters**

Classification	HQES Office(s)	Calendar Year (Actual)			
		2006	2007	2008	2009
Deputy Attorneys (DAGs)	Northern California ¹	6,610.25	6,084.50	5,007.25	5,167.75
	Los Angeles Metro	6,349.00	6,388.00	13,527.75	17,083.50
	San Diego (Other Southern California)	4,535.50	3,777.50	5,625.50	5,988.75
	Total	17,494.75	16,250.00	24,160.50	28,240.00
Paralegals, Analysts, and Special Agents	Northern California ¹	235.25	286.25	201.75	175.00
	Los Angeles Metro	189.50	739.00	1,166.75	1,193.75
	San Diego (Other Southern California)	1,391.25	1,369.25	1,847.25	1,386.00
	Total	1,816.00	2,394.50	3,215.75	2,754.75
Total	Northern California ¹	6,845.50	6,370.75	5,209.00	5,342.75
	Los Angeles Metro	6,538.50	7,127.00	14,694.50	18,277.25
	San Diego (Other Southern California)	5,926.75	5,146.75	7,472.75	7,374.75
	Total, Excluding Supervising DAGs	19,310.75	18,644.50	27,376.25	30,994.75

Classification	HQES Office(s)	Fiscal Year (Interpolated)		
		2006/07	2007/08	2008/09
Deputy Attorneys (DAGs)	Northern California ¹	6,347.38	5,545.88	5,087.50
	Los Angeles Metro	6,368.50	9,957.88	15,305.63
	San Diego (Other Southern California)	4,156.50	4,701.50	5,807.13
	Total	16,872.38	20,205.26	26,200.26
Paralegals, Analysts, and Special Agents	Northern California ¹	260.75	244.00	188.38
	Los Angeles Metro	464.25	952.88	1,180.25
	San Diego (Other Southern California)	1,380.25	1,608.25	1,616.63
	Total	2,105.25	2,805.13	2,985.26
Total	Northern California ¹	6,608.13	5,789.88	5,275.88
	Los Angeles Metro	6,832.75	10,910.76	16,485.88
	San Diego (Other Southern California)	5,536.75	6,309.75	7,423.76
	Total, Excluding Supervising DAGs	18,977.63	23,010.39	29,185.52

¹ Includes Fresno, Sacramento, Oakland, and San Francisco offices, including CCU support services.

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Table VI-1. HQES Attorney Hours Charged to Investigations per Completed Investigation

Performance Indicator	2006/07				2007/08				2008/09			
	Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total
Estimated Hours Charged ¹ (see Exhibit VI-6)	6,347	6,369	4,157	16,872	5,546	9,958	4,702	20,205	5,088	15,306	5,807	26,200
Investigations Closed without Citation	221	213	100	534	282	212	178	672	221	213	100	534
Investigations Closed with Citation Issued	5	14	22	41	1	14	11	26	6	17	16	39
Investigations Referred for Prosecution	107	86	101	294	100	76	71	247	103	75	74	252
Total Investigations Closed or Referred for Prosecution ²	333	313	223	869	383	302	260	945	330	305	190	825
HQES Attorney Hours Charged per Completed Investigation	19	20	19	19	14	33	18	21	15	50	31	32
Hourly Billing Rate for Attorney Services	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158
Average Attorney Cost per Case	\$3,002	\$3,160	\$3,002	\$3,002	\$2,212	\$5,214	\$2,844	\$3,318	\$2,370	\$7,900	\$4,898	\$5,056

¹ Data shown includes hours charged by Lead Prosecutors and other Deputy Attorneys to Investigation, Section-Specific Tracking, and Client Service matters.

² Data shown excludes cases involving licensees on probation, Petitions for Modification or Termination of Probation, and Petitions for Reinstatement. The excluded cases are assumed to be proportionately distributed throughout the State.

As shown by Table VI-1, during 2008/09 HQES Attorneys assigned to Los Angeles Metro region cases billed:

- ❖ 60 percent more hours per completed investigation as were billed by Attorneys assigned to Other Southern California region cases (50 hours per completed investigation compared to 31 hours per completed investigation)
- ❖ More than three times (3x) as many hours per completed investigation as were billed by Attorneys assigned to Northern California region cases (50 hours per completed investigation compared to 15 hours per completed investigation).

Assuming a \$158 per hour billing rate for Attorney services, on a per case basis Attorneys working on Northern California region cases billed the Medical Board an average of less than \$2,400 per investigation completed during 2008/09. This compares to an average of about \$4,900 billed per completed investigation for Other Southern California region cases, and an average of \$7,900 billed per completed investigation for Los Angeles Metro region cases.

If HQES had charged an average of \$2,400 in Attorney fees per completed investigation during 2008/09 for all completed investigations, statewide, HQES' billings to the Medical Board for Attorney services would have been about \$2.0 million, or about \$2.2 million less than the estimated amount actually billed (\$4.2 million). Conversely, if HQES had charged \$7,900 in Attorney fees per

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completed investigation for all completed investigations, statewide, billings to the Medical Board for Attorney services would have been about \$6.5 million or nearly \$2.35 million more than the estimated amount actually billed.

In an effort to better understand Los Angeles Metro office Attorney charges for investigation-related services, we researched a sample of Los Angeles Metro office cases selected from HQES' June 2009 Invoice Report to the Medical Board. The Invoice Report shows time charges during the month for each matter that had time charged during the billing period, and also cumulative charges for fiscal year 2008/09, and cumulative charges for the matter including charges from prior fiscal years. We selected all cases that were included in the June 2009 billing with more than 40 hours billed during 2008/09, irrespective of the number of hours charged during June. Twenty-eight (28) cases were selected. Of the 28 cases, nine (9) were assigned to the Valencia office, 11 were assigned to the Cerritos office, three (3) were assigned to the Diamond Bar office, and four (4) were assigned to the Glendale office. Within these offices, the cases were assigned to various Investigators. The cases involved a mix of medical malpractice reports, Section 805 reports, sexual misconduct and impaired physician complaints, prescribing violations, and other quality of care and physician conduct matters. Of the 28 cases, seven (7) were assigned to one HQES Attorney, six (6) were assigned to another HQES Attorney, three (3) were assigned to a third HQES Attorney, and the remaining 12 cases were assigned to 10 other HQES Attorneys. **Table VI-2**, below, summarizes the disposition and current status of these 28 cases as of mid-June 2010 (1 year later).

**Table VI-2. Disposition and Status of Selected Los Angeles Metro Cases
with Attorney Time Charged During June 2009**

Pending or Closed	Number	Referred for Prosecution	Number
Pending Investigation	2	Referred for Prosecution, Accusation Not Yet Filed	3
Closed – Without Referral or Citation	12	Referred for Prosecution, Accusation Filed (Pending Settlement or Hearing)	4
Closed – Subject Passed Competency Exam	2	Referred for Criminal Prosecution and PC 23 (License Restricted)	1
Closed – Recommended for Citation	1	Referred for Prosecution, Disciplinary Action	2
Referred to Office of Safe Medicine (Pending OSM Investigation)	1		
Total	18	Total	10

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With the assistance of Medical Board staff, we researched each of these 28 cases. The histories of several of these cases illustrate the benefits of having HQES Attorneys working jointly with Medical Board Investigators during the Investigation Stage. For example, HQES Attorneys helped to issue and enforce subpoenas for records, assisted in interviewing parties involved with the matter, provided advice and direction on the course and direction of the investigations, promptly prepared and filed pleadings, and sought adoption of disciplinary actions. However, the case histories also illustrate a number of significant, and troubling, problems with the services provided by HQES' Los Angeles Metro office. Some of these problems may also exist, to a lesser extent, at other HQES offices. These problems include:

Performing Detailed Document and Record Reviews and Analyses – These case histories show that some Los Angeles Metro office Attorneys are substantively involved in performing detailed document and record reviews and analyses during the Investigation Stage. These activities appear to go well beyond providing legal advice and direction to the Medical Board regarding the course and direction of the investigation as provided in Section 12529.6 of the Government Code and in the *Vertical Prosecution Manual* adopted by HQES and the Medical Board. Nothing in Section 12529.6 suggests or implies that HQES Attorneys should be as intensively involved as they are in performing these types of investigation activities. The *VE Manual* specifically defines the role of the Primary DAG as follows:

“Works closely with other team members and, in conjunction with Supervising Investigator I, directs Investigators in obtaining evidence. Also, provides legal advice to the Medical Board and prosecutes the case.”

Excessive Time Spent on Cases that are Closed – These case histories show that some Los Angeles Metro office Attorneys spend as much time on cases that close as on cases that are referred for prosecution. The theory that greater Attorney involvement during the Investigation Stage will enable faster identification and earlier closure of cases is not supported by actual experience.

Delayed Filing of Pleading – Even though Attorneys were substantively involved with all of these cases, accusations were not promptly prepared for 3 of 6 cases that were referred for prosecution. The three (3) cases were referred for prosecution 5 to 7 months ago and, as of late-June, 2010, the accusations were not yet prepared.

Delayed Prosecution – Rather than initiating prosecution of a single patient case involving sexual misconduct (with a patient) was referred for prosecution, the Primary DAG directed that the Medical Board investigate a case involving a second potential victim. The Primary DAG was extensively involved with each step of this supplemental investigation, which took eight (8) additional months to complete. Another five (5) months elapsed before the accusation was filed. Several additional months elapsed before the Primary DAG requested a hearing, which was not scheduled for another six (6) months. Throughout this period the Subject continued to practice without restriction.

Rejecting Completed Case Investigations – HQES' Los Angeles office declined to file a case that one of its Primary DAGs worked on extensively (more than 300 hours over three years). During the investigation the Subject was placed on probation following investigation of another complaint involving similar treatment issues. The Decline to File Memorandum was not

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issued until just a few days before expiration of the statute of limitations. In consultation with HQES management, the HQES promptly transferred the case to another HQES office where a different Attorney came to work early the next day to prepare and file a pleading. Several months later the Medical Board accepted a settlement agreement negotiated by the second HQES office that imposed additional discipline.

The problems highlighted by the above case histories are not isolated cases. Additional analyses and case history summaries showing the prevalence of several of these problems, particularly in the Los Angeles region, are presented in Section VII (*Prosecutions and Disciplinary Actions*). Additionally, these cases highlight various internal control problems with the posting of Attorney time charges (e.g., time charges are sometimes posted to Investigation matters that reference a different Medical Board complaint from the case actually being investigated). The cases also highlight the outstanding work that HQES Attorneys are capable of performing, such as occurred when HQES' San Diego office accepted a case that the Los Angeles Metro office rejected, prepared and filed an accusation and petition to revoke probation within a day to avoid expiration of the statute of limitations on the case, and successfully negotiated additional discipline within a period of several months of the filing.

F. Medical Consultant and Outside Expert Services and Expenditures

Generally, each District office has 2 to 3 part-time Medical Consultants assigned, and most of the Medical Consultants usually work at their assigned office for several hours either 1 or 2 days per week. Total wages paid to Medical Consultants during 2008/09 were \$852,000 (\$71,000 per month) for a total of 13,991 paid hours of services (\$61 per hour). This is equivalent to an average of about 22 paid hours per week for each District office. However, due to paid holidays, vacation, sick leave, and other paid time off, the actual number of hours worked by the Medical Consultants was less than 13,991 hours, and the average number of hours worked per week per District office was less than 22 hours.

At the beginning of 2008/09 the hours paid to Medical Consultants were restricted by Executive Order S-09-09 which temporarily suspended the use of all part-time staff by agencies throughout the State. During 2008/09, Medical Consultant availability varied significantly between District offices and regions. For example, during 2008/09 an average of 15 paid hours per week, or less, of Medical Consultant services was utilized by some District offices while, at other District offices, an average of 25 paid hours per week, or more, of Medical Consultant services was utilized. Only one (1) District office (Cerritos) utilized the equivalent of more than one (1) full-time Medical Consultant position.

During 2008/09 the District offices completed investigations of 550 quality of care cases and 404 other (physician conduct) cases. For cases involving quality of care issues, Medical Consultants are usually substantively involved in the investigations, provided they are available. Medical Consultants are usually involved less frequently with other cases. Medical Consultants spend an average of less than 25 hours working on each completed case in which they are involved, assuming that (1) at least 10 percent of the hours paid to Medical Consultants are for paid time off, and (2) substantive involvement with only about 500 completed cases per year, which is possibly

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understated. The amount of time spent by the Medical Consultants on these cases includes performance of, or assistance with, all of the following activities:

- ❖ Ad-hoc consultations to Medical Board Investigators, HQES Attorneys, and District office Supervisors
- ❖ Preparation and attendance at Subject interviews, including pre-interview planning and post-interview debriefing meetings
- ❖ Reviews of medical records
- ❖ Identification of cases that should be closed without obtaining an Expert opinion
- ❖ Identification and selection of Medical Experts
- ❖ Preparation of Medical Expert packages
- ❖ Review of Medical Expert reports.

Depending of their availability and area(s) of specialization, Medical Consultants can potentially impact a District office's need for outside Medical Experts and the average timeframe to complete investigations. Although there are many factors that can significantly impact the timeframe needed to complete investigations, the two (2) District offices with the highest Medical Consultant expenditures during 2008/09 (Cerritos and Sacramento) also had comparatively low average elapsed times per completed investigation for that same year (an average of 11 months and 10 months, respectively, compared to a statewide average for all District offices of nearly 14 months).

Medical Experts are involved in fewer cases than the Medical Consultants and, except for their possible involvement in hearings, provide a more limited scope of services. During 2008/09, \$598,570 was billed by Medical Experts for case review services. Some Medical Experts may not all fully charge the Medical Board for all time spent on Medical Board matters. The billing rate for case review services is currently \$150 per hour. During 2008/09 the Medical Experts charged the Medical Board an average of less than 12 hours of time per completed case review, or about one-half the average amount of time utilized by the Medical Consultants. While the Medical Experts charge an average of less than 12 hours of time to complete the case reviews and prepare their Expert opinion, available data suggests that the provision of these services oftentimes extends over a period of 2 to 3 months, or longer. On average, the Medical Board's cost for Expert opinions is less than \$1,800 per completed review.

On a statewide basis, only 38 percent of all Medical Expert reviews are completed within one (1) month, and 23 percent take longer than two (2) months. While there is some variability, the frequency distributions of elapsed times to complete these reviews at individual District offices are similar to the statewide distribution. More than 30 percent of the Medical Expert reviews took longer than two (2) months to complete at one District office in each of the three regions (Sacramento, Valencia, and San Diego). Overall, the average elapsed time to complete Medical Expert reviews was 48 days (about 7 weeks).

It is our understanding that, during the early-1990s, the Medical Board routinely obtained two (2) Medical Expert opinions for single patient cases, but that this practice was discontinued. However, it is evident that there have been ongoing disagreements regarding needs for obtaining more than one (1) Medical Expert opinion during the Investigation Stage, particularly in the Los Angeles Metro region, and that the disagreements are not limited to single patient cases. In some cases significant disputes with District office Supervisors and

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Investigators have arisen over this issue primarily because of concerns about increased risks of harm to patients and the general public, but also because of adverse impacts on workflow, caseloads, costs, and the availability of Medical Experts to perform reviews of other cases.

In connection with requirements to obtain a second Medical Expert opinion, it should not be overlooked that nearly all quality of care cases, and many other cases, were previously reviewed by a Medical Specialist as part of CCU's complaint screening process, and that the Medical Specialist determined that the departures warranted referral of the case for investigation. Additionally, the District office Medical Consultant also completes a review of all of these same cases. Thus, the first Medical Expert's opinion is actually the second, or third, review of the case resulting in a determination that either an extreme departure or multiple simple departures, or both, occurred. The second Medical Expert's review would be the third, or fourth, medical review of the case. It is our understanding that, outside of the Los Angeles Metro region, second opinions are rarely requested unless the case involves a second medical specialty, or it is determined that a case will proceed to hearing, which isn't determined sometime after the pleading is filed and, even then, still might not be needed if the departure is obvious. The overwhelming majority of cases are settled without a hearing, thus avoiding the need to obtain a second Medical Expert opinion in most cases.

It is our understanding that Enforcement Program and HQES management recently conferenced during April 2010 and reached an agreement to require two (2) Medical Expert opinions for all single patient cases. Although Enforcement Program and HQES management apparently reached an agreement to universally require two (2) Medical Expert opinions for all single patient cases, the actual practice in the field has not changed. District office Supervisors and HQES Supervising DAGs outside the Los Angeles Metro region rarely require a second Medical Expert opinion for single patient cases, except when an opinion is needed in a second specialty area or it appears likely.

G. Recommendations for Improvement

The recommendations presented below concern Medical Consultant staffing, the availability of outside Medical Experts, and retention of Investigators. Additional recommendations that would impact investigations are included in Section X (*Organizational and Management Structures*), including recommendations involving:

- ✓ Restructuring the handling of Section 801 cases
- ✓ Restructuring the management of District office investigations
- ✓ Scaling back and optimizing HQES involvement in District office investigations
- ✓ Developing new organizational structures and processes for managing HQES expenditures and tracking cases following referral for prosecution
- ✓ Improving workload and performance reporting processes.

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1. Medical Consultant Staffing

As noted in the Enforcement Monitor's 2004/05 reports, "the medical consultant's (MC) function is central to the speed and quality of QC cases processing at the district office level; however problems regarding medical consultant availability, training, and proper use contribute significantly to lengthy investigations and inefficient operations. . . Shortages of medical consultant time have made it continuously difficult for investigators to obtain sufficient medical consultant assistance. . ." However, the Medical Consultant's function is not limited to quality of care cases. They are also involved in many physician conduct cases. Additionally, their availability is critical not just to the process of reviewing Expert opinion reports, as emphasized by the Enforcement Monitor. Rather, the Medical Consultants are critical during earlier stages of the investigation during which, for example, medical records are initially received and reviewed, the Subject is interviewed, a decision is made as to whether to obtain an Expert opinion, potential Experts are identified and a selection decision is made, and the Expert package and instructions are prepared for the Expert's review.

Perhaps most importantly, the Medical Consultant is a key (perhaps the key) participant in the process of assessing, prior to referral of a case to an outside Expert, whether the facts and circumstances of a case, particularly for quality of care cases, indicate that an extreme departure or multiple simple departures occurred and, hence, whether to close the case or continue the investigation. In fact, the Medical Consultant's involvement in reviewing the Expert's opinion, which is the last step in the investigation process, is only one of their many important responsibilities. If the Expert has clearly presented their opinion as to whether an extreme departure or multiple simple departures has occurred, and support for the opinion is clearly organized and presented, then subsequent involvement of the Medical Consultant will probably be minimal. However, if the Expert's opinion is not clearly stated or well-supported in their report, the Medical Consultant's role is key in assessing the Expert's report and determining whether, or how, to proceed from that point forward (e.g., collect additional evidence, obtain clarification of the opinion, close the case, refer the case for prosecution, etc.).

Additionally, the Medical Board's pool of Medical Consultants serves as a gatekeeper on the flow of cases to Experts. In many cases the Medical Consultants are sufficiently qualified in the specialties involved to determine whether a case should be closed, avoiding completely the need for review services from an outside Medical Expert. To the extent that the Medical Consultants are able to make such determinations, the flow of cases to, and the Medical Board's needs for, outside Medical Experts is reduced. This not only reduces the timeframes to complete these investigations, but enables redirection of District office resources to other cases. It also helps to preserve the availability of outside Medical Experts for use on other cases.

Since publication of the Enforcement Monitor's reports there has been very little change in the availability of Medical Consultants. Needs in this area have not been emphasized. Additional Attorney positions (10) were authorized for HQES, additional Investigator and Assistant Investigator positions (8) were authorized for the Medical Board, additional positions (6) were authorized to reestablish an OSM Unit, additional positions (4) were authorized for the Probation Program and, most

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recently, new non-sworn positions (6) and a number of other Enforcement Program positions are expected to be authorized as part of the 2010/11 Budget, but no additional funding for Medical Consultants was included in this package.

Recommendation No. VI-1. *Augment Medical Consultant staffing. Medical Consultants should be available to all District offices all of the time (e.g., the equivalent of at least one full-time position per office, although actual availability will be less than full time due to vacations, sick leave and other time off). Because the Medical Consultant positions are classified as Permanent Intermittent, work hours can be adjusted to accommodate fluctuating workload demands, assuming a sufficient pool of resources is available to provide the services and the physicians are willing to work the number of hours needed. Augment funding for additional Medical Consultant positions by reducing expenditures for HQES investigation-related services (e.g., in the Los Angeles region).*

2. Medical Expert Resources

Although Medical Experts are of vital importance to the success of investigations and prosecutions, the Expert Reviewer Program has suffered from chronic weaknesses inherent in the system. A major problem, perhaps the most critical, is the limitation on utilization of the most qualified Medical Experts. While the Medical Board has attempted to remedy some of these problems by increasing the billing rate for Medical Expert review services from \$100 to \$150 per hour, the rate increase did not address restrictions on the Board's use of its most qualified Medical Experts.

Under current Board policy, Medical Experts may not be used more than three (3) times per year. As with medical procedures, Medical Experts tend to become more qualified as they complete more reviews. However, under current policy, at the very point when the Medical Experts may become most qualified, and also faster and more effective, they must stop work until another year. As defense counsels are under no such restrictions, under the current system the Investigators and Prosecutors are severely handicapped.

Recommendation No. VI-2. *Eliminate the limitation on reutilization of Medical Experts and augment the Medical Expert pool and enhance capabilities. In addition to strengthening Expert Reviewer oversight and overall Expert Reviewer Program management and administration, consider redirecting some funding currently used for HQES investigation-related services toward establishing a new program under which the Medical Board would contract for the services of a pool of physicians to provide Expert Review services (e.g., through an Interagency Agreement with one or more University of California Medical Centers, although this model may have its own problems relating to conflicts of interest).*

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3. Investigator Retention

It is unlikely that Enforcement Program performance will improve significantly unless Investigator workforce capability levels are stabilized. Medical Board management does not control pay and benefit levels, mandated furloughs, baby boomer retirements, or recruitment efforts by other agencies, but it can impact District office work environments in significant and meaningful ways that can help to minimize Investigator attrition. A strategy to retain experienced Investigators should include efforts to create a work environment to promote communication with staff to provide assurances that work problems will be addressed. This strategy should include the following initiatives:

- ✓ Reducing and simplifying Investigator caseloads
- ✓ Increasing the availability of Medical Consultants
- ✓ Targeting HQES Attorney involvement during investigations to those cases where such involvement is needed
- ✓ Limiting HQES Attorney involvement to activities that are appropriately performed by an Attorney (e.g., providing legal advice and direction)
- ✓ Promoting uniformity in the use of requests for supplemental investigations and decline to file cases to ensure that such requests and handling are reasonable and defensible, and do not unnecessarily delay the filing of accusations or result in inappropriate case closures.

Additionally, needs exist for all appropriate members of the Medical Board's Executive Management Team, and their counterparts at the Department of Justice, to meet jointly with staff from each District office and communicate directly to them that they are important and that management is committed to addressing as many of their issues and concerns as they reasonably can. Additionally, a process should be outlined for completing a structured diagnostic review of all of the factors contributing to excessive staff turnover during the past several years, and developing and implementing a plan to address related improvement needs.

Recommendation No. VI-3. *Develop and implement an Immediate Action Improvement Plan to address critical District office workload and work environment issues. Meet with staff at each District office to present the Improvement Plan and outline the process for identifying and implementing further improvements. Conduct a structured diagnostic review of factors contributing to excessive Investigator turnover during the past several years, and develop and implement a Longer-Term Improvement Plan to reduce Investigator attrition and rebuild the Enforcement Program's field investigation workforce capabilities and competencies.*

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VII. Prosecutions and Disciplinary Outcomes

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VII. Prosecutions and Disciplinary Actions

This section summarizes results of our assessment of prosecutions and disciplinary outcomes. Following referral of cases from Medical Board Headquarters Units or the District offices, prosecutions are largely carried out by HQES which prepares the pleading, negotiates proposed settlements, and represents the Medical Board at administrative hearings. Our assessment focused on determination of the numbers of prosecutions completed and related disciplinary outcomes prior to, concurrent with, and following implementation of VE during 2006, the average elapsed time to complete the prosecutions and disciplinary actions, and expenditures for related HQES services.

Results of the assessment show that the number of accusations filed, the number of proposed stipulations and proposed decisions received, and the number of disciplinary actions have all declined. Several other secondary output and performance measures also have declined. Concurrently, the elapsed time to file accusations has decreased, but this decrease is largely attributable to a decrease in the Los Angeles region from an abnormally high level in prior years. In the Los Angeles region the average elapsed time remains higher than in other regions due, in part, to (1) mis-use of requests for supplemental investigations, and (2) extended periods of inactivity while cases are pending at HQES following referral of the cases for prosecution. The average elapsed time from filing to settlement (stipulation received) has also decreased. However, there are significant performance variations between regions. The decrease in composite elapsed times from filing to settlement during this period, to a statewide average of 11 months during the past two (2) years, is attributable to improved performance in the Los Angeles and Other Southern California regions. However, even with this improvement, the average elapsed time for the Los Angeles region during the past two (2) years lagged performance of the other two regions. For the Northern California region, the elapsed times from filing to stipulation received generally averaged about ten (10) months throughout the past six (6) years.

A. Prosecutions Completed

In recent years, the number of completed prosecutions, as reflected by the number of proposed decisions and stipulations approved by the Medical Board, has decreased as compared to the number approved in prior years. There was little or no change in the number of default decisions or in the number of accusations withdrawn or dismissed.

B. Disciplinary Actions

Disciplinary action data show a decrease in the proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation. During 2008/09 only 64 percent of disciplinary actions required license revocation, surrender, suspension, or probation. During the preceding five (5) years the percent of disciplinary actions involving license revocation, surrender, suspension, or probation ranged from 66 percent to 78 percent. This decrease in the proportion of disciplinary actions involving license revocation, surrender, suspension, or probation may be attributable to a combination of factors including (1) variations in the composition of cases referred for prosecution, (2) shifts in settlement negotiation strategies, and (3) recent legislative changes enabling issuance of public reprimands, with conditions, in lieu of stronger types of discipline. Additional information regarding this variance is presented in Subsection I (*Disciplinary Outcomes by Region*).

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C. Pending Accusations and Legal Cases

In recent years there was little change in the number of pending accusations or total pending legal cases. The number of pending accusations fluctuated between about 125 and 150 cases, and the number of pending legal cases, after declining to about 400 cases during 2006/07, from about 500 cases previously, increased again to a level of 500 cases during the next two (2) years. Recent decreases in the number of cases referred for prosecution from the District offices have not resulted in corresponding decreases in the number of pending legal action cases.

D. Elapsed Time to File Accusations and Complete Prosecutions

During 2008/09 there was a marginal improvement in the average elapsed time to file accusations, and a more substantive improvement in the average elapsed time to complete prosecutions. The average elapsed time to file accusations decreased by about three (3) weeks (to 3.4 months during 2008/09 from an average of about 4.0 months during the preceding 4 years). The average elapsed time to complete prosecutions decreased by about three (3) months (to 12.5 months during 2008/09 from an average of 15.7 months during the preceding 4 years).

E. Regional Variations in Performance

Key output and performance variances between geographic regions, and significant changes that occurred during that past several years, include the following:

Accusations Filed – The number of accusations filed increased significantly in the Northern California region and, concurrently, decreased significantly in the Los Angeles and Other Southern California regions. In the Northern California region more than 60 accusations were filed each of the past three (3) years compared to only 50 accusations filed per year during the preceding two (2) years. In contrast, during this same period the Los Angeles and Other Southern California regions, each of which previously filed more than 60 accusations per year, filed an average of fewer than 55 accusations per year. During 2008/09 the Los Angeles and the Other Southern California regions each filed only 40 accusations. The number of accusations filed for Out-of-State cases fluctuated between 40 and 60 cases per year throughout the past six (6) years, and consistently averaged about 50 cases per year. All (or nearly all) of these accusations are prepared and filed by HQES' San Francisco office.

Post-Filing Stipulations Received – During 2008/09, 156 post-filing stipulations were received, a significant decrease from the levels attained during prior years which averaged about 200 stipulations per year. The decrease during 2008/09 is attributable primarily to a large decrease in the number of post-filing stipulations submitted by the Other Southern California region. There were also decreases in the number of post-filing stipulations submitted for probation revocation and Out-of-State cases. The decline in post-filing stipulations submitted for Out-of-State cases may be inversely correlated with the comparatively high

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number of Out-of-State cases resolved by issuance of a pre-filing public letter of reprimand (PLR) during 2007/08 and 2008/09 (28 PLRs issued per year compared to an average of 14 PLRs issued per year during the preceding four (4) years).

Ratio of Stipulations Received to Proposed Decisions Received – Historically, the Northern California region has had a significantly higher ratio of stipulations received to proposed decisions received than the Los Angeles and Other Southern California regions. In recent years this differential narrowed somewhat, but the ratio for the Northern California region was still significantly higher than the ratio for either of the other regions (4.3 stipulations per proposed decision for the Northern California region compared to 3.4 stipulations per proposed decision for the Los Angeles region and 3.3 stipulations per proposed decision for the Other Southern California region).

Appeals to Superior Court – The number of appeals to Superior Court, and related outcome measures, are too small to provide a valid basis for drawing conclusions, except to note that, on average, a few more cases per year are usually appealed in the Los Angeles and Other Southern California regions than are appealed in the Northern California region. However, the number of appeals in all three (3) regions is very low (e.g., during 2008/09, there were only three (3) appeals of cases that were investigated by each of the three (3) regions, plus three (3) additional appeals involving probation revocation cases).

F. Average Elapsed Times from Transmittal to HQES to Accusation Filed

Exhibit VII-1, on the next page, shows average elapsed times from transmittal of the case to HQES to accusation filed, by year, from 2004 through 2009, by Identifier. All (or almost all) Out-of-State cases are handled by HQES' San Francisco office and, as shown by Exhibit VII-1, accusations for these cases are consistently filed within an average elapsed time of not more than about two (2) months. For cases with District office Identifiers, the average elapsed times from transmittal to filing are longer and, for these cases, the average elapsed time from transmittal to filing decreased by about six (6) weeks since 2005, but is unchanged compared to 2004. The decrease since 2005 in the average elapsed time to file accusations is attributable nearly entirely to a decrease during the past four (4) years in the average elapsed time to file accusations in the Los Angeles region. In the Los Angeles region the average elapsed time to file accusations decreased from nearly eight (8) months during 2005 to about five (5) months during 2009. However, the average elapsed time shown for the Los Angeles region for 2005 (7.8 months) was 3.4 months (77 percent) longer than the average elapsed time for the region during the prior year.

**Average Elapsed Times from Transmittal of Case to HQES to Accusation Filed, by Identifier
2004 through 2009**

Including Cases with Timeframes Exceeding 18 Months

Excluding Cases with Timeframes Exceeding 18 Months

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	3.6	61	4.4	54	3.0	163	3.7
2005	56	4.6	57	7.8	71	4.0	184	5.4
2006	54	3.2	46	8.7	49	6.0	149	5.8
2007	66	4.1	65	9.2	67	3.1	198	5.4
2008	60	2.6	50	5.9	46	3.9	156	4.0
2009	72	4.0	52	4.9	63	3.0	187	3.9

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	3.6	61	4.4	52	2.7	161	3.6
2005	55	4.1	55	6.9	70	3.8	180	4.8
2006	54	3.2	43	8.0	48	4.8	145	5.2
2007	65	3.8	55	7.1	66	2.9	186	4.5
2008	60	2.6	49	5.5	44	3.1	153	3.7
2009	71	3.6	49	3.8	61	2.5	181	3.3

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		Other (IDENT 20, 21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	49	2.3	3	1.9	10	3.2	225	3.3
2005	52	1.1	0	0.0	8	9.5	244	4.6
2006	50	1.3	2	6.5	3	1.0	204	4.6
2007	38	1.4	0	0.0	4	2.9	240	4.8
2008	59	2.0	2	2.5	6	5.4	223	3.5
2009	48	2.2	1	0.6	6	4.7	242	3.6

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		Other (IDENT 20, 21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	47	0.8	3	1.9	10	3.2	221	3.0
2005	52	1.1	0	0.0	5	2.2	237	4.0
2006	50	1.3	2	6.5	3	1.0	200	4.1
2007	38	1.4	0	0.0	4	2.8	228	3.9
2008	59	2.2	2	2.5	5	1.4	219	3.2
2009	48	2.2	1	0.6	6	4.7	236	3.1

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During 2005, just prior to implementation of VE, the average elapsed time to file accusations in the Los Angeles region suddenly spiked up, and continued to increase in subsequent years, eventually reaching a peak of more than nine (9) months during 2007, before decreasing to lower levels during 2008 and 2009. **Table VII-1**, below, shows average elapsed times from transmittal to filing for cases investigated by each of the Los Angeles region’s District offices from 2004 through 2009. As shown by Table VII-1, the variances in the aggregate regional data are also evident at each of the Los Angeles region’s four (4) District offices.

**Table VII-1. Average Elapsed Time from Transmittal of Case to HQES to Accusation Filed
Los Angeles Metro District Offices**

District Office	2004		2005		2006		2007		2008		2009	
	Number of Filings	Average Time (Months)										
Valencia	14	4.4	14	8.3	10	8.1	15	6.4	13	6.8	11	7.8
Ceritos	23	5.2	21	7.7	16	9.2	18	7.6	20	4.0	17	4.4
Diamond Bar	10	1.9	9	7.3	9	7.3	13	16.4	7	4.5	12	2.5
Glendale	14	5.0	13	7.9	11	9.7	19	8.0	10	9.4	12	5.5
Total	61	4.4	57	7.8	46	8.7	65	9.2	50	5.9	52	4.9

Exhibit VII-2, on the next two pages, provides frequency distributions of elapsed time from transmittal of the case to HQES to accusation filed, by Identifier. The data presented in Exhibit VII-2 show that, until recently, fewer than a dozen cases per year referred for prosecution to HQES’ Los Angeles office were filed within two (2) months of transmittal of the case. During 2007, only 15 Los Angeles region cases were filed within four (4) months of transmittal of the case. In contrast, during this same year 43 accusations for Northern California region cases and 52 accusations for Other Southern California region cases were filed within four (4) months. More recently, during 2009, 32 accusations were filed within four (4) months of transmittal for Los Angeles region cases, a significant improvement for the Los Angeles region. However, during 2009, much higher numbers of accusations were filed within four (4) months of transmittal in the other regions of the State (47 in the Northern California region and 54 in the Other Southern California region).

Frequency Distribution of Elapsed Times from Transmittal of Case to HQES to Accusation Filed
2005 to 2009

Case Identifier	Elapsed Time from Transmittal to Filing ¹	2005		2006		2007		2008		2009	
		Number	Percent								
Northern California District Offices	2 Months or Less	18	33%	30	56%	28	43%	31	52%	26	37%
	3 to 4 Months	15	27%	9	17%	15	23%	17	28%	21	30%
	5 to 6 Months	8	15%	7	13%	7	11%	5	8%	12	17%
	7 to 12 Months	13	24%	7	13%	11	17%	7	12%	10	14%
	More than 12 Months	1	2%	1	2%	4	6%	0	0%	2	3%
	Total	55	100%	54	100%	65	100%	60	100%	71	100%
	Average Elapsed Time	4.1 Months		3.2 Months		3.8 Months		2.6 Months		3.6 Months	
Los Angeles Metro District Offices	2 Months or Less	9	16%	6	14%	7	13%	12	24%	20	41%
	3 to 4 Months	11	20%	4	9%	8	15%	11	22%	12	24%
	5 to 6 Months	6	11%	6	14%	11	20%	10	20%	6	12%
	7 to 12 Months	19	35%	15	35%	20	36%	10	20%	9	18%
	More than 12 Months	10	18%	12	28%	9	16%	6	12%	2	4%
	Total	55	100%	43	100%	55	100%	49	100%	49	100%
	Average Elapsed Time	6.9 Months		8.0 Months		7.1 Months		5.5 Months		3.8 Months	
Other Southern California District Offices	2 Months or Less	18	26%	13	27%	28	42%	26	59%	32	52%
	3 to 4 Months	29	41%	11	23%	24	36%	9	20%	22	36%
	5 to 6 Months	11	16%	9	19%	7	11%	4	9%	3	5%
	7 to 12 Months	11	16%	12	25%	7	11%	3	7%	3	5%
	More than 12 Months	1	1%	3	6%	0	0%	2	5%	1	2%
	Total	70	100%	48	100%	66	100%	44	100%	61	100%
	Average Elapsed Time	3.8 Months		4.8 Months		2.9 Months		3.1 Months		2.5 Months	

¹ Excludes 33 cases taking longer than eighteen (18) months to file, including 19 Los Angeles Metro region cases (58 percent).

Frequency Distribution of Elapsed Times from Transmittal of Case to HQES to Accusation Filed
2005 to 2009

Case Identifier	Elapsed Time from Transmittal to Filing ¹	2005		2006		2007		2008		2009	
		Number	Percent								
All District Office Identifiers	2 Months or Less	45	25%	49	34%	63	34%	69	45%	78	43%
	3 to 4 Months	55	31%	24	17%	47	25%	37	24%	55	30%
	5 to 6 Months	25	14%	22	15%	25	13%	19	12%	21	12%
	7 to 12 Months	43	24%	34	23%	38	20%	20	13%	22	12%
	More than 12 Months	12	7%	16	11%	13	7%	8	5%	5	3%
	Total	180	100%	145	100%	186	100%	153	100%	181	100%
	Average Elapsed Time	4.8 Months		5.2 Months		4.5 Months		3.7 Months		3.3 Months	
Other Identifiers (IDENTS 16, 19, 20, 21, and 23)	2 Months or Less	48	84%	45	82%	33	79%	47	71%	38	69%
	3 to 4 Months	5	9%	8	15%	6	14%	8	12%	7	13%
	5 to 6 Months	3	5%	1	2%	3	7%	10	15%	4	7%
	7 to 12 Months	1	2%	1	2%	0	0%	1	2%	6	11%
	More than 12 Months	0	0%	0	0%	0	0%	0	0%	0	0%
	Total	57	100%	55	100%	42	100%	66	100%	55	100%
	Average Elapsed Time	2.2 Months		1.5 Months		1.5 Months		2.0 Months		2.5 Months	
Total Accusations Filed	2 Months or Less	93	39%	94	47%	96	42%	116	53%	116	49%
	3 to 4 Months	60	25%	32	16%	53	23%	45	21%	62	26%
	5 to 6 Months	28	12%	23	12%	28	12%	29	13%	25	11%
	7 to 12 Months	44	19%	35	18%	38	17%	21	10%	28	12%
	More than 12 Months	12	5%	16	8%	13	6%	8	4%	5	2%
	Total	237	100%	200	100%	228	100%	219	100%	236	100%
	Average Elapsed Time	4.0 Months		4.1 Months		3.9 Months		3.2 Months		3.1 Months	

¹ Excludes 33 cases taking longer than eighteen (18) months to file, including 19 Los Angeles Metro region cases (58 percent).

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Among the most significant factors that appear to contribute to extended elapsed times from transmittal to filing of the accusation are included:

- 1) Requests for supplemental investigations, *and*
- 2) Limited activity while the case is pending at HQES.

With the assistance of Medical Board staff we researched both of these sources of delay by researching the histories of nearly two (2) dozen individual cases. Results of this research illustrate the nature and magnitude of the problems and frustrations experienced during the past several years by Medical Board management and staff in the Los Angeles region and, to a lesser extent, in other parts of the State. Furthermore, difficulties in handing off of cases for prosecution appear to be greatest in the Los Angeles region where HQES Attorneys are most involved with investigations. These case histories also show that, in the Los Angeles region, it is no at all unusual for cases to languish at HQES for periods of 6 to 8 months, or longer, before an accusation is filed.

Additionally, it is apparent from these case histories that neither HQES nor the Medical Board has developed effective processes for regularly tracking and following-up on filings that are not prepared on a timely basis. HQES does not provide the Medical Board with a planned filing date that could be used to ensure alignment of HQES and Medical Board expectations regarding the urgency of the case and then track whether the filings are past due. In the absence of effective status tracking processes, HQES Managers and Supervisors appear to operate under the false impression that a high percentage of accusations are prepared within 30 to 60 days, which is simply not true irrespective of how narrowly the measure is defined. The Medical Board distributes listings of all pending cases on a monthly basis to all Enforcement Program and HQES Managers and Supervisors, but Enforcement Program management does not regularly follow-up with HQES regarding pleadings that are past due (e.g., by specifically alerting HQES about cases where a pleading was not received within period of 45 to 60 days), and HQES does not provide the Medical Board with any reporting regarding the status of cases referred for prosecution where the pleadings have not yet been prepared or filed. Follow-ups on overdue pleadings, at least in the Los Angeles region, appear to occur only when initiated by Los Angeles region District office Investigators or Supervisors, and these follow-ups appear to occur on an ad-hoc, rather than regular, basis.

1. Requests for Supplemental Investigations

Between 2004 and 2009, a total of 63 cases had one or more supplemental investigations completed by the District offices, statewide, but nearly 70 percent of these cases were assigned to Los Angeles region offices. On average, the supplemental investigations took 3 to 4 months to complete. The total number of cases with supplemental investigations submitted by Los Angeles region offices during 2005 (12) was more than double the number submitted during the prior year (5), and greater than the number of cases with supplemental investigations completed over the entire 6-year period in each of the other regions of the State. In subsequent years, the number of cases with supplemental investigations completed by Los Angeles region offices remained at elevated levels, but gradually declined. During 2009, Los Angeles District offices completed

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supplemental investigations for four (4) cases, more than completed by all other District offices throughout the rest of the State. The Diamond Bar and Cerritos District offices were responsible for most of these Los Angeles region cases (15 and 13, respectively).

With the assistance of Medical Board staff, we researched each of the 15 supplemental investigation cases assigned to the Diamond Bar office. These cases involved a mix of single and multiple-patient cases and various types of complaints, including cases involving quality of care issues, excessive testing or treatment, sexual misconduct, criminal violations, excessive prescribing, and fraud. With one exception, all of the supplemental investigations were requested and completed prior to the filing of an accusation. The scope of most of the supplemental investigations encompassed either (1) obtaining an additional Medical Expert opinion, or (2) obtaining an Addendum to a Medical Expert opinion. Following completion of these supplemental investigation activities, HQES declined to file two (2) cases. In one of these cases the decline to file was issued after first requesting and obtaining a second Medical Expert opinion which found multiple extreme and simple departures. Accusations were filed for the remaining 11 cases (including two consolidated cases). For these 11 cases, the average elapsed time from transmittal to filing of the accusation was 10 months. Nine (9) of these cases were settled without a hearing. None of the cases that had two (2) Medical Expert opinions went to hearing. Two (2) cases proceeded to hearing. One (1) of these cases was a single patient case and the other case was a multiple patient case. Both of these cases had just one (1) Medical Expert opinion. Both of the cases that proceeded to hearing were dismissed. It is not clear that either case was dismissed due to problems with the Medical Expert or with the quality of their opinion. However, the defense may have benefitted in these cases from have two (or possibly more) Medical Experts as compared to HQES' use of only a single Expert.

These case histories show that HQES' use of the supplemental investigation process contributed significantly to the extended elapsed times from transmittal to filing that occurred with Diamond Bar's cases beginning during 2005 and continuing, to a lesser extent, in subsequent years. The case histories also show that, in many instances, Diamond Bar's cases languished for an extended period following transmittal to HQES. It is unclear what, if any, consumer protection or other benefits were realized from HQES' requests for additional Medical Expert opinions and Addendum reports, and associated delays in the drafting and filing of the accusations.

2. Extended Periods of Limited Activity While Cases are Pending at HQES

Enforcement Program Managers, Supervisors, and Investigators commented to us about persistent problems with cases languishing at HQES after referral for prosecution, especially in the Los Angeles region. To substantiate their experience, Medical Board staff in the Los Angeles region provided us with synopses of seven (7) cases which were recently transmitted to HQES' Los Angeles office (mid- to late-2009). Accusations for six (6) of these cases were not prepared by HQES until up to 10 months later in mid-2010 (one case is still pending). The cases involved two (2) District offices in the Los Angeles region and several different Lead Prosecutors and Primary DAGs.

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G. Stipulations Prepared and Average Elapsed Times from Accusation Filed to Stipulation Received

For cases with District office Identifiers the average elapsed time from accusation filed to stipulation received decreased during the last several years (from an average of about 15 months to an average of about 11 months). However, there were significant performance variations between the different geographic regions of the State. For the Northern California region, the elapsed times generally averaged about 10 months throughout the past six (6) years. The decrease in composite elapsed times during this period, to a statewide average of 11 months during the past two (2) years, is attributable to improved performance in the Los Angeles and Other Southern California regions. However, even with this improvement, the average elapsed time for the Los Angeles region during the past two (2) years lagged performance of the other two regions.

H. Administrative Hearings and Average Elapsed Times from Accusation Filed to Decision Received

Only about 10 to 15 percent of cases proceed to hearing as most cases are settled prior to hearing. For cases with District office Identifiers, about 20 hearings are completed per year compared to an average of about 150 total case dispositions (stipulations plus proposed decisions). For cases with District office Identifiers, during the past two (2) fiscal years (2007/08 and 2008/09) an average of 18 to 20 months elapsed from accusation filed to proposed decision received, about the same as the average for the preceding two (2) years (2005/06 and 2006/07). Also, the average elapsed times during the past two (2) years were about the same in all major geographic regions of the State (18 to 19 months). Due to the small numbers of cases involved (about a dozen cases per year for each region), it is unclear whether the average elapsed times have changed significantly in any of the three major geographic regions of the State.

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I. Disciplinary Outcomes by Region

Exhibit VII-3, on the next page, shows disciplinary actions, by type of discipline, by Identifier for (1) the 4-year period from 2003/04 through 2006/07, and (2) the 2-year period from 2007/08 through 2008/09. Additionally, Exhibit VII-3 shows the percentage of disciplinary actions involving license revocation, surrender, suspension, or probation. As shown by Exhibit VII-3, during the past two (2) years there were significant regional variations in disciplinary outcomes.

Northern California Region

Total Disciplinary Actions – The total number of disciplinary actions decreased by about 9 percent (from an average of 56 actions per year to an average of 51 actions per year).

Composition of Disciplinary Actions – The number of disciplinary actions involving license revocation, surrender, suspension, or probation decreased by 7 percent (from an average of 40.25 actions per year to an average of 37.50 actions per year). The proportion of disciplinary actions involving license revocation, surrender, suspension, or probation increased marginally (from 72 percent to 74 percent).

Los Angeles Region

Total Disciplinary Actions – The total number of disciplinary actions decreased by about 13 percent (from an average of 71 actions per year to an average of 62 actions per year).

Composition of Disciplinary Actions – The number of disciplinary actions involving license revocation, surrender, suspension, or probation decreased by 20 percent (from an average of 52 actions per year to an average of 41.5 actions per year). The number of public reprimands issued changed very little. The proportion of disciplinary actions involving license revocation, surrender, suspension, or probation decreased from 74 percent to 67 percent.

Other Southern California Region

Total Disciplinary Actions – The total number of disciplinary actions increased by about 10 percent (from an average of 58 actions per year to an average of 66 actions per year).

Composition of Disciplinary Actions – There was a significant increase in the number of public reprimands issued (from an average of 15 per year to an average of 22 per year). The number of disciplinary actions involving license revocation, surrender, suspension, or probation was unchanged. Due to the increase in number of public reprimands, the proportion of disciplinary actions involving license revocation, surrender, suspension, or probation decreased from 75 percent to 66 percent.

**Disciplinary Outcomes by Identifier
2003/04 through 2008/09**

2003/04 through 2006/07 (4 Years)

Disciplinary Outcome	Cases with District Office Identifiers								Cases with Other Identifiers						Total	
	Northern California		Los Angeles Metro		Other Southern CA		Total		Out of State (16)		Probation (19 & D's)		Other (20 to 23, 27)			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Revocation	11	5%	24	9%	23	10%	58	8%	46	22%	31	31%	7	13%	142	13%
Surrender	59	26%	46	16%	47	20%	152	21%	88	43%	33	33%	7	13%	280	26%
Suspension Only	0	0%	0	0%	3	1%	3	0%	0	0%	0	0%	0	0%	3	0%
Probation with Suspension	19	9%	35	12%	23	10%	77	10%	1	0%	9	9%	2	4%	89	8%
Probation Only	72	32%	103	37%	77	33%	252	34%	43	21%	27	27%	37	69%	359	33%
Public Reprimand	62	28%	74	26%	59	25%	195	26%	28	14%	1	1%	1	2%	225	20%
Total Disciplinary Outcomes	223	100%	282	100%	232	100%	737	100%	206	100%	101	100%	54	100%	1,098	100%
4-Year Average	56		71		58		184		52		25		14		275	
Revocation/Surrender/Probation %	72%		74%		75%		74%		86%		99%		98%		80%	

2007/08 through 2008/09 (2 Years)

Disciplinary Outcome	Cases with District Office Identifiers								Cases with Other Identifiers						Total	
	Northern California		Los Angeles Metro		Other Southern CA		Total		Out of State (16)		Probation (19 & D's)		Other (20 to 23, 27)			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Revocation	12	12%	14	11%	12	9%	38	11%	29	27%	10	27%	1	6%	78	15%
Surrender	19	19%	19	15%	21	16%	59	17%	31	28%	13	35%	2	13%	105	20%
Suspension Only	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Probation with Suspension	7	7%	10	8%	6	5%	23	6%	2	2%	2	5%	0	0%	27	5%
Probation Only	37	36%	40	32%	48	37%	125	35%	22	20%	12	32%	10	63%	169	33%
Public Reprimand	27	26%	41	33%	44	34%	112	31%	25	23%	0	0%	3	19%	140	27%
Total Disciplinary Outcomes	102	100%	124	100%	131	100%	357	100%	109	100%	37	100%	16	100%	519	100%
2-Year Average	51		62		66		179		55		19		8		260	
Revocation/Surrender/Probation %	74%		67%		66%		69%		77%		100%		81%		73%	

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With respect to the Los Angeles region, it is unclear whether there is a correlation between:

- 1) The decreased proportion of disciplinary actions involving license revocation, surrender, suspension, or probation for Los Angeles cases, *and*
- 2) The improved average elapsed times to reach settlement achieved in the Los Angeles region during the past several years.

Additionally, if there is a correlation between these findings, it is unclear whether the correlation is due to weaker or less well-prepared cases, a change in the composition of the cases, less effective prosecution of the cases, or a combination of these factors.

J. Expenditures for HQES Prosecution Services

HQES Attorneys post time charges for prosecution-related activities to “Administrative” matters that are opened for each individual case. In four (4) of the past five (5) years, HQES Attorneys charged between 30,000 and 32,000 hours to Administrative matters. As shown by **Table VII-2**, on the next page, the number of hours charged by HQES to Administrative matters during 2007 (37,000) was significantly higher than any of the other years. On a calendar year basis, during the past five (5) years the number of hours charged by HQES Attorneys to Administrative matters:

- 1) Increased by about 20 percent in the Northern California region (from about 11,000 hours to about 13,000 hours)
- 2) Increased by about 30 percent in the Los Angeles region (from about 10,000 hours to about 13,000 hours) and then decreased by about 23 percent (to about 10,000 hours)
- 3) Increased by about 20 percent in the Other Southern California region (from about 9,000 hours to about 11,000 hours) and then decreased by about 18 percent (from about 11,000 hours to less than 9,000 hours).

On a fiscal year basis, the trends are the same, although less pronounced. HQES’ hourly billing rates for Attorney services during 2008/09 and 2009/10 were \$158 and \$170, respectively, or an average of \$164 per hour. Assuming a \$164 hourly billing rate for Attorney services, estimated billings during 2009 for prosecution-related services for cases assigned to the Northern California region were about \$2.1 million compared to less than \$1.6 million for cases assigned to the Los Angeles and Other Southern California regions.

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**Table VII-2. Hours Charged by HQES Attorneys to Administrative Matters
2005 through 2009¹**

HQES Office(s)	Calendar Year (Actual)				
	2005	2006	2007	2008	2009
Northern California ²	11,333	11,718	12,960	12,231	13,026
Los Angeles Metro	10,150	9,696	12,937	11,820	9,823
San Diego (Other Southern California)	9,220	8,290	11,265	8,144	8,923
Total	30,703	29,704	37,161	32,195	31,772

HQES Office(s)	Fiscal Year (Interpolated)			
	2005/06	2006/07	2007/08	2008/09
Northern California ²	11,525	12,339	12,596	12,628
Los Angeles Metro	9,923	11,316	12,378	10,822
San Diego (Other Southern California)	8,755	9,777	9,704	8,534
Total	30,203	33,432	34,678	31,984

¹ Excludes hours charged to Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters

² Includes Fresno, Sacramento, Oakland, and San Francisco offices.

As discussed previously, there are significant variations between regions in the number of prosecutions completed, as well as variations in other output and performance metrics, such as the proportion of disciplinary actions involving license revocation, surrender, suspension, or probation. **Exhibit VII-4**, on the next page, shows the number of prosecutions completed by year, by region, for (1) cases with District office Identifiers, (2) SOI-related stipulations and decisions, and (3) cases with Out-of-State Identifiers. Separate performance ratios are shown excluding, and including, Out-of-State cases which, when included, are weighted to reflect HQES staff estimates that, on average, these cases take about 15 percent as much time to complete as SOIs and cases with District office Identifiers. As shown by Exhibit VII-4, including a 15 percent weighting of Out-of-State cases, the number of hours charged by HQES Attorneys per completed case was about the same for each of the three major geographic regions of the State during both 2006/07 and 2008/09 (an average of about 150 hours per completed case). During 2007/08 the number of hours charged per completed case was much higher than this average for the Los Angeles region (179 hours charged per completed case), and much lower than this average for both the Northern California and the Other Southern California regions (132 hours per completed case and 103 hours per completed case, respectively).

Estimated HQES Attorney Hours Charged per Completed Prosecution - 2006/07 through 2008/09

Output or Performance Indicator		2005/06 (Total)	2006/07				2007/08				2008/09			
			Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total
Hours Charged to Administrative Matters by HQES Attorneys ¹		30,203	12,339	11,316	9,777	33,432	12,596	12,378	9,704	34,678	12,628	10,822	8,534	31,984
Completed Cases with District Office Identifiers ²	Default Decisions	6	2	0	3	5	5	3	2	10	1	6	5	12
	Accusations Withdrawn or Dismissed	22	5	4	6	15	11	6	19	36	8	8	4	20
	Post-Filing Stipulations Submitted	143	45	52	42	139	41	46	58	145	40	45	37	122
	Proposed Decisions Submitted	33	9	17	13	39	9	14	15	38	11	12	12	35
	Total Completed Cases with District Office Identifiers	204	61	73	64	198	66	69	94	229	60	71	58	189
Statement of Issues (SOI) - Stipulations and Proposed Decisions Submitted (IDENT 20)		27	16	0	0	16	21	0	0	21	15	0	0	15
Completed Cases with Out-of-State Identifiers	Default Decisions	12	7	0	0	7	9	0	0	9	17	0	0	17
	Accusations Withdrawn or Dismissed	2	5	0	0	5	10	0	0	10	3	0	0	3
	Post-Filing Stipulations Submitted	21	39	0	0	39	31	0	0	31	23	0	0	23
	Proposed Decisions Submitted	7	8	0	0	8	5	0	0	5	10	0	0	10
	Total Completed Cases with Out-of-State Identifiers	42	59	0	0	59	55	0	0	55	53	0	0	53
Total Completed Cases, Including SOIs and Cases with Out-of-State Identifiers (IDENT 16)		273	136	73	64	273	142	69	94	305	128	71	58	257
Ratio	HQES Attorney Hours Charged per Completed Prosecution Cases with District Identifiers and SOIs Only	131	160	155	153	156	145	179	103	139	168	152	147	157
	HQES Attorney Hours Charged per Completed Prosecution Cases with District or Out-of-State Identifiers and SOIs - Weighted ³	127	144	155	153	150	132	179	103	134	152	152	147	151
Hourly Billing Rate for Attorney Services		\$146	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158
Average Attorney Cost per Case		\$20,066	\$22,752	\$24,490	\$24,174	\$23,700	\$20,856	\$28,282	\$16,274	\$21,172	\$24,016	\$24,016	\$23,226	\$23,858

¹ Data shown excludes hours charged for cases classified as Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters.

² Data shown excludes cases involving Probationers, petitions for modification or termination of probation, petitions for reinstatement, and CME audit failure, Operation Safe Medicine, and Internet cases. The excluded cases are believed to be proportionately distributed throughout the State.

³ Out-of-State cases which, on average, take substantially less Attorney time to complete, are weighted 15 percent.

VII. Prosecutions and Disciplinary Actions

During 2007/08, HQES' Los Angeles office billed significantly more hours to Administrative matters than billed during both 2006/07 or 2008/09, but completed fewer prosecutions, resulting in a higher average number of hours billed per completed case. The especially low average number of hours billed during 2007/08 per completed case shown for HQES' San Diego office is partially attributable to withdrawal or dismissal of an unusually large number of cases (19) during 2007/08 (a non-positive outcome). However, due to the especially large total number of cases completed by the San Diego office, even if the performance ratio is adjusted to exclude most of the withdrawn/dismissed cases, the average number of hours billed per completed case would still be significantly lower than shown for both of the other regions.

In summary, a portion of the additional staffing resources authorized for HQES to support implementation of VE was utilized to provide higher levels of prosecution-related services. This is especially evident during 2007, and was concentrated primarily in HQES' Los Angeles and San Diego (Other Southern California) offices. Subsequently, during 2008 and 2009, these HQES offices redirected some of these resources toward providing higher levels of investigation-related services. There may also have been some shifting in the reporting of hours for the some prosecution-related activities (e.g., time spent on ISOs, TROs, and PC 23s and drafting accusations is sometimes posted to Investigation matters). In contrast, in the Northern California region there were only minimal shifts during the past two (2) years in the allocation of Attorney resources between investigation and prosecution-related services. Additionally, although fewer hours were billed by the Los Angeles office for prosecution services during 2008/09 compared to the prior two (2) years, the number of hours billed per completed case was still the same, or higher, than billed for cases handled in each of the other two geographic regions of the State (even without adjusting for time posted to Investigation matters for prosecution-related services, such as time spent on ISOs, TROs, and PC 23s and drafting accusations). Finally, during the past several years an average of less than 150 Attorney hours were billed per completed case (weighted) and the Medical Board's cost for these services averaged about \$23,000 per case (weighted).

K. Recommendations for Improvement

Below we discuss several key recommendations for improving prosecution process performance. These recommendations concern (1) supplemental investigations, (2) decline to file cases, and (3) Out-of-State cases. Additional recommendations that would impact prosecutions are included in Section X (*Organizational and Management Structures*), including recommendations involving:

- ✓ Identifying "Best Practices" in Vertical Enforcement from the data gathered, instituting these practices uniformly throughout the State, and amending the pilot to include these practices for further analysis
- ✓ Scaling back and optimizing HQES Attorney involvement in District office investigations
- ✓ Restructuring the management of District office investigations to create consistency of investigation handling under MBC/HQES functions under VE
- ✓ Restructuring the handling of Section 801 cases

VII. Prosecutions and Disciplinary Actions

- ✓ Developing new organizational structures and processes for managing HQES expenditures and tracking cases following referral for prosecution
- ✓ Improving workload and performance reporting processes.

1. Supplemental Investigations and Decline to File Cases

It is apparent from our review that HQES DAGs in Los Angeles request supplemental investigations and decline to file accusations more frequently than other offices. When a supplemental investigation is requested or an accusation filing is declined by Los Angeles while other HQES offices would accept and prosecute the same case, it triggers a dispute between HQES and Medical Board staff that consumes enormous amounts of resources at all levels throughout both organizations. These disputes are contentious and may poison working relationships. Ironically, these disputes primarily occur in the Los Angeles region where DAG involvement in the investigation process is greatest.

Recommendation No. VII-1. *Establish independent panels to review all requests for supplemental investigations and all decline to file cases. The reviews should be completed expeditiously (e.g., within 1 to 2 days of issuance of the request for supplemental investigation or Decline to File Memorandum). For Northern California cases, the panel members should include a Regional Manager and Supervising DAG from the Southern California region, plus the Medical Board's HQES Services Monitor (see Recommendation No. X-6). For Southern California cases, the panel members should include a Regional Manager and Supervising DAG from the Northern California region, plus the Medical Board's HQES Services Monitor. The panels should review all decline to file cases and all requests for supplemental investigations for any cases where preparation of the pleading will be delayed pending completion of the supplemental investigation, and then advise the Chief of Enforcement, the Senior Assistant Attorney General, and all Medical Board and HQES Managers and Supervisors involved in the matter as to the results of their review, including recommended disposition of the matter.*

VII. Prosecutions and Disciplinary Actions

2. Out-of-State Cases

The processes used to prepare accusations for Out-of-State cases are currently working reasonably well. Some Out-of-State cases are currently handled by Medical Board staff without HQES involvement, but most cases are referred to HQES, which prepares an accusation and, in most cases, negotiates a surrender of the Subject's license. It is unclear why an HQES Attorney is needed to perform these services for all of these cases. Additional staffing for DCU is expected to be authorized through the 2010/11 Budget which could provide DCU with the capability to draft many of these accusations, file the pleading, and negotiate related license surrenders. HQES Attorney involvement could be limited to reviewing the draft accusation and stipulation (on-line) and handling a limited number of more complex cases. Use of Medical Board staff in lieu of HQES Attorneys would reduce costs for these services and enable redirection of HQES resources to other cases.

Recommendation No. VII-2. *Restructure the processes used for preparing accusations for Out-of-State cases to reduce the number of cases referred to HQES. Utilize DCU staffing resources to draft accusations and license surrender stipulations for Out-of-State cases.*

VIII. Probation Program

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VIII. Probation Program

Results of this assessment show that the investigations and prosecutions of Probationers are being adversely impacted by the same factors as are impacting investigations and prosecutions of Non-Probationers. Recommendations for improvement that would impact the investigations and prosecutions of Probationers are included in Sections H (*Investigations*), and Section L (*Organizational and Management Structures*), including recommendations involving:

- ✓ Restructuring the management of District office investigations
- ✓ Scaling back and optimizing HQES Attorney involvement in District office investigations
- ✓ Developing new organizational structures and processes for managing HQES expenditures and tracking cases following referral for prosecution
- ✓ Improved workload and performance reporting processes.

Additionally, needs exist to improve the processes used to ensure that on-going probation monitoring functions are regularly and properly performed.

Recommendation No. VIII-1. *Develop systems for tracking and reporting completion of quarterly reviews, random office visits, and other key probation monitoring activities.*

Currently, petitions for modification or termination of probation are submitted to DCU which forwards the petitions and supporting documentation to the Probation Unit Manager who researches the cases and determines whether to assign the petitions to Probation Unit staff or refer to the District offices for investigation. Cases involving Probationers with compliance deficiencies or another active investigation are referred to the District offices. Otherwise, the cases are assigned to staff within the Probation Units. Cases referred to the District offices are handled as VE cases, with joint assignment of an HQES Attorney and an Investigator to each case. Following investigation by either the Probation Unit or the District office, and irrespective of the Probationer's compliance record or the nature of the requested changes to the terms and conditions of their probation, the petitions are transmitted to HQES which presents the cases for hearing.

It is unclear why cases referred to the District offices are included in the VE Pilot Project as they are not complaints and the basic character of these cases, and the types of investigations performed, are completely different from complaints. It is also unclear why hearings are required for all of these matters. A Medical Board analyst could potentially review the cases prior to referral to HQES and make a determination, in some cases, as to whether to accept the petition and then present it directly to the Board, without any involvement of HQES and OAH. The remaining cases could still be referred to HQES for hearing.

Recommendation No. VIII-2. *Restructure the processes used for investigating petitions for modification or termination of probation. Exclude cases referred to the District offices from the VE Program, and screen out petitions from referral to HQES that do not need a hearing before an ALJ.*

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IX. Integrated Assessment of Enforcement Program Performance

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IX. Integrated Assessment of Enforcement Program Performance

This assessment highlights significant changes in overall Enforcement Program outputs and performance that occurred during the past several years following implementation of VE. Key statistical measures of overall Enforcement Program performance include:

- ✓ Number of ISOs/TROs sought and granted
- ✓ Number of accusations filed and average elapsed time from referral for investigation to accusation filed
- ✓ Number of stipulations received and average elapsed time from referral for investigation to stipulation received
- ✓ Number of disciplinary actions, decomposed by level of discipline imposed.

Since implementation of VE during 2006 there has been a marked deterioration in overall enforcement process performance. Investigator turnover has increased, fewer interim suspension actions are taken, investigations take longer to complete, fewer cases are referred for prosecution, and there has not been any significant improvement in the disciplinary outcomes achieved or the timeframe to achieve these outcomes. Concurrently, the Medical Board's costs for HQES legal services have increased due to rate increases and increased Attorney staffing authorized to support implementation of VE. Of particular concern is the increase in the amount of time needed to complete quality of care case investigations. These investigations already take an average of more than 18 months to complete for cases that are referred for prosecution.

The more intensive involvement of HQES Attorneys in investigations appears to be contributing to elevated attrition of seasoned Investigators and deteriorating Enforcement Program performance. These impacts are most apparent in the Los Angeles region where HQES Attorney involvement is greatest (2 to 3 times higher than the level of involvement of HQES Attorneys in other regions of the State). Recently implemented policy changes requiring a second Medical Expert opinion for most (or all) single patient cases assigned to Los Angeles District offices could further increase the amount of time needed to complete some quality of care case investigations, increase Investigator caseloads, reduce the availability of Medical Experts, particularly in specialized areas of practice, and increase Investigator turnover and Medical Board costs. Finally, as aged cases migrate from the Investigation Stage to the Prosecution Stage during 2009/10 and subsequent years, it is likely that average elapsed times from case referral for investigation to stipulation received will increase.

There are a number of factors over the past several years that have contributed to the Enforcement Program's inability to meet its goals. The loss of Investigators to a number of state agencies is likely to have contributed, although it is not possible to know whether or to what extent goals would have been met if fewer Investigators had separated from the Board. It is, however a fact that the Board has experienced a number of lateral transfers (non-promotional) to other State agencies subsequent to implementation of Vertical Enforcement. Some staff were disappointed that pay raises did not materialize, case levels did not decline as hoped, and the Investigators were not transferred to the Department of Justice. It is also a fact that there are tensions between Medical Board and HQES management, and a lack of consistency of VE implementation among regions. All parties involved are jointly responsible for ensuring stability and an

IX. Integrated Assessment of Enforcement Program Performance

employment environment conducive to productivity, and it would appear that significant and continuing problems in this area have not been sufficiently addressed. Although current Enforcement Program staffing levels are higher than they have been in several years and the workforce is stable, likely due to current economic conditions, as the economy improves the Medical Board may again experience high attrition and vacancy rates if improvements are not made.

A. Complaints Handled and Average Elapsed Times from Initiation to Referral for Investigation or Prosecution

During 2008/09 the average elapsed time to close or refer complaints for investigation or prosecution was about 2.5 months, excluding a significant number of non-jurisdictional complaints closed during the Intake Stage. For complaints not reviewed by a Medical Specialist, the average elapsed time to close or refer complaints for investigation or prosecution was about two (2) months. For complaints reviewed by a Medical Specialist, the average time to close or refer the complaints was about four (4) months. Some High Priority complaints are referred for investigation or prosecution with only limited screening. Consequently, for complaints referred for investigation or prosecution, the average elapsed time was shorter than the average elapsed time for complaints that are closed and referred for investigation or prosecution (about 2.1 months for complaints that are referred for investigation or prosecution compared to 2.6 months for complaints that are closed or referred). Reflecting additional time requirements to obtain records and have a Medical Consultant review the cases, the average elapsed time to close or refer quality of care complaints, which account for about one-half of all complaints, was about three (3) months. The average elapsed time to close or refer other complaints was less than two (2) months. Following implementation of requirements for review of all quality of care complaints by a Medical Specialist, the proportion of complaints referred for investigation or prosecution decreased by about 15 percent (from 20 percent to 17 percent). In recent years only about 17 percent of complaints were referred for investigation or prosecution.

During the past several years, the number of complaints opened decreased by about 5 percent, the number of complaints closed decreased by about 10 percent, and the number of complaints referred for investigation or prosecution decreased by about 15 percent. Concurrently, the number of pending complaints and the average elapsed time to close or refer cases increased by about 25 percent. Recent growth in the number of pending complaints and increases in average elapsed times to close or refer complaints appear unrelated to implementation of Specialist review requirements earlier in the decade. Rather, these increases, which are concentrated in the past two (2) years, appear to be primarily a result of:

- ❖ The reduced availability of staffing resources due to restrictions on the use of overtime, staff turnover and vacancies, and work furloughs
- ❖ Changes in the composition of complaints, including significant decreases in Out-of-State and Medical Board-originated cases which, on average, are closed or referred for investigation or prosecution much more quickly than other complaints.

IX. Integrated Assessment of Enforcement Program Performance

B. ISOs/TROs Sought and Granted

It was anticipated that, as a result of earlier involvement of HQES Attorneys in case investigations, increased numbers of ISOs and TROs would be sought and granted, which would enhance consumer protection by more quickly restricting the physician's practice of medicine. During the past several years, significantly fewer ISOs and TROs were sought. Also, significantly fewer were granted. Implementation of VE has not increased the number of ISOs and TROs sought and granted, notwithstanding higher levels of Attorney involvement in the investigations. Instead, since implementation of VE, the number of ISOs and TROs sought and granted has decreased by more than 30 percent. This decrease significantly exceeds any decrease that could be attributed to reductions in the number of cases referred for investigation.

C. Accusations Filed and Average Elapsed Times from Referral for Investigation to Accusation Filed

Another anticipated benefit of VE was a reduction in elapsed times from referral of a case for investigation to filing of the accusation. For example, it was expected that with HQES Attorneys more involved with investigations, it would take less time to obtain medical and other records needed to determine the merits of a complaint. Also, cases that were not viable could be identified and closed more quickly, thereby enabling redirection of resources to other cases, and accelerating completion of the investigations while concurrently improving the quality of the cases. Finally, because an HQES Attorney would have directed various investigative activities, including the gathering of evidence, interviewing patients, witnesses, and subjects, selecting a Medical Expert, and reviewing the Medical Consultant's and Medical Expert's reports, and reports prepared by the Investigator, it would take significantly less time to prepare the accusation, which provides notice to the public of alleged negligence or misconduct by a licensee.

As shown by **Exhibit IX-1**, on the next page, these expected performance improvements have not been realized. For cases with District office Identifiers, the average elapsed time from referral for investigation to accusation filed increased by two (2) months during the past several years. Average elapsed times from referred for investigation to accusation filed increased in all three (3) geographic regions. However, there were significant performance variances between the regions. The Northern California and Other Southern California regions had much shorter average elapsed times than the Los Angeles region (17 to 19 months for the Northern California and Other Southern California regions compared to 22 to 23 months for the Los Angeles region, a difference of 5 to 6 months). From this data it is abundantly clear that the much higher level of involvement of HQES Attorneys in Los Angeles region cases has not provided any differential benefit in terms of achieving lower average elapsed times from referral of a case for investigation to filing of the accusation. The higher level of involvement of HQES Attorneys in Other Southern California region cases, as compared to the level of involvement of HQES Attorneys in Northern California region cases, also has not provided any differential benefit in terms of achieving lower average elapsed times from referral a case for investigation to filing of the accusation.

**Average Elapsed Times from Referral to Investigation to Accusation Filed, by Identifier
2004 through 2009**

Including Cases with Transmittal to Filing Timeframes Exceeding 18 Months

Excluding Cases with Transmittal to Filing Timeframes Exceeding 18 Months

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	17	61	19	54	14	163	17
2005	56	19	56	22	71	16	183	19
2006 ²	54	17	45	21	50	17	149	18
2007	66	17	65	22	67	16	198	18
2008	60	18	50	21	45	18	155	19
2009	72	19	51	21	64	19	187	20

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	17	61	19	53	14	162	17
2005	55	18	55	21	71	16	181	18
2006 ²	54	17	43	21	48	16	145	18
2007	65	16	55	20	66	16	186	17
2008	60	18	49	20	43	18	152	19
2009	71	18	48	20	61	19	180	19

Year	Cases with Other Identifiers ¹						Total All Case Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ, CME Audit, and Internet (IDENT 20,21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	2	13	3	19	10	11	178	16
2005	2	8	0	0	5	27	190	19
2006 ²	3	9	1	35	0	0	153	18
2007	5	12	0	0	1	18	204	18
2008	4	10	2	23	0	0	161	19
2009	0	0	1	36	6	15	194	19

Year	Cases with Other Identifiers ¹						Total All Case Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ, CME Audit, and Internet (IDENT 20,21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	2	13	3	19	10	11	177	16
2005	2	8			2	17	185	18
2006 ²	3	9	1	35			149	18
2007	5	12			1	18	192	17
2008	4	10	2	23			158	18
2009			1	36	6	15	187	19

¹ Over the six-year period from 2004 through 2009, excludes 279 accusations filed related to Out-of-State (IDENT 16) cases transmitted by DUC directly to HQES, and 16 accusations filed related to Headquarters, CME audit failure, and Internet cases (IDENTs 20, 21, and 23) transmitted by various Headquarters Units directly to HQES. Also excludes five (5) cases involving petitions to revoke probation (IDENT 'D').

² The Vertical Enforcement Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

IX. Integrated Assessment of Enforcement Program Performance

D. Accusations Withdrawn or Dismissed

With greater HQES Attorney involvement in investigations, it might be expected that fewer accusations would be withdrawn or dismissed. However, the number of accusations withdrawn or dismissed is small in comparison to the total number of accusations filed (about 10 percent), and accusations may be withdrawn or dismissed due to changing circumstances and other factors that are completely outside of the control of both the Medical Board and HQES (e.g., successful completion of the Diversion Program, death of the Subject, etc.).

A review of the statistical data appears to show that dismissals and withdrawals have remained essentially constant over the past five years. Changes appear to be due to statistical spikes only, and do not reflect any continuous trend or pattern.

During the past five (5) years there have not been any sustained changes in the number of accusations withdrawn, and the number of accusations dismissed recently increased. Due to a one-year spike in accusations withdrawn and dismissed during 2007/08, the average number of accusations withdrawn or dismissed during the past two (2) years (29 cases per year) was significantly higher than the average number of accusations withdrawn or dismissed during the preceding three (3) years (21 cases per year).

Most of the accusations that were withdrawn or dismissed during 2007/08 involved cases that were investigated by District offices in the Northern California or Other Southern California regions. During 2007/08, 26 accusations were withdrawn and 10 were dismissed. About a dozen cases were withdrawn after determining that there was not sufficient evidence to prevail at a hearing. Other causes for these withdrawals included:

- ❖ The Medical Expert changed their opinion (about a half-dozen cases)
- ❖ The license was cancelled, the respondent died, or the statute of limitations ran (several cases)
- ❖ The Subject successfully completed the Diversion Program (2 cases).

The unusually high number of accusations withdrawn during 2007/08 did not persist into 2008/09.

IX. Integrated Assessment of Enforcement Program Performance

E. Stipulations Prepared and Average Elapsed Times from Referral for Investigation to Stipulation Received

Implementation of VE was expected to reduce average elapsed times from referral of a case for investigation to stipulation received, which effectively represents completion of the prosecution phase of the enforcement process. It was anticipated, for example, that in addition to reducing the average elapsed times to complete investigations and file accusations, that implementation of VE might (1) marginally increase the proportion of cases that are settled without a hearing, and (2) reduce the average elapsed time to negotiate a settlement and prepare the stipulation.

With respect to increasing the proportion of cases that settle rather than proceed to hearing, about 80 to 85 percent of cases usually settle without a hearing. Thus, it was considered unlikely that implementation of VE would significantly increase the proportion of cases that might settle without a hearing. On an annual basis for the past six (6) years, the proportion of cases that did not settle, and proceeded to hearing, fluctuated between 15 and 20 percent. There is no evidence that implementation of VE had any significant beneficial impact in terms of increasing the proportion of cases that settle without a hearing.

As shown by **Exhibit IX-2**, on the next page, for cases with District office Identifiers:

- ❖ The number of stipulations submitted decreased during the last several years, particularly in the Los Angeles and Other Southern California regions
- ❖ The average elapsed times from referral for investigation to stipulation received changed very little and, for all regions, this performance measure was only marginally lower during the past three (3) years than during the preceding three (3) years.

However, as aged cases migrate from the Investigation Stage to the Prosecution Stage during 2009/10 and subsequent years, it is likely that the average elapsed times from referral for investigation to stipulation received will increase. Additionally, there are significant performance variations between geographic regions of the State. For example, the Los Angeles region consistently had significantly higher average elapsed times from referral for investigation to stipulation received than the other regions. During the past two (2) years the average elapsed time for the Los Angeles region was about seven (7) months longer than the average elapsed time for the Northern California region, and about three (3) months longer than the average elapsed time for the Other Southern California region.

**Average Elapsed Times from Referral for Investigation to Stipulation Received, by Identifier
2004 through 2009**

Including Cases with Post-Investigation Elapsed Times Exceeding 3 Years

Excluding Cases with Post-Investigation Elapsed Times Exceeding 3 Years

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004	50	2.2	64	3.1	39	2.5	153	2.7
2005	36	2.4	49	3.1	50	2.4	135	2.7
2006 ²	40	2.4	66	3.1	38	2.7	144	2.8
2007	48	2.0	33	2.9	55	2.8	136	2.5
2008	30	2.1	45	2.6	44	2.4	119	2.4
2009	52	2.2	45	3.0	34	2.4	131	2.5

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004	48	2.1	60	3.0	39	2.5	147	2.6
2005	34	2.3	43	2.9	49	2.4	126	2.5
2006 ²	37	2.1	59	2.9	33	2.3	129	2.5
2007	48	2.0	32	2.8	51	2.5	131	2.4
2008	29	1.9	41	2.5	41	2.3	111	2.3
2009	50	2.1	41	2.8	33	2.4	124	2.4

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20, 22, and 23)			
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004					1	0.6	154	2.6
2005	2	1.3	4	4.0	7	2.4	148	2.7
2006 ²					2	4.0	146	2.8
2007	4	1.1	2	3.6	2	0.7	144	2.5
2008	3	1.4	1	1.3	3	2.8	126	2.4
2009	1	3.3	1	2.9	1	0.9	134	2.5

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20, 22, and 23)			
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004					1	0.6	148	2.6
2005	2	1.4	2	3.1	7	2.4	137	2.5
2006 ²					1	3.8	130	2.5
2007	4	1.1	2	3.6	2	0.7	139	2.3
2008	3	1.4	1	1.3	2	1.6	117	2.2
2009	1	3.2	1	2.9	1	0.9	127	2.4

¹ Over the six-year period from 2004 through 2009, excludes 24 subsequent submissions related to the same complaint, 176 stipulations related to Out-of-State (IDENT 16) cases transmitted by DCU directly to HQES, and 82 cases involving petitions to revoke probation (IDENT 'D').

² The Vertical Enforcement Pilot Project was jointly implemented by the Medical Board and HQES during January 2006.

IX. Integrated Assessment of Enforcement Program Performance

Finally, as shown by **Table IX-1, below**, during the past several years average elapsed times from referral for investigation to stipulation received have changed very little for either quality of care or for other cases. It was anticipated that the elapsed times for quality of care cases would be impacted most by implementation of VE (e.g., by reducing the time taken to obtain medical and other records). The average elapsed time to investigate and prosecute quality of care cases remains at least eight (8) months longer than the average elapsed time for other cases (i.e., an average of about 2.7 years, or longer, for quality of care cases compared to an average of about 2.0 years for other cases).

Table IX-1. Average Elapsed Times from Referral for Investigation to Stipulation Received, by Type of Case¹ - 2005 through 2009

Calendar Year	Quality of Care Cases		Other Cases		Total	
	Number of Stipulations	Average Elapsed Time	Number of Stipulations	Average Elapsed Time	Number of Stipulations	Average Elapsed Time
2005	102	2.8 Years	35	2.2 Years	137	2.6 Years
2006 ²	102	3.2 Years	42	1.9 Years	144	2.8 Years
2007	98	2.7 Years	42	2.2 Years	140	2.5 Years
2008	90	2.7 Years	32	1.7 Years	122	2.4 Years
2009	88	2.8 Years	44	2.1 Years	132	2.6 Years

¹ Over the five-year period from 2005 through 2009, excludes 24 subsequent stipulation submittals related to the same complaint, 141 stipulations related to Out-of-State (IDENT 16) cases transmitted by DCU directly to HQES, eight (8) cases involving probationers (IDENT 19), fifteen (15) cases originated by various Headquarters Units (IDENTs 20, 22, and 23), and 65 cases involving petitions to revoke probation (IDENT 'D').

² The Vertical Enforcement Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

F. Efficiency of Investigations and Prosecutions

Expectations that implementation of VE would improve efficiency have not been realized. To support implementation of VE, eight (8) additional Investigator and Assistant Investigator positions and 10 additional HQES Attorney positions were authorized. These additional positions increased Investigator staffing by about 10 percent and increased HQES Attorney staffing by more than 20 percent. Following implementation of VE, the number of investigations completed, the number of cases referred for prosecution, the number of accusations filed, and the number of stipulations prepared have all declined by 15 percent or more. Additionally, during this period the number of pending investigations and the number of pending legal cases both increased by more than 15 percent. In summary, higher levels of resources are now being used to produce increasingly lower levels of output.

IX. Integrated Assessment of Enforcement Program Performance

G. Disciplinary Outcomes

Exhibit IX-3, on the next page, shows disciplinary outcomes by referral source for (1) a baseline period of four years from 2003/04 through 2006/07, and (2) the most recent two fiscal years. As shown by Exhibit IX-3, the total number of disciplinary actions decreased from an average of 312 per year during the 4-year baseline period to an average of 292 per year for the past two years. Additionally, the decrease in numbers of disciplinary actions is even greater if Out-of-State cases, which are rarely handled by the District offices, are excluded. The data presented in Exhibit IX-3 show that disciplinary outcomes have not improved since implementation of VE.

As discussed previously, there was no change in the number disciplinary actions involving license revocation, surrender, suspension, or probation for Other Southern California region cases, and the number of public reprimands increased significantly (from an average of 15 per year, to an average of 22 per year). While the number of disciplinary actions taken involving Northern California region cases decreased by about 10 percent in recent years, there was only a minimal decrease in the number of disciplinary actions taken that required license revocation, surrender, suspension, or probation. In contrast, in recent years the number of disciplinary actions taken involving Los Angeles cases decreased by 13 percent overall, and the number of disciplinary actions involving license revocation, surrender, suspension, or probation decreased by 20 percent. The change in the number and types of disciplinary actions taken on cases investigated by Los Angeles region offices was the largest contributor to the decreases that have recently occurred in (1) the overall number of disciplinary actions taken, and (2) the number of disciplinary actions taken involving license revocation, surrender, suspension, and probation. These decreases were only partially offset by an increase in the number of public reprimand actions taken on cases investigated by District offices within the Other Southern California region.

In recent years the number of disciplinary actions taken involving cases investigated by Los Angeles and Other Southern California region District offices each accounted for about 35 percent of all disciplinary actions taken on cases with District office Identifiers. In contrast, Northern California region cases accounted for only 28 percent of all disciplinary actions taken on cases with District office Identifiers. The comparatively lower proportion of disciplinary actions taken involving Northern California region cases reflects comparatively lower numbers of accusations filed in prior years. However, recent decreases in the number of accusations filed involving Los Angeles and Other Southern California region cases will likely lead to fewer disciplinary actions taken in the future on cases investigated by District offices in both of these regions. In contrast, the number of accusations filed involving cases investigated by Northern California region offices increased in recent years, which will likely lead to an increase in disciplinary actions taken in the future.

HQES recently changed the geographic boundaries of its offices. Portions of the areas previously served by the Sacramento and San Diego offices were transferred to the Los Angeles office. These shifts could complicate future efforts to compare regional performance over time.

**Disciplinary Actions by Referral Source
(Average Annual Rate)**

Referral Source	Conventional Enforcement - 2003/04 to 2006/07					Vertical Enforcement - 2007/08 to 2008/09					Change				
	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions
Patient, Patient Advocate, Family Member or Friend, Including 801.01(E) Reports	11.8	5.3	15.8	20.5	53.4	10.5	1.5	11.5	21.0	44.5	(1.3)	(3.8)	(4.3)	0.5	(8.9)
Insurance Companies and Employers, Including 801.01(B&C) Reports	5.1	1.8	11.0	18.3	36.2	2.0	0.5	11.5	19.0	33.0	(3.1)	(1.3)	0.5	0.7	(3.2)
Health Facilities (Section 805 and Non-805 Reports)	9.8	2.0	11.0	5.5	28.3	9.5	2.0	13.0	3.0	27.5	(0.3)	0.0	2.0	(2.5)	(0.8)
California Department of Health Services (or Successor State Agency)	3.8	2.3	7.3	3.0	16.4	4.5	1.0	7.5	3.5	16.5	0.7	(1.3)	0.2	0.5	0.1
M.D., Pharmacist, Allied Health or Healing Arts Licensee, or Medical Society or Association	5.8	1.3	5.3	3.3	15.7	5.0	0.5	2.0	4.5	12.0	(0.8)	(0.8)	(3.3)	1.2	(3.7)
CII - Department of Justice, Criminal Identification and Information Bureau	4.5	0.5	2.0	0.8	7.8	5.5	0.0	3.5	1.0	10.0	1.0	(0.5)	1.5	0.2	2.2
Other Governmental Agencies, Including FDA, DEA, Other DCA Boards and Bureaus, and 801 Reports	4.1	2.1	4.0	2.6	12.8	3.5	1.5	3.5	1.5	10.0	(0.6)	(0.6)	(0.5)	(1.1)	(2.8)
Other ¹	7.0	1.8	2.8	2.6	14.2	3.5	2.0	3.5	1.5	10.5	(3.5)	0.2	0.7	(1.1)	(3.7)
Police/Sheriff Department, Coroner's Office, District Attorney, and Courts (803 Reports, Criminal Filings, and Non-Felony and Felony Conviction Reports)	5.3	1.3	3.0	0.5	10.1	3.0	0.5	2.0	0.5	6.0	(2.3)	(0.8)	(1.0)	0.0	(4.1)
Licensee Self-Reporting (2240(A), 801.01, 802.01, 802.1 and Misdemeanor Conviction Reports)	0.3	1.0	0.8	4.5	6.6	0.5	0.5	1.0	2.5	4.5	0.2	(0.5)	0.2	(2.0)	(2.1)
California Attorney General and Department of Justice, Including Medi-Cal Fraud and Narcotics Enforcement Bureaus	0.8	0.3	0.8	0.3	2.2	2.0	0.0	1.0	0.5	3.5	1.2	(0.3)	0.2	0.2	1.3
Total, Excluding Out of State and Medical Board Originated Cases	58.3	19.7	63.8	61.9	203.7	49.5	10.0	60.0	58.5	178.0	(8.8)	(9.7)	(3.8)	(3.4)	(25.7)
Out of State Medical/Osteopathic Boards	34.1	0.5	11.0	20.8	66.4	31.0	1.0	11.0	40.0	83.0	(3.1)	0.5	0.0	19.2	16.6
Medical Board Originated Cases	16.0	3.3	15.0	7.6	41.9	11.0	2.5	13.5	4.5	31.5	(5.0)	(0.8)	(1.5)	(3.1)	(10.4)
Total, Including Out of State and Medical Board Originated Cases	108.4	23.5	89.8	90.3	312.0	91.5	13.5	84.5	103.0	292.5	(16.9)	(10.0)	(5.3)	12.7	(19.5)

¹ Includes CA Medical Review Inc., 803.6, 364.1, and NPDB reports, Jury Verdict Weekly, HEAL, MQRC District, WE Tip, Consumer or Industry Group, Employee, Co-worker, Witness, Informant, Anonymous, and Unknown.

X. Organizational and Management Structure

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X. Organizational and Management Structures

This section summarizes results of our analysis of the Medical Board's organizational and management structures. Our analyses focused primarily on Enforcement Program organizational structures and management issues. Organizational structure and management issues concerning the Licensing Program are addressed separately in Section XI (*Licensing Program*).

A. Investigations of Section 801 Cases

The Medical Board is currently planning to establish a new Sacramento-based unit that will use non-sworn staff to investigate Section 801 and selected other cases. Section 801 cases are distinguished from other cases because they involve a reported settlement of a malpractice case, and a substantial portion of the investigative activity involves identifying, collecting, and reviewing medical and other records, such as transcripts of depositions or court proceedings. Medical Board management believe that investigations of many of these cases can be completed by non-sworn staff, working jointly with HQES Attorneys, without referring the cases to District offices for investigation by a sworn Investigator. Non-sworn staff and clerical support resources are expected to become available in stages during 2010/11 and 2011/12 as part of a currently pending BCP that is expected to be included in the State's 2010/11 Budget. Section 801 cases currently account for about 10 percent of all cases referred to the District offices for investigation.

Recommendation X-1. *Restructure the handling of Section 801 cases by establishing a centralized unit comprised of non-sworn staff to investigate Section 801 and selected other cases.*

B. Management of District Office Investigations

The current management of field investigations differs among regions. Vertical Enforcement has been implemented differently in different offices with varied success. Conflicts have arisen among Board and HQES at all levels throughout the State, but particularly in the Los Angeles region. Conversely, in some offices staff are respectful of each other's roles in the process and there is greater productivity. The level of DAG involvement with investigators also varies, with the Los Angeles office by far having the most DAG involvement in investigations while referring fewer cases for prosecution.

While problems with some critical investigative activities have always been experienced, and are to be expected (scheduling of interviews), they appeared to have not been helped by the implementation of VE, and may have been made worse. Disagreements about the need for supplemental investigation activities and the need for second Medical Expert opinions create conflicts that have not been finally resolved, and continue to fuel disagreements. The conflicts need a final resolution based on best practices.

The statutes and policies governing VE should be amended to establish the best practices identified and as implemented in the Northern and Other Southern California regions. Currently, the statutes "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." Different regions have interpreted this code differently, giving rise to different investigation practices by MBC and HQES staff. This ambiguity should be addressed so that there is a uniform understanding of everyone's

X. Organizational and Management Structures

role in the process. Without such clarification, the Medical Board will continue to have responsibility for investigations while having little authority over their direction.

The Medical Board should be clearly identified in statute as the sole, final authority for purposes of determining whether to continue an investigation. HQES' responsibility regarding such decisions should be limited, as provided by current statutes, to providing advice to the Board. In cases where the Medical Board elects to continue an investigation, HQES Attorneys should be available and supportive of these efforts, irrespective of any prior advice or decision. If the case is again referred for prosecution after the investigation is completed, then HQES can always reject the case at that time.

Recommendation No. X-2. *Amend the statutes governing Vertical Enforcement to clarify the Medical Board's sole authority to determine whether to continue an investigation.*

Another significant problem with the management of District office investigations involves the extent of HQES Attorney involvement with the investigations, irrespective of the nature or complexity of the case. A high level of Attorney involvement in some investigations is warranted and beneficial to many, but not all, investigations. Prior to implementation of VE, the availability of HQES Attorneys to provide substantive legal support for investigations was limited to only a small percentage of cases. Now, in some cases, the pendulum has swung too far in the other direction. In some cases HQES Attorneys are now substantively involved in investigations where a lesser level of involvement would be just as beneficial, while avoiding many of the communication and coordination problems that otherwise arise.

Currently, in some parts of the State the HQES Lead Prosecutor, who may also be a Supervising DAG, generally works collaboratively with the Medical Board's District office Supervisor, reviews incoming cases (usually only one or two cases per week per office), regularly attends Quarterly Case Review meetings, and spends a few hours one or two days per week at the District office providing general consultation services to District office staff. In consultation with the District office Supervisor, needs are jointly identified for assignment of a Primary DAG to provide more substantive legal support services for specific cases on an exception basis. For other cases, the HQES Lead Prosecutor or Supervising DAG, along with the District office Supervisor, continues to monitor the status and progress of the cases and provides ad-hoc legal advice and consultation regarding the course of the investigation. With this approach an HQES Attorney would, for example, attend a Subject interview in only selected cases.

In contrast with this approach, in some parts of the State a Primary DAG is usually assigned to each new case, and is then expected to be substantively involved throughout the investigation. In some cases this extends to participation, not just in Subject Interviews, but also to interviews with complainants, witnesses, and others, and not just for cases involving sexual misconduct. The activities of the Primary DAGs also can include conducting detailed reviews and analysis of medical and other records, review of the qualifications of potential Medical Experts, preparation of the instructions for the Medical Expert, review of the package submitted to the Medical Expert, and numerous other activities. With this approach, communications and coordination among all of the different team members, for all of the cases, necessarily becomes much more cumbersome and complex.

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Another dimension of this problem involves conflicts related to the use of Lead Prosecutors (LPs). The statutes governing VE require that each investigation referred to a District office “be simultaneously and jointly assigned to an investigator and to the deputy attorney general in (HQES) responsible for prosecuting the case if the investigation results in the filing of an accusation.” The interim assignment of the LP to most cases at some District offices does not appear to be fully consistent with this requirement. The use of LPs was not incorporated in the VE model recommended by the Enforcement Monitor. It was created to address problems experienced after VE was implemented, including logistical, resource availability, and other problems associated with reviewing and assigning incoming cases and resolving communication problems and conflicts between District office and HQES staff.

In some cases a Supervising DAG has served as the LP. This approach can reduce communication and coordination problems because the Supervising DAG has direct supervising authority over subordinate Attorneys. However, Supervising DAGs are apparently not always sufficiently available to perform the LP role for all District offices. Consequently, the Supervising DAG usually assign a subordinate Attorney to serve as the LP. The ability of the assigned Attorney to effectively perform some key LP duties appears to be highly dependent on (1) the authority delegated to the LP by their Supervising DAG, (2) the ability of the LP to exercise the authority delegated to them, and (3) the relationships between the LPs and their peers. Thus, the effectiveness of the LP appears to be highly dependent on the management style of their Supervising DAG and the individual personality characteristics and interpersonal skills of the LP.

To reduce these conflicts, the statutes should be modified to eliminate mandatory requirements for joint assignment of a DAG for all cases referred for investigation. As a practical matter it cannot usually be determined when a District office investigation is opened whether the case will proceed to prosecution (most do not). Additionally, it is completely unrealistic to expect that the assignment of a DAG to a case will exist “for the duration of the disciplinary matter”, although it is preferable to minimize such changes. While it is beneficial to have an Attorney regularly available to review new investigations, attend case review meetings, monitor the status of pending investigations, and provide ad-hoc legal advice and assistance to Investigators, the mandatory assignment of a Primary DAG to all investigations is excessive and results in a multi-million dollar waste of valuable resources that could be better utilized for other purposes. Every case referred for investigation should not have to be “double-teamed”.

The assignment of Primary DAGs to cases during the Investigation Stage should be permissive, based primarily on the complexity and needs of the case as jointly determined by the District office Supervisor and the Supervising DAG (or their designees). Assignment decisions should be made with due care, taking into consideration all of the other, sometimes conflicting, workload and resource demands of both the Medical Board and HQES. If not needed, a Primary DAG should not be assigned to a case. Management judgment should be exercised in making case assignment decisions, rather than mechanically applying a one-size-fits-all approach to all investigations which results in higher Attorney caseloads, sub-optimal utilization of staffing resources, and poor overall performance. The assignment of a Primary DAG to all cases is as bad, or worse, than the pre-VE system where HQES Attorneys were largely unavailable to assist Medical Board Investigators during the Investigation Stage. There can, and should be, a more balanced approach between these two extremes that enables higher levels of Attorney support during the Investigation Stage when more intensive involvement is needed (not just because an Attorney is assigned, is available, and chooses to spend time working on the case).

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Recommendation No. X-3. *Implement the best practices, identified and as implemented in the Northern and Other Southern California regions, statewide to optimize effective HQES Attorney involvement in investigations. Amend the statutes and policies governing Vertical Enforcement to establish the best practices identified in the Northern and Other Southern California regions. It would be helpful to amend the statute to make primary DAG assignments permissive, allowing Medical Board and HQES supervisors to jointly review incoming investigations to identify which cases would benefit from VE. Clarifying the statute as to the agencies' roles, responsibilities, and authority over investigations would help assure greater uniformity of investigations among regions.*

C. Management of HQES Expenditures and Cases Referred for Prosecution

There are significant deficiencies with both Medical Board and HQES management of cases referred for prosecution. The processes currently used for identifying and tracking the status of cases after they are referred for prosecution are frequently failing, particularly in the Los Angeles region. These processes appear, particularly in the Los Angeles region, to be largely dependent on individual District office Investigator or Supervisor detection and follow-up of past due cases. These follow-ups sometimes do not occur until several months after a case is referred for prosecution, or longer. Failures by the Medical Board to transmit cases and failures by HQES to acknowledge receipt of a referred case, and to communicate its acceptance or rejection of the case, exacerbates and further complicates this problem. However, even without these other problems, the absence of a planned completion date from HQES regarding when a pleading will be prepared makes it difficult for anybody to know which cases are being treated as urgent matters and whether the pleadings are past due. Similar problems sometimes occur after the pleading is filed (e.g., when several months elapse before a Request to Set is submitted on a case that the Medical Board considers urgent because the Subject poses a significant risk).

Recommendation No. X-4. *Require HQES to inform the Medical Board Regional Manager and HQES Services Monitor of the planned date for completing a pleading. The notice should be required to be provided within five (5) business days of referral of any case for prosecution. Also, require that all Medical Board Regional Managers meet (or conference) on a monthly basis with their HQES counterparts to review the status of all previously referred cases for which an accusation has not yet been filed.*

There also are significant deficiencies with both Medical and HQES oversight and management of expenditures for legal services (both investigation and prosecution). Currently, it appears that nobody at either HQES or the Medical Board closely reviews or analyzes the 700 to 900 page Invoice Report that the Attorney General provides to the Medical Board each month to support their charges (which are paid automatically by a funds transfer by the State Controller's Office from the Medical Board's fund to the Department of Justice). Instead, the Invoice Report appears to go directly from an administrative services unit in the Department of Justice to the Medical Board's fiscal unit, which maintains a cumulative tabulation of total expenditures for budget status tracking purposes and then files the report.

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Needs exist to develop and implement a process that requires that the Supervising DAGs, Deputy Assistant Attorney General, District office Supervisors, and Regional Managers review and approve the reasonableness of HQES' charges to all matters billed each month. The scope of the review should include verification that the charges are posted to the correct cases. The Supervising DAGs should review and approve the time charges posted to Investigation and Administrative matters, or note exceptions that require correction, and then submit their portions of the Invoice Report to the Deputy Assistant Attorney General for final approval and submission to the Medical Board's HQES Services Monitor. Concurrently, District office Supervisors should confirm that the time charges posted to Investigation matters are consistent with the Investigation activities performed during the reporting period, note any exceptions that require correction or further evaluation, and then submit their portions of the Invoice Report to their Regional Manager. The Regional Managers should review the charges posted to pending Administrative matters as part of their responsibilities related to tracking the status of pending accusations (see Recommendation No. XII-4, above), note any exceptions that require correction or further research, and then submit their region's portion of the Invoice Report to the Medical Board's HQES Services Monitor. The Medical Board's HQES Services Monitor should monitor completion of all of the supervisory and management reviews and, in consultation with the Senior Assistant Attorney General, initiate corrective actions to address any exceptions or other problems identified as a result of completing the reviews.

Recommendation No. X-5. *Develop and implement an HQES Invoice Report review and approval process that provides for review of the reasonableness of HQES time charges. As necessary, require that HQES create new summary templates that display time charge data in a summary format that facilitates completion of these reviews.*

Recommendation No. X-6. *Establish a new HQES Services Monitor position within the Medical Board's Enforcement Program to coordinate the provision of services to the Medical Board by HQES, continuously monitor and evaluate HQES performance and costs, resolve conflicts that arise between the agencies, and prepare and provide regular reports to Executive Management, the Medical Board, and oversight and control agencies.*

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D. Management Reports

New monthly management reports should be developed and provided to Enforcement Program and HQES Managers and Supervisors, and Medical Board Executive Management. At a minimum, the reports should provide the following summary level output and performance measures for the reporting period, and for the preceding 12 months period:

- ✓ Number of investigations closed, by Identifier, and average elapsed time from referred for investigation to closure
- ✓ Number of investigations referred for prosecution, by Identifier, and average elapsed time from referred for investigation to referred for prosecution
- ✓ Total number of investigations closed or referred for prosecution, by identifier, and average elapsed time from referred for investigation to closed or referred for prosecution
- ✓ Number of accusations filed, by Identifier, average elapsed time from referred for prosecution to accusation filed, and average elapsed time from referred for investigation to accusation filed
- ✓ Number of stipulations received, by Identifier, average elapsed time from accusation filed to stipulation received, and average elapsed time from referred for investigation to stipulation received
- ✓ Number of proposed decisions received, by Identifier, average elapsed time from accusation filed to proposed decision received, and average elapsed time from referred for investigation to proposed decision received.

Additionally, the monthly performance reports should provide consolidated output and performance data by geographic region and for the State as a whole (Northern California, Los Angeles, and Other Southern California). Quarterly summaries of this same information should be prepared and provided to the Medical Board. The quarterly summaries should also include fiscal year-to-date totals and time series data for the preceding three (3) fiscal years. Finally, all of the reports should possibly include a limited number of selected other output and performance measures, such as data regarding interim suspension activities (e.g., ISOs and PC 23s), petitions to revoke probation, compelled competency examinations, or disciplinary outcomes.

Recommendation No. X-7. *Develop new monthly management reports showing key output and performance measures by business unit and for the State as a whole. (Presently, data is provided to the Board on a statewide basis only.) Provide the monthly reports to all Enforcement Program and HQES Managers and Supervisors and to designated Medical Board Executive Office Managers and staff. Develop and provide the Board with quarterly Enforcement Program Output and Performance Summary reports that include data for the most recently completed quarter and time series data for the preceding three (3) fiscal years.*

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E. Government Code Section 12529.6(e) Requirements

To carry out the Legislatures intent in requiring use of the Vertical Enforcement Model, and to enhance the Vertical Enforcement process, Section 12529.6 of the Government Code requires that the Medical Board:

- ❖ Increase its computer capabilities and compatibilities with HQES in order to share case information
- ❖ Establish and implement a plan to locate its Enforcement Program staff and HQES staff in the same offices, as appropriate
- ❖ Establish and implement a plan to assist in team building between its Enforcement Program staff and HQES staff to ensure a common and consistent knowledge base.

All of these requirements should be modified, or repealed. Each of these requirements is briefly discussed below.

Computer Capabilities and Case Information Sharing – The Medical Board is currently supporting DCA’s efforts to develop the BREEZE2 System which would completely replace the Medical Board’s legacy Application Tracking System (ATS) and also the Complaint Tracking System (CAS). The Medical Board should not invest additional resources in CAS to make it compatible with HQES’ ProLaw System. However, the Medical Board should provide HQES with standard reports available from CAS to enable HQES to monitor the status of pending investigations and prosecutions. Additionally, the Medical Board should provide HQES with summary level *Enforcement Program Output and Performance Reports* (see Recommendation No. X-7).

Co-location of District Office and HQES Staff – Co-location of District office and HQES staff would be inconsistent with our recommendations for more selective application of VE. Instead, as practiced currently, the Medical Board should be required to provide suitable space for Lead Prosecutors and Primary DAGs to work at its District offices, when needed (e.g., using “hoteling”).

Team Building and Development of a Common and Consistent Knowledge Base – The Medical Board and HQES should be jointly responsible for developing training programs and providing them to their respective staff as needed to provide staff in both agencies with a common and consistent knowledge base. Requirements related to team-building should be addressed as part of the structured diagnostic review of factors contributing to elevated attrition of Medical Board Investigators that is recommended in Section VI (See Recommendation No. VI-3).

Recommendation No. X-8. *Amend or repeal Subsection(e) of Section 12529.6 of the Government Code. The Medical Board should not invest in CAS to make it more compatible with HQES’ ProLaw System and should not permanently co-locate Medical Board Investigators and HQES Attorneys.*

X. Organizational and Management Structures

F. Oversight of HQES Services

When it was created during 1990, HQES was authorized 22 DAG positions. Following its formation, HQES also established a goal to file all accusations within 60 days of receipt of a completed investigation. The Legislation creating HQES also required that DAGs work on-site at the Medical Board's offices to assist with complaint handling and investigations. However, HQES determined that it was severely understaffed, and did not comply with this latter requirement. During 1992 and 1993 the Medical Board provided funding for 22 additional DAG positions (44 total Attorney positions). Subsequently, during the late-1990s, the Deputy in District Office (DIDO) Program was introduced whereby a DAG worked at each District office one or two days per week to provide prosecutorial guidance during investigations. However, the DIDO Program was not always consistently implemented at all District offices.

To support implementation of VE, an additional ten (10) Attorney positions were authorized for in 2006. In addition to the Senior Assistant Attorney General, HQES is currently authorized 53 Attorney positions, plus four (4) Analyst positions. HQES also has seven (7) filled Secretary positions. However, even with these resources, and notwithstanding declines in the number of cases referred for prosecution, HQES continues to experience significant delays in filing accusations and in performing post-filing prosecutorial activities. In recent years HQES has filed fewer accusations and the number of interim suspensions also has declined. Concurrently, the number of pending accusations and the number of pending legal actions have increased.

The results of this assessment show that issues concerning HQES' performance have persisted for the past 20 years, notwithstanding authorization and funding of significant staffing increases. Results of the assessment also show that output and performance levels of HQES' Los Angeles office are significantly lower than in other regions of the State, even though available staffing resources are disproportionately allocated to that office. The types of performance problems occurring in HQES' Los Angeles office, as illustrated by the various case histories reviewed as part of this assessment, are especially disturbing, and cannot be attributed to differences in the types of cases investigated by Los Angeles District offices or differences in the quality of those offices' completed investigations. While HQES' Los Angeles office presumably has many very competent and dedicated Attorney's on its staff, the problems identified, unfortunately, reflect poorly on the entire office. Also, the problems occurring at HQES' Los Angeles office should not color perceptions of the organization as a whole, although similar problems may sometimes occur at the other offices,

The Medical Board, and even the Department of Consumer Affairs, is limited in its ability to exercise oversight of HQES services because it is entirely dependent on HQES to provide legal support services and must work collaboratively with them on an ongoing basis. Periodic reviews of HQES' services, costs, and performance should be completed by an independent entity, and results of the review should be provided to Department of Justice and Medical Board management as well as to oversight and control agencies.

Recommendation No. X-9. *Conduct periodic performance reviews of the services, costs, and performance of HQES, including the performance of each HQES office. Provide results of the reviews to Department of Justice and Medical Board management and to oversight and control agencies.*

XI. Licensing Program

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XI. Licensing Program

Below we present and briefly discuss seven (7) recommendations resulting from our review of HSC's study of the Licensing Program and other related analyses performed as part of our assessment.

Recommendation No. XI-1. *Implement HSC's Recommended Business Process Improvements*

Medical Board staff from the Licensing Program and other business units spent considerable time working with HSC to identify and assess the recommendations for improvement presented in HSC's report. Additionally, about \$40,000 was expended for the study. Potential benefits associated with implementing HSC's recommendations for improvement should not be lost. As determined appropriate, the Licensing Program should implement HSC's recommended business process improvements. If implemented, many of the recommendations could marginally improve internal effectiveness or efficiency, or the level of service provided to applicants, without incurring any significant additional costs.

Recommendation No. XI-2. *Conduct a Limited, High-Level Business Case Analysis of Potential Benefits, Costs, and Risks of a Document Management System (DMS)*

The Medical Board should consider conducting a limited, high-level business case analysis of potential benefits and costs of a DMS. This analysis should include researching document management systems used by DCA or other California State Government agencies and departments, such as the Contractors State License Board. Additionally, the analysis should include obtaining information from potential vendors, but not necessarily development and issuance of a Request for Information (RFI) as suggested by HSC. The analysis should focus on identifying and quantifying, where practicable, potential efficiency and other improvements that might be achieved, developing order of magnitude estimates of costs to develop and maintain the system, and comparing the potential benefits with the estimated costs. Additionally, the analysis should include an analysis of significant risk factors associated with development and implementation of such a system. If supported, the Business Case Analysis can be used to support development of Feasibility Study Report (FSR), if needed.

Recommendation No. XI-3. *Obtain Authorization to Convert Recently Established Limited-Term Positions to Permanent Status*

Based on the limited, high-level analysis of historical Licensing Program workload and staffing completed as part of our assessment, it appears that the eight (8) new positions proposed in the 2010/11 BCP would fully restore positions lost earlier in the decade and also provide additional positions justified on the basis of increased workloads since that time. Additionally, given the nature of the medical profession and health care industry needs for additional licensed physicians, it is highly unlikely that application workloads will diminish over time. Finally, when positions are classified as limited-term, there is a greater risk of higher staff turnover as incumbents transfer to other positions rather than risk losing their job in the event the position expires. Therefore, we recommend obtaining authorization to convert the recently established limited-term positions to a permanent status as soon as practicable. We understand that these positions were converted to a permanent status effective July 1, 2010.

XI. Licensing Program

Recommendation No. XI-3. *Scale Back the Use of Retired Annuitants, Student Assistants, and Overtime, if Furloughs are Discontinued*

As discussed above, the recent addition of eight (8) new limited-term positions appears to be sufficient to fully restore positions lost earlier in the decade and also provide additional capabilities to process the larger number of license applications now submitted. Therefore, the Licensing Program should be able to significantly reduce its use of retired annuitants and student assistants, and overtime. We understand that Medical Board management has already begun implementing this recommendation.

Recommendation No. XI-5. *Conduct a Detailed Analysis of Licensing Program Workload and Staffing Requirements after a New Licensing Program Chief is Appointed*

The Licensing Program could potentially benefit from completion of a detailed analysis of Licensing Program workload and staffing requirements. Such an analysis could help Licensing Program management to (1) optimize the alignment of workload demands with available staffing capabilities and (2) determine how best to organize staff and needs for reclassification of existing positions, including determination of whether it would be beneficial to reclassify a rank and file position to the supervisory level to enhance management capabilities and further reduce supervisory spans of control. Implementation of this recommendation should be deferred until after a new Licensing Program Chief is appointed.

Recommendation No. XI-6. *Develop an Integrated Framework for Planning and Managing Licensing Program Performance*

Licensing Program management should develop an integrated framework for planning and managing Licensing Program performance that encompasses (1) establishing program goals and objectives, (2) developing plans, (3) monitoring operations, and (4) reporting results. The framework should be developed around a common set of quantified measures of outputs produced, resources used, service levels provided, and performance levels achieved.

Recommendation No. XI-7. *Resume Audits of Licensee Compliance with CME Requirements*

Audits of compliance with CME requirements are essential to ensure that licensee compliance levels do not deteriorate, and should be resumed as soon as practicable.

Appendix A
Summary Listing of Recommended Improvements

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Summary Listing of Recommendations for Improvements

Section III. License Fees, Expenditures, and Fund Condition

Recommendation No. III-1. Closely review each of the Attorney General's monthly Invoice Reports for the past three (3) fiscal years (2007/08 through 2009/10) to identify case billing inconsistencies by regions or billing anomalies that may have occurred. If significant over-charges are identified, request an adjustment in future billing periods.

Recommendation No. III-2. Maintain the current \$783 initial and biennial fee structure. Reserves will likely fall below the 4-month ceiling set forth in statute within the next two to three years.

Section V. Complaint Intake and Screening

Recommendation No. V-1. Augment the Specialist Reviewer pool in targeted medical specialties and counsel or replace current Medical Specialists who consistently fail to complete reviews on a timely basis, or amend the governing statutes to provide flexibility to refer complaints for investigation without review by a Medical Specialist.

Recommendation No. V-2. Augment CCU's workforce capabilities. When authorized, fill the new CCU and OST positions. Develop a specific plan detailing the program development and performance improvement goals and objectives that will be achieved by increasing authorized CCU and OST staffing levels. Track progress relative to the plan and provide periodic reports to the Medical Board showing progress in achieving each of the plan's goals and objectives.

Recommendation No. V-3. Resume surveys of CCU customer satisfaction levels and compile and publish the results of the surveys.

Section VI. Investigations

Recommendation No. VI-1. Augment Medical Consultant staffing. Medical Consultants should be available to all District offices all of the time (e.g., the equivalent of at least one full-time position per office, although actual availability will be less than full time due to vacations, sick leave and other time off). Because the Medical Consultant positions are classified as Permanent Intermittent, work hours can be adjusted to accommodate fluctuating workload demands, assuming a sufficient pool of resources is available to provide the services and the physicians are willing to work the number of hours needed. Offset costs for additional Medical Consultant positions by reducing expenditures for HQES investigation-related services (e.g., in the Los Angeles region).

Recommendation No. VI-2. Eliminate the limitation on reutilization of Medical Experts and augment the Medical Expert pool and enhance capabilities. In addition to strengthening Medical Expert oversight and overall Expert Reviewer Program management and administration, consider redirecting some funding currently used for HQES investigation-related services toward establishing a new program under which the Medical Board would contract for the services of a pool of physicians to provide Expert Review services (e.g., through an Interagency Agreement with one or more University of California Medical Centers, although this model may have its own problems relating to conflicts of interest).

Recommendation No. VI-3. Develop and implement an Immediate Action Improvement Plan to address critical District office workload and work environment issues. Meet with District office staff at each office to present the Improvement Plan and to outline a process for identifying and implementing further improvements. Conduct a structured diagnostic review of factors contributing to excessive Investigator turnover during the past several years, and develop and implement a Longer-Term Improvement Plan to reduce Investigator attrition and rebuild the Enforcement Program's field investigation workforce capabilities and competencies.

Summary Listing of Recommendations for Improvements

Section VII – Prosecutions and Disciplinary Actions

Recommendation No. VII-1. Establish independent panels to review all requests for supplemental investigations and all decline to file cases. The reviews should be completed expeditiously (e.g., within 1 to 2 days of issuance of the request for supplemental investigation or Decline to File Memorandum). For Northern California cases, the panel members should include a Regional Manager and Supervising DAG from the Southern California region, plus the Medical Board’s HQES Services Monitor (see Recommendation No. X-6). For Southern California cases, the panel members should include a Regional Manager and Supervising DAG from the Northern California region, plus the Medical Board’s HQES Services Monitor. The panels should review all decline to file cases and all requests for supplemental investigations for any cases where preparation of the pleading will be delayed pending completion of the supplemental investigation, and then advise the Chief of Enforcement, the Senior Assistant Attorney General, and all Medical Board and HQES managers and supervisors involved in the matter as to the results of their review, including recommended disposition of the matter.

Recommendation No. VII-2. Restructure the processes used for preparing accusations for Out-of-State cases to reduce the number of cases referred to HQES. Utilize DCU staffing resources to draft accusations and license surrender stipulations for Out-of-State cases.

Section VIII – Probation Program

Recommendation No. VIII-1. Develop systems for tracking and reporting completion of quarterly reviews, random office visits, and other key probation monitoring activities.

Recommendation No. VIII-2. Restructure the processes used for investigating petitions for modification or termination of probation. Exclude cases referred to the District offices from the VE Program, and screen out petitions from referral to HQES that do not need a hearing before an ALJ.

Section X – Organizational and Management Structures

Recommendation No. X-1. Restructure the handling of Section 801 cases by establishing a centralized unit comprised of non-sworn staff to investigate Section 801 and selected other cases.

Recommendation No. X-2. Amend the statutes governing Vertical Enforcement to clarify the Medical Board’s sole authority to determine whether to continue an investigation.

Summary Listing of Recommendations for Improvements

Section X – Organizational and Management Structures *(continued)*

Recommendation No. X-3. Implement the best practices, identified and as implemented in the Northern and Other Southern California regions, statewide to optimize effective HQES Attorney involvement in investigations. Amend the statutes and policies governing Vertical Enforcement to establish the best practices identified in the Northern and Other Southern California regions. It would be helpful to amend the statute to make primary DAG assignments permissive, allowing Medical Board and HQES supervisors to jointly review incoming investigations to identify which cases would benefit from VE. Clarifying the statute as to the agencies' roles, responsibilities, and authority over investigations would help assure greater uniformity of investigations among regions.

Recommendation No. X-4. Require HQES to inform the Medical Board Regional Manager, District office and HQES Services Monitor of the scheduled date for completing a pleading. The notice should be required to be provided within five (5) business days of referral of any case for prosecution. Also, require that all Medical Board Regional Managers meet (or conference) on a monthly basis with their HQES counterparts to review the status of all previously referred cases for which an accusation has not yet been filed.

Recommendation No. X-5. Develop and implement an HQES Invoice Report review and approval process that provides for review of the reasonableness of HQES time charges. As necessary, require that HQES create new summary templates that display time charge data in a summary format that facilitates completion of these reviews.

Recommendation No. X-6. Establish a new HQES Services Monitor position within the Medical Board's Enforcement Program to coordinate the provision of services to the Medical Board by HQES, continuously monitor and evaluate HQES performance and costs, resolve conflicts that arise between the agencies, and prepare and provide regular reports to Executive Management, the Medical Board, and oversight and control agencies.

Recommendation No. X-7. Develop new monthly management reports showing key output and performance measures by business unit and for the State as a whole. (Presently, data is provided to the Board on a statewide basis only). Provide the monthly reports to all Enforcement Program and HQES Managers and Supervisors and to designated Medical Board Executive Office Managers and staff. Develop and provide the Board with quarterly Enforcement Program Output and Performance Summary reports that include data for the most recently completed quarter and time series data for the preceding three (3) fiscal years.

Recommendation No. X-8. Amend or repeal Subsection(e) of Section 12529.6 of the Government Code. The Medical Board should not invest in CAS to make it more compatible with HQES' ProLaw System and should not permanently co-locate Medical Board Investigators and HQES Attorneys.

Recommendation No. X-9. Conduct periodic performance reviews of the services, costs, and performance of HQES, including the performance of each HQES office. Provide results of the reviews to Department of Justice and Medical Board management and to oversight and control agencies.

Summary Listing of Recommendations for Improvements

Section XI – Licensing Program

Recommendation No. XI-1. Implement HCS’ recommended business process improvements.

Recommendation No. XI-2. Conduct a limited, high level business case analysis of potential benefits, costs, and risks of a Document Management System (DMS).

Recommendation No. XI-3. Obtain authorization to convert recently established limited-term positions to permanent status.

Recommendation No. XI-4. Scale back the use of retired annuitants, student assistants, and overtime, if furloughs are discontinued.

Recommendation No. XI-5. Conduct a detailed analysis of Licensing Program workload and staffing requirements after a new Licensing Program Chief is appointed.

Recommendation No. XI-6. Develop an integrated framework for planning and managing Licensing Program performance.

Recommendation No. XI-7. Resume audits of licensee compliance with CME requirements.



Medical Board of California

Program Evaluation Volume II – Final Report

August 31, 2010

**BENJAMIN
FRANK** LLC
MANAGEMENT
CONSULTANTS

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August 31, 2010

Ms. Linda Whitney, Executive Director
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, California 95815

**Program Evaluation
Volume II – Final Report**

Dear Ms. Whitney,

We are pleased to present this *Final Report* which documents the major findings, conclusions, and recommendations resulting from our review of the Medical Board's programs. The report presents results of extensive analyses we performed of the Medical Board's complaint intake and screening, investigation, and prosecution processes, including numerous analyses targeted specifically on assessing fiscal and program performance impacts resulting from implementation of Vertical Enforcement (VE) during 2006. Additionally, we completed assessments of other aspects of the Board's programs as required pursuant to our contract with the Board. A condensed version of this report is provided under separate cover (*Volume I – Summary Report*).

In addition to quantitative and qualitative analyses, this report includes summaries of the results of reviews we completed of several dozen individual investigation and prosecution case histories. The individual case histories help to illustrate certain aspects of various problems currently being experienced by the Medical Board that are not as apparent from anecdotal input or statistical data. Some of these cases have already been settled or closed, while other cases are still pending final disposition. Because of the sensitive and confidential nature of these matters, considerable information was excluded from this report regarding the nature of the cases and their handling by the Medical Board and HQES.

* * * * *

We appreciate the opportunity to be of service to the Medical Board. If you have any questions or need additional information, please contact me at 916.425.1475.

Very truly yours,

BENJAMIN FRANK, LLC



Benjamin Frank
Chief Executive Officer

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I. Introduction

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I. Introduction

During 2009 the Medical Board, along with all of the State’s other health profession licensing programs, were the subject of a series of critical reports in the Los Angeles Times and other newspapers that highlighted the extended timeframes needed to complete investigations and initiate disciplinary actions against regulated professionals. These reports also highlighted related problems with large, and growing, workloads and backlogs at these agencies. In response to this recent publicity, a series of organizational changes were implemented at the Board of Registered Nursing, which was the primary focus of these reports. Additionally, the Governor and the newly-appointed Director of Consumer Affairs pledged to implement broad reforms to improve patient safety by reducing backlogs of work at all of the health profession licensing Boards, and initiating administrative and program oversight improvements. Concurrently, at its July Quarterly Meeting, the members of the Medical Board’s Governing Board expressed concerns about the newspaper reports, and about growing backlogs of work in the Licensing and Enforcement programs, increased turnover of staff, the impacts of work furloughs, and management’s plans to achieve meaningful effectiveness and efficiency improvements.

To address the above concerns, the Governing Board authorized the Executive Director to undertake a comprehensive, independent evaluation of the Medical Board. A Request for Offers (RFO) to perform the study was issued on August 25, 2009. During September 2009 the Medical Board conducted bidder interviews, completed its evaluation of proposals, and awarded the contract to Benjamin Frank, LLC. A contract to perform the assessment was issued on October 26, 2009. Performance of the contract commenced on November 4, 2009. The term of the contract extends to August 31, 2010.

This remainder of this section summarizes the purpose and scope of this study and our technical approach to performing the assessment. The section also includes a summary of significant data constraints and limitations and their potential impacts on the assessment. Subsequent sections of the report are organized as follows:

Section	Title	Section	Title
II.	Overview of the Evolution of the Medical Board’s Governance Structure, Licensing Fees, and Enforcement Program	VII.	Prosecutions and Disciplinary Outcomes
III.	Fees, Expenditures, and Fund Condition	VIII.	Probation Program
IV.	Profile of Complaints Opened and Dispositions	IX.	Integrated Assessment of Enforcement Program Performance
V.	Complaint Intake and Screening	X.	Organizational and Management Structures
VI.	Investigations	XI.	Licensing Program.

I. Introduction

A. Project Purpose and Scope

As set forth in the Medical Board's RFO, the purpose of this study was to conduct an independent and unbiased review of the Medical Board's organizational structure and core programs to identify strengths and weaknesses of current operations and develop recommendations for improvements. The scope of the review encompassed assessment of the Medical Board's governance structure including:

- ❖ Board size and composition
- ❖ Board capability to fulfill its mission, goals, and objectives
- ❖ Board meeting effectiveness in policy development
- ❖ The effectiveness of training provided to Board members.

The study scope also encompassed review of the Medical Board's internal organizational and management structures. Additionally, the study scope included assessment of:

- ❖ The sufficiency of fees to meet legislative goals and mandates
- ❖ The value of services provided by external agencies
- ❖ The value of services provided by contractors
- ❖ The uses and effectiveness of major equipment purchases
- ❖ Identification of laws, regulations, policies, and procedures that may hinder effectiveness
- ❖ The effectiveness of IT applications used for enforcement and licensing.

Finally, the study scope included development of other recommendations for improvement, including assessment of the possible elimination or transfer of non-critical functions to enable re-direction of resources to critical functions.

Initially, to refine the scope and focus of our assessment efforts, we completed a preliminary diagnostic review of the Medical Board's expenditures and Enforcement Program performance during the past five (5) years. The results of this review indicated that, subsequent to implementation of Vertical Enforcement during 2006, costs for legal services provided by the Attorney General escalated rapidly while other legal service costs declined. Concurrently, the number of cases referred for investigation, the number of completed Investigations referred for Prosecution, the number of accusations filed, the number of stipulated settlements and proposed decisions submitted, and the number of disciplinary actions all declined. Additionally, the average elapsed time to complete investigations increased while the average elapsed time to complete prosecutions declined.

I. Introduction

Given the amount of funding utilized for legal services provided by the Attorney General (currently more than \$1 million per month) and these other cost and Enforcement Program performance trends, it was jointly determined, in consultation with Medical Board management, that the primary focus of this assessment should be on (1) identifying and assessing the impacts of the VE Pilot Project on the Enforcement Program, (2) identifying and assessing the benefits provided from the increased expenditures for VE-related legal services, (3) identifying and assessing other factors contributing to deteriorating Enforcement Program performance, and (4) developing an *Enforcement Program Improvement Plan*.

I. Introduction

B. Technical Approach

Our approach to performing this assessment was initially organized into the following major components:

- ❖ Assessment of licensing fees and fund condition
- ❖ Assessment of cashiering business units and processes
- ❖ Assessment of Licensing Program business units and processes
- ❖ Assessment of complaint-handling business units and processes
- ❖ Assessment of investigation and prosecution business units and processes
- ❖ Assessment of Probation Program business units and processes
- ❖ Assessment of internal organizational structure and effectiveness
- ❖ Assessment of Governing Board size, composition, and effectiveness.

A summary of our approach to performing each of these tasks is provided below.

1. Assessment of Licensing Fees and Fund Condition

As part of this assessment we collected, compiled, and summarized data regarding historical and projected revenues and expenditures. Additionally, we reviewed and summarized the history of the Medical Board's licensing fees and statutory requirements pertaining to the Medical Board's fund reserves. We also reviewed prior reports prepared by the Bureau of State Audits concerning the Medical Board's fund condition. Finally, we conducted analyses of current and projected revenues and expenditures, the sufficiency of the Medical Board's reserve funds, and compliance with applicable statutory requirements.

2. Assessment of Cashiering Business Units and Processes

As part of this assessment we interviewed the Supervisor of the Medical Board's Cashiering Unit. We also interviewed the Supervisor of DCA's Cashiering Unit.

I. Introduction

3. Assessment of Licensing Business Units and Processes

The assessment of Licensing Program business units and processes was limited to conducting a critical review of a recently completed detailed analysis of Licensing Program business units and processes that was recently completed by another consulting firm (Hubbert Systems Consulting). We also incorporated results of assessments we completed in other related areas.

4. Assessment of Complaint-Handling Business Units and Processes

As part of this assessment we collected, compiled, and analyzed complaint-handling workload, workflow, staffing, and performance data covering the period from 2000/01 through 2009/10. Additionally, we scheduled and conducted individual and small group interviews with Central Complaint Unit (CCU) managers, supervisors, and staff. We also researched and summarized the history and evolution of the Medical Board's complaint-handling processes. Our analyses focused on changes in performance during the past several years and on assessment of the impacts of Medical Specialist reviews on process performance.

5. Assessment of Investigation and Prosecution Business Units and Processes

As part of this assessment we collected, compiled, and analyzed investigation and prosecution workload, workflow, staffing, and performance data covering the period from 2000/01 through December 2009. Additionally, we researched and summarized the history and evolution of the Medical Board's investigation and prosecution processes. We scheduled and conducted individual interviews with Enforcement Program Managers and individual and small group interviews with Supervisors and Investigators at six (6) District offices throughout the State. We also scheduled and conducted interviews with representatives of HQES' offices in Los Angeles, Sacramento, San Diego, and San Francisco and with representatives of DCA's Division of Investigation. Finally, we collected, compiled, and analyzed HQES billings to the Medical Board and data provided by HQES regarding hours charged for investigation and prosecution services. Our analyses focused on identification and assessment of changes in performance since implementation of the VE Pilot Project during 2006. To develop a better understanding of variations and changes in Enforcement Program performance, and problems currently experienced, we researched several dozen individual case histories.

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6. Assessment of Probation Program Business Units and Processes

As part of this assessment we collected, compiled, and analyzed Probationer-related workload, workflow, staffing, and performance data covering the period from 2000/01 through December 2009, including workload, workflow, and performance data related to the review and investigation of complaints involving Probationers, and petitions for modification or termination of probation. We also researched and summarized the history and evolution of the Probation Program. Additionally, we scheduled and conducted interviews with current and former Probation Program Managers and Supervisors. We also discussed the handling of probation cases with representatives of HQES' offices in Sacramento, San Francisco, Los Angeles, and San Diego. Finally, to develop a better understanding of variations and changes in Probation Program performance, and problems currently experienced, we researched several individual case histories.

7. Assessment of Internal Organizational Structure and Effectiveness

The assessment of internal organizational structure and effectiveness focused on review and analysis of the different approaches used by HQES to direct the completion of investigations in different geographic regions of the State. Additionally, we assessed the dual management structure used to direct Medical Board Investigators in conducting investigations. Finally, we identified and assess alternative approaches to organizing and management investigations and prosecutions.

8. Assessment of Governing Board Size, Composition, and Effectiveness.

As part of this assessment we researched and summarized the history and evolution of the Governing Board's structure, size, and composition. We also developed a customized survey to obtain input from all Board members regarding the Board's structure, size, composition, effectiveness, training provided to members of the Board, and suggestions for improvements. A sufficiently high response rate was not reached to enable development of any findings, conclusions, or recommendations for improvements based on the survey responses.

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C. Medical Board Data Constraints and Effects

As part of this assessment Medical Board staff produced several dozen sets of data pertaining to the intake, screening, investigation, and prosecution of complaints, disciplinary outcomes, and other related activities and events. The data provided also included mandated reports submitted by licensees, insurers, and other government agencies, reports submitted by medical/osteopathic boards in other states, Medical Board-originated complaint records, petitions for modification or termination of probation, Petitions for reinstatement, and other matters that are tracked using the Medical Board’s Complaint Tracking System (CAS), such as statements of issues (SOIs) and probationary license certificates issued to some new licensees in lieu of full licensure. We filtered, compiled, summarized, and analyzed the data provided as needed for purposes of this study. Where required, we requested and were provided with replacement or supplemental sets of data were requested and provided. To the extent practicable we corrected significant anomalies in the data and, where appropriate, excluded some records from our analyses.

In any database as large as that maintained and used by the Medical Board for tracking complaints, investigations, prosecutions, and disciplinary actions, there is always some incomplete or incorrect data (or “noise”). However, as best we can determine, the data used for our analyses was substantially complete and reasonably accurate. Also, isolated variances in individual records would generally tend to have offsetting impacts and, even if the variances were not offset, the isolated variances would not significantly impact aggregate annual measures of workload, output, or performance. Also, any impacts on the aggregate measures would tend to be consistent over time in both direction and magnitude.

In the past, and currently, a major area of contention between the Medical Board and HQES involves differences in how the two agencies determine the average amount of time that elapses between referral (or transmittal) of a case to HQES for prosecution and filing of an accusation. The Medical Board generally measures the total elapsed time from transmittal of the case to HQES to the filing of the accusation. HQES generally measures the elapsed time from its acceptance of a case for prosecution to completion of its preparation of a pleading. Several significant differences between the measurement approaches used by the two agencies are outlined below.

- ❖ The Medical Board’s measurement approach includes the elapsed time between transmittal of the case to HQES and HQES’ acceptance of the case for prosecution. Generally, the difference between these two approaches should be limited to a period of just a few days or, at most, a few weeks. However, in some cases HQES requests that the Medical Board complete a supplemental investigation and may not formally accept the case for prosecution until the supplemental investigation is completed and accepted. In some cases, multiple supplemental investigations may be requested. In these circumstances the elapsed time between transmittal of the case and filing of the accusation includes a significant amount of time related to completing one or more supplemental investigations. This additional elapsed time would be included in the Medical Board’s elapsed time measures, but not in the HQES’ elapsed time measures.

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- ❖ The Medical Board's elapsed time measurement approach includes elapsed time from HQES' submittal of the accusation to the Medical Board to the filing of the accusation. In some cases the Medical Board may request that HQES modify the accusation which can delay the filing. This additional elapsed time is included in the Medical Board's elapsed time measures, but not in HQES' elapsed time measures.

Because of these and other differences, the average elapsed time metrics calculated by HQES are necessarily significantly shorter than the average elapsed time metrics calculated by the Medical Board.

While the data maintained in CAS appears to be reasonably complete and accurate for most data elements, it appears that some updates to CAS are not always consistently posted by District office staff for various interim investigation activities, including activities involving (1) medical records requests, (2) Complainant and Subject interviews, and (3) Medical Consultant case reviews. In some cases CAS is updated to show when the activity commenced (e.g., requested medical records, requested or scheduled a Complainant or Subject interview, or submitted records to the Medical Consultant or a Medical Expert for their review), but CAS is not updated to show when the activity was completed). In other cases CAS is updated only when the activity is completed, or not updated to show either initiation or completion of the activity. Sometimes, interim investigation activity updates are not posted until the investigation is completed. To varying degrees, District office Supervisors post updates to CAS when reviewing completed case files prior to closure or referral of the case for prosecution. Consequently, statistical data generated regarding these interim activities, although more complete with the passage of time, may still understate actual activity levels. Additionally, measures of the average elapsed time to complete these interim activities may not be representative of actual performance. The measures related to obtaining Medical Records are especially limited. Medical records are sometimes requested from multiple sources for the same case, but the Medical Board's performance measures typically only count each case once. Also, in some cases the records submitted are incomplete or overly redacted and are re-requested. The Medical Board's measures count the records as received irrespective of the completeness or quality of the records provided, and do not account for supplemental submissions. Because of these deficiencies and complexities, we did not perform any analyses of changes in (1) the number of completed medical records requests, or (2) the average elapsed time to submit responses to these requests.

In the past concerns have surfaced about the extent to which measures of Enforcement Program performance focus on outputs without consideration of the quality of the outputs (e.g., measures of the number of cases referred for prosecution, without consideration of the quality of the completed investigations). Our analysis included assessment of the following measures which potentially reflect the quality of completed investigations, but which have various inherent limitations:

Supplemental Investigations – If a completed investigation does not contain sufficient evidence to meet the burden of proof, HQES can request a supplemental investigation to address the deficiencies. However, HQES Attorneys sometimes request supplemental investigations to strengthen a case even though another HQES Attorney might consider the initial submission sufficient without further investigation.

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HQES Decline to File – If a completed investigation does not contain sufficient evidence to meet the burden of proof that cannot reasonably be corrected with a supplemental investigation, HQES can decline to file the case. However, HQES Attorneys sometimes reject cases that other HQES Attorneys accept for prosecution.

Accusations Withdrawn or Dismissed – If after an accusation is filed it is determined that there is insufficient evidence to meet the burden of proof, HQES can, with the permission of the Board, withdraw the accusation or, if the case proceeds to hearing, the Hearing Officer can dismiss the case. However, accusations can be, and oftentimes are, withdrawn or dismissed for reasons completely unrelated to the quality of the completed investigation (e.g., successful completion of Diversion Program, death of the physician, settlement with a citation or public letter of reprimand, cancellation of the license, modified Expert opinion, etc.).

A final area of concern about statistical measures of Enforcement Program performance involves consideration of not just the number of disciplinary actions taken by the Medical Board, but also the level of discipline imposed. To address this concern, our assessment includes analysis, where appropriate, of the number and proportion of public reprimands compared to other types of discipline imposed (license revocation, surrender, suspension, or probation). Additionally, where appropriate, we segregated disciplinary actions taken related to complaints investigated by the Medical Board's District offices from disciplinary actions taken related to other types of cases (e.g., license surrenders resulting from disciplinary actions taken by medical/osteopathic boards in other states).

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D. Health Quality Enforcement Section Data Constraints and Effects

In the past, concerns have been expressed about the failure to include HQES data in prior analyses of Enforcement Program performance. Accordingly, as part of this assessment, in mid-January 2010 we asked HQES' Senior Assistant Attorney General to provide us with detailed organization charts and staffing rosters for HQES, to disclose to us the availability of any workload, workflow, or performance data showing how VE had impacted investigation or prosecution processes, and to provide us with any general background information that would be helpful to us in performing our assessment. HQES provided us with staff rosters showing HQES positions, by office, but provided no other information to us in response to this request.

During February 2010 we met with the HQES' Supervising DAGs and selected Attorneys at HQES' offices in San Diego, Los Angeles, Sacramento, and San Francisco. At each of these meetings we requested copies of any background documents or statistical data that HQES thought might be helpful to us for purposes of our assessment of the impacts of VE on the investigation and prosecution processes. At these meetings we were told that Los Angeles-based HQES technical support staff could potentially provide us with workload, workflow, and performance data that was available from HQES' ProLaw System. With the exception of a one-page spreadsheet summarizing the number of Investigation and Administrative matters opened and closed by HQES during 2009, no other data or other background information was provided to us following these meetings.

On March 3, 2010, we submitted to HQES' Senior Assistant Attorney General a draft data request listing about 20 specific sets of data. The draft data request included requests for time series data for the past 4 to 5 years regarding:

- ❖ Numbers of hours charged to Investigation matters
- ❖ Numbers of Investigation matters opened and closed
- ❖ Numbers of Subject interviews attended
- ❖ Numbers of Expert opinions reviewed
- ❖ Numbers of Final Reports of Investigation reviewed
- ❖ Numbers of ISOs, TROs, and PC 23s
- ❖ Numbers of hours charged to Administrative matters
- ❖ Number of Administrative matters opened and closed
- ❖ Numbers of accusations and SOIs prepared
- ❖ Numbers of petitions to revoke probation prepared
- ❖ Numbers of stipulations prepared
- ❖ Number of administrative hearings attended.

We also requested extracts of data showing the migration of cases, by milestone, through the investigation and prosecution processes, and the hours charged to each completed case. We reviewed the draft data request with HQES' Senior Assistant Attorney General and HQES' technical support specialist to identify items for which sufficiently complete and reliable data were not available and to identify ways to better align the data request with the specific data elements captured within the ProLaw System. Finally, HQES agreed to provide us with the requested data on a flow basis as it was prepared, with a goal of providing all of the requested data by March 31, 2010. A

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revised data request was transmitted to HQES' Senior Assistant Attorney General on March 9, 2010. The revised data request excluded nearly one-half of the items included in the draft data request because:

- ❖ The data is captured in ProLaw, but is substantially incomplete or reliable (e.g., numbers of investigation and Administrative cases closed)
- ❖ The data is only captured in ProLaw in non-standardized "case notes" (e.g., numbers of Subject interviews, Expert report reviews, and Report of Investigation reviews)
- ❖ More reliable data was believed to be available from the Medical Board (e.g., numbers of ISOs, TROs, and PC 23s).

We also consolidated data elements to make it simpler and easier for HQES to provide the requested data.

After a period of nearly a month, HQES provided a partial response to the revised data request. However, in terms of completeness and quality, there appeared to be some significant deficiencies with some of the data provided. We requested additional information from HQES regarding these deficiencies. HQES was non-responsive to this request.

On April 22, 2010, the Medical Board re-submitted the revised data request to HQES. Additionally, the Medical Board again requested an explanation of the completeness and quality deficiencies identified with some of the previously provided data. The Medical Board also requested additional data regarding hours charged for Investigation Stage-related activities that would supplement data previously provided by HQES regarding hours charged to specific Investigation matters. Finally, the Medical Board requested that HQES submit a schedule indicating when the requested data would be provided.

As of June 20, 2010, the following three (3) sets of useable statistical data had been provided by HQES:

- ❖ Numbers of Investigation matters opened, by HQES office, by year (CY2006 through CY2009)
- ❖ Numbers of hours charged to Investigation matters, by classification level, by HQES office, by year (CY2006 through CY2009)
- ❖ Numbers of hours charged to Administrative matters, by classification level, by HQES office, by year (CY2005 through CY2009).

During late-June, HQES provided data showing the number of Administrative matters opened by HQES office by year (CY2005 through CY2009). This data set also included information showing the completion of pleadings, settlement agreements, and other milestones for these matters. However, the data is incomplete because it does not include pleadings, settlement agreements, and other milestones completed during 2005, and subsequent years, related to Administrative matters opened by HQES during 2004 and prior years. Thus, the data was of limited utility for purposes of this analysis.

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Finally, in mid-July HQES provided data showing Investigation matters opened by HQES office by year (CY2006 through CY2009). This data set also included information showing the assignment of an Attorney to each case and acceptance of the case for prosecution. However, because HQES only began tracking cases referred for investigation after January 1, 2006, the data provided for the first several years following implementation of Vertical Enforcement is incomplete and not representative of all completed investigations. For example, the cases shown as referred for prosecution during 2006 only includes cases referred for investigation after 2005 and, hence, only includes a small number of investigations that were completed in less than one (1) year. The data provided for cases referred for prosecution during 2009 (and possibly the latter part of 2008) is the only data that appears reasonably complete. The data provided for these cases is not completely consistent with comparable data separately provided by the Medical Board. For example, HQES' data shows somewhat fewer cases referred for prosecution, possibly due to failure to open separate Investigation matters for each complaint referred for investigation. On a statewide basis, the average elapsed timeframes to complete the investigations, as shown by HQES' data for cases referred for prosecution during 2008 and 2009, were similar to comparable data obtained from the Medical Board (e.g., an average elapsed time of about 15 to 16 months). However, because of the limitations mentioned above, the data provided by HQES for cases referred for prosecution during 2009 is not comparable to HQES' data for prior years (2006 through 2008). For 2009, HQES' data shows significantly longer average elapsed times to complete investigations of cases referred for prosecution in the Los Angeles Metro region than for other geographic regions of the State (an average of 16.8 months for the Los Angeles Metro region compared to an average of 15.3 months in the Other Southern California region and an average of 14.3 months in the Northern California region).

II. Overview of the Evolution of the Medical Board's Governance Structure, License Fees, and Enforcement Program

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II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

This section presents an overview of the history and evolution of the Medical Board's governance structure, licensing fees, and Enforcement Program. The overview of the Enforcement Program highlights a 35-year history of efforts to strengthen discipline and reduce the time required to complete complaint intake/screening, investigation, and prosecutorial processes. A more detailed chronicle of the history of the Medical Board from the mid-1970s through 2004/05 is included in the *Initial* and *Final Reports* prepared by the Medical Board Enforcement Monitor (dated November 1, 2004 and November 1, 2005, respectively). The section is organized as follows:

Subsection	Title
A.	Governing Board Structure and Composition
B.	Licensing Fees, Expenditures, and Fund Condition
C.	Complaint Intake and Screening
D.	Investigations and Prosecutions
1.	1980 to 1990
2.	1991 to 2000
3.	2001 to 2004
4.	2005 to 2009
E.	Section 805 Reports and Investigations
F.	HQES Staffing Resource Allocations
G.	Enforcement Program Attrition History
H.	Prior Analyses of the Impacts of Vertical Enforcement
1.	November 2007 Medical Board Analysis
2.	June 2009 Integrated Solutions for Business and Government, Inc. Analysis
3.	Medical Board Quarterly Reports
I.	Probation Program
J.	Diversion Program
K.	Current Enforcement Program Organization and Staffing Resource Allocations
L.	Pending 2010/11 Budget Change Proposals.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

A. Governing Board Structure and Composition

Prior to 1975, the Medical Board, known then as the Board of Medical Examiners (BME), had 11 members, of which 10 were physicians. During this period, responsibility for physician discipline was largely delegated to physician-dominated regional Medical Quality Review Committees (MQRCs). The MQRCs were five-member panels that held medical disciplinary hearings and made recommendations to the (BME). The BME rarely disciplined physicians for incompetence or gross negligence and nearly all disciplinary actions took two (2) to three (3) years to complete.

Concurrently, during the early-1970s, medical malpractice insurance premiums in the State skyrocketed due to increased costs associated with medical malpractice litigation. The insurance premium increases threatened to disrupt delivery of physician services, particularly to economically disadvantaged segments of the population. In response, the *Medical Injury Compensation Reform Act* (MICRA) was enacted (AB 1, Keene) during a 1975 Special Session of the Legislature. MICRA established a \$250,000 cap on non-economic damages in medical malpractice actions, such as damages for pain and suffering, and limited the contingency fees that could be charged by the plaintiff's counsel. Additionally, MICRA abolished the Board of Medical Examiners and created a new Board of Medical Quality Assurance (BMQA) consisting of 12 physician members and seven (7) public members. BMQA was organized into three divisions:

- ❖ A 7-member Division of Licensing (DOL) responsible for administering licensing examinations, issuing licenses, and administering a new Continuing Medical Education (CME) program
- ❖ A 7-member Division of Medical Quality (DMQ) responsible for overseeing the BMQA's Enforcement Program and disciplinary actions
- ❖ A 5-member Division of Allied Health Professions (DAHP) responsible for overseeing non-physician Allied Health Licensing Programs (AHLPs) that were placed under the jurisdiction of the BMQA.

MICRA also transferred responsibility for investigating complaints against physicians from the Department of Consumer Affairs (DCA) to the BMQA, and added public members to the MQRCs which continued to be responsible for conducting disciplinary hearings. Finally, MICRA added several mandatory reporting requirements, including requirements that:

- ❖ Insurers and insureds report to the BMQA the payment of judgments, settlements, and arbitration awards in medical malpractice actions (Sections 801 and 802 of the Business and Professions Code)
- ❖ Court clerks report to the BMQA criminal charges and convictions against physicians (Section 803 of the Business and Professions Code)

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

- ❖ Hospitals and health care institutions report to the BMQA adverse peer review actions taken against physicians (Section 805 of the Business and Professions Code).

During 1990 the BMQA was renamed the Medical Board of California (AB 184, Speier) and, in 1993, the DAHP was abolished and its members were combined with the DMQ (SB 916, Presley). SB 916 also abolished the MQRCs and assigned responsibility for conducting medical disciplinary hearings to the Office of Administrative Hearings (OAH). SB 916 preserved the DMQ's authority to review disciplinary actions, but divided the DMQ into two panels for purposes of reviewing (1) stipulated settlement agreements (STIPs) that are oftentimes entered into in lieu of proceeding to an Administrative Hearing, and (2) proposed decisions (PDs) prepared by Administrative Law Judges (ALJs) for cases where a hearing is held.

Effective January 1, 2003, two (2) additional public members were added to the DMQ (SB 1950, Figueroa), thereby increasing the size of the Medical Board to 21 total members, including 12 physicians and nine (9) public members. With these additions, the DOL had seven (7) members (4 physicians and 3 public members) and the DMQ had 14 members (8 physicians and 6 public members). For purposes of reviewing STIPs and PDs, each DMQ panel was allocated seven (7) members (4 physicians and 3 public members).

Effective January 1, 2008, the DOL and DMQ were consolidated into a single 15-member governing Board, including eight (8) physicians and seven (7) public members (AB 253, Eng). This is the fewest physician members that the Medical Board has ever had. Additionally, AB 253 mandated that the Medical Board delegate to the Executive Director authority to adopt Default Decisions and specified types of STIPs.

To carry out its responsibilities, the Medical Board subsequently established the following 15 Standing Committees:

- | | |
|---|---|
| ❖ Executive Committee | ❖ Physician Wellness Committee |
| ❖ Access to Care Committee | ❖ Malpractice Task Force |
| ❖ Cultural & Linguistic Competency Work Group | ❖ Enforcement Committee |
| ❖ Public Education Committee | ❖ Licensing Committee (including Application Review Subcommittee) |
| ❖ Midwifery Advisory Council | ❖ Physician Supervision Advisory Committee (supervision of allied health professionals) |
| ❖ Physician Recognition Committee | ❖ Physician Discipline – Panel A |
| ❖ Special Faculty Permit Review Committee | ❖ Physician Discipline – Panel B. |
| ❖ Special Programs Committee | |

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

B. Licensing Fees, Expenditures, and Fund Condition

During 1992, initial and biennial renewal fees for physicians and surgeons were increased to \$480 (\$240 per year) from \$400 previously (\$200 per year). Subsequently, during November 1993 the Medical Board adopted Emergency Regulations increasing initial and biennial renewal fees to \$600 (\$300 per year). The primary purpose of the higher fees was to fund a 100 percent increase in staffing for the Health Quality Enforcement Section (HQES) within the Office of the Attorney General (from 22 Attorney positions, to 44 Attorney positions). At the time, HQES Attorneys were carrying an average of 30 cases per position and taking an average of 16 months to file accusations. Initial and biennial renewal fees remained at the \$600 level until 2003 when they were increased marginally to \$610 (\$305 per year).

Effective January 1, 2006, initial and biennial fees were statutorily increased to a maximum of \$790 (\$395 per year). This increase was needed to replenish the Medical Board's depleted reserves and to fund general cost increases and additional Investigator and HQES Attorney positions in support of implementation of the VE Pilot Project (see Section D). By May 1 of each year, the Medical Board is required to set the fee for the next subsequent fiscal year, subject to the ceiling set in statute. The fee is required to be sufficient to recover actual costs of operating the Medical Board's Licensing Program as projected for the fiscal year commencing on the date that the fees become effective. Initially, provisions were included in the statutes stating that it was the intent of the Legislature that the Medical Board also maintain a reserve fund equal to two months' operating expenditures.

In conjunction with the 2006 fee increase, the statutory provisions governing the reimbursement of investigative and enforcement costs, by licensees subject to disciplinary action by the Medical Board (cost recovery), were repealed. Subject to several limiting provisions set forth in statute, the maximum initial and biennial licensee fees may be increased above the current \$790 ceiling to recover the difference, if any, between (1) the average amount of reimbursements (cost recovery) paid for investigation and enforcement costs during the three fiscal years preceding July 1, 2006, and (2) any increase in investigation and enforcement costs incurred following July 1, 2006, as compared to average costs during the three fiscal years preceding July 1, 2006. The purpose for incorporating these provisions was to enable the Medical Board to potentially recover some of the increased costs of investigation and enforcement that would otherwise have been paid by licensees subject to disciplinary action if the provisions governing cost recovery had not been repealed.

During 2007, initial and biennial renewal fees were increased by \$15 to \$805. Then, following termination of the Diversion Program, these fees were reduced by \$22 to \$783. Additionally, during 2010/11, some licensees will receive a \$22 renewal credit reflecting their prior over-payment of Diversion Program costs when they renewed their license during 2008/09.

Exhibit II-1, on the next page, delineates actual personal services and operating expenditures by year for the past five (5) years, and projected expenditures for 2009/10. As shown by Exhibit II-1, total expenditures peaked at a level of about \$49.5 million during 2007/08, and then declined by \$1.75 million (4 percent) during 2008/09. The recent decrease in expenditures was due to (1) a decrease in salaries and benefits paid to Medical Board staff, (2) reductions in major and minor equipment purchases, and (3) decreases in general

Historical and Budgeted Medical Board Expenditures

Personal Service and Operating Expenditures		Actual					2009/10 Budget ³
		2004/05	2005/06	2006/07 ¹	2007/08	2008/09 ²	
Personal Services	Salaries/Wages, Including Fitness Incentive Pay	\$12,688	\$12,647	\$13,253	\$13,527	\$13,425	\$13,336
	Staff Benefits	5,620	4,719	5,067	5,340	5,327	6,005
	Temporary Help (Medical Consultants, Retired Annuitants, and Student Assistants)	1,154	1,143	1,270	1,742	1,321	1,144
	Board Members	33	32	34	24	24	31
	Overtime (Primarily for the Licensing Program)	21	31	77	86	196	12
	DEC	21	32	27	22	0	0
	Salary Savings	0	0	0	0	0	(836)
	Total Personal Services Expenses	\$19,537	\$18,604	\$19,728	\$20,741	\$20,293	\$19,692
General Expenses	Printing, Communications, and Postage	\$1,413	\$1,050	\$1,121	\$1,350	\$1,475	\$1,603
	General Expense, Minor Equipment, and Insurance	535	626	716	928	721	472
	Travel	291	314	380	403	379	397
	Vehicle Operation/Other Items	273	269	350	446	300	262
	Training	57	45	79	74	89	66
		Total General Expenses	\$2,569	\$2,304	\$2,646	\$3,201	\$2,964
	Facilities Operation (Rent)	\$1,851	\$1,963	\$2,814	\$2,235	\$2,173	\$2,702
	Professional Services	\$605	\$788	\$1,397	\$1,386	\$870	\$983
	Fingerprint Reports	\$358	\$382	\$380	\$334	\$332	\$492
	Major Equipment (Items greater than \$5,000)	\$295	\$370	\$375	\$192	(\$9)	\$333
Legal Services	Attorney General Services	\$8,292	\$8,596	\$11,247	\$12,316	\$11,881	\$13,347
	Evidence/Witness Fees	1,563	1,367	1,215	1,391	1,519	1,893
	Office of Administrative Hearings	1,248	915	1,200	1,344	1,099	1,863
	Court Reporter Services	69	113	143	158	128	175
		Total Legal Services	\$11,172	\$10,991	\$13,805	\$15,209	\$14,627
Allocated Administrative & Data Processing	Department Prorata	\$3,296	\$3,395	\$3,670	\$3,906	\$3,671	\$3,882
	Statewide Prorata	1,185	1,315	1,376	1,794	2,323	1,699
	Consolidated Data Center (Teale)	304	293	238	259	300	647
	Data Processing	289	321	128	232	224	125
		Total Administrative and Data Processing Services	\$5,074	\$5,324	\$5,412	\$6,191	\$6,518
Other Expenses	DOI Investigations	\$0	\$0	\$0	\$2	\$0	\$0
	State Controller's Office (Including 21st Century Project)	0	0	0	38	2	0
	Special Adjustment	(24)	0	0	(1)	10	0
	Court-Ordered and Tort Payments	7	2	13	3	0	0
		Total Miscellaneous Expenses	(\$17)	\$2	\$13	\$42	\$12
	Total Operating Expenses	\$21,907	\$22,124	\$26,842	\$28,790	\$27,487	\$30,941
	Total Personal Services and Operating Expenses	\$41,444	\$40,728	\$46,570	\$49,531	\$47,780	\$50,633

¹ In 2006/07, authorized staffing levels increased by 12.50 positions (2.0 Diversion Program, 4.0 Investigators, 4.0 Investigative Assistants, 2.0 Information System Analysts, and 0.5 Staff Services Analyst).

² In 2008/09, authorized staffing levels decreased by 12.40 positions due to termination of the Diversion Program.

³ The 2009/10 budget incorporates cost-savings related to the Furlough Friday Program and includes unfunded allocations for six (6) new Operation Safe Medicine positions (**\$500,000**), four (4) new Probation Program positions (**\$300,000**), and contracts for Telemedicine (\$399,734 for the first year), an evaluation of Medical Board programs (\$159,300), and an analysis of Licensing Program business processes (\$40,350).

II. Overview of the Evolution of the Medical Board’s Governance Structure, Licensing Fees, and Enforcement Program

administrative and operating expenses, including reduced expenditures for professional services and lower costs for support services provided by the Department of Consumer Affairs (DCA). These expenditure reductions resulted primarily from spending controls implemented during 2008/09 in response to the State’s General Fund fiscal crisis. Additionally, charges during 2008/09 for legal services provided by the Attorney General and OAH were more than \$600,000 lower than the amounts charged during the prior fiscal year.

Over the 5-year period from 2004/05 through 2008/09, total expenditures increased by about \$6.3 million (15 percent). **Table II-1**, below, shows the primary categories of expense that contributed to these increased costs. As shown by Table II-1, costs for legal services provided by the Attorney General increased significantly on both an absolute and percentage basis, and accounted for more than one-half of the total increase in expenditures during this period. In contrast, costs for services provided by OAH fluctuated between \$0.9 million and \$1.4 million during this same period, and the most recent year’s costs for OAH services were about average for the period (\$1.1 million). The increased costs for Attorney General services reflect the combined impacts of rate increases during this period and the authorization of 10 additional Attorney positions to support implementation of Vertical Enforcement.

Table II-1. Expenditure Increases - 2004/05 through 2008/09

Category	Amount	Percent Increase
Attorney General Services	\$3.6 million	43%
State Prorata	\$1.1 million	96%
Personal Services	\$0.8 million	4%
Department Prorata	\$0.4 million	11%
Facilities (Rent)	\$0.3 million	17%
Total	\$6.2 million	18%

During 2007, the Bureau of State Audits (BSA) completed a statutorily mandated review of the Medical Board’s fund condition. The BSA determined that the Medical Board consistently exceeded the two-month reserve ceiling set forth in statute, and recommended that the Medical Board reduce its fees. No changes were made to these fees in the following years. However, during 2009 the provisions governing the fund reserve were modified, effective January 1, 2010, to enable the Medical Board to maintain a level of reserves equal to between two (2) and four (4) months operating expenditures (AB 501, Emmerson). Additionally, AB 501 requires the Office of State Audits, within the Department of Finance, to complete another review of the Medical Board’s revenues, expenses, and reserves (by June 1, 2012). Costs of this review are required to be funded from existing resources.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

C. Complaint Intake and Screening

During the 1980s complaint intake and screening were handled by a handful of Customer Service Representatives (CSRs) dispersed across regional offices in Sacramento, San Francisco, Los Angeles, and San Bernardino/San Diego. Each regional office also had 1 to 2 full-time Medical Consultants who assisted the CSRs in determining which complaints should be referred for field investigation. During this period the Medical Board received fewer than 5,000 complaints per year, of which about one-half involved negligence/competency (quality of care) issues. About one-half of complaints received were referred to the District offices for investigation. Complaints that were not referred for investigation were referred to other agencies, mediated and closed, or closed based on a determination that no violation of governing statutes or regulations was involved (e.g., billing disputes).

During the early-1990s the Medical Board consolidated responsibility for complaint intake and screening in the Sacramento Headquarters Central Complaint Unit (CCU). Since that time the number of positions authorized for the CCU has grown. The CCU is currently authorized 24 positions, including two (2) supervisors and 22 subordinate Associate Government Program Analysts (AGPAs), Staff Services Analysts (SSAs), Management Services Technicians (MSTs), and Office Technicians (OTs). About two-thirds of CCU staff are classified at the SSA or AGPA levels, which are higher classification levels than their predecessor CSR positions (i.e., the top step salary of an SSA is 7 percent above the top step of a CSR, and the top step of an AGPA is 29 percent above the top step of a CSR).

In the early-2000s CCU was reorganized into two specialized sections based on the type of complaint handled. CCU staffing levels changed little in subsequent years. Currently, each section is supervised by a Staff Services Manager I (SSM I) and subordinate staff are allocated about equally between the two sections.

Quality of Care Section (10 AGPA/SSA/MST positions) – The Quality of Care Section handles all quality of care (QC) complaints. Most staff are assigned to specific geographic regions of the State. One AGPA position has lead responsibility for identifying and selecting outside Medical Specialists to review complaints, where needed, and performs related case file transfer and tracking functions.

Physician Conduct Section (9 AGPA/SSA/MST positions) – The Physician Conduct (PC) Section handles all other categories of complaints involving physicians and surgeons, plus all AHLP complaints. Most staff are assigned specific categories or types of complaints (e.g., Section 805 reports, criminal arrest and conviction reports, complaints involving certain types of offenses, such as fraud, sexual misconduct, corporate practice, and advertising violations, and AHLP complaints). Staff are cross-trained to fill in for other staff when absences, vacation, or turnover occur.

Clerical support services for the CCU are provided by one (1) full-time and two (2) part-time OTs. Additionally, within the CCU, one (1) AGPA position is assigned responsibility for the Cite and Fine Program.

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In the early 1990s, Attorneys were assigned to work at the CCU on a part-time basis to assist in evaluating and screening complaints. During October 2003 the assignment of this position was formalized in response to legislative requirements enacted twelve (12) years earlier during 1991 (SB 2375, Presley).

Also during 2003, CCU began implementing a new Specialty Reviewer process pursuant to requirements set forth in SB 1950 (Figueroa). The Specialty Reviewer requirement was enacted to help reduce the number of complaints referred for Investigation, and related needs to conduct field investigations in cases where it might not be warranted. Prior to implementation of the Specialty Reviewer process, a physician not specializing in the Subject physician's case may have reviewed the complaint and, in some cases, were unable to make a preliminary determination regarding the merits of the complaint because they lacked knowledge of, and experience with, the medical specialty involved. In these circumstances the cases were referred for investigation where a more specialized medical professional would make a determination on the merits of the case as a part of the field investigation process. Pursuant to requirements established by SB 1950 (Section 2220.08 of the Business and Professions Code), before any quality of care complaint is referred for field investigation, it must be reviewed by "one or more medical experts with pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." The evaluation must include a review of relevant patient records, a statement or explanation of the care and treatment provided by the physician, expert testimony or literature provided by the subject physician, and any additional information requested by the reviewer that may assist in determining whether the care provided constitutes a departure from the standard of care. However, if this information is not provided to the Medical Board within ten (10) working days after its request, the complaint may be reviewed by the Expert Reviewer and referred to a District office for investigation without the information.

Including all complaints that are determined to be outside of the Medical Board's jurisdiction, CCU currently handles about 7,200 complaints per year involving physicians and surgeons, or about 50 percent more complaints than were handled during the 1980s. These complaints include about 1,000 mandated reports that are submitted to the Medical Board pursuant to statutory requirements that were not in effect prior to 1990. The number of complaints received by the Medical Board has grown modestly over time, but more slowly than the growth rate of the industry during this period (e.g., the number of licensed physicians and surgeons practicing in California grew by about 100 percent over the past 25 years). CCU now performs a much more rigorous review of complaints than was previously performed and, except for disputes involving the release of the patients records, does not attempt to mediate complaints. CCU currently refers fewer than 20 percent of complaints for investigation, including some high-priority complaints that are automatically referred for investigation with only limited screening (e.g., Section 805 reports), and either closes or refers complaints received within an average of 60 to 75 days, with some cases taking longer than six (6) months to close or refer for investigation.

For some types of cases CCU works collaboratively with the Discipline Coordination Unit (DCU). For example, CCU receives a significant number of reports of physician discipline from licensing boards in other states. Following intake by CCU, these cases are forwarded directly to DCU which reviews each case and, if needed, requests additional records. DCU may then close the case, prepare a

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

proposed settlement agreement with the licensee (referred to as a pre-filing stipulation), or refer the case to HQES' San Francisco office for prosecution. District offices are rarely involved with these cases, unless the licensee is practicing in California.

Exhibit II-2, on the next page, provides a statistical overview of complaints opened and dispositions from 2000/01 through 2008/09. Over the past eight (8) years, the numbers of complaints opened and referred for investigation or Prosecution have decreased, even after accounting for reductions due to changes in the reporting of (1) change of address citations, and (2) non-jurisdictional complaints identified during CCU's initial intake process. The reduction in number of complaints opened is attributable primarily to reductions in the number of:

- ❖ Medical malpractice reports received from insurers and licensed physicians
- ❖ Disciplinary action reports received from other states
- ❖ Complaints submitted by patients and others
- ❖ Complaints opened by Medical Board staff.

The reduction in number of complaints referred for investigation or prosecution is attributable primarily to:

- ❖ Reductions in the number of complaints received from external sources (e.g., fewer medical malpractice reports and disciplinary action reports from other states)
- ❖ Reductions in the number of Medical Board-originated complaints
- ❖ Improved screening of complaints following the 2003 implementation of the Specialty Reviewer requirement for quality of care complaints
- ❖ The accumulation of additional backlogs of pending complaints (e.g., from about 1,000 cases in June 2005 to more than 1,300 cases in June 2009).

The decrease in number of complaints opened has been only partially offset by recent increases in the number of criminal charge and conviction self-reports received by the Medical Board. The recent increase in this category of mandated reports is due to new requirements (SB 231, Figueroa) that licensees self-report misdemeanor convictions. This requirement became effective in January 2006. During 2008/09, 91 reports were received compared to only 16 reports received during 2005/06.

As shown by Exhibit II-2, during the early part of the decade the Medical Board closed or referred for investigation or prosecution significantly more complaints than were opened, and reduced the backlog of open complaints by 50 percent (from 2,000 open complaints to 1,000 open complaints). However, in recent years fewer complaints have been closed or referred for investigation or prosecution than

Overview of Complaints Opened and Dispositions - 2000/01 through 2008/09

Category of Complaints		2000/01 through 2002/03 (3-Year Avg.)	2003/04	2004/05 ¹	2005/06	2006/07	2007/08	2008/09 ²
Mandated Reports	Malpractice Reports from Insurers (Section 801 & 801.1)	888	787	722	726	676	597	605
	Malpractice Self-Reports (Section 801(c), 802, and 803.2)	328	228	212	185	187	150	204
	Malpractice Reports from Others (Section 803)	24	3	9	6	10	6	2
	Coroner Reports (Section 802.5)	32	18	23	11	22	16	16
	Health Care Facility Reports (Section 805)	146	157	110	138	127	138	122
	Surgical Death/Complication Self-Reports (Section 2240(a))	8	14	11	2	10	7	6
	Criminal Charge and Conviction Self-Reports (Section 802.1 and 803.5)	33	33	20	16	29	76	91
Total Mandated Reports	1,459	1,240	1,107	1,084	1,061	990	1,046	
Disciplinary Action Reports Submitted by Other States (IDENT 16)		323	371	448	385	279	288	258
Medical Board Originated Complaints with District Office Identifiers		286	212	202	216	216	161	113
Medical Board Originated Complaints with Headquarters Identifier ^{1 3} (IDENT 20, Excluding Petitions)		375	377	281	133	31	65	102
Medical Board Originated Complaints with CME Audit Failure Identifier (IDENT 21)		66	0	0	1	140	75	0
Medical Board Originated Complaints with Probationer Identifiers (IDENT 19)		6	13	22	23	9	11	34
Medical Board Originated Complaints with Other Identifiers ⁴ (IDENTs 22, 23, and 25)		32	12	7	9	10	6	10
Petitions for Modification or Termination of Probation (IDENT 26)		29	37	42	50	47	37	40
Petitions for Reinstatement (IDENT 27)		14	25	19	13	21	9	18
Other Complaints and Reports ^{1 2} Includes NPDB (26 in 2008/09)		5,968	5,953	5,375	5,749	5,445	5,197	4,821
Total Complaints and Other Matters Opened^{1 2}		8,558	8,240	7,503	7,663	7,259	6,839	6,442
Complaints and Other Matters Closed		5,967	6,837	6,603	6,349	6,105	5,608	5,303
Complaints and Other Matters Referred for Investigation or Prosecution ^{1 3} Incl. PLRs (31 in 2008/09)		2,355	1,887	1,443	1,331	1,182	1,133	1,123
Total Complaints and Other Matters Closed or Referred for Investigation or Prosecution^{1 2 3}		8,322	8,724	8,046	7,680	7,287	6,741	6,426
Percent of Cases Referred for Investigation or Prosecution^{1 3}		28%	22%	18%	17%	16%	17%	17%
Reported Average Days to Close or Refer Cases for Investigation or Prosecution ^{1 2 3}		55 Days	76 Days	66 Days	54 Days	54 Days	61 Days	75 Days
Reported Open Complaints and Petitions (End of Period)		2,019	1,566	1,011	1,086	1,133	1,283	1,323

¹ Effective in January 2005, change of address citations were no longer counted as complaints or investigations.

² Effective in 2008/09, some complaints received and determined by CCU to be outside of the Medical Board's jurisdiction were no longer counted as received or closed, thereby increasing the CCU's reported average elapsed time to process complaints.

³ Includes probationary license certificates, SOIs, and criminal conviction notification, advertising violation, and cite and fine non-compliance cases. Also includes change of address citation cases (through December 2004),

⁴ Includes Operation Safe Medicine, Internet Crimes Unit, and probation violation citation cases.

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have been opened. This has resulted in continuous increases in the number of pending complaints. At the end of 2008/09 there were 1,323 pending complaints. This is 300 (30 percent) more pending complaints than existed at the end of 2004/05. Inevitably, the growing number of open complaints will soon translate into longer average processing times, particularly given the continuation of the Furlough Friday Program through June 2010. Ultimately, over a period of several years, these complaint-handling delays will adversely impact aggregate Enforcement Program performance measures (e.g., total elapsed time from receipt of complaint to disciplinary outcome).

Since 2004/05, the number of complaints closed, adjusted for recent changes in the reporting of change of address citations and non-jurisdictional complaints, decreased by about 10 percent. Concurrently, the number of complaints referred for investigation or prosecution decreased by about 15 percent, after adjustment for changes in the reporting of change of address citation cases. During the past two (2) years an average of 1,128 complaints was referred for investigation or prosecution – about 200 fewer complaints than were referred during 2004/05, after adjustment for changes in the reporting of change of address citations. Over the past five (5) years, the Medical Board has consistently closed about 83 to 84 percent of all complaints, and referred the remaining 16 to 17 percent for investigation or prosecution.

From 2004/05 through 2007/08, the Medical Board maintained an average processing timeframe for all complaints of about two (2) months (60 days). The recent increase in the average complaint processing time to 75 days in 2008/09 is partially attributable to elimination of about 800 non-jurisdictional complaints from the calculation of this performance measure.

Finally, Exhibit II-2 shows that, in recent years, fewer complaints have been closed or referred each year than have been opened. This has resulted in continuous increases in the number of pending complaints. At the end of 2008/09 there were 1,323 pending complaints. This is 300 (30 percent) more pending complaints than existed at the end of 2004/05. Recent increases in the number of pending complaints are correlated with increases in the average time to close or refer cases for Investigation or Prosecution.

Exhibit II-3, on the next page, provides an overview of 2008/09 complaints received and dispositions by referral source. As shown by Exhibit II-3, complaints received from patients, patient advocates, family members, and friends account for the largest share of complaints received (58 percent). However, fewer than 10 percent of these complaints are referred for investigation. During 2008/09, 81 cases from these sources were referred for prosecution, representing 2 percent of complaints received from these sources. Even though only a small proportion of these cases are investigated and subsequently referred for prosecution, cases from these referral sources still account for more than 30 percent all cases referred for investigation and a comparable proportion of cases referred for prosecution (excluding Out-of-State and Medical Board-originated cases).

Overview of 2008/09 Complaint Handling and Dispositions by Referral Source

Referral Source	Quality of Care Complaints and Reports										Other Types of Cases										Total						
	CCU and Other HQ Business Units					Closed by Investigation					Referred for Prosecution (HQES or DA)	Total INV Closures and Legal Referrals	CCU and Other HQ Business Units					Closed by Investigation					Referred for Prosecution (HQES or DA)	Total INV Closures and Legal Referrals			
	Received	Reviewed by Medical Consultant	Closed	Referred to Investigation									Received	Reviewed by Medical Consultant	Closed	Referred to Investigation									Received	Reviewed by Medical Consultant	Closed
				No.	%	No Cite	Cite	No.	%	No Cite	Cite	HQES				DA ⁷											
Patient, Patient Advocate, Family Member or Friend (including 801.01(E) Reports)	2,075	1,165	1,810	247	12%	130	10	58	1	199	1,681	52	1,567	75	5%	59	3	18	4	84	3,756	1,217	3,377	322	202	81	2%
Insurance Companies and Employers (including 801.01(B&C) and NPDB Reports)	597	428	468	105	18%	92	7	27	0	126	14	1	11	3	21%	4	0	2	0	6	611	429	479	108	103	29	5%
Health Facilities (805 and Non-805 Reports)	82	0	4	80	95%	40	3	28	0	71	49	0	22	23	51%	12	2	10	0	24	131	0	26	103	57	38	29%
California Department of Health Services (or Successor State Agency)	38	17	19	14	42%	9	1	6	0	16	22	4	12	7	37%	7	1	1	0	9	60	21	31	21	18	7	12%
M.D., Pharmacist, Allied Health or Healing Arts Licensee, or Medical Society or Association	52	27	32	26	45%	14	0	6	1	21	235	10	216	31	13%	20	1	3	1	25	287	37	248	57	35	11	4%
CII - Department of Justice, Criminal Identification and Information Bureau	0	0	0	0	NMF	0	0	0	0	0	186	0	166	45	21%	19	1	25	0	45	186	0	166	45	20	25	13%
Other Governmental Agencies, Including FDA, DEA, Other DCA Boards and Bureaus, and 801 Reports	51	32	37	20	35%	10	0	2	0	12	42	0	40	9	18%	9	1	11	0	21	93	32	77	29	20	13	14%
Other ¹	71	16	46	25	35%	11	1	7	0	19	286	9	252	53	17%	29	0	11	3	43	357	25	298	78	41	21	6%
Police/Sheriff Department, Coroner's Office, District Attorney, and Courts (803 Reports, Criminal Filings, Non-Felony and Felony Conviction Reports)	32	10	23	16	41%	9	0	3	0	12	35	1	10	16	62%	7	2	6	0	15	67	11	33	32	18	9	13%
Licensee Self-Reporting (2240(A), 801.01, 802.01, 802.1, and Misdemeanor Conviction Reports)	204	149	141	35	20%	22	1	6	0	29	85	1	77	7	8%	4	1	1	0	6	289	150	218	42	28	7	2%
California Attorney General and Department of Justice, Including Medi-Cal Fraud and Narcotics Enforcement Bureaus	6	0	1	1	50%	1	0	1	0	2	24	0	27	1	4%	1	0	1	0	2	30	0	28	2	2	2	7%
Total, Excluding Out of State and Medical Board Cases	3,208	1,844	2,581	569	18%	338	23	144	2	507	2,659	78	2,400	270	10%	171	12	89	8	280	5,867	1,922	4,981	839	544	243	4%
Out of State Medical/Osteopathic Boards ² (IDENT 16)	21	0	0	0	NMF	N/A	0	20	0	20	237	0	161	1	1%	2	0	69	0	71	258	0	161	1	2	89	34%
Medical Board Cases with District Identifiers (IDENTs 2 to 18, except 16)	47	10	19	31	62%	19	0	16	2	37	66	0	40	35	47%	31	0	12	4	47	113	10	59	66	50	34	30%
Medical Board Cases with Probationer Identifier (IDENT 19)	2	0	1	1	50%	3	0	0	0	3	32	0	1	24	96%	12	0	19	0	31	34	0	2	25	15	19	56%
Medical Board Cases with Other Identifiers ³ (IDENTs 20 to 25)	4	2	2	2	50%	1	2	0	0	3	108	0	74	6	8%	2	2	46	1	51	112	2	76	8	7	47	42%
Petitions for Reinstatement or Modification or Termination of Probation ⁴ (IDENTs 26 and 27)	0	0	0	0	NMF	0	0	0	0	0	58	0	0	58	100%	2	0	37	0	39	58	0	0	58	2	37	64%
Total, Including Out of State and Medical Board Cases	3,282	1,856	2,603	603	19%	361	25	180	4	570	3,160	78	2,676	394	13%	220	14	272	13	519	6,442	1,934	5,279	997	620	469	7%

¹ Includes CA Medical Review Inc., 803.6, 364.1, and NPDB Reports, Jury Verdict Weekly, HEAL, MQRC District, WE Tip, Consumer or Industry Group, Employee, Co-worker, Witness, Informant, Anonymous, and Unknown.

² Out-of-State cases are researched by the Discipline Coordination Unit (DCU) and, where appropriate, referred directly to HQES. Cases are only assigned to District offices when the licensee is practicing in California.

³ Includes Probationary License Certificates, SOIs, and CME Audit Failure, Advertising Violation, Citation Non-Compliance, Operation Safe Medicine (OSM) and Internet Crimes Unit cases. These matters are nearly always directly referred for prosecution by the originating Headquarters Unit without any District office involvement.

⁴ Petitions are initially handled by the Discipline Coordination Unit (DCU) which forwards the petition and supporting documentation to the District offices. The District offices complete required background research, interview the Petitioner and their references, prepare a Report of Investigation summarizing results of their review, and then forward the completed case to HQES.

⁵ Includes 31 Pre-Filing Public Letter of Reprimand (PLR) cases not actually referred to HQES (Patient = 1, Insurer = 4, MD = 1, Licensee Self-Report = 1, and Out of State = 24).

⁶ Excludes ten (10) dual referrals.

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Exhibit II-3 also shows the flow of cases through the complaint intake/screening and investigation process for more than a dozen other major categories of complaints, including the following three (3) categories which account for nearly 40 percent of cases referred for prosecution (excluding Out-of-State and Medical Board-originated cases):

Medical Malpractice Reports – Medical malpractice reports represent nearly 10 percent of opened complaints. By definition, almost all of these cases involve quality of care issues. About 20 percent of these cases are referred for investigation and about 30 percent of the cases referred for investigation are referred for prosecution. While only about 5 percent of these cases are referred for prosecution, medical malpractice reports nonetheless account for more than 10 percent of cases referred for prosecution (excluding Out-of-State and Medical Board-originated cases).

Section 805 Reports – Section 805 Reports may, or may not, involve quality of care issues (60 percent are quality of care cases). While Section 805 cases represent only about 2 percent of opened complaints, most of the cases (including nearly all quality of care cases) are referred for investigation. More than 60 percent of the cases referred for investigation are referred for prosecution. Section 805 cases account for about 15 percent of cases referred for prosecution (excluding Out-of-State and Medical Board-originated cases).

Criminal Arrest and Conviction Reports – Complaints opened based on criminal arrest and conviction reports, submitted by the Department of Justice, represent only about 3 percent of opened complaints. By definition, none of these cases involve quality of care issues. About 20 percent of the cases are referred for investigation. More than 50 percent of the cases referred for investigation are referred for prosecution. These cases account for about 10 percent of cases referred for prosecution (excluding Out-of-State and Medical Board-originated cases).

Disciplinary action reports from medical/osteopathic boards in other states (referred to as Out-of-State cases) also account for significant numbers of complaints opened. Additionally, these cases, which are rarely referred for investigation, represent the largest category of complaints referred for prosecution (89 of 469 total cases referred for prosecution, including 24 cases settled with a pre-filing public letter of reprimand (PLR) and, hence, not actually referred for prosecution). Even if PLRs are excluded, Out-of-State cases still account for a large number and a high percent of cases referred for prosecution (65 cases and 15 percent of total referrals, respectively).

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Finally, Exhibit II-3 shows that Medical Board-originated cases account for about 29 percent of all cases referred for prosecution (137 of 469 cases referred for prosecution). Most Medical Board-originated cases do not involve quality of care issues. Most of these cases involve:

- ❖ Probationary License Certificates (issued to new licensees in lieu of full licensure)
- ❖ Statements of Issues (SOIs)
- ❖ Citation non-compliance
- ❖ Probation violations
- ❖ CME audit failures
- ❖ Petitions for Modification/Termination of Probation
- ❖ Petitions for Reinstatement
- ❖ Operation Safe Medicine cases
- ❖ Internet Crimes Unit cases.

Except to open the complaint records in CAS, these cases are not usually handled by CCU and, because of the nature of the matters, these cases are much more likely to be referred for prosecution (or hearing in the case of SOIs and petitions) than complaints received from the public and other external referral sources.

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D. Investigations and Prosecutions

This section summarizes major legislative and other changes impacting the Medical Board's investigation and prosecution processes over the past 30 years. These efforts include several major comprehensive reform initiatives and numerous targeted changes and improvements. **Over the past three (3) decades the number of cases referred for investigation decreased, but the number of cases resulting in disciplinary action increased.** However, concerns have been raised nearly continuously throughout this period about the extended timeframes needed to complete investigations and prosecutions. Additionally, during the past several years the number of cases referred for investigation, the number of investigations completed, the number of cases referred for prosecution, and the number of disciplinary actions all decreased.

1. 1980 to 1990

Throughout the 1980s a series of reports by the Office of the Auditor General, the Assembly Office of Research, the Legislative Analyst's Office (LAO), the Little Hoover Commission, and the Center for Public Interest Law (CPIL) documented significant deficiencies with the BMQA's Enforcement Program. Identified deficiencies included a highly fragmented organizational structure, large case backlogs at all stages of processing, and minimal disciplinary actions. To address these deficiencies, during 1989/90 an additional 28 Investigator positions were authorized for the Enforcement Program (18 permanent positions and 10 limited-term positions).

During 1990 adverse publicity regarding the Medical Board's Enforcement program, and new reports from the LAO and the U.S. Department of Health and Human Services highlighting continuing Enforcement program deficiencies, prompted support for adoption of a new physician discipline system. The *Medical Judicial Procedures Improvement Act* (SB 2375, Presley), which was signed into law during September 1990, restructured the Medical Board's Enforcement Program by:

- ✓ Creating a new Health Quality Enforcement Section (HQES) within the Attorney General's Office, organizationally separate from the Licensing Section, with specialized responsibility for prosecuting medical disciplinary cases generated by the Medical Board and AHLPS. The statutes required the HQES Chief to:
 - “. . . assign attorneys to assist [the Division of Medical Quality] in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit . . . , to assist in evaluating and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.”
- ✓ Creating a new Medical Quality Hearing Panel (MQHP), a specialized panel of Administrative Law Judges (ALJs) within the Office of Administrative Hearings (OAH) to hear medical discipline cases

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- ✓ Shifting DMQ's primary focus from rehabilitating physicians to consumer protection.
- ✓ Enabling the Division of Medical Quality (DMQ) to seek Interim Suspension Orders (ISOs) to halt the practice of dangerous physicians
- ✓ Requiring DMQ to establish a goal, by January 1, 1992, of allowing not more than six (6) months to elapse from receipt of a complaint to completion of the investigation, or one (1) year in the case of specified complex complaints
- ✓ Providing absolute immunity from civil liability for physicians who serve as Expert Reviewers and Expert Witnesses to the Medical Board in disciplinary proceedings (Section 43.8 of the Civil Code)
- ✓ Providing fast track superior court judicial review of DMQ disciplinary decisions
- ✓ Extending the time between license revocation and filing of a petition for reinstatement from one (1) to three (3) years.

Additionally, SB 2375 introduced new mandatory reporting requirements, including requirements that (1) coroners report when they suspect a physician's gross negligence is a cause of death (Section 802.5 of the Business and Professions Code), (2) local prosecutors report the filing of felony charges against physicians (Sections 803.5 and 803.6 of the Business and Professions Code), (3) court clerks transmit conviction records and preliminary hearing transcripts, and (4) probation officers transmit certain probation reports on physicians

Initially, 22 Deputy Attorney General (DAG) positions were assigned to HQES and a goal was established to file all accusations within 60 days of receipt of a completed investigation. However, HQES determined that it was severely understaffed and, as a result, could not place Prosecutors on-site at the Medical Board's offices to assist Medical Board staff with complaint handling and investigations. Concurrently, the Director of the OAH appointed all of the OAH's ALJs to the new MQHP, thereby effectively defeating the intent of the statute to develop a specialized pool of ALJs within the OAH.

2. 1991 to 2000

During 1991 the Auditor General completed a review of the Medical Board which found that investigations were taking an average of fourteen (14) months to complete, substantially longer than the 6-month goal set forth in statute, that HQES took more than six (6) months to file an accusation in a fully investigated case, significantly exceeding its own 60-day goal, and that, for cases that proceeded to hearing, another nine (9) months elapsed from filing of the accusation to completion of the hearing. Subsequently, in an effort to address excessive caseloads at HQES (up to 30 cases per position) and extended

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timeframes to file accusations, during 1992 and 1993 the Medical Board provided funding for 22 additional HQES Attorney positions (44 total Attorney positions).

During the early-1990s the Medical Board, HQES, and OAH continued to be the subject of adverse publicity and criticism by the media and outside agencies charged with reviewing its Enforcement Program. During 1993 a second major Enforcement Program reform bill was enacted (SB 916, Presley). SB 916, which was signed into law during October 1993, made the following significant changes to the Medical Board's Enforcement Program:

- ❖ Abolished the DAHP, transferred its members to the DMQ, and divided the DMQ into two panels for purposes of reviewing stipulations and proposed decisions
- ❖ Limited the number of ALJs that the Director of OAH could appoint to the MQHPs (a maximum of 25 percent of all OAH Hearing Officers)
- ❖ Abolished the MQRCs
- ❖ Eliminated Superior Court judicial review of DMQ decisions and, instead, provided for review of DMQ decisions through a Writ of Mandate to a Court of Appeal (subsequently modified prior to enactment (SB 609, Rosenthal) to preserve Superior Court review, but enable appeal of Superior Court decisions by a Petition of Extraordinary Writ)
- ❖ Authorized the DMQ to establish panels or lists of experts to assist in administering the Enforcement Program
- ❖ Enhanced Investigators' authority to obtain medical records, and enabled imposition of fines up to \$1,000 per day for refusal to comply with the Medical Board's record requests
- ❖ Authorized issuance of public letters of reprimand (PLR) for minor violations in lieu of filing an Accusation
- ❖ Authorized the Director of DCA to audit and review inquires and complaints regarding Medical Board licensees at the request of a consumer or licensee
- ❖ Codified the Medical Board's public disclosure policy
- ❖ Required the State Auditor to audit the Medical Board's Enforcement Program, including services provided by the HQES and the OAH (by March 1, 1995)
- ❖ Increased initial and biennial renewal fees to \$600 (\$300 per year).

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

During 1994 the Medical Board restructured its Medical Consultant workforce by (1) replacing its full-time Chief Medical Consultant position with a position (or positions) that would report directly to the governing Board, and (2) abolishing all full-time Medical Consultant positions, most of whom were no longer actively in practice, and replacing them with a larger number of part-time positions who would continue to be active practitioners. The Medical Board also adopted (1) a set of minimum qualifications for Expert Reviewers, and (2) regulations for issuing citations and imposing fines for minor violations.

Throughout the mid- and late-1990s the Medical Board continued to experience chronic delays in completing Investigations, and also in filing accusations after the Investigations were completed. During this period the number of complaints received increased to nearly 8,000 complaints per year, of which about 25 percent were referred for investigation (2,000 per year). Investigator caseloads, which sometimes averaged as many as 25 to 30 cases per position, were considered excessive. During this period it continued to take the Medical Board longer than a full year, on average, to complete investigations. No increases in Medical Board staffing were authorized throughout this period.

During 1997 the Deputy in District Office (DIDO) Program was introduced whereby a DAG from HQES worked at each District office one to two days per week to provide prosecutorial guidance during investigations. By this time HQES had reduced the average timeframe to file accusations to about five (5) months. The DIDO Program was not always consistently implemented at all District offices.

During 1998 legislation was enacted that established a statute of limitations on the timeframe available to the Medical Board to complete Investigations (AB 2719, Gallegos). AB 2719 required that accusations be filed within three (3) years of discovery of the act, or within seven (7) years of the act, whichever occurs first. These changes resulted in legal challenges to a number of investigations that had been pending at the Medical Board for periods exceeding these limitations. As a result of these limitations, investigations are now always either closed or referred for prosecution within a maximum of three (3) years of receipt of the initiating complaint. This requirement also effectively caps the maximum time that an investigation can remain open, irrespective of whether the investigation is actually completed.

3. 2001 to 2005

During 2001 the Medical Board created two proactive enforcement units; the Operation Safe Medicine (OSM) and Internet Crimes Units. OSM was structured as a small team of Investigators and support staff focusing on the unlicensed practice of medicine, particularly in at-risk communities. The Internet Crimes Unit, which typically consisted of just one (1) or two (2) Investigators, targeted Internet activities, such as misleading advertising, prescribing drugs without an examination, and narcotics trafficking. Both units were expected to work collaboratively with other state, local, and federal law enforcement agencies and prosecutors.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

Chronic delays in investigating complaints continued to plague the Enforcement Program after the turn of the century. These delays prompted another wave of adverse publicity during 2002 and a series of related hearings by the Joint Legislative Sunset Review Committee. Subsequently, during September 2002, SB 1950 (Figueroa) was signed into law to address the Medical Board's Enforcement Program deficiencies. Major changes made by SB 1950 involving investigations and prosecutions included:

- ✓ A delineation of five types of "priority" cases that were seen as representing the greatest threat of harm to the public and, therefore, should be investigated and prosecuted on an expedited basis by the Medical Board and HQES
- ✓ Requirements that an ALJ that finds a physician has engaged in multiple acts of sexual exploitation to include an Order of Revocation with their PD
- ✓ Definition of the basis for imposing discipline for "repeated negligent acts"
- ✓ Authorization of the appointment of an independent "Enforcement Monitor" by the Director of DCA to conduct a review of the Medical Board's Enforcement and Diversion Programs.

Pursuant to requirements of SB 1950, during August 2003 the Director of DCA appointed CPIL to serve as the Medical Board's Enforcement Monitor. In November 2004 CPIL issued an *Initial Report* that highlighted the extended timeframes and delays in the Investigation process (an average of more than 11 months from receipt of a complaint to completion of the Investigation). Factors cited by CPIL as contributing to the extended timeframes needed to complete investigations included:

- ❖ The complexity and difficulty of Medical Board cases, including changes in the composition of cases referred for Investigation due to improved screening of complaints by CCU and challenges posed in meeting the applicable burden of proof which requires "clear and convincing proof to a reasonable certainty"
- ❖ The loss of 19 Investigator positions between 2000 and 2004
- ❖ Outdated procedures manuals, insufficient Investigator training, and inadequate or inconvenient Investigator access to law enforcement databases and commercial applications
- ❖ Investigator recruitment and retention problems attributed to the lower pay and benefits of Medical Board Investigators compared to the pay and benefits available at competing agencies, such as the Department of Justice
- ❖ Chronic delays in obtaining Medical Records and in scheduling and completing Subject interviews

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

- ❖ A 15 percent reduction in Medical Consultant hours imposed during 2003/04, insufficient training of Medical Consultants, inadequate monitoring and management of Medical Consultant performance, and delays throughout the process associated with the limited availability of Medical Consultant resources (e.g., medical record reviews, Subject interviews, Expert Reviewer identification and selection, and Expert package preparation)
- ❖ Reductions in the availability of Medical Experts due to insufficient outreach by Medical Consultants and the increased use of Medical Experts by CCU, the limited availability of Medical Experts in highly specialized fields, insufficient training of Medical Experts, and Medical Expert Program management deficiencies
- ❖ Increased use of defense counsel by physicians
- ❖ Inadequate communication, coordination, and teamwork between the Medical Board's Investigators and HQES Prosecutors, and an inability of HQES to provide DIDO Attorneys to some District offices and assist CCU with incoming complaint reviews
- ❖ Inadequate communication and coordination with other State and local law enforcement agencies.

Notwithstanding the above problems, CPIL noted that Medical Board Investigators had closed more cases than opened during the past several years (e.g., 2,117 cases closed during 2003/04 compared to 1,887 opened), and were carrying record low caseloads (about 18 cases per position).

CPIL also highlighted the extended timeframes for HQES to file accusations (an average of 2 to 3 months, depending on whether Medical Board or HQES statistical data are used), and the extended total elapsed time to reach a disciplinary outcome (an average of 2.6 years from receipt of a complaint to final disposition for cases where a disciplinary outcome was reached). Factors cited by CPIL as contributing to the extended timeframes to complete prosecutions included:

- ❖ Insufficient HQES staffing due to the loss of six (6) Attorney positions
- ❖ Insufficient coordination and teamwork with Medical Board Investigators
- ❖ Case tracking and management information system deficiencies
- ❖ Inconsistent policies and procedures and the absence of a standard policies and procedures manual
- ❖ Statutory requirements that hearings be held in locations where the HQES and OAH did not have offices.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

To address deficiencies identified with the investigation and prosecution processes, CPIL presented an integrated set of recommendations. CPIL's recommendations included:

- ✓ Implementation of a Vertical Prosecution Model, now commonly referred to as Vertical Enforcement (VE), in which the trial Attorney and Investigator would be assigned as the team to handle a complex case upon referral for investigation
- ✓ Restoration of the 19 Investigator positions lost during the past several years, plus 10 other Enforcement Program positions, resumption of the OSM and Internet Crimes Units, and formation of two (2) regional rapid response teams to handle major cases of unusual complexity and emergency matters
- ✓ Restoration of the six (6) lost HQES Attorney positions and provision of additional assistance by HQES to the CCU
- ✓ Better and more extensive use of Interim Suspension Orders (ISOs) and Temporary Restraining Orders (TROs)
- ✓ Stricter and more consistent enforcement of a comprehensive medical records procurement policy
- ✓ Development and enforcement of a consistent policy on physician interviews
- ✓ Improved cooperation with other State and local prosecutors by both the Medical Board and HQES
- ✓ Expansion and improvement of the Medical Consultant Program, including a restoration of the 15 percent reduction to budgeted Medical Consultant hours, improved training of Medical Consultants, and greater Medical Consultant involvement in training Expert Reviewers
- ✓ Increased pay levels and improved training for Expert Reviewers
- ✓ Improved training for Investigators and improved Investigator access to law enforcement databases and commercial applications
- ✓ Development of a policy and procedures manual for HQES Attorneys
- ✓ Modification of the statutes governing the venue for Hearings to enable HQES to require that they be held at locations where HQES and OAH have offices.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

Exhibit II-4, on the next page, summarizes authorized Medical Board staffing levels for the 10-year period from 2000/01 through 2009/10 for the Executive and Administration, Licensing, and Enforcement Programs, excluding the Diversion Program which was terminated in 2008/09. As shown by Exhibit II-4, in 2000/01 the Medical Board was authorized a total of 300 positions, including 90 Investigator positions. During the next several years, as a result of the State's General Fund fiscal crisis, 48 positions were abolished (16 percent), including:

- ❖ 10.5 Executive and Administration positions (20 percent)
- ❖ 3 Licensing Program positions (8 percent)
- ❖ 34 Enforcement Program positions (17 percent).

Over the 4-year period from 2000/01 to 2003/04, authorized staffing levels for the Medical Board's Regional and District offices, excluding staffing for the Probation Program, were reduced by 30 positions (from 137 positions to 107 positions). The staffing reductions imposed on the District offices included elimination of 18 Investigator positions (from 77 positions to 59 positions), representing a 23 percent reduction in authorized Investigator positions. In response to these circumstances, the Medical Board disbanded the OSM and Internet Crime Units. As shown by Exhibit II-4, authorized staffing levels for the Enforcement Program, and throughout the Medical Board, remained at historically low levels through 2005/06.

4. 2005 to 2009

During 2005, SB 231 (Figueroa) was signed into law mandating implementation of Vertical Prosecution (or Enforcement). Section 12529.6(b) of the Government Code states:

" . . . 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".

There are several ambiguities in the construction of this statute. For example, it is somewhat ambiguous whether the Medical Board must accept the Attorney General's advice. It might be argued that the Investigator assigned to a case is prohibited from pursuing an investigation if the Attorney General directs that no further investigation occur. Alternatively, it might be argued that there is no requirement that the Medical Board follow the advice provided regarding the disposition of an investigation. There also is ambiguity regarding the expected level of involvement of the Attorney General in evidence

**Authorized Medical Board Positions - 2000/01 through 2009/10
Excluding Diversion Program**

Business Unit		Position Classification	2000/01	2001/02	2002/03 ¹	2003/04 ²	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	
Total Authorized Positions			299.7	298.7	282.2	253.9	252.0	251.0	261.5	261.1	262.2	272.2	
Executive, Administrative, and IT Services			53.8	52.5	44.5	44.5	44.3	43.3	45.3	44.1	40.1	40.0	
Licensing Program			40.6	43.1	41.6	37.8	37.4	37.4	37.9	40.7	45.8	45.7	
Enforcement Program	Headquarters	CEA II / Deputy Chief	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	2.0	
		Supervising Investigator II									1.0	1.0	
		Supervising Investigator I	2.0	2.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0	2.0	2.0
		Senior Investigator / Investigator	1.0	1.0	1.0						1.0	2.0	2.0
		Investigator Assistant	2.0	1.0									
		Staff Services Manager II/I	3.0	2.0	2.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	4.0
		Analyst (AGPA/SSA/JSA)	27.0	27.0	26.0	26.0	27.0	27.0	26.0	26.0	26.0	26.0	26.0
		Technical and Clerical Support	13.0	14.0	14.0	12.5	11.5	11.5	12.5	10.6	9.6	9.6	9.6
	Total - Headquarters Enforcement	51.0	50.0	48.0	45.5	45.5	45.5	45.5	45.5	44.6	46.6	46.6	
	Regional and District Offices³	Supervising Investigator II (Regional Managers)	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
		Supervising Investigator I	13.0	12.0	12.0	11.0	11.0	11.0	11.0	11.0	11.0	12.0	13.0
		Senior Investigator / Investigator	77.3	72.0	69.0	59.0	59.0	56.0	60.0	59.0	70.0	74.0	
		Investigator Assistant	9.0	11.0	9.0	7.0	7.0	8.0	11.0	11.0			
		Technical and Clerical Support	23.4	20.5	20.5	17.5	17.1	14.1	14.1	14.0	14.0	14.0	15.0
		Temporary Help	11.0	11.0	11.0	11.0	9.6	9.6	9.6	9.6	9.6	9.6	9.2
	Total - Regional and District Offices	136.7	129.5	124.5	108.5	106.7	101.7	108.7	107.6	108.6	108.6	114.2	
	Probation	Supervising Investigator II	1.0	1.0	1.0			1.0	1.0	1.0			
		Supervising Investigator I	1.0	2.0	3.0	2.0	2.0	3.0	3.0	3.0			
		Senior Investigator / Investigator	12.0	17.0	16.0	12.0	12.0	14.0	14.0	14.0			
		Investigator Assistant	2.0	1.0	2.0	2.0	2.0	2.0	3.0	3.0			
		Staff Services Manager I										1.0	1.0
Inspector III											3.0	3.0	
Inspector II/I											13.0	16.0	
Analyst (AGPA/SSA/JSA)											1.0	1.0	
Technical and Clerical Support		1.6	2.6	1.6	1.6	2.0	3.0	3.0	3.0	3.0	3.0	4.0	
Temporary Help						0.1	0.1	0.1	0.1	0.1	0.1	0.7	
Total - Probation	17.6	23.6	23.6	17.6	18.1	23.1	24.1	24.1	24.1	21.1	25.7		
Total Enforcement Program			205.3	203.1	196.1	171.6	170.3	170.3	178.3	176.3	176.3	186.5	
Total Investigators and Inspectors	Senior Investigator / Investigator	90.3	90.0	86.0	71.0	71.0	70.0	74.0	74.0	72.0	76.0		
	Investigator Assistant	13.0	13.0	11.0	9.0	9.0	10.0	14.0	14.0	0.0	0.0		
	Subtotal	103.3	103.0	97.0	80.0	80.0	80.0	88.0	88.0	72.0	76.0		
	Inspector III/II/I									16.0	19.0		
	Total	103.3	103.0	97.0	80.0	80.0	80.0	88.0	88.0	88.0	95.0		

¹ Excludes 15 eliminated positions.

² Excludes 28 eliminated positions.

³ Includes Operation Safe Medicine Unit positions.

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gathering and other investigative activities. For example, it might be argued that the Attorney General's involvement is limited to providing direction to the Investigator and advice as to the disposition of the cases. Alternatively, it might be argued that, to accomplish these purposes, the Attorney General generally would need to perform other activities, such as reviewing key documents and interview summaries. By extension, it also might be argued that the Attorney General must be substantively involved in all major investigative activities (e.g., preparing for and conducting interviews with subjects, witnesses, and others, reviewing and analyzing medical and other records, selecting Experts and preparing Expert packages, reviewing Expert reports, etc.).

VE was implemented statewide beginning January 1, 2006, representing a third major restructuring of the Medical Board's Enforcement Program within a period of 20 years. Concurrently, SB 231 repealed the statutory provisions governing the reimbursement of investigative and enforcement costs by licensees subject to disciplinary action by the Medical Board (cost recovery). Opponents of the repeal of cost recovery argued that licensees would have less incentive to settle Disciplinary Action cases as there would no longer be any financial penalty for delaying a settlement, or for not settling and, instead, proceeding to Administrative Hearing.

To support implementation of VE, ten (10) additional Attorney positions were authorized for HQES, which fully restored the six (6) Attorney positions previously eliminated. However, the Medical Board's Investigator positions were not transferred to HQES, as recommended by CPIL. Also, the Investigators' position classifications and pay scales were not upgraded to the Special Agent level as would have occurred if the positions had been transferred.

Per the Enforcement Monitor's *Initial Report*, dated November 1, 2004 (page ES-22), VE was intended to address long-standing problems that contributed to the extended timeframes needed to complete investigations and prosecutions, and would provide significant benefits, including all of the following:

Improved Efficiency and Effectiveness – The system linking Medical Board Investigators and HQES Attorneys was characterized by its lack of coordination and teamwork. Medical Board Investigators generally functioned without close coordination with the trial Prosecutor that would ultimately handle the case, seldom worked directly with or received guidance from the Attorney who prosecuted their cases, and received limited legal support for their investigative work. With few exceptions the system permitted only inadequate communication and consultation between the primary field Investigator and the Attorney who would prepare the pleading and try the case. Multiple Attorneys could become involved in the case (the DIDO, initially, the Supervising DAG for review and assignment following investigation, and the trial DAG for pleading and prosecution). The lack of teamwork and coordination through the life of the case wasted effort and contributed to operational inefficiencies and last-minute requests for additional Investigation as the cases neared administrative hearing. It was expected that VE would enable the HQES Prosecutor and the Medical Board Investigator to communicate often and work together to coordinate their

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activities. The assigned trial DAG would provide input to the Investigation Plan, guide the investigation, assist in obtaining medical records, and participate in the selection of the Expert Reviewer and in the identification of documents and records transmitted to the Expert Reviewer.

Reduced Case Cycle Times – The Medical Board's Enforcement Program was found to be plagued by excessive case cycle times and delays in the investigation and prosecution processes. It was expected that VE would shorten case timeframes as Prosecutors became more involved in obtaining medical records and other evidence gathering activities. Additionally, HQES Attorneys would assist in evaluating cases earlier during the process, and in identifying weak or problematic cases that should be subject to dismissal or early settlement, leading to earlier case dispositions. Finally, the earlier involvement of Prosecutors would lead to greater use of preliminary relief actions, such as Interim Suspension Orders (ISOs).

Improved Investigator and Prosecutor Morale, Recruitment, and Retention – These benefits were expected to accrue from greater operational efficiency and a greater sense of accomplishment that would flow from teaming Investigators with Prosecutors, and following cases through to their disciplinary conclusion. These benefits would be enhanced if the Medical Board's Investigators were transferred to the Department of Justice, and upgraded to Special Agents, which did not occur.

Improved Training for Investigators and Prosecutors – Medical Board Investigators were seldom involved in the Pre-Hearing and Hearing process to which their work was directed. Through participation in these processes, Investigators would achieve a better understanding of the significance of legal strategies, evidence issues, interview techniques, and witness selection and preparation. Investigator participation in the administrative hearing process would substantively enhance Investigator skills. Concurrently, HQES Attorneys would gain a greater appreciation for the challenges of the investigation process.

Improved Commitment to Cases – With VE, the Attorney who helped to work up the case would be more invested in the case, and more committed to achieving the ultimate disciplinary outcome of the case.

Improved Perception of the Fairness of the Process – This benefit would only accrue if Medical Board Investigators were transferred to the Department of Justice, which did not occur.

At the time that VE was implemented (2006), staffing levels at the Medical Board's District offices were 25 percent lower than existed earlier in the decade. Additionally, Investigator caseloads were growing and the average time to complete investigations had been steadily increasing for several years.

To support implementation of VE, eight (8) new positions were authorized for the Enforcement Program (4 Investigators and 4 Assistant Investigators). The additional positions were authorized beginning with the 2006/07 fiscal year (6 months

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after implementation of VE commenced). The new positions only partially restored the 35 District office positions that had been eliminated since the beginning of the decade. Given the extended lead times to hire and train new staff, these additional resources were largely unavailable to support implementation of VE for the first full year following implementation of this new approach to conducting investigations. Subsequently, the Medical Board reclassified the four (4) new Assistant Investigator positions to Inspectors and assigned the positions to the Probation Units. Concurrently, a comparable number of Investigator positions assigned to the Probation Units were reassigned to the District offices. In summary, the Medical Board's District offices were not initially provided with any additional resources to assist them in responding to the additional workload demands associated with coordinating their investigation activities with HQES Attorneys and responding to the Attorneys' directions regarding the conduct of the investigations.

Shortly following initial implementation of VE, during 2007 the Department of Justice (DOJ) adopted a new Supervising Deputy Attorney General (SDAG) classification for use throughout the DOJ. Previously, selected Deputy Attorneys (DAGs) within HQES and other DOJ business units served as Acting Supervisors, and were commonly referred to as Supervising DAGs, but did not have formal supervisory authority over other Attorneys. During 2007, six (6) HQES Attorneys were appointed as SDAGs, including two (2) SDAGs for the San Diego office which previously had only one (1) Acting SDAG position. Currently, in addition to San Diego's two (2) SDAG positions, two (2) SDAGs are assigned to HQES' Los Angeles Metro office, one (1) SDAG is assigned to the HQES' San Francisco office, and one (1) SDAG is assigned to HQES' Sacramento office. Although unrelated to implementation of VE, the creation of an additional SDAG position in HQES' San Diego office, and the adoption of higher pay scales for all HQES SDAG positions, was viewed unfavorably by Medical Board Investigators and Supervising Investigators whose classifications and pay scales were not upgraded as had been expected.

To guide the implementation of VE, the Medical Board and HQES jointly developed a *Vertical Prosecution Manual* that defined the roles and responsibilities of the members of the VE Team, as follows:

Investigator – Develops and updates Investigation Plans and Progress Reports (IPPRs), conducts investigations, and participates in the administrative hearing process under (1) the supervision of their Supervising Investigator I and II, Deputy Chief, and Chief of Enforcement, and (2) the direction of the assigned Primary DAG.

Medical Consultant – Provides medical input and advice through reviews of medical records, participation in Subject interviews, selection of Expert Reviewers, and evaluation of Medical Expert opinions under (1) the supervision of the Supervising Investigator I and II, Deputy Chief, and Chief of Enforcement, and (2) the direction of the assigned Primary DAG.

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Supervising Investigator I – Supervises Investigators, Medical Consultants, and other District office staff to ensure progression of the cases for which they are responsible. Also completes monthly reports, monitors case progress through case reviews, and handles personnel matters.

Supervising Investigator II – Supervises Supervising Investigator Is, develops and implements Board policy, develops and implements training, handles complex personnel matters, acts as liaison to other government agencies, and signs subpoenas.

Deputy Chief – Manages Supervising Investigator IIs and overall Enforcement Program operations, including Training, Internal affairs, Background Investigations, and Probation.

Enforcement Chief – Supervises Deputy Chiefs and manages the overall Enforcement Program.

Primary DAG (PDAG) – Works closely with other team members and, in conjunction with Supervising Investigator I, directs Investigators in obtaining evidence. Also, provides legal advice to the Medical Board and prosecutes the case.

Supervising DAG (SDAG) – Supervises and provides support for DAGs, oversees and monitors investigations, and supervises Prosecutions.

Senior Assistant Attorney General – In conjunction with the Executive Director of the Medical Board, oversees and bears responsibility for all investigations and prosecutions.

Additionally, although not proposed as part of the Vertical Prosecution Model recommended by the Enforcement Monitor, HQES created a new **Lead Prosecutor (LP)** designation for selected DAGs to support implementation of VE. HQES assigned one (1) LP to each Medical Board District office to act as HQES' principal liaison to that office. The LP is jointly assigned to each case along with a second DAG. The LP is required to review all incoming complaints and determine whether the complaints warrant an investigation or should be closed without investigation. The determination of whether to close a complaint without investigation is required to be made in consultation with the District office Supervisor. If the LP determines that an investigation is warranted, they are required to inform the assigned Investigator and then review and approve the Investigator's Investigation Plan.

The LP is also required to identify cases in which an ISO or Penal Code Section 23 (PC 23) appearance is necessary, and notify the SDAG. In such cases the SDAG is required to designate the second DAG as the Primary DAG responsible for the ISO or PC 23 appearance. The SDAG is also required to designate the second DAG as the Primary DAG for cases involving sexual abuse or misconduct, mental or physical illness, and complex criminal conviction cases. Finally, whenever the LP determines that it is likely a violation of law may be found, the second DAG is required to replace the LP as the Primary DAG

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on the case for all purposes. If the second DAG is assigned as Primary DAG, then the LP is required to monitor the progress of the investigation and the appropriateness of the direction provided by the Primary DAG. If the second DAG is not assigned by the SDAG as the Primary DAG, then the LP is required to act as the Primary DAG throughout the investigation and prosecution of the case. LPs are required to be physically present at their assigned District office to the extent necessary to fully discharge their responsibilities.

Exhibit II-5, on the next page, summarizes other significant policies and guidelines set forth in the *Vertical Prosecution Manual*. Additionally, the *Vertical Prosecution Manual* identifies and defines the following "Statistical Measure Efficiency of the Vertical Prosecution Model":

"In addition to any other statistical measure that may be later identified, one statistical measure that shall be used to assess the efficiency of the vertical prosecution model, as described in Senate Bill 231, shall be the length of time from receipt by the Board's District Office of the original complaint from the Board's Central Complaint Unit to the date that the investigation is closed or a Request to Set is submitted to the Office of Administrative Hearings."

Medical Board Investigators and HQES DAGs "are jointly responsible for this statistical measure of efficiency". The manual notes that "in its early stages, it is anticipated that use of the "vertical prosecution model" may extend the time it takes to complete some investigations."

Subsequently, in April 2008 the Medical Board and HQES issued a set of *Joint Vertical Enforcement Guidelines* which supplement the policies and guidelines initially set forth in the *Vertical Prosecution Manual*. **Exhibit II-6**, following Exhibit II-5, summarizes some of the key policies and procedures contained in the *Joint Vertical Enforcement Guidelines*.

As is evident from the policies and guidelines governing VE, authority and accountability for the conduct and completion of investigations is now significantly more fragmented than before with as many as 5 to 6 different Medical Board and HQES staff regularly involved in many cases, including the District office Supervisor, Investigator, and Medical Consultant, and as many as three (3) HQES Attorneys (SDAG, LP, and Primary DAG). The number of Medical Board and HQES staff who become involved with each case can be (and often is) even greater when (1) cases are reassigned to different Investigators or Prosecutors to balance workloads, (2) a change is made to the LP assigned to a District office, or (3) turnover occurs among either Medical Board or HQES staff. The involvement of all of these personnel has created needs for continuous documentation and distribution of communications between most (or all) of these staff throughout the course of the investigation to keep all of the members of the VE Team updated and informed regarding the status and progress of the investigation, and to coordinate a series of investigative activities that typically extend over a period of at least 1 to 2 years, including:

Summary of Other Significant Vertical Enforcement Policies and Guidelines

- “Direction” is defined as “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.”
- Supervising Investigator Is are expected to jointly assign cases to Investigators in consultation with the LP, and assist in ensuring that investigative assignments are completed, as directed by the assigned DAG, in a timely and efficient manner.
- Supervising Investigator Is are cautioned not to undermine the direction authority of the assigned DAGs, and DAGs are cautioned not to undermine the supervisory authority of the Supervising Investigator Is.
- Investigators are required, within five (5) days of assignment of a case, to prepare and submit a Plan of Investigation to the Primary DAG for their review and approval. The Primary DAG is required to review and approve the Plan of Investigation within five (5) days.
- The investigation is required to be completed pursuant to the Investigation Plan and Progress Report (IPPR). The IPPR is required to be updated as significant events occur and investigative tasks are completed and, as necessary, with any modifications submitted to, and approved by, the Primary DAG.
- The Investigator and Primary DAG are required to maintain a running e-mail thread documenting their communications and the progress of the investigation. Copies of the IPPR and subsequent IPPR emails are required to be sent to both the LP and the Supervising Investigator I.
- The Primary DAG may participate in subject or witness interviews, and is required to discuss the interview with the Investigator prior to commencement of the interview. The Medical Consultant is required to participate in the pre-interview discussion if they will be attending the interview.
- A review of the case is expected to be completed, on-site whenever possible, prior to referral of a case to an Expert Reviewer. The Medical Consultant is required to participate in the case review whenever possible. The Primary DAG is required to insure that the selected Medical Expert is appropriate for the case. The Investigator is required to promptly provide a copy of the Expert Reviewer’s initial report to the Primary DAG and the Medical Consultant, and to review the Expert’s report and determine whether clarification of the report or additional investigation is needed. The Primary DAG is encouraged to consult with the Medical Consultant to make these same determinations, and to inform the Investigator if additional investigation is required.
- At any point a Primary DAG may submit a recommendation to the LP to close a case. The LP is required to review and approve or disapprove the recommendation to close a case within ten (10) business days.
- The Primary DAG is required to determine whether a completed investigation will be accepted for prosecution within five (5) business days of submission. In cases where closure is recommended, the Primary DAG is required to review and approve or disapprove the recommended disposition within ten (10) business days.
- The assigned Investigator is expected to attend the administrative hearing, unless released
- If disagreements arise between the Investigator and the Primary DAG regarding an investigation that they are unable to resolve, the Investigator and Primary DAG are required to discuss the matter with the Lead Prosecutor, Supervising Investigator I, and/or Supervising Investigator II. If the disagreement remains unresolved, the matter is required to be submitted to the SDAG who, after consultation with the Chief of Enforcement, shall issue a determination. If the disagreement still remains unresolved, it is required to be submitted to the Senior Assistant Attorney General who, after consultation with the Chief of Enforcement and Executive Director of the Medical Board, shall issue a final determination.

Summary of Additional Vertical Enforcement Policies and Guidelines

Case Intake Documents – At a minimum, LPs must be provided copies, in hard copy or soft copy format, of the consumer complaint, including all attachments, all medical records sent with the case, all CCU documentation, all CCU Medical Consultant documentation, including attachments, and any statement provided by the respondent to, or from, CCU.

Complainant, Witness, and Subject Interviews – Primary DAGs are expected to participate in ALL Complainant interviews in cases involving sexual misconduct, and in ALL Subject interviews. Investigators are required to schedule these interviews on dates that the Primary DAG is available. The Primary DAG may request that the LP participate in the interview if the Primary DAG will be unavailable and the interview would be unreasonably delayed if postponed until the Primary DAG was available. Investigators are required to notify the Primary DAG of other interviews and the Primary DAG is required to notify the Investigator as to whether they want to attend the interviews within specified timeframes (e.g., 5 business days). If no response from the Primary DAG is received, the Investigator may proceed with the interview without the Primary DAG, but is required to notify the SDAG of the lack of response. All participants are required to review the case and prepare for and plan the interviews, including allocating sufficient time for meeting in person for a pre-interview meeting.

Subpoenas – Investigators and Primary DAGs are strongly encouraged to work together in preparing subpoenas. The Investigator is responsible for preparing the subpoena but, whenever requested, the Primary DAG or LP should assist the Investigator. Primary DAG or LP reviews of subpoenas are required to be completed within five (5) business days of submission. An additional five (5) business days is allowed for the DAG or LP to make changes to the subpoena. If no response is received within ten (10) business days, the Investigator may forward the subpoena to the Supervising Investigator II for approval.

Expert Package Reviews – The Investigator is required to notify the Primary DAG when an Expert Package is available for review, and to provide a copy of the notification to the Supervising Investigator I, the LP, and the SDAG. The LP should review the Expert Package if the Primary DAG is unable to do so within ten (10) days of the notification.

Case Reviews – LPs are expected to participate in all case reviews. Supervising Investigator Is are required to provide at least ten (10) days notice to the LP of all Quarterly Case Reviews and, also, any other case review, and to schedule the case reviews for the LP's normal day in the District office.

Case Closures – To ensure that no meritorious cases is closed prematurely, all cases should remain open and under active investigation until a determination is made by the Primary DAG or LP, in consultation with the Investigator and Supervising Investigator, that the case has no merit or there is insufficient evidence to establish a violation of law. If there is a disagreement over whether to close a case, the disagreement is required to be resolved in accordance with the Dispute Resolution procedures set forth in the *Vertical Prosecution Manual*. If the Dispute Resolution procedures are not invoked within five (5) business days of the disagreement, the Investigation is required to be promptly closed by both HQES and the Medical Board, with the date of closure posted as the date that the Primary DAG directed or approved closure of the case.

Referral of Cases for Prosecution – The Supervising Investigator is required to notify the Primary DAG when a completed investigation is ready for review. The Primary DAG is required to determine, within five (5) business days, whether the case will be accepted for prosecution. If accepted for prosecution, the Primary DAG should promptly sign and date the Investigation Report, without any interlineations, such as "case received", and provide the signature page to the Supervising Investigator. If the case is rejected, the Primary DAG should document via email the reasons for the rejection and, if appropriate, recommended additional investigation and submit the email to the Investigator and Supervising Investigator within the five (5) business day timeframe provided for acceptance or rejection of the case. If the Primary DAG is unavailable to review the request, the LP may review the transmittal and accept or reject the case within the allotted timeframe, if so requested by the Primary DAG.

Criminal Cases – Cases involving investigations of unlicensed persons are excluded from the Vertical Enforcement process.

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- ✓ Developing the initial plan for conducting the investigation and subsequent updates to the plan
- ✓ Requesting medical records and reviewing documents received in response to the requests
- ✓ Interviewing complainants, witnesses, and subjects, including related pre-interview case file review and planning meetings and post-interview debriefings
- ✓ Selecting Expert Reviewers
- ✓ Preparing and reviewing Expert Reviewer packages
- ✓ Reviewing Expert Reviewer reports
- ✓ Reviewing completed cases not referred for prosecution
- ✓ Reviewing cases referred for prosecution.

The preceding activities tend to be completed sequentially because subsequent activities typically cannot fully commence until prior activities are substantially completed. For example, most quality of care cases, and many physician conduct cases, generally progress sequentially through the following six (6) major stages of activity during the course of completing an investigation:

Stage 1 – Incoming complaints are reviewed to determine whether to investigate the case. Nearly all cases are accepted for Investigation.

Stage 2 – Background research is completed, records are requested and reviewed, and interviews with the complainant and witnesses are scheduled and conducted to better define the scope of the investigation and to identify and frame possible violations.

Stage 3 – The case is submitted to the Medical Consultant for review. Then an interview with the Subject is scheduled and conducted. Quality of care cases referred for investigation are rarely closed without first interviewing the Subject. The Medical Consultant usually participates in these interviews. Criminal cases and petitions are not usually submitted to the Medical Consultant for review and the Subject is not usually interviewed. Investigations of other types of physician conduct cases oftentimes include a Medical Consultant review of the case or a Subject interview, or both.

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Stage 4 – Following the Subject interview, if completed, a determination is made as to whether to have an Expert Reviewer review the case. Then an Expert Reviewer is selected. Concurrently, an Expert Package is assembled to submit to the Expert Reviewer. Most quality of care cases and many physician conduct cases, excluding criminal cases and petitions, are submitted to an Expert Reviewer who determines whether the evidence supports a finding of gross negligence, repeated acts of negligence, or other professional misconduct. The Medical Consultant is usually substantively involved in these activities, particularly if the case involves quality of care issues.

Stage 5 – The Expert Reviewer's report is reviewed to determine whether to perform additional investigative work, request additional review by the Expert Reviewer or clarification of their report, close the case, or refer the case for prosecution. The Medical Consultant is usually substantively involved in these activities, particularly if the case involves quality of care issues.

Stage 6 – For both closed cases and cases referred for prosecution, the final Report of Investigation and supporting documentation are reviewed and approved.

At any point during the process, needs for additional records or interviews may be identified resulting in a resumption of earlier-stage work. These needs may be identified during the course of the investigation by the Investigator, Medical Consultant, District office Supervisor, or Primary DAG (if assigned and substantively involved with the investigation), or during a formal periodic Quarterly Case Review meetings between the District office Supervisor and Investigator, and Lead Prosecutor, if attending.

There are some disparities between the policies and guidelines established for the VE Pilot Project and actual case investigation practices, and considerable variability in how VE has been implemented in different regions throughout the State. For example:

Lead Prosecutor Assignments – For some District offices an SDAG rather than a DAG serves as LP. At some District offices the assigned LP rarely changes while, at other District offices, the LP is changed on a rotational basis. At some District offices where Primary DAGs are assigned to most cases, the LP serves as an intermediary or liaison between the Investigator and the Primary DAG, and the Investigator and Primary DAG directly interface only on an exception basis. At other District offices where Primary DAGs are assigned to most cases, the Investigator and Primary DAG usually interface directly, and the LP only becomes involved when there are disagreements or problems between the Investigator and Primary DAG. Depending on the location of the District office and other factors, LPs usually have either one (1) or two (2) regularly scheduled days each week where they are expected to physically visit their assigned District office (not necessarily for the full day).

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Case Intake and Investigator Assignments – For most District offices incoming complaints are accepted by the District office Supervisor and assigned to an Investigator without any involvement or consultation with the LP. Concurrently, the case file is transmitted to the LP. At some District offices a physical copy of the entire case file is staged for the LP's review on their next regular duty day at the District office. At other District offices a soft copy of the case file is created and emailed to the LP but, if there are a large number of supporting documents, copies of all of the documents may not always be provided. Generally, the LP's review of a new complaint and their opening of a new Investigation matter in HQES' ProLaw System occurs at some point after the opening of the investigation by the District office, after the District office Supervisor's assignment of an Investigator to the case, and, in some cases, after the initiation of investigation activities.

Primary DAG Assignments – For some District offices a Primary DAG is usually assigned by the SDAG to each new investigation following the LP's opening of the new investigation matter in HQES' ProLaw System. For District offices where the SDAG serves as the LP, the assignment of a Primary DAG can occur concurrent with the SDAG's case intake review. For some District offices a Primary DAG is only assigned to an investigation on an exception basis (e.g., cases involving sexual misconduct or if requested by the District office) or the assignment of a Primary DAG is usually deferred until much later during the investigation process (e.g., when the case is ready to be transmitted to an Expert Reviewer or following completion of the investigation when the case is ready to be referred for prosecution).

Initial Investigation Plan Preparation and Review – For most District offices the assigned Investigator prepares the initial Investigation Plan, submits it to the District office Supervisor, LP, Primary DAG (if assigned), and others, as required (which varies among the District offices), and commences the investigation. HQES Attorneys rarely suggest any changes to the initial Investigation Plan. At some District offices the Investigators do not commence their investigation until either the LP or Primary DAG approves the initial Investigation Plan (which is required to be provided within 5 business days, but can take longer due to absences, vacations, or other factors).

Medical and Other Records – For some District offices complete copies of all medical and other records collected during the investigation are forwarded to the Primary DAG as they are obtained. In other District offices copies of these records are forwarded on an as-needed basis or are always forwarded to only some of the Primary DAGs assigned to the office's cases.

Subject Interviews – At some District offices the Primary DAG is expected to attend all Subject interviews. At other District offices either the LP attends most Subject interviews on behalf of the Primary DAGs or an HQES Attorney (usually either the LP or Primary DAG) only attends Subject Interviews on an exception basis (e.g., cases involving sexual misconduct or if requested by the District office). At some District offices the LP rarely attends Subject interviews. Attorney practices regarding completion of pre-interview case file reviews, attendance at pre-interview

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planning meetings, and the extent of their participation during the interview vary greatly depending on individual Attorney work style differences. Primary DAGs sometimes fail to show for Subject interviews that they were scheduled to attend.

Expert Reviewer Selection and Expert Package Review – For some District offices the Primary DAG is usually substantively involved in selecting an Expert Reviewer and reviewing Expert packages. At other District offices the Primary DAG is not usually substantively involved in the investigation until this point in the process. At other District offices the Primary DAG usually declines to review the Expert Package. In some cases the Primary DAGs are not substantively involved in reviewing the Expert package because they were previously substantively involved in the case during earlier stages of the investigation. At some District offices an HQES Attorney (Primary DAG or LP) is only involved in Expert Reviewer-related activities on an exception basis. There is considerable variability in Medical Board and HQES practices related to the preparation and review of Expert packages.

Completed Investigation Case Reviews – For some District offices most completed cases are regularly reviewed and accepted for closure or prosecution within required timeframes (5 business days for cases recommended for prosecution and 10 business days for cases recommended for closure). For other District offices the completed cases oftentimes are not reviewed and approved within the required timeframes. At some District offices there appear to be chronic problems with these processes with HQES either (1) delaying the closure or transmittal of cases by requesting completion of additional investigation activity, or (2) not informing the District office regarding its approval or disapproval of the recommended case disposition, or not doing so on a timely basis. According to Medical Board staff, there is considerable variability in HQES practices related to acceptance of cases for prosecution.

Investigator Attendance at Hearings – Investigators attend hearings to assist the DAGs prosecuting the cases, however, hearings are rarely conducted (fewer than 50 per year for cases investigated by District offices). When hearings are held, it is a major drain of resources as the hearing may extend over a period of weeks. The experience, however, is valuable and essential for the growth and development of seasoned Investigators.

Finally, ambiguities in the statutes mandating use of the VE Model appear to underlie some of variability that exists in how VE was implemented in different regions of the State. Additionally, there is great deal of variability in the relationships between Medical Board Investigators and HQES Attorneys. Generally, there is a fairly high level of friction between Investigators and Attorneys throughout the State. However, the relationships are particularly poor in the Los Angeles Metro region. One source of the friction and conflict between Medical Board and HQES staff is variability in the perceptions of different individuals regarding the Legislative intent in mandating use of the VE Model, and ambiguities in the statutes requiring its use.

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Following implementation of VE, during 2007/08 and 2008/09, there were some minor shifts in authorized positions between various programs and business units within the Medical Board. Collectively these shifts increased authorized staffing for the Licensing Program by eight (8) positions (21 percent), but most of this increase is attributable to a concurrent transfer of the Cashiering Unit to the Licensing Program. Subsequently, in 2009/10, ten (10) additional positions were authorized for the Enforcement Program, the first increases since the addition of eight (8) Investigator and Assistant Investigator positions in 2006/07. Six (6) additional positions were authorized to re-establish the OSM Unit (1 Supervising Investigator, 4 Investigators, and 1 Office Technician) and four (4) additional positions were authorized for the Probation Program (3 Inspectors and 1 Office Technician). No additional positions were authorized for the District offices to support implementation of VE and investigate growing backlogs of complaints against licensed physicians.

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E. Section 805 Reports and Investigations

The Medical Board relies heavily upon Section 805 reporting to identify instances of physician negligence or misconduct. Initially, legislation enacted during 1975 (AB 1, Keene) required submission of these reports and, during the early-1990s, the Medical Board received an average of 159 Section 805 Reports per year (which was considered seriously deficient). Since that time, major legislative changes have been enacted to improve Section 805 reporting, but the number of reports submitted has continued to decline.

During the early 1990s, SB 2375 (Presley) and SB 916 (Presley) were enacted to improve Section 805 reporting. SB 2375 increased the fines charged for failure to submit Section 805 Reports (to a maximum of \$5,000 for failure to submit a required report, or \$10,000 for willful failure to submit a required report). SB 16 enhanced Section 805 reporting (e.g., by reducing the timeframes to submit required reports). Subsequently, during 2001, SB 16 (Figueroa) was enacted to address problems with Section 805 reporting. SB 16 significantly increased the maximum fines for failure to file a Section 805 Report (to a maximum of \$50,000 for failure to submit a required report, or \$100,000 for willful failure to submit a required report). SB 16 also required that the Medical Board contract with the Institute for Medical Quality, a subsidiary of the California Medical Association (CMA), to conduct a comprehensive study of the peer review process to determine the continuing validity of Section 805 reporting requirements. A written report was required to be submitted to the Medical Board and the Legislature by November 1, 2002 (later extended to November 1, 2003). Due to budget constraints, this study was never completed.

In 2005 legislation was enacted (SB 231, Figueroa) which required that the Medical Board contract with an independent entity to conduct the peer review study previously required by SB 16. A written report was required to be submitted to the Medical Board and the Legislature by July 31, 2007 (later extended to July 31, 2008). In July 2008 this study was completed. The study was conducted by a non-profit healthcare consulting organization (Lumetra). Lumetra found failures throughout current peer review process, including inconsistent standards and practices, a lack of objective and confidential review, insufficient transparency, extensive delays and inefficiencies, and prohibitive costs. Lumetra also concluded that the current peer review process rarely leads to Section 805 Reports and that the high costs associated with Section 805 reporting may influence the pursuit of cases against physicians. According to Lumetra:

“Entities can take multiple steps to follow the letter but avoid the “spirit” of the 805 law by using tactics such as pressuring an offending physician to resign for reasons other than “medical cause or reason”, by having summary suspensions less than 14 days, by negotiating with an offending physician privately through attorneys to avoid an 805 report, or by offering extended educational sessions and other remedial opportunities that would not trigger an 805 report.”

Lumetra recommended a re-design and restructuring of the peer review process, including establishment of a separate, independent peer review organization that would investigate cases referred to it by the peer review organizations, and then make recommendations regarding the filing of Section 805 reports or taking other corrective action. Under this proposed model, responsibility for hearings concerning a final proposed action by a peer review body, including the filing of Section 805 reports, would be transferred from health

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care facilities to the Medical Board or a designated independent organization. The Medical Board would continue to investigate all Section 805 Reports and, if appropriate, initiate disciplinary actions. To date, Lumetra's recommendations have not been implemented.

Although the number of Section 805 reports submitted to the Medical Board has declined in recent years (from an average of about 150 reports per year during the early-2000s to an average of 129 reports per year during the past three (3) years), the average elapsed time to complete investigations of these reports has increased dramatically. **Exhibit II-7**, on the next page, shows average elapsed times, by year for the past four (4) years, to complete investigations of Section 805 cases that were referred to HQES for prosecution. As shown by Exhibit II-7, about 30 to 40 Section 805 case investigations were completed each year with a referral for prosecution. During 2005/06 the timeframe to complete these investigations exceeded two (2) years in only two (2) cases, and 90 percent of the investigations were completed in a period of two (2) years or less. Since 2005/06 the timeframes to complete these investigations increased significantly. For example:

- ❖ The average elapsed time to refer Section 805 quality of care cases for prosecution increased by 44 percent (from 16.7 months to 24.0 months). During 2008/09, 50 percent of these quality of care cases took longer than two (2) years to Investigate. In contrast, during 2005/06 only 10 percent of these cases took longer than two (2) years to investigate.
- ❖ The average elapsed time to refer other (non-quality of care) Section 805 cases for prosecution increased by 22 percent (from 9.4 months to 11.5 months).
- ❖ On an aggregate basis, the number of Section 805 cases that took longer than two (2) years to Investigate and refer for prosecution increased every year subsequent to 2005/06. In 2008/09, 15 of 37 Section 805 cases referred for prosecution (41 percent) took longer than two years to investigate.

Throughout this period, the average elapsed time to investigate Section 805 cases that were closed, and not referred for prosecution, was about 14 months. This average elapsed time includes cases that were closed because the investigation was not completed with statutorily-mandated timeframe limitations.

Finally, Section 805 cases referred for prosecution may be less likely than other types of cases to have a successful disciplinary outcome. For example, during 2007/08 as especially large number of accusations (36 cases) were withdrawn or dismissed, excluding Out of State and Headquarters cases. Eight (8) of these (22 percent) were Section 805 cases. Of 26 accusations that were withdrawn, six (6) were Section 805 cases (31 percent). Additionally, Section 805 cases may account for a disproportionate share of multiple complaint cases. For example, of 126 multiple complaint cases that had a disciplinary outcome during 2007/08 and 2008/09, 14 percent (18 cases) were Section 805 cases.

**Summary of Section 805 Case Investigations Referred for Prosecution
2005/06 through 2008/09**

Case Type	Elapsed Time to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	1 Year or Less	3	15%	6	27%	2	7%	1	4%
	1 to 2 Years	15	75%	10	45%	17	59%	13	46%
	2 to 3 Years	2	10%	6	27%	10	34%	14	50%
	Total	20	100%	22	100%	29	100%	28	100%
	Average Number of Months	16.7 Months		17.3 Months		21.3 Months		24.0 Months	
Other Cases	1 Year or Less	6	75%	8	57%	5	38%	5	56%
	1 to 2 Years	2	25%	6	43%	7	54%	3	33%
	2 to 3 Years	0	0%	0	0%	1	8%	1	11%
	Total	8	100%	14	100%	13	100%	9	100%
	Average Number of Months	9.4 Months		10.7 Months		16.4 Months		11.5 Months	
Total	1 Year or Less	9	32%	14	39%	7	17%	6	16%
	1 to 2 Years	17	61%	16	44%	24	57%	16	43%
	2 to 3 Years	2	7%	6	17%	11	26%	15	41%
	Total	28	100%	36	100%	42	100%	37	100%
	Average Number of Months	14.6 Months		14.7 Months		19.8 Months		21.0 Months	

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F. HQES Staffing Resource Allocations

Table II-2, below, shows filled HQES positions by year from 2004/05 through 2008/09. Excluding temporary help (retired annuitants) and Secretaries (7 positions) assigned to HQES' Senior Assistant Attorney General and each of six (6) Supervising DAGs, 58 full-time, permanent positions were authorized for HQES, including:

- ❖ 1 Senior Assistant Attorney General
- ❖ 6 Supervising Deputy Attorneys
- ❖ 47 Deputy Attorneys (all levels)
- ❖ 3 Senior Legal Analysts
- ❖ 1 Associate Government Program Analyst.

Prior to implementation of Vertical Enforcement, HQES did not have an Associate Government Program Analyst position and had nine (9) fewer Attorney positions. The Secretary positions are not shown as budgeted to HQES in the *Wage and Salary Supplements to the Governor's Budgets*.

**Table II-2. Health Quality Enforcement Section Staffing Profile
2004/05 through 2008/09**

Classification	Filled Positions				
	2004/05	2005/06 ¹	2006/07	2007/08	2008/09
Senior Assistant Attorney General (CEA)	1.00	1.00	1.00	1.00	1.00
Supervising Deputy Attorney General (SDAG)	Not Applicable		4.40	6.00	6.00
Deputy Attorney General IV	29.90	29.70	32.30	27.10	24.00
Deputy Attorney General III	10.40	10.30	9.80	17.80	19.00
Deputy Attorney General	1.30	3.90	3.90	2.00	2.70
Senior Legal Analyst	3.00	3.00	3.00	3.00	3.00
Associate Government Program Analyst	0.00	0.00	0.00	0.70	1.00
Total, Excluding Secretaries and Temporary Help	45.60	47.90	54.40	57.60	56.70

¹ The Vertical Enforcement Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

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Table II-3, below, shows allocations of authorized SDAG, DAG, and Senior Legal Analyst positions by HQES office during 2008/09 and 2009/10 as shown on HQES’ staffing rosters. Currently, nearly one-half of HQES’ Attorneys are assigned to the Los Angeles Metro office, 30 percent are assigned to Northern California offices (Sacramento and San Francisco), and less than one-quarter are assigned to the San Diego office. During 2009/10, authorized Attorney staffing for HQES was reduced by four (4) positions. All of the reductions were absorbed by the Sacramento, San Francisco, and San Diego offices. None of the reductions were absorbed by the much larger Los Angeles Metro office. Additionally, one (1) vacant Attorney position was shifted to the Los Angeles Metro office to accommodate unrelated personnel placement needs at that location. To better balance workload between the various HQES offices, the geographic boundaries of the Los Angeles Metro office were recently extended, both North and South, to encompass portions of the areas served previously by HQES’ Sacramento and San Diego offices.

Table II-3. Health Quality Enforcement Section Staff Allocations by Office

Fiscal Year	HQES Office Location	Position Classification			Total ¹		Percent of DAGs
		Supervising Deputy Attorney General (SDAG)	Deputy Attorney General (DAG)	Senior Legal Analyst	Number	Percent	
2008/09	Sacramento, San Francisco, and Oakland	2	16	1	19	33%	33%
	Los Angeles Metro	2	20	1	23	40%	42%
	San Diego (Other Southern California)	2	12	1	15	26%	25%
	Total Allocated Positions¹	6	48	3	57	100%	100%
2009/10	Sacramento and San Francisco	2	13	1	16	30%	30%
	Los Angeles Metro	2	21	1	24	45%	48%
	San Diego (Other Southern California)	2	10	1	13	25%	23%
	Total Allocated Positions¹	6	44	3	53	100%	100%

¹ Excludes one (1) Senior Assistant Attorney General position, one (1) Associate Government Program Analyst (AGPA) position based in HQES’ Los Angeles office, and seven (7) Secretary positions.

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Table II-4, below, shows the significant shift that has occurred during the past several years in the number of Attorney hours charged by HQES to Medical Board investigations. As shown by Table II-4, the number of hours charged by HQES Attorneys to Medical Board investigations increased significantly during the past three (3) years, and virtually all of the additional hours were charged by Attorneys based in HQES’ Los Angeles Metro office. During 2009, Los Angeles Metro office Attorneys charged more than 17,000 hours to Medical Board Investigations compared to fewer than 6,000 hours charged to investigations by Attorneys in each of the other regions of the State. The hours charged to investigations by Los Angeles Metro office Attorneys during 2009 accounted for 60 percent of all HQES Attorney hours charged to investigations.

Table II-4. Hours Charged by HQES Staff to Investigation Matters
Includes Hours Charged to Investigation Matters, Section-Specific Tracking and Client Service

Class	HQES Office(s)	2006	2007	2008	2009
Attorneys	Northern California ¹	6,610.25	6,084.50	5,007.25	5,167.75
	Los Angeles Metro	6,349.00	6,388.00	13,527.75	17,083.50
	San Diego (Other Southern California)	4,535.50	3,777.50	5,625.50	5,988.75
	Total	17,494.75	16,250.00	24,160.50	28,240.00
Paralegals and Analysts	Northern California ¹	235.25	286.25	201.75	175.00
	Los Angeles Metro	189.50	739.00	1,166.75	1,193.75
	San Diego (Other Southern California)	1,391.25	1,369.25	1,847.25	1,386.00
	Total	1,816.00	2,394.50	3,215.75	2,754.75
Total ²	Northern California ¹	6,845.50	6,370.75	5,209.00	5,342.75
	Los Angeles Metro	6,538.50	7,127.00	14,694.50	18,277.25
	San Diego (Other Southern California)	5,926.75	5,146.75	7,472.75	7,374.75
	Total	19,310.75	18,644.50	27,376.25	30,994.75

¹ Includes San Francisco, Oakland, Sacramento, and Fresno offices.

² Excludes Supervising Deputy Attorneys (SDAGs) and Special Agents.

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In contrast with the distribution of Attorney billings shown in Table II-4, **Table II-5**, below, shows much smaller differences between geographic regions in the number of hours charged by HQES Attorneys to prosecutions. Generally, more hours are charged for prosecutions by HQES' Northern Region offices than are charged by HQES' other two regional offices. However, HQES' San Francisco and Sacramento offices handled nearly all Out-of-State and SOI cases. In both the Northern California and Other Southern California regions, HQES Attorneys charged significantly more hours to prosecutions than charged to investigations. In contrast, in the Los Angeles Metro region, the proportions of time charged to investigations and prosecutions are reversed, with significantly fewer hours charged to prosecutions during 2009 (9,823) than charged to investigations (17,084).

Table II-5. Hours Charged by HQES Staff to Administrative Matters
Excludes Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters.

Class	HQES Office(s)	2005	2006	2007	2008	2009
Deputy Attorney General	Northern California ¹	11,333	11,718	12,960	12,231	13,026
	Los Angeles Metro	10,150	9,696	12,937	11,820	9,823
	San Diego (Other Southern California)	9,220	8,290	11,265	8,144	8,923
	Total	30,703	29,704	37,161	32,195	31,772
Paralegals and Analysts	Northern California ¹	92	15	65	317	157
	Los Angeles Metro	579	835	463	514	1,191
	San Diego (Other Southern California)	151	98	81	133	263
	Total	822	947	608	964	1,610
Supv. Deputy Attorney General	Northern California ¹	99	221	212	106	160
	Los Angeles Metro	36	7	127	0	0
	San Diego (Other Southern California)	343	207	43	113	198
	Total	477	436	382	219	358
Total	Northern California ¹	11,524	11,954	13,237	12,654	13,342
	Los Angeles Metro	10,765	10,538	13,527	12,334	11,014
	San Diego (Other Southern California)	9,713	8,595	11,388	8,391	9,384
	Total	32,002	31,086	38,151	33,378	33,740

¹ Includes San Francisco, Oakland, Sacramento, and Fresno offices.

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The time charges by Los Angeles Metro Attorneys are also disproportionate to the geographic distribution of licensees. As shown by **Exhibit II-8**, on the next page, only about 30 percent of active licensees are based in counties served by HQES’ Los Angeles Metro office. Counties served by HQES’ Northern California offices account for 44 percent of active licensees while counties served by HQES’ San Diego office account for 25 percent of active licensees.

The time charges by Los Angeles Metro Attorneys are also disproportionate to the geographic distribution of Investigations opened and cases referred for Prosecution. As shown by **Exhibit VI-3**, in Section VI (*Investigations*), the number of investigations opened and number of cases referred for prosecution by District offices in each of the three major geographic regions of the State generally parallels the geographic distribution of licensees. For example:

- ❖ The Northern California region accounts for about 38 percent of investigations opened and 36 percent of cases referred for Prosecution
- ❖ The Los Angeles Metro region accounts for about 35 percent of investigations opened and 32 percent of cases referred for Prosecution
- ❖ The Other Southern California region accounts for about 27 percent of Investigations opened and 32 percent of cases referred for Prosecution.

The data shown in Exhibit VI-3 is fully consistent with data shown in **Table II-6**, below, separately provided by HQES, showing the number of Investigation matters opened by HQES in each major region of the State during each of the past four (4) years. As shown by Table II-6, Investigation matters opened for Los Angeles Metro cases account for about one-third of all Investigation matters opened by HQES.

Table II-6. Investigation Matters Opened by HQES

HQES Office(s)	2006	2007	2008	2009	Total	
					Number	Percent
Northern California ¹	374	387	392	340	1,493	38%
Los Angeles Metro ²	306	350	365	340	1,361	34%
San Diego ³ (Other Southern California)	339	287	232	264	1,122	28%
Total	1,019	1,024	989	944	3,976	100%

¹ Includes HQES’ San Francisco, Oakland, Sacramento, and Fresno offices.

² Data shown for 2009 includes 47 Fresno cases.

³ Data shown for 2006 excludes 39 pre-2006 cases.

Active, In-State Licensees, By County
June 30, 2009

Northern California Counties						Los Angeles Metro Counties	
Alameda	4,449	Marin	1,534	Santa Clara	6,946		
Alpine	1	Mariposa	16	Santa Cruz	710	Los Angeles	27,556
Amador	70	Mendocino	219	Shasta	451	Santa Barbara	1,199
Butte	474	Merced	226	Sierra	0	Ventura	1,675
Calaveras	51	Modoc	6	Siskiyou	88	Total	30,430
Colusa	10	Mono	36	Solano	843	Percent	30%
Contra Costa	3,020	Monterey	885	Sonoma	1,360	Other Southern California Counties	
Del Norte	44	Napa	488	Stanislaus	900		
El Dorado	302	Nevada	258	Sutter	202	Imperial	131
Fresno	1,828	Placer	1,032	Tehama	51	Inyo	45
Glenn	13	Plumas	36	Trinity	12	Orange	9,250
Humboldt	286	Sacramento	4,248	Tulare	476	Riverside	2,818
Kern	1,110	San Benito	40	Tuolumne	130	San Bernardino	3,524
Kings	136	San Francisco	5,761	Yolo	572	San Diego	9,428
Lake	80	San Joaquin	1,054	Yuba	49	Total	25,196
Lassen	39	San Luis Obispo	806	Total	44,274	Percent	25%
Madera	177	San Mateo	2,749	Percent	44%	Statewide Total	99,900

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Finally, as shown by **Table II-7**, below, the total hours charged by Attorneys assigned to HQES’ offices in Northern California and San Diego (Other Southern California) offices for investigations and prosecutions have changed little during the past several years (18,000 hours and 13,000 hours per year, respectively). In contrast, the total number of hours charged Los Angeles Metro Attorneys have exploded and, in 2009, exceeded the number of hours charged in each of the other two geographic regions by 50 to 80 percent.

Table II-7. Hours Charged by HQES Attorneys to Investigations and Prosecutions

Matter	HQES Office(s)	2006	2007	2008	2009
Investigations ²	Northern California ¹	6,610	6,085	5,007	5,168
	Los Angeles Metro	6,349	6,388	13,528	17,084
	San Diego (Other Southern California)	4,536	3,778	5,626	5,989
	Total - Investigations	17,495	16,250	24,161	28,240
Prosecutions	Northern California ¹	11,718	12,960	12,231	13,026
	Los Angeles Metro	9,696	12,937	11,820	9,823
	San Diego (Other Southern California)	8,290	11,265	8,144	8,923
	Total - Prosecutions	29,704	37,161	32,195	31,772
Total ³	Northern California ¹	18,328	19,045	17,238	18,194
	Los Angeles Metro	16,045	19,325	25,348	26,907
	San Diego (Other Southern California)	12,826	15,042	13,770	14,912
	Total - Investigations and Prosecutions	47,198	53,411	56,356	60,012

¹ Includes San Francisco, Oakland, Sacramento, and Fresno offices.

² Includes Section-Specific Tracking and Client Service hours.

³ Excludes Supervising Deputy Attorneys (SDAGs).

The differences in hours charged by HQES Attorneys in each of the three major geographic regions of the State reflects significant differences in their level of involvement in Medical Board investigations, and substantive differences in the way that VE has been implemented. Since 2006, Los Angeles Metro office Attorneys have become increasingly involved in Medical Board investigations and have, for several years, been much more intensively involved in investigations than Attorneys based in HQES’ other offices. As a result, during 2009 expenditures for Attorney services provided by HQES’ Los Angeles Metro office were more than \$1.4 million greater than expenditures for Attorney services provided by HQES’ Northern California offices, and more than \$2.0 million greater than expenditures for Attorney services provided by HQES’ San Diego office.

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G. Enforcement Program Attrition History

Exhibit II-9, on the next page, shows the number of Investigators, Senior Investigators, and Supervising Investigators that separated from the Medical Board by year from 2004 through 2009. During the two (2) years prior to implementation of VE (2004 and 2005), the Enforcement Program lost thirteen (13) Investigators, Senior Investigators, and Supervising Investigators, including nine (9) employees who retired from State service, one (1) employee who transferred to DCA's Division of Investigation, and three (3) employees who left State service. Beginning during 2006, concurrent with implementation of VE, there was a sharp acceleration in staff turnover within the Enforcement Program. Ten (10) Enforcement Program Investigators, Senior Investigators, and Supervising Investigators retired from State service during 2006 and 2007. This is about the same number of staff with these classifications as retired during the preceding two (2) years. However, in contrast with prior years, 17 other Investigators, Senior Investigators, and Supervising Investigators separated from the Medical Board, including:

- ❖ 8 employees who transferred to DCA's Division of Investigation
- ❖ 3 employees who transferred to the Department of Justice
- ❖ 5 employees who transferred to other State agencies
- ❖ 1 employee that left State service.

Similarly, during the next two (2) years (2008 and 2009), nine (9) Investigators, Senior Investigators, and Supervising Investigators retired from State service. Concurrently, 17 others in these same classifications separated from the Medical Board, including

- ❖ 7 employees who transferred to DCA's Division of Investigation
- ❖ 3 employees who transferred to the Department of Justice
- ❖ 4 employees who transferred to other State agencies
- ❖ 3 employees who left State service.

In summary, during the past four (4) years more than one-half of the Enforcement Program's Investigators, Senior Investigators, and Supervising Investigators separated from the Medical Board. Only about one-third of the separations were due to retirements (fewer than 5 positions per year). Thirty (30) Investigators, Senior Investigators, and Supervising Investigators (7.5 positions per year) transferred to other State agencies, including 14 who transferred to DCA's Division of Investigations. The staff that separated during this period were highly experienced, with an average of eight (8) years experience with the Medical Board prior to their separation. Geographically, a disproportionate share of the separations was from Northern Region District offices which concurrently experienced both a large number of retirements and a large number of other separations. In contrast, the other two geographic regions had a lower number of total separations because they either had fewer retirements (Los Angeles Metro region) or had fewer other separations (Other Southern California region).

Enforcement Program Attrition History

Business Unit	Retirements			Transfers to Other State Agencies									Other Separations			Total Separations					
				DCA Division of Investigation			Department of Justice			Other State Agencies									Total		
	2004 and 2005	2006 and 2007	2008 and 2009	2004 and 2005	2006 and 2007	2008 and 2009	2004 and 2005	2006 and 2007	2008 and 2009	2004 and 2005	2006 and 2007	2008 and 2009	2004 and 2005	2006 and 2007	2008 and 2009	2004 and 2005	2006 and 2007	2008 and 2009			
Sacramento	3		1					1					1						3	1	1
San Jose			1		1							1	1	1			1		0	1	3
Fresno	2	1	1		1				1		2		3	1					2	4	2
Pleasant Hill	1	1	1														1		1	1	2
Total Northern Region	6	2	4	0	2	0	0	1	1	0	2	1	0	5	2	0	0	2	6	7	8
Diamond Bar									1						1		1		0	0	2
Torrance/Cerritos		1			1								1			1			0	3	0
Glendale		1			1	1							1	1	2				2	2	1
Valencia						3									3	1			1	0	3
Total LA Metro Region	0	2	0	0	2	4	0	0	1	0	0	0	0	2	5	3	1	1	3	5	6
Tustin	1	1	1																1	1	1
San Diego		1	1			1							1		2				0	1	3
San Bernardino	1	1	1		1									1					1	2	1
Rancho Cucamonga								1						1					0	1	0
Total Southern Region	2	3	3	0	1	1	0	1	0	0	0	1	0	2	2	0	0	0	2	5	5
Total - District Offices	8	7	7	0	5	5	0	2	2	0	2	2	0	9	9	3	1	3	11	17	19
Area Supervisors		1	1	1	1								1	1					1	2	1
Probation North	1				1			1						2	0				1	2	0
Probation LA Metro or South			1		1	1			1		3	1		4	3				0	4	4
Headquarters/Executive		2										2			2				0	2	2
Total	9	10	9	1	8	6	0	3	3	0	5	5	1	16	14	3	1	3	13	27	26

¹ Excludes 1 position that failed Academy training and 1 position that retired and then reinstated.

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We met with representatives of DCA's Division of Investigation to determine how many of the Medical Board's staff received a promotion when they transferred to that agency. Of the 14 positions that transferred to DCA during the past four (4) years, 12 were lateral transfers (86 percent) and did not receive any pay increase. Additionally, we understand that, for nearly all of these staff, the primary factors contributing to their decisions to separate from the Medical Board were:

- ❖ Difficulty and frustration working with HQES Attorneys
- ❖ Dissatisfaction with Medical Board management (e.g., effectiveness in resolving issues with HQES)
- ❖ An inability to effectively utilize their investigative skills under the VE Model.

High Investigator turnover over the past four (4) years necessarily compounded the performance problems that the Medical Board was already experiencing as a result of staffing reductions imposed on the District offices earlier in the decade. Additionally, the smaller pool of remaining seasoned Investigators was increasingly used throughout this period to provide training and mentoring to newly hired and less experienced staff.

As of late-2009 the Medical Board had thirteen (13) vacant Investigator positions, representing 16 percent of total authorized Investigator series positions. Typically, California State Government agencies operate with only about 5 percent of their positions vacant. The relatively high Investigator vacancy rate is partially attributable to the recent creation of five (5) new Investigator series positions for the Rancho Cucamonga-based OSM Unit (1 Supervising Investigator and 4 Investigators). In late-2009, Los Angeles Metro region offices accounted for a disproportionate share of vacant positions due, in part, to the recent transfer of four (4) Investigator series positions from Los Angeles Metro District offices to the OSM Unit. As with the lateral transfers of Medical Board staff to DCA's Division of Investigation, the Investigators that transferred to the OSM Unit did not receive a salary increase and are no longer be required to work under the direction of HQES Attorneys. As of May 2010, the Investigator vacancy rate was reduced to 5 percent (with positions in background accounted for as filled).

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H. Prior Analyses of the Impacts of Vertical Enforcement

Analyses of the impacts of Vertical Enforcement were previously completed during 2007 and 2009. Additionally, a one-page summary statistical report is provided on a quarterly basis to the Medical Board's Governing Board as part of the Board's quarterly meeting package. Below we summarize the findings and conclusions presented in these reports and identified deficiencies with the information provided.

I. November 2007 Medical Board Analysis

In November 2007 the Medical Board reported to the Legislature that implementation of VE had reduced the average time to complete investigations by ten (10) days. The Medical Board also reported reductions in:

- ❖ The average time to close cases without prosecution (6 days)
- ❖ The average time to obtain medical records (28 days)
- ❖ The average time to conduct physician interviews (20 days)
- ❖ The average time to obtain Medical Expert opinions (33 days)
- ❖ The average time for HQES to file accusations (29 days).

Some of these above findings appear inconsistent. For example, unless there were offsetting increases in the time needed for other investigative activities (which were not reported), it is difficult to reconcile the significant reductions shown in the average time to obtain medical records, conduct physician interviews, and obtain Medical Expert opinions with the minimal reductions shown in the total elapsed time to complete the investigations (10 days, or 6 days excluding cases referred for prosecution). Alternatively, there may be deficiencies with some of the data used for this report.

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2. June 2009 Integrated Solutions for Business and Government, Inc. Analysis

During 2009 the Medical Board commissioned a study by an independent consultant (Integrated Solutions for Business and Government, Inc.) to review Enforcement Program statistical data collected by the Medical Board from 2005 through 2008. In June 2009 the consultant reported that (1) significantly fewer investigations were completed during 2008 as compared to 2005 (1,100 during 2008 compared to 1,382 during 2005, including AHLP investigations), and (2) significantly fewer accusations were filed (205 during 2008 compared to 224 during 2005, including AHLP accusations). The consultant also reported that investigation timeframes had increased significantly. The consultant's findings included the following:

- ❖ For cases closed without a citation, public letter of reprimand, or referral for prosecution, the average elapsed time to complete investigations increased by more than three (3) months (to 12 months)
- ❖ For cases referred for prosecution, the average elapsed time to complete investigations increased by more than two (2) months (to 13 months)
- ❖ For cases referred for prosecution, the average elapsed time for HQES to file accusations decreased by a week (to about 5 months)
- ❖ For cases with an accusation filed, the average elapsed time from assigned for investigation to filing of the accusation increased by more than a month (to nearly 19 months).

3. Medical Board Quarterly Reports

Since mid-2008, a summary statistical report has been provided on a quarterly basis to the Medical Board's Governing Board as a part of its quarterly meeting packet. The current version of the Quarterly Report provides, on one page, a series of investigation and prosecution-related performance measures, by calendar year (or calendar quarter for partial years), for each period from 2005 through the most recently completed quarter. Data are presented for a subset of all cases categorized as "VE" cases, and for "All" cases combined. Data for "Non-VE" cases is not presented, but can be imputed from the other data presented. **Exhibit II-10**, on the next page, presents the same data as presented in the most recently published Quarterly Report for the five-year period from 2005 through 2009, plus imputed data for "Non-VE" cases. Below we provide an analysis of the data presented in Exhibit II-10, including analyses of identified deficiencies with the data.

**Quarterly Board Report
Investigation and Prosecution Timeframes¹**

Indicator	2005	2006			2007			2008			2009			2005 to 2009 Increase/ (Decrease) All ²	
	Prior to VE	All	Non-VE ²	VE	All	Non-VE ²	VE	All	Non-VE ²	VE	All	Non-VE ²	VE		
Shorter Cycle Interim Investigation Activities	Calendar Day Age from Request to Suspension Order Granted														
	Average	51	44	88	4	34	21	38	19	19	19	52	260	39	1
	Median	17	3	N/A	2	22	N/A	23	10	N/A	10	23	N/A	23	6
	Record Count	24	21	10	11	17	4	13	21	4	17	17	1	16	(7)
	Calendar Day Age from Request to Receipt of Medical Records														
	Average	58	53	78	37	59	163	57	63	378	58	73	0	73	15
	Median	32	31	N/A	26	31	N/A	31	28	N/A	28	32	N/A	32	0
	Record Count	475	376	148	228	264	5	259	256	4	252	243	0	243	(232)
	Calendar Day Age from Request to Physician Interview														
	Average	48	51	56	43	52	73	50	63	63	63	52	0	52	4
	Median	36	42	N/A	38	37	N/A	36	41	N/A	42	37	N/A	37	1
	Record Count	597	453	281	172	406	35	371	473	7	466	696	0	696	99
	Calendar Day Age from Request to Receipt of Expert Opinion														
	Average	51	47	50	35	51	80	43	50	50	50	48	48	48	(3)
	Median	41	35	N/A	31	36	N/A	35	39	N/A	38	36	N/A	35	(5)
Record Count	519	424	342	82	344	74	270	374	15	359	426	2	424	(93)	
Extended Cycle Time Processes	Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution														
	Average	271	299	326	138	330	637	268	374	822	358	383	1,727	381	112
	Median	252	285	N/A	134	304	N/A	269	335	N/A	324	346	N/A	346	94
	Record Count	827	703	601	102	648	109	539	609	21	588	673	1	672	(154)
	Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed														
	Average	556	554	607	140	543	730	340	565	928	493	584	956	578	28
	Median	525	504	N/A	120	523	N/A	339	541	N/A	486	575	N/A	569	50
	Record Count	187	149	132	17	198	103	95	157	26	131	189	3	186	2
	Calendar Day Age from Accusation Filed to Disciplinary Outcome³														
	Average	608	602	610	85	576	633	188	561	768	243	473	840	339	(135)
	Median	526	466	N/A	99	426	N/A	182	384	N/A	238	351	N/A	309	(175)
	Record Count	212	195	192	3	226	197	29	203	123	80	198	53	145	(14)

¹ Excludes Out-of-State (IDENT 16) and Headquarters (IDENT 20) cases.

² Supplemental data elements imputed from other data contained in the report.

³ Excludes Outcomes with no accusation filed.

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Suspension Orders – This is a measure of the number of requests for suspension orders granted and the average and median elapsed days from request to issuance of the suspension orders. The data presented includes interim suspension orders (ISOs), temporary restraining orders (TROs), and PC 23s. The data presented show that 24 suspension orders were granted during 2005, prior to implementation of VE. In all subsequent years fewer than 24 suspension orders were granted. In the most recent year (2009), 17 suspension orders were granted (32 percent fewer than granted during 2005). In 2009, the average number of elapsed days to obtain a suspension order (52 days) was nearly identical to the average number of elapsed days shown for 2005 (51 days).

Requests for Medical Records – This is a measure of the number of completed requests for medical records and the average and median elapsed days from request to receipt of the records. The data presented shows that 475 medical records requests were completed during 2005, prior to implementation of VE. In all subsequent years significantly fewer requests for medical records were completed. In the most recent year (2009), only 243 requests were completed (49 percent fewer than completed during 2005). In 2009, the average elapsed time to obtain medical records (73 days) was more than two (2) weeks longer than the average elapsed time shown for 2005 (58 days). However, much of the data shown in the Quarterly Report appears to be substantially incomplete. Complete data should probably show at least 400 to 500 requests for medical records per year. A possible source of this undercounting is a failure by District office staff to consistently post updates to CAS showing when medical records were requested and received. Additionally, medical records are sometimes requested from more than one provider for the same case and, in some cases, the records initially provided by the respondent are incomplete or are excessively redacted, prompting requests for supplemental submissions. These circumstances are not reflected in the data presented. In summary, the record counts and elapsed time data shown in the Quarterly Reports may not be representative of all completed medical record requests for some (or all) of the years shown.

Physician Interviews – This is a measure of the number of completed Subject interviews and the average and median elapsed days from request to completion of the interview. The data presented shows that 597 Subject Interviews were completed during 2005, prior to implementation of VE. In each of the next three (3) years, the Quarterly Report shows that 20 to 30 percent fewer Subject interviews were completed. Then, in the most recent year (2009), the Quarterly Report shows that 696 Subject interviews were completed (16 percent more than completed in 2005, and nearly 50 percent more than completed during the prior year). In 2009, the average elapsed time to complete Subject interviews (52 days) was marginally higher than the average elapsed time shown for 2005 (48 days). However, the data shown for most years appears to be substantially incomplete. Complete data should probably show at least 600 Subject interviews completed for all years. A possible source of this undercounting is a failure by District office staff to consistently post updates to the CAS system showing when each Subject interview was actually scheduled and completed. For example, in some years Medical Board staff may not have regularly posted CAS updates for so called

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"Knock and Talk" interviews because such interviews are not scheduled and completed in the same manner as are office interviews. In summary, the record counts and elapsed time data shown in the Quarterly Reprints may not be representative of all completed Subject interviews for several of the years shown. Also, this statistic does not capture any changes in the elapsed time needed to coordinate the scheduling of Subject interviews with the HQES' Primary DAG, if assigned.

Expert Opinions – This is a measure of the number of completed Expert opinions and the average and median elapsed time from request to receipt of the Expert opinion. The data presented shows that 519 Expert opinions were completed during 2005, prior to implementation of VE. In all subsequent years, about 20 to 30 percent fewer Expert opinions were completed. The need for Expert opinions is also dependent, in part, of the availability and capabilities of the Medical Consultants assigned to each District office. Medical Consultants, if sufficiently available, can potentially review many quality of care cases and, thereby, limit the number of cases submitted to the outside Medical Experts. Conversely, if Medical Consultant capabilities are limited, either in terms of availability or areas of specialization, then more cases may be referred to the outside Medical Experts. In 2009 the average elapsed time to complete Expert opinions (48 days) was marginally shorter than the average elapsed time to complete Expert opinions shown for 2005 (51 days). However, shifts in the mix of cases referred to outside Medical Experts could impact the average elapsed time to prepare the Expert opinions. Additionally, it is unclear whether the record counts and elapsed time data shown in the Quarterly Reports are representative of all completed Expert opinions for any particular year. Finally, this statistical measure does not account for the quality of the completed reports, or related needs for revised or supplemental reports.

Investigation Closed without Referral for Prosecution – This is a measure of the number of cases closed without referral for prosecution and the average and median elapsed time from assigned for investigation to closure of the case. The data presented show that 827 cases were closed following investigation during 2005, prior to implementation of VE. In all subsequent years, about 20 to 30 percent fewer cases were closed following investigation. Due to the extended cycle times associated with completing most investigations (1 to 2 years, or longer), the comparative data presented for VE (and Non-VE) cases during 2006, 2007, and 2008 are misleading and meaningless. Initially, all extended cycle time cases are included in the Non-VE case counts and no extended cycle time cases are included in the VE case counts because only investigations initiated after December 31, 2005, are included. In subsequent years, fewer cases with the most extended cycle times are included in the Non-VE case counts resulting in progressively longer average elapsed times (i.e., 326 days in 2006, 637 days in 2007, 822 days in 2008, and 1,727 days for a single remaining Non-VE case that was closed in 2009, nearly 5 years after it was assigned for investigation). Concurrently, increasingly larger numbers of more extended cycle time cases are included in the VE case counts, also resulting in progressively longer average elapsed times (i.e., 138 days in 2006, 268 days

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in 2007, 358 days in 2008, and 381 days in 2009). Eventually, as shown by the data presented for 2009, the average elapsed times shown for VE cases and for All cases combined converge (381 days and 383 days, respectively). In 2009, the average elapsed time to complete an investigation that was not referred for prosecution was 12.6 months (383 days). This was more than 3.5 months (40 percent) longer than the nine (9) month average elapsed time shown for 2005. Historically, cases closed without referral for prosecution represent about two-thirds of all completed investigations.

Accusations Filed – This is a measure of the number of accusations filed and the average and median elapsed time from assignment of the case for investigation to filing of the accusation. The data presented show that 187 accusations were filed during 2005, prior to implementation of VE. In subsequent years, the number of accusations filed fluctuated between about 150 and 200 per year. In the most recent year (2009), about the same number of accusations were filed (189) as were filed in 2005. Due to the extended cycle times associated with completing most Investigations and filing accusations (1 to 2 years, or longer), the comparative data presented for VE (and Non-VE) cases from 2006 through 2008 are misleading and meaningless. Initially, all extended cycle time cases are included in the Non-VE case counts and no extended cycle time cases are included in the VE case counts because only Investigations initiated after December 31, 2005, are included. In subsequent years, fewer cases with the most extended cycle times are included in the Non-VE case counts resulting in progressively longer average elapsed times (i.e., 607 days in 2006, 730 day in 2007, 928 days in 2008, and 956 days for three remaining Non-VE cases that were filed in 2009, more than two years after assigned for investigation). Concurrently, increasingly larger numbers of more extended cycle time cases are included in the VE case counts, also resulting in progressively longer average elapsed times (i.e., 140 days in 2006, 340 days in 2007, 493 days in 2008, and 578 days in 2009). Eventually, as shown by the data presented for 2009, the average elapsed times shown for VE cases and for All cases combined converge (578 days and 584 days, respectively). In 2009, the average elapsed time from assigned for investigation to accusation filed was more than 19 months (584 days). This was about one (1) month (5 percent) longer than the 18 month average elapsed time shown for 2005. Historically, cases referred for prosecution represent about one-third of all completed investigations.

Disciplinary Outcomes – This is a measure of the number of completed prosecutions and the average and median elapsed days from accusation filed to Board action. The data presented shows 212 disciplinary outcomes during 2005, prior to implementation of VE. In subsequent years, the number of disciplinary outcomes fluctuated between about 195 and 225 per year. In the most recent year (2009) there were fewer Disciplinary Outcomes (198) than in 2005. Due to the extended cycle times associated with prosecuting cases (typically 1 to 2 years, or longer), the comparative data presented for VE (and Non-VE) cases from 2006 through 2009 are misleading and meaningless. Initially, all extended cycle time cases are included in the Non-VE case counts and no extended cycle time cases are

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included in the VE case counts because only cases involving Investigations initiated after December 31, 2005, are included. In subsequent years, fewer cases with the most extended cycle times are included in the Non-VE case counts resulting in progressively longer average times (i.e., 610 days in 2006, 633 days in 2007, 768 days in 2008, and 840 days in 2009). Concurrently, increasingly larger numbers of more extended cycle time cases are included in the VE case counts, also resulting in progressively longer average times (i.e., 85 days in 2006, 188 days in 2007, 243 days in 2008, and 339 days in 2009). Eventually, perhaps in 2010 or 2011, the average elapsed times shown for VE cases and for All cases combined will converge. In 2009, the average elapsed time to complete prosecutions was 15.6 months (473 days). This was about 4.4 months (22 percent) shorter than the 20 month average elapsed time shown for 2005. However, this statistical measure is somewhat misleading because it does not account for the additional elapsed time, or changes in the average elapsed time, to investigate these cases and file the accusation. As discussed previously, the average elapsed time from assigned for investigation to accusation filed during 2009 was more than 19 months (about 1 month longer than shown for 2005). Thus, based on the data shown in the Quarterly Reports, the combined total average elapsed time to investigate *and* prosecute cases in 2009 was about 34 to 35 months (19 months plus 15.6 months). This compares to a combined total average elapsed time of 38 months in 2005, prior to implementation of VE. This is equivalent to a 10 percent reduction in total elapsed time for these cases. Historically, about one-third of cases assigned for investigation are referred for prosecution, and about 80 percent of these cases eventually reach a disciplinary outcome (about 25 percent of all cases investigated).

In summary, the statistical data presented in the Quarterly Reports show:

- ❖ A significant (32 percent) decrease in the number of suspension orders granted, and no significant change in the elapsed time to obtain the suspension orders
- ❖ A significant (20 to 30 percent) decrease in the number of cases closed following investigation, which historically account for about two-thirds of all completed investigations, and a significant (40 percent) increase in the average elapsed time to complete these investigations (from 9 months to 12.6 months)
- ❖ No significant change in the number of cases with a disciplinary outcome, which historically account for about 25 percent of all completed investigations, and a limited (10 percent) decrease in the average elapsed time to investigate and prosecute these cases (from 38 months to 34 to 35 months).

Finally, with respect to the disciplinary outcomes, no data is presented showing whether there was any change in the level of discipline imposed.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

I. Probation Program

Physicians placed on probation are subject to monitoring by Medical Board staff of the Probationer's compliance with the terms and conditions of their probation. These terms and conditions may include practice restrictions, requirements to complete specified educational, training, or treatment programs, or to take a professional competency or psychiatric examination.

Since the early-1990s the Medical Board has maintained a network of regional probation offices in Sacramento and the Los Angeles Metro area (e.g., Cerritos and Rancho Cucamonga). In addition to complete intake interviews of new probationers and monitoring Probationer compliance with the terms and condition of their probation, Investigators assigned to these offices also were responsible for investigating (1) complaints involving Probationers, (2) petitions of modification or termination of probation, and (3) petitions for reinstatement.

During the early-2000s, about 500 probationers were assigned to the Probation program, including about 100 cases that were inactive because the Probationer was practicing outside the State. During 2003/04 the total number of Probationers increased by about 10 percent to 547 cases. Since that time the number of Probationers has fluctuated between 510 and 550 cases. As of June 30, 2009, there were a total of 545 probation cases, including 109 inactive cases. Probation Program Investigators typically carried an average caseload of about 36 cases per position.

In recent years the Medical Board referred for investigation an average of 48 complaints involving Probationers per year. Many of these cases were actually originated by Probation Program Investigators. On average, about two-thirds of these cases were closed following investigation and about one-third were referred to HQES for prosecution. The proportion of cases referred for prosecution is comparable to that for cases involving Non-Probationers. The average elapsed time to complete these investigations recently increased from an average of less than 10 months for the 3-year period from 2005/06 through 2007/08, to nearly 11 months during 2008/09. During the past several years the average elapsed times to complete investigations of Probationers have been several months shorter than the average elapsed times to complete Investigations of Non-Probationers. This differential widened during the past several years in parallel with the deterioration in the average elapsed time required by District offices to complete investigations of Non-Probationers.

Over the past 10 years the Medical Board received an average of about 40 petitions for modification or termination of probation per year. The number of petitions for modification or termination of probation received fluctuated within a range of 30 to 50 petitions per year. Variations in the number of petitions for modification or termination of probation received appear to be correlated with the number of Probationers. During 2008/09, 40 petitions for modification or termination of probation were received. Also over the past 10 years, the Medical Board received an average of about 16 Petitions for Reinstatement per year. The number of petitions for reinstatement received fluctuated within a range of 10 and 25 petitions per year. During 2008/09, 18 petitions for reinstatement were received. Over the past six (6) years, the total number of all petitions received fluctuated within a fairly narrow range (50 to 65 per year). Investigations of petitions are generally completed more quickly than Investigations of complaints. During 2008/09 the average elapsed time to complete

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

investigations of petitions for modification or termination of probation was about six (6) months and the average elapsed time to complete investigations of petitions for reinstatement was about nine (9) months.

Until recently, authorized staffing for the Probation Program typically consisted of about 24 total positions, including:

- ❖ 1 Supervising Investigator II (based in Sacramento)
- ❖ 3 Supervising Investigator I (1 per office)
- ❖ 14 Senior Investigator/Investigator (4 to 5 per office)
- ❖ 3 Investigator Assistant (1 per office)
- ❖ 3 Clerical Support staff (1 per office).

However, during 2008/09 the Medical Board transferred all of its Assistant Investigator positions to the Probation Program and reclassified the positions to Inspector I/II. Concurrently, the Probation Program's Supervisory and Management positions were reclassified to non-sworn classifications (i.e., the 3 Supervising Investigator positions were reclassified to Inspector III and the Supervising Investigator II position was reclassified to Staff Services Manager I). Subsequently, during 2009/10 three (3) new Inspector positions and one (1) new support position were authorized for the Probation Program. Currently, the Probation Program is authorized a total of 26 positions, including one (1) Staff Services Manager I, three (3) 3 Inspector III, 16 Inspector I/II, and five (5) Technical/Clerical Support staff.

Concurrent with the organizational restructuring of the Probation Program, responsibility for investigation of complaints involving Probationers and petitions for reinstatement was transferred to the District offices. Also, petitions for modification or termination of probation were transferred to the District in cases, except in cases where the Petitioner has generally been complying with the terms and conditions of their probation and there are not any pending investigations involving the Petitioner. The workload restructuring will enable Probation Program staff to focus their efforts on monitoring Probationer compliance with the terms and conditions of their probation. As part of this restructuring, the scope of the VE Pilot Project was expanded to include District office investigations of complaints involving Probationers, some petitions for modification or termination of probation, and all petitions for reinstatement. Prior to 2008/09, HQES Attorneys were not usually involved with these investigations.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

J. Diversion Program

The Medical Board's Diversion program was first implemented in 1981. It was one of only a few State-operated impaired physician programs. The Medical Board's Diversion Program was a monitoring program and not a treatment program. Participants attempting to recover from their addiction were required to contract with the Diversion Program for a five-year period. The contract typically required participation in a treatment program, attendance at group meetings, random bodily fluid testing, and worksite monitoring. Medical Board staff developed customized contracts for each participant and then monitored the participant's compliance with the terms and conditions of their contract. During their participation in the Diversion Program, physicians were generally permitted to continue in practice, subject to the terms and conditions of their contract. The identity of participants in the Diversion Program was kept confidential. Some Diversion Program services, including the drug testing, laboratory, and group meeting components, were contracted out. Diversion Program staff maintained responsibility for case management and overall Diversion Program management and administrative functions.

During the 1980s, a series of reviews of the Diversion Program was completed by the Auditor General. The first review was completed in 1982. This review identified deficiencies with the Division of Medical Quality's oversight of the Diversion Program and with the Diversion's Program's monitoring of participants and the termination of participants that failed to comply with program requirements. A second review was completed during 1985. This review again identified deficiencies with the monitoring of participants and with the termination of participants that failed to comply with Diversion Program requirements. Also, deficiencies were identified with the collection of urine specimens and with the Medical Board's oversight of the Diversion Program. During 1986 a third review was completed. Again the Auditor General found systemic deficiencies with participant monitoring, including completion of periodic personal visits with the assigned Case Manager and the worksite monitoring, urine collection processes, and administrative record-keeping processes.

In 1996 the scope of the Diversion Program was expanded to include treatment for mental and physical disabilities unrelated to substance abuse (AB 1974, Friedman). In 2002 the Diversion Program was further expanded to include singly-diagnosed mentally ill physicians (SB 1950, Figueroa). Throughout this period, participation in the Diversion Program increased, but staffing levels remained unchanged. At one point when caseloads increased from 50 cases per Case Manager to more than 80 cases per Case Manager, new participant entries were delayed until caseloads decreased to more manageable levels.

During 2003/04 a comprehensive evaluation of the Diversion Program was completed by CPIL as a part of CPIL's assignment as the Medical Board Enforcement Monitor. At the time of the study, there were about 250 participants in the program. Authorized Diversion Program staffing included a Program Administrator based in Sacramento, five (5) Case Managers dispersed across the State, and four (4) Sacramento-based support staff (the same as existed in the mid-1990s). CPIL found that the Diversion Program's most important monitoring mechanisms were failing, including the Program's urine collection system which was the primary means used to monitor participants' sobriety and detect relapses. CPIL also concluded that:

- ❖ Case Managers were not consistently performing required monitoring activities

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

- ❖ Worksite monitoring and treating psychotherapist reporting were deficient
- ❖ There was an absence of enforceable rules or standards, including rules and standards regarding the handling of potentially dangerous physicians and the consequences for relapse
- ❖ The Diversion Program was significantly understaffed and isolated from the rest of the Medical Board.

CPIL developed a comprehensive set of ten (10) major recommendations for improvement to address the identified deficiencies.

During 2006/07 two (2) additional positions were authorized for the Diversion Program. During 2007 a follow-up review was completed by the Bureau of State Audits to determine whether the deficiencies identified by CPIL had been addressed. The Bureau of State Audits identified continuing systemic deficiencies, including significant deficiencies with the biologic fluid testing component of the program. Following publication of these findings, the Medical Board voted not to support legislation to continue the Diversion Program after June 30, 2008, when existing legislation would otherwise sunset the program. In November 2007 a transition plan for program participants was developed and approved by the Medical Board, and implemented during the remainder of the 2007/08 fiscal year. On July 1, 2008, the statutes governing the Diversion Program became inoperative and, by operation of law, were repealed on January 1, 2009.

II. Overview of the Evolution of the Medical Board’s Governance Structure, Licensing Fees, and Enforcement Program

K. Current Enforcement Program Organization and Staffing Resource Allocations

The Medical Board currently has 76 authorized Investigator and Senior Investigator positions, plus 19 Supervising Investigators (I or II). As shown by **Table II-8**, below, 10 of these positions are allocated to various Headquarters Units.

Table II-8. Investigator Positions Allocated to Headquarters Units

Headquarters Unit	Supervising Investigator I/II	Investigator/ Senior Investigator
Operation Safe Medicine (OSM)	1	4
Office of Standards and Training	3	2
Total Investigator Positions	4	6

The Medical Board’s District offices are organized into three (3) regional groups (Northern California, Los Angeles Metropolitan, and Other Southern California). Four (4) District offices are assigned to each region. A Supervising Investigator II oversees the operations of each region. Within each District office, a Supervising Investigator I provides first level supervision. Subordinate staffing typically consists of six (6) full-time Investigators (Investigator or Senior Investigator) and 1 to 2 full-time clerical support staff (Office Technician or Office Assistant). A few offices have only five (5) Investigators. In total, 96 permanent, full-time positions are currently authorized for the District offices, including 12 Supervising Investigators, 70 Investigators or Senior Investigators, and 14 Office Technicians or Office Assistants.

Some offices supplement their Investigator staffing capabilities with part-time, retired annuitants Investigators. About one-half of the offices supplement their clerical support staffing capabilities with part-time, retired annuitant Office Technicians or Office Assistants. Additionally, each District office is authorized 2 to 3 part-time Medical Consultants. While Investigator positions are allocated equally among District offices, Medical Consultant staffing levels vary considerably. For example, during 2008/09 the Medical Consultants at some District offices were paid a combined total of more than 1,500 hours (the equivalent of about 0.7 positions). At other District offices the Medical Consultants worked a combined total of less than 800 hours (the equivalent of less than 0.4 positions). Due to holidays, vacation, sick leave, and other paid time off, the hours actually worked by the Medical Consultants are less than the hours paid.

Including the Regional Area Supervisors, District office Supervisors, Investigators and Senior Investigators, and clerical support staff, each of the three (3) regions is allocated 30 to 35 percent of total available staffing resources, with the fewest positions allocated to the Other Southern California region. These allocations are reasonably consistent with the geographic distribution of cases referred for Investigation. As shown by **Exhibit VI-3** in Section VI (*Investigations*), about 38 percent of cases opened are assigned to District offices in the Northern California region, 35 percent of cases opened are assigned to District offices in the Los Angeles Metro region, and 27 percent of cases opened are assigned to District offices in the Other Southern California region.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

L. Pending 2010/11 Budget Change Proposals

A currently pending Budget Change Proposal (BCP), if adopted, would increase authorized Enforcement Program staffing by 22.50 positions. **Table II-9**, below, shows the planned disposition of the additional positions that would be authorized by this BCP.

Table II-9. Proposed New Enforcement Program Positions

Business Unit	2010/11				2011/12		Total
	SSM I	INDI- Sworn Staff	AGPA	MST/OT	INDI- Sworn Staff	AGPA	
CCU, Quality of Care Section			3.0				3.0
CCU, Physician Conduct Section			1.0	0.5			1.5
CCU, Case Management/Projects	1.0		1.0	1.0			3.0
Expert Reviewer Program			2.0				2.0
Office of Standards and Training			2.0				2.0
Disciplinary Coordination Unit						1.0	1.0
Assistant to Chief of Enforcement						1.0	1.0
Enforcement Analysts	1.0	3.0	1.0	1.0	3.0		9.0
Total	2.0	3.0	10.0	2.5	3.0	2.0	22.5

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

The BCP would provide:

- ❖ 2 positions to strengthen and enhance management and administration of the Expert Reviewer Program (e.g., Expert recruitment and training)
- ❖ 2 positions for the Office of Standards and Training, primarily to provide training-related services for CCU staff
- ❖ 1 position for the Discipline Coordination Unit to provide closer monitoring of disciplinary action cases
- ❖ 1 position to serve as an Assistant to the Chief of Enforcement
- ❖ 2 CCU positions to be used primarily to enhance screening of AHLP cases
- ❖ 5.5 CCU positions to be used primarily to enhance intake and screening of physician and surgeon Quality of Care cases and to improve management and administration of the specialty review process
- ❖ 9 positions to perform investigations, including six (6) "non-sworn" staff, with two (2) of the positions designated for AHLP cases.

It has not yet been decided whether the new "non-sworn" investigation positions will be based at Headquarters and will be used to conduct desk investigations of Section 801 (medical malpractice) cases, plus possibly some petitions for modification or termination of probation, petitions for reinstatement, criminal conviction reports, and probation violation cases. A workload-based analysis justifying the need for the nine (9) "non-sworn" positions was not prepared, but available data show that Section 801 cases alone currently account for about 10 percent of all cases referred to the District offices for investigation.

III. License Fees, Expenditures, and Fund Condition

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III. License Fees, Expenditures, and Fund Condition

Since increasing initial and biennial renewal fees for physicians and surgeons from \$600 to \$790, effective January 1, 2006, there have been continuing concerns regarding whether the higher fees are justified. Section 2435(h) of Article 20 of the *Medical Practice Act*, adopted in conjunction with the January 2006 fee increase, placed a statutory cap on the amount of reserves that the Medical Board could accumulate in its Contingent Fund. Section 2435(h) stated that "It is the intent of the Legislature that, in setting fees pursuant to this section, the board shall seek to maintain a reserve in the Contingent Fund of the Medical Board of California equal to approximately two months' operating expenditures."

Following adoption of the fee increase, during 2007 the Bureau of State Audits (BSA) completed a review of the Board's financial status and revenue, expenditure, and reserve projections. BSA concluded that, ". . . the Medical Board exceeded the mandated reserve, or fund balance, level by more than 100 percent in fiscal year 2006/07 and, therefore, needs to consider reducing or refunding license fees for physicians and surgeons." However, during 2009, Section 2435(h) was modified (AB 501, Emmerson) to enable the Medical Board to maintain a higher reserve fund balance equal to two to four months operating expenditures.

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

AB 501 also modified Section 2435(i) to require that the Office of State Audits and Evaluation, within the Department of Finance, complete another review of the Medical Board's financial status, including its revenue, expense, and reserve projections. This review is required to be completed by June 1, 2012. The scope of the review also encompasses assessment of the impact of a \$6 million loan from the Medical Board Contingent Fund to the General Fund made pursuant to the *Budget Act of 2008*. Funding was not provided for the review.

This section presents results of our assessment of the Medical Board's current fiscal status and compliance with Section 2435(h) of the *Medical Practice Act*. Additionally, we critically reviewed each major category of expenditures. Results of our review show that, within 2 to 3 years, the Medical Board's reserves are likely to decrease to a level equivalent to less than four (4) months' operating expenditures. Additionally, we determined that expenditures for HQES legal services have escalated rapidly in recent years, and now account for more than 25 percent of total expenditures. We also identified potential internal control issues involving HQES' billings to the Medical Board, and potential overcharges for HQES' services.

III. License Fees, Expenditures, and Fund Condition

The section is organized as follows:

Subsection	Title
A.	Fees and Other Revenues
B.	Personal Services and Operating Expenditures
C.	Reimbursements and Prior Year Adjustments
D.	Fund Condition
E.	Compliance with Section 2435(h) of the <i>Medical Practice Act</i> .

III. License Fees, Expenditures, and Fund Condition

A. Fees and Other Revenues

Table III-1, below, shows actual fees and other revenues collected for each of the past five (5) years, and budgeted fees and other revenues for 2009/10. As shown by Table III-1, total fees and revenues reached a peak level of \$52.1 million during 2007/08. Total fees and other revenues subsequently declined to \$51.3 million during 2008/09, and are projected to decline further to \$50.3 million during 2009/10.

Table III-1. Medical Board Contingent Fund Revenues

Revenues	Actual					2009/10 Budget
	2004/05	2005/06 ¹	2006/07	2007/08	2008/09	
Initial Licensing Fees (125700)	\$4,368	\$5,143	\$5,703	\$5,596	\$5,557	\$5,650
Renewal Fees (125800)	31,436	36,147	42,415	44,917	44,670	43,692
Other Fees, Fines, and Penalties (125600)	231	311	348	354	371	379
Delinquent Fees (125900)	79	79	94	102	101	101
Miscellaneous Revenue	61	51	40	43	42	35
Interest	369	566	1,088	1,079	572	429
Total Revenues	\$36,544	\$42,297	\$49,688	\$52,091	\$51,313	\$50,286

¹ Initial and biennial renewal fees increased to \$790 effective January 1, 2006.

The decrease in fee and other revenue collections is due primarily to a projected decline in renewal revenue in 2009/10. Renewal fees were projected to decrease by \$1 million during 2009/10. Through March 2010, actual renewal fees were \$40.8 million, or 93 percent of the amount projected for the full year. While a disproportionate share of renewal fees is normally collected during the first part of the year, actual renewal fees may exceed the amount budgeted, potentially by as much as \$1 million (equivalent to the amounts collected during each of the prior two (2) fiscal years).

Another factor contributing to the recent decreases in fee and revenue collections was a decrease in interest earnings. Due to declining market interest rates, interest earnings decreased by \$0.5 million during 2008/09. Interest earnings are projected to decrease further during 2009/10. Due to historically low short-term market rates, actual interest earnings through March 2010 were only \$90,000. Interest earnings during 2009/10 may be significantly less than the amount budgeted.

In summary, actual fees and other revenues for 2009/10 are unlikely to be less than budgeted. Due to greater than projected renewal fee collections, total fees and other revenues for 2009/10 could be significantly higher than budgeted. A portion of any surplus renewal fees collections could be offset by lower than projected interest earnings.

III. License Fees, Expenditures, and Fund Condition

B. Personal Services and Operating Expenditures

Exhibit III-1, on the next page, delineates actual personal services and operating expenditures by year for the past five (5) years, and projected expenditures for 2009/10. As shown by Exhibit III-1, total expenditures peaked at a level of about \$49.5 million during 2007/08, and then declined by \$1.75 million (4 percent) during 2008/09. The recent decrease in expenditures was due to (1) a decrease in salaries and benefits paid to Medical Board staff, (2) 4eductions in major and minor equipment purchases, and (3) decreases in general administrative and operating expenses, including reduced expenditures for professional services and lower costs for support services provided by DCA. These expenditure reductions resulted primarily from spending controls implemented during 2008/09 in response to the State's General Fund fiscal crisis. Additionally, charges during 2008/09 for legal services provided by the Attorney General and OAH were more than \$600,000 lower than the amounts charged during the prior fiscal year. Additional information regarding significant recent changes in expenditures is provided below.

1. Personal Services Expenditures

Expenditures for staff salaries and benefits were initially projected to decline by about \$1 million during 2009/10. However, primarily as a result of additional temporary help and overtime expenditures to reduce Licensing Program application backlogs, actual personal services expenditures during 2009/10 are unlikely to show much, if any, decrease from 2008/09 levels. Excluding decreases attributable to elimination of the Diversion Program, over the past five (5) years, total expenditures for personal services increased very little (less than 5 percent). The increase in expenditures for personal services over this period was limited by the Furlough Friday Program which reduced budgeted 2009/10 expenditures by nearly 15 percent. Without the Furlough Friday Program, expenditures for personal services over the past five (5) years would have increased by nearly 20 percent (about 4 percent per year).

Personal services expenditures include costs for part-time (Permanent Intermittent) Medical Consultants. Generally, each District office has 2 to 3 Medical Consultants assigned, and most of the Medical Consultants usually work at their assigned office for several hours either one or two days a week. During 2008/09 the Medical Consultants were paid a total of 13,991 hours (equivalent an average of about 22 paid hours per week per District office, or less than 7 full-time positions, statewide). Due to paid holidays, vacation, sick leave, and other paid time off, the actual hours worked by Medical Consultants during 2008/09 was less than 13,991 hours, and the average number of hours worked per week per District office was less than 22 hours. Total wages paid to Medical Consultants during 2008/09 were \$852,000 (\$61 per hour).

Historical and Budgeted Medical Board Expenditures

Personal Service and Operating Expenditures		Actual					2009/10 Budget ³
		2004/05	2005/06	2006/07 ¹	2007/08	2008/09 ²	
Personal Services	Salaries/Wages, Including Fitness Incentive Pay	\$12,688	\$12,647	\$13,253	\$13,527	\$13,425	\$13,336
	Staff Benefits	5,620	4,719	5,067	5,340	5,327	6,005
	Temporary Help (Medical Consultants, Retired Annuitants, and Student Assistants)	1,154	1,143	1,270	1,742	1,321	1,144
	Board Members	33	32	34	24	24	31
	Overtime (Primarily for the Licensing Program)	21	31	77	86	196	12
	DEC	21	32	27	22	0	0
	Salary Savings	0	0	0	0	0	(836)
	Total Personal Services Expenses	\$19,537	\$18,604	\$19,728	\$20,741	\$20,293	\$19,692
General Expenses	Printing, Communications, and Postage	\$1,413	\$1,050	\$1,121	\$1,350	\$1,475	\$1,603
	General Expense, Minor Equipment, and Insurance	535	626	716	928	721	472
	Travel	291	314	380	403	379	397
	Vehicle Operation/Other Items	273	269	350	446	300	262
	Training	57	45	79	74	89	66
	Total General Expenses	\$2,569	\$2,304	\$2,646	\$3,201	\$2,964	\$2,800
Facilities Operation (Rent)		\$1,851	\$1,963	\$2,814	\$2,235	\$2,173	\$2,702
Professional Services		\$605	\$788	\$1,397	\$1,386	\$870	\$983
Fingerprint Reports		\$358	\$382	\$380	\$334	\$332	\$492
Major Equipment (Items greater than \$5,000)		\$295	\$370	\$375	\$192	(\$9)	\$333
Legal Services	Attorney General Services	\$8,292	\$8,596	\$11,247	\$12,316	\$11,881	\$13,347
	Evidence/Witness Fees	1,563	1,367	1,215	1,391	1,519	1,893
	Office of Administrative Hearings	1,248	915	1,200	1,344	1,099	1,863
	Court Reporter Services	69	113	143	158	128	175
	Total Legal Services	\$11,172	\$10,991	\$13,805	\$15,209	\$14,627	\$17,278
Allocated Administrative & Data Processing	Department Prorata	\$3,296	\$3,395	\$3,670	\$3,906	\$3,671	\$3,882
	Statewide Prorata	1,185	1,315	1,376	1,794	2,323	1,699
	Consolidated Data Center (Teale)	304	293	238	259	300	647
	Data Processing	289	321	128	232	224	125
	Total Administrative and Data Processing Services	\$5,074	\$5,324	\$5,412	\$6,191	\$6,518	\$6,353
Other Expenses	DOI Investigations	\$0	\$0	\$0	\$2	\$0	\$0
	State Controller's Office (Including 21st Century Project)	0	0	0	38	2	0
	Special Adjustment	(24)	0	0	(1)	10	0
	Court-Ordered and Tort Payments	7	2	13	3	0	0
	Total Miscellaneous Expenses	(\$17)	\$2	\$13	\$42	\$12	\$0
Total Operating Expenses		\$21,907	\$22,124	\$26,842	\$28,790	\$27,487	\$30,941
Total Personal Services and Operating Expenses		\$41,444	\$40,728	\$46,570	\$49,531	\$47,780	\$50,633

¹ In 2006/07, authorized staffing levels increased by 12.50 positions (2.0 Diversion Program, 4.0 Investigators, 4.0 Investigative Assistants, 2.0 Information System Analysts, and 0.5 Staff Services Analyst).

² In 2008/09, authorized staffing levels decreased by 12.40 positions due to termination of the Diversion Program.

³ The 2009/10 budget incorporates cost-savings related to the Furlough Friday Program and includes unfunded allocations for six (6) new Operation Safe Medicine positions **(\$500,000)**, four (4) new Probation Program positions **(\$300,000)**, and contracts for Telemedicine (\$399,734 for the first year), an evaluation of Medical Board programs (\$159,300), and an analysis of Licensing Program business processes (\$40,350).

III. License Fees, Expenditures, and Fund Condition

2. General Expenses

The 2009/10 budget for general expenses, including printing, communications, postage, minor equipment, insurance, travel, and vehicle operations expenditures, was projected to decrease to \$2.8 million from more than \$2.9 million during 2008/09. Actual expenditures through March 2010 were \$1.6 million. For the full year actual expenditures are unlikely to be greater than the amount budgeted, and could be significantly less than budgeted. These cost-savings are attributable largely to implementation of expenditure control measures in response to the State's General Fund fiscal crisis. Over the past five (5) years, general expenses have increased minimally (less than 10 percent).

3. Facilities (Rent)

The 2009/10 budget for facility expenses was projected to increase to \$2.7 million from \$2.1 million during 2008/09. These expenditures are largely encumbered at the beginning of the year. Through March 2010, actual expenditures were \$2.1 million, or \$0.6 million less than budgeted. For the full year it is likely that actual expenditures will be significantly less than budgeted. Over the past five (5) years, rent costs have increased minimally (15 percent).

4. Professional and Other Services

For 2009/10, expenditures for professional services were budgeted to increase from \$0.9 million to \$1.0 million. However, the Medical Board's 2009/10 budget did not provide funding for several new professional services contracts, including contracts for the Telemedicine Pilot Program (\$399,734), an analysis of Licensing Program business processes (\$40,350), and this Medical Board Program Evaluation (\$159,300). Because of these additional costs, it is anticipated that actual professional services expenditures during 2009/10 will exceed the amount budgeted by several hundred thousand dollars. For 2009/10, the largest contract for services is a \$450,000 contract with First Data Merchant Services for statutorily mandated merchant credit card services. Other major recurring services contracts include:

- ❖ Department of Justice – Controlled Substance Utilization Review and Evaluation System (*\$150,000*)
- ❖ National Data Services – Plastic Pocket Licenses (*\$53,238*)
- ❖ Lexis/Nexis – Legal and Public Records (*\$50,400*)
- ❖ DFS Services, LLC – Credit Card Acceptance Services (*\$29,000*)
- ❖ Medtox Laboratories – Statewide Drug Testing (*\$16,050*)
- ❖ State Personnel Board – Psychological Screening for Peace Officers (*\$14,577*).

III. License Fees, Expenditures, and Fund Condition

5. Major Equipment Purchases

The 2009/10 budget for major equipment provided \$300,000 of funding to purchase new vehicles and other major equipment, such as copy machines, costing more than \$5,000. Due to expenditure controls implemented in response to the State's General Fund fiscal crisis, actual expenditures for major equipment will likely be significantly less than the amount budgeted. Historically, the Medical Board spends several hundred thousand dollars per year for major equipment purchases, principally for fleet and information technology infrastructure replacements.

6. Legal Services

During the past four (4) years expenditures for legal services increased by \$3.6 million (33 percent), from \$11 million during 2005/06 to \$14.6 million during 2008/09. Additionally, expenditures for legal services were projected to increase an additional 18 percent (\$2.7 million) during 2009/10. Expenditures for all categories of legal services were projected to increase significantly during 2009/10. Costs for services provided by the Attorney General were projected to increase by \$1.4 million (12 percent) and costs for services provided by OAH were projected to increase by \$0.7 million (69 percent). Significant increases were also projected for both evidence/witness fees and court reporter services. These budget projections appear to reflect an expectation that, during 2009/10, there would be a significant increase in prosecutorial activity and the number of administrative hearings. At the time these budget projections were prepared (Summer 2008), there was an expectation that implementation of the VE Pilot Project, and associated increases in HQES staffing, would result in faster referrals of cases for prosecution, reduced elapsed times from referral of cases for prosecution to settlement or hearing, and a reduction in the number of pending legal cases.

Through March 2010, actual expenditures for legal services provided by the Attorney General were \$9.9 million (75 percent of the amount budgeted). In contrast, costs for OAH through March 2010 were only \$0.56 million (30 percent of the amount budgeted) and expenditures for evidence/witness fees and court reporter services were only \$1.2 million (58 percent of the amount budgeted). Based on actual expenditures through March 2010, it is likely that costs for services provided by the Attorney General during 2009/10 will be about the same as the level budgeted, and that costs for all other legal services will be significantly less than budgeted.

Over the past five (5) years, evidence/witness fees have fluctuated between \$1.2 million and \$1.5 million. Of the total \$1.5 million amount spent during 2008/09, about 75 percent (\$1.1 million) was for Medical Expert review services, including:

- ❖ \$361,000 for Medical Specialist reviews of complaints during the initial complaint intake/screening process (an average of about 2.5 hours per case reviewed)

III. License Fees, Expenditures, and Fund Condition

- ❖ \$599,000 for investigation case reviews and Expert Witness testimony services (equivalent to an average of less than 15 hours per case reviewed, assuming about 400 completed case reviews).

Most of the remaining \$171,000 of expenditures for Medical Expert services was for competency evaluations (\$149,000).

Over the past five (5) years costs for legal services provided by the Attorney General increased by more than \$5 million (60 percent). In contrast, all of the Medical Board's other costs increased by only \$4.1 million (12 percent). The increase in costs for legal services provided by the Attorney General is partially attributable to a 30 percent increase in staffing (10 positions) that was authorized to support implementation of VE. Additionally, the hourly rates charged by the Attorney General increased. For example, over the past five (5) years the hourly rates charged for Attorneys increased by 22 percent, from \$139 per hour during 2004/05 to \$170 per hour during 2009/10. In contrast to the large increase in costs for legal services provided by the Attorney General, costs for evidence/witness fees, OAH, and court reporter services declined by 5 percent (from \$2.9 million during 2004/05 to \$2.75 million during 2008/09). Costs for legal services provided by the Attorney General currently account for more than 25 percent of total Medical Board expenditures.

The payment of the Attorney General's charges to the Medical Board is accomplished by the State Controller's Office (SCO). Payment by the SCO is not dependent on review or approval of the Attorney General's charges by the Medical Board. However, the Medical Board can review and analyze detailed time charge information supporting the charges that is included in a 700 to 900 page Invoice Report provided to the Medical Board each month. If errors are identified, the Medical Board can request an adjustment in subsequent billings.

The Attorney General's monthly Invoice Report details the hours charged by Attorneys and other HQES staff to each Investigation and Administrative matter opened in the agency's ProLaw System. Time charges are posted in quarter hour increments and coded and annotated to characterize the services provided. Separate pages of the report show, for each open matter, the time charged during the reporting period for each person that charged time to the matter, by date. Time that cannot be charged to individual cases, such as supervisory and management time, or general support services, is usually charged to a general client service matter. Some exceptions to this occur when staff incorrectly charge their general administrative support time to the wrong matter. Most staff charge some time to the general client service matter, but most non-Supervisory Attorneys charge nearly all of their time to individual cases. Time may also be charged to matters that are opened for Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters. The invoices can include some charges from non-HQES staff involved in Medical Board matters. However, time charges to Investigation and Administration matters, along with time charged to the general client service matter, account for most of the total hours charged.

During the course of our review we identified two (2) instances in which HQES Attorneys appear to have misreported a significant portion of their time during 2008/09. One of the Attorneys was the designated Lead Prosecutor for a Northern

III. License Fees, Expenditures, and Fund Condition

California District office and the second Attorney was the designated Lead Prosecutor for a Los Angeles Metro District office. **Exhibit II-2**, on the next three pages, provides recaps of the August 2008, January 2009, and June 2009 time charges for both of these Attorneys. The billing recaps show these Attorneys charged nearly all of their available hours to the Medical Board for Lead Prosecutor activities, with very few hours (or no hours at all) charged to specific Investigation or Prosecution matters. In contrast, other Attorneys throughout the State, irrespective of whether or not they are designated as Lead Prosecutors, generally do not charge all (or nearly all) of their time to the Medical Board, unless they are working full-time (and in some cases extended hours) preparing for and attending a hearing. In most cases Lead Prosecutors carry their own Investigation and Administrative caseloads in addition to their Lead Prosecutor assignments, and charge a portion of their time to these other matters. The only HQES personnel who generally charge very little time, or no time at all, to specific cases are the Senior Assistant Attorney General, the Supervising DAGs, and support staff.

We reviewed the Northern California Lead Prosecutor's time charges for August 2008, January 2009, and June 2009 with the Medical Board's District office Supervisor and with the Lead Prosecutor's Supervising DAG. Both Supervisors told us that the time charges appeared to be significantly overstated. Neither Supervisor could provide an explanation of how the Attorney had actually spent his time during these three (3) sample months. Both Supervisors confirmed that the time was not spent performing the Lead Prosecutor activities shown in these billings to the Medical Board. At the time of our review, this Attorney had already been reassigned to other duties and was no longer serving as a Lead Prosecutor.

We also reviewed the Los Angeles Metro Lead Prosecutor's time charges for August 2008, January 2009, and June 2009 with the Medical Board's District office Supervisor and the Lead Prosecutor's Supervising DAG. The District office Supervisor told us that the time charges, as shown, appeared to be significantly over-stated, but acknowledged that she didn't have complete knowledge of other activities in which the Lead Prosecutor might have been involved during these periods. The Supervising DAG also acknowledged that the Lead Prosecutor did not spend all of her time only performing Lead Prosecutor activities as shown in the billings, but suggested that HQES could research the matter and provide additional information that would account for all of the time charged. We did not ask HQES to research this matter further because further investigation of this issue was outside of the scope of our assessment.

With respect to these billings, we again emphasize that we reviewed all of the time charges by all HQES Attorneys for three (3) different months during 2008/09. During these months few other Attorneys ever charged all (or nearly) all of their available hours to the Medical Board except if they were preparing for, or attending, a hearing. In these circumstances, the hours to prepare for and attend the hearing were charged directly to the appropriate Administrative matter. During the three (3) sample months the Northern California Lead Prosecutor charged no hours to specific Administrative matters and the Los Angeles Metro Lead Prosecutor charged only one (1) day of time (8 hours) to a specific Administrative matter during one of the three (3) months, and a couple of hours of time on two (2) different days in another month.

**Sample Billings to Medical Board for Selected Lead Prosecutors
August 2008**

Date	Day	Northern California Lead Prosecutor			Los Angeles Metro Lead Prosecutor		
		Hours	Task Description	Narrative	Hours	Task Description	Narrative
08/01/08	Friday				8.00	Case Management	Case management and appearance at arraignment
08/04/08	Monday	10.00	Contract/Document Preparation	Preparation of Interim Suspension Order.	8.00	Case Review	VP/LP DBDO
08/05/08	Tuesday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO
08/06/08	Wednesday	10.00	Contract/Document Preparation	Interim Suspension Order Hearing.	8.00	Case Review	VP/LP DBDO
08/07/08	Thursday				8.00	Case Review	VP/LP DBDO
08/08/08	Friday	10.00	Contract/Document Preparation	Preparation of Interim Suspension Order.	8.00	Case Review	VP/LP DBDO
08/11/08	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO
08/12/08	Tuesday	10.00	Oral/Written Advice	Advice on investigations.	8.00	Case Review	VP/LP DBDO
08/13/08	Wednesday	10.00	Oral/Written Advice	Advice on investigations.	4.00	Case Review	VP/LP DBDO
08/14/08	Thursday	10.00	Document/Contract Review	Opening cases from D.O. and IPPR review.	4.00	Case Review	VP/LP DBDO
08/15/08	Friday				8.00	Case Review	VP/LP DBDO
08/18/08	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	4.00	Case Review	VP/LP DBDO Case Review
08/19/08	Tuesday	10.00	Oral/Written Advice	Advice on investigations.	8.00	Case Review	VP/LP DBDO Case Review
08/20/08	Wednesday	10.00	Client Consultation	Advice on pending cases.	8.00	Case Review	VP/LP DBDO Case Review
08/21/08	Thursday	10.00	Investigation Office Visit	Sac D.O. visit and advice on investigations.	8.00	Case Review	VP/LP DBDO Case Review
08/22/08	Friday				8.00	Case Review	VP/LP DBDO Case Review
08/25/08	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO Case Advice and Review
08/26/08	Tuesday	10.00	Oral/Written Advice	Advice on "Named Party" investigation	8.00	Advice	VP/LP DBDO Case Advice and Review
08/27/08	Wednesday	10.00	Oral/Written Advice	Vice on investigations.	8.00	Case Review	VP/LP DBDO Case Advice and Review
08/28/08	Thursday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO Case Advice and Review
08/29/08	Friday				4.00	Advice	VP/LP DBDO Case Advice and Review
Total Hours		160.00			152.00		

**Sample Billings to Medical Board for Selected Lead Prosecutors
January 2009**

Date	Day	Northern California Lead Prosecutor			Los Angeles Metro Lead Prosecutor		
		Hours	Task Description	Narrative	Hours	Task Description	Narrative
01/01/09	Thursday		State Holiday			State Holiday	
01/02/09	Friday						
01/05/09	Monday	10.00	Investigation Offiice Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO Case Review
01/06/09	Tuesday	10.00	Oral/Written Advice	Advice on investigations.			
01/07/09	Wednesday	10.00	Client Consultation	Investigators case review.	8.00	Case Review	VP/LP DBDO Case Review
01/08/09	Thursday	5.00	Document/Contract Review	Ippr evaluations.	3.00	Settlement Conference	Preparation for ESC 1/9/09
					2.00	Travel	Commute to/from DBDO
					3.00	Advice	VP/LP Advice & Case Review
01/09/09	Friday				2.50	Settlement Preparation/ Negotiation	ESC - Administrative Law Judge Montoya
					5.50	Case Review	LP/VP DBDO Case Review
01/12/09	Monday	10.00	Investigation Offiice Visit	Sac D.O. visit.	8.00	Case Review	LP/VP DBDO Case Review
01/13/09	Tuesday	10.00	Document/Contract Review	Investigation subpoena reviews.	8.00	Case Review	LP/VP DBDO Case Review
01/14/09	Wednesday				8.00	Case Review	LP/VP DBDO Case Review
01/15/09	Thursday				8.00	Case Review	LP/VP DBDO Case Review
01/16/09	Friday				8.00	Case Review	LP/VP DBDO Case Review
01/19/09	Monday		State Holiday			State Holiday	
01/20/09	Tuesday				8.00	Case Review	LP/VP DBDO Case Review
01/21/09	Wednesday				8.00	Case Review	LP/VP DBDO Case Review
01/22/09	Thursday				8.00	Case Review	LP/VP DBDO Case Review
01/23/09	Friday				6.00	Case Review	LP/VP DBDO Case Review
01/26/09	Monday	10.00	Investigation Offiice Visit	Sac D.O. visit.	8.00	Advice	LP/VP DBDO Case Review
01/27/09	Tuesday	10.00	Oral/Written Advice	Advice on investigations.	8.00	Case Review	LP/VP DBDO Case Review
01/28/09	Wednesday	10.00	Document/Contract Review	Subpoena reviews.	8.00	Case Review	LP/VP DBDO Case Review
01/29/09	Thursday	10.00	Investigation Offiice Visit	Sac D.O. visit.	8.00	Case Review	LP/VP DBDO Case Review
01/30/09	Friday						
Total Hours		95.00			134.00		

Sample Billings to Medical Board for Selected Lead Prosecutors
June 2009

Date	Day	Northern California Lead Prosecutor			Los Angeles Metro Lead Prosecutor		
		Hours	Task Description	Narrative	Hours	Task Description	Narrative
06/01/09	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/02/09	Tuesday	10.00	Oral/Written Advice	Advice on investigations at Fresno and Sac D.O.'s.	5.00	Advice	LP/VP MBC DBDO Case Advice and Review
06/02/09	Tuesday				3.00	Travel	Commute to/from DBDO
06/03/09	Wednesday	10.00	Document/Contract Review	Subpoena reviews.	8.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/04/09	Thursday	6.00	Investigation Office Visit	Sac D.O. visit.	5.00	Advice	LP/VP MBC DBDO Case Advice and Review
06/04/09	Thursday				3.00	Travel	Commute to/from DBDO
06/05/09	Friday				8.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/08/09	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/09/09	Tuesday	10.00	Oral/Written Advice	Advice on investigations.	5.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/09/09	Tuesday				3.00	Travel	Commute to/from DBDO
06/10/09	Wednesday	10.00	Investigation Office Visit	Sac D.O. work with investigators.	8.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/11/09	Thursday				6.00	Advice	LP/VP MBC DBDO Case Advice and Review
06/12/09	Friday				4.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/15/09	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO Case Advice and Review
06/16/09	Tuesday	10.00	Oral/Written Advice	Advice on investigations.			
06/17/09	Wednesday				8.00	Case Review	VP/LP DBDO Case Advice and Review
06/18/09	Thursday	15.00	Investigation Office Visit	Fresno D.O. visit.	3.00	Travel	Commute to/from DBDO
06/18/09	Thursday				5.00	Case Review	VP/LP DBDO Case Advice and Review
06/19/09	Friday				8.00	Advice	VP/LP DBDO Case Advice and Review
06/22/09	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	6.50	Advice	VP/LP DBDO Case Advice and Review
06/23/09	Tuesday	10.00	Document/Contract Review	Reviewing investigation reports.	3.00	Travel	Commute to/from DBDO
06/23/09	Wednesday				5.00	Advice	VP/LP DBDO Case Advice and Review
06/24/09	Thursday	10.00	Oral/Written Advice	Discussing cases with investigators.	8.00	Case Review	VP/LP DBDO Case Advice and Review
06/25/09	Friday	5.00	Investigation Office Visit	Sac D.O. visit.	3.00	Travel	Commute to/from DBDO
06/25/09	Friday	5.00	Client Consultation	Discussion with sup. 1 re new cases.	5.00	Advice	VP/LP DBDO Case Advice and Review
06/26/09	Saturday				8.00	Advice	VP/LP DBDO Case Advice and Review
06/28/09	Monday						
06/29/09	Tuesday	10.00	Investigation Office Visit	Sac D.O. visit.			
06/30/09	Wednesday	10.00	Oral/Written Advice	Advice on investigations to district office investigators for MBC.	3.00	Travel	Commute to/from DBDO
06/30/09	Wednesday				5.00	Advice	VP/LP MBC DBDO
Total Hours		161.00			152.50		

III. License Fees, Expenditures, and Fund Condition

In summary, during 2008/09, and possibly in some prior years and subsequently, the Medical Board may have been charged for some time that was not spent on Medical Board matters. The 700 to 900 page monthly Invoice Reports submitted to the Medical Board are not reviewed by HQES' Supervising DAGs and also are not reviewed by Medical Board staff, except at an aggregate level as needed for budget tracking purposes. It is our understanding that various reports are provided to HQES managers and supervisors on a monthly basis that enable them to review the reasonableness of subordinate staff time charges, but it appears that not all Supervising DAGs are fully utilizing these reports to ensure that time charges are posted properly by all of their staff.

Recommendation No. III-1. *Closely review each of the Attorney General's monthly Invoice Reports for the past three (3) fiscal years (2007/08 through 2009/10) to identify case billing inconsistencies by regions or billing anomalies that may have occurred. If significant over-charges are identified, request an adjustment in future billing periods.*

7. Allocated Administrative and Data Processing Costs

The 2009/10 budget for allocated administrative and data processing costs was projected to decrease to about \$6.35 million from about \$6.5 million in 2008/09. The amount budgeted for 2009/10 was 2.6 percent greater than actual expenditures for 2007/08. Based on actual expenditures through March 2010, total expenditures for allocated administrative and data processing costs during 2009/10 are likely to be approximately the same as the amount budgeted. Over the past five (5) years allocated administrative and data processing costs have increased by 25 percent, primarily due to increased allocations of Statewide Prorata and DCA administrative costs.

8. Total Personal Services and Operating Expenses

While actual expenditures for both personal services and outside professional services during 2009/10 are likely to be significantly greater than budgeted, these excess expenditures are likely to be more than offset by significant under-expenditures in several other areas, including general expenses, rent, major equipment, and legal services, except for services provided by the Attorney General. Total expenditures are unlikely to exceed the \$50.6 million amount budgeted for 2009/10, and could be significantly less than budgeted.

III. License Fees, Expenditures, and Fund Condition

C. Reimbursements and Prior Year Adjustments

Exhibit III-3, on the next page, shows reimbursements and prior year adjustments to the Medical Board Contingent Fund for each of the past five (5) years, and reimbursements budgeted for 2009/10. As shown by Exhibit III-3, budgeted reimbursements decreased during 2008/09 due to reduced reimbursements for probation monitoring. Reimbursements for probation monitoring were projected to decline further during 2009/10. However, through March 2010, actual reimbursements for probation monitoring were \$0.95 million, or 95 percent of the \$1 million amount budgeted. Reimbursements for probation monitoring during 2009/10 will likely exceed the amount budgeted.

Each year an adjustment to prior year costs is posted to the Medical Board's Contingent Fund. In recent years the adjustments have always been credits and, in some years, the amount of the credit has been significant (e.g., more than \$0.5 million). The amount of the adjustment, if any, that will be posted for 2009/10 cannot be determined.

Historical and Budgeted Medical Board Revenues, Expenditures, and Fund Reserves

Fund Condition Summary		Actual					2009/10 Budget ⁴
		2004/05	2005/06 ¹	2006/07 ²	2007/08	2008/09 ³	
Total Revenues		\$36,544	\$42,297	\$49,688	\$52,091	\$51,313	\$50,286
Personal Services Expenses		\$19,537	\$18,604	\$19,728	\$20,741	\$20,293	\$19,692
Operating Expenses		21,907	22,124	26,842	28,790	27,487	30,941
Total Personal Services and Operating Expenses		\$41,444	\$40,728	\$46,570	\$49,531	\$47,780	\$50,633
Adjustments	Reimbursements - Scheduled (Fingerprinting and Criminal Cost Recovery)	\$378	\$408	\$393	\$347	\$330	\$384
	Reimbursements - Unscheduled (Probation Monitoring)	2,120	1,819	1,495	1,498	1,215	1,000
	Distributed Costs (Budgeted AHLP Reimbursements)	646	791	711	691	677	677
	Internal Cost Recovery (Additional AHLP Reimbursement)	0	0	0	151	145	150
	Prior Year Reserve Adjustments	(1)	150	551	152	613	Unknown
Total Expenditures, Including Adjustments		\$38,301	\$37,560	\$43,420	\$46,692	\$44,800	\$48,422
Surplus/(Deficit)		(\$1,757)	\$4,737	\$6,268	\$5,399	\$6,513	\$1,864
Physician Loan Repayment Program		(\$1,150)	(\$1,150)	\$0	\$0	\$0	\$0
Teale Data Center Adjustment		78	0	0	0	0	0
Loan to General Fund		0	0	0	0	(6,000)	0
End of Year Reserves		\$8,540	\$12,127	\$18,395	\$23,794	\$24,307	\$26,171
Estimated Months Reserve (based on subsequent year expenditures)		2.7	3.4	5.1	6.4	6.0	6.0
Authorized Positions, Including Diversion Program		263.1	263.1	275.6	275.6	262.2	272.2

¹ Initial and biennial renewal fees increased \$790 effective January 1, 2006.

² In 2006/07 authorized staffing levels increased by 12.50 positions (2.0 Diversion Program, 4.0 Investigators, 4.0 Investigative Assistants, 2.0 Information System Analysts, and 0.5 Staff Services Analyst).

³ In 2008/09 authorized staffing levels decreased by 12.40 positions due to termination of the Diversion Program.

⁴ The 2009/10 budget incorporates cost-savings related to the Furlough Friday Program and includes unfunded allocations for six (6) new Operation Safe Medicine positions (**\$500,000**), four (4) new Probation Program positions (**\$300,000**), and contracts for the Telemedicine Pilot Program (\$399,734 for the first year), an evaluation of Medical Board programs (\$159,300), and an analysis of Licensing Program business processes (\$40,350).

III. License Fees, Expenditures, and Fund Condition

D. Fund Condition

Exhibit III-3, on the previous page, shows the amount of the surplus/(deficit) for the Medical Board Contingent Fund by year for the past five (5) years, and the projected surplus for 2009/10. Exhibit III-3 also shows end-of-year reserves for each year. As shown by Exhibit III-3, surpluses have been generated each year since implementation of the last fee increase during 2006. The amount of the surpluses ranged from \$4.7 million during 2005/06 to \$6.5 million during 2008/09. For 2009/10 a surplus of \$1.9 million was projected. However, it is likely that the surplus for 2009/10 will be greater than \$1.9 million due to:

- ✓ Higher than projected renewal fees
- ✓ Lower than projected expenditures for general expenses, rent, and major equipment
- ✓ Lower than projected expenditures for legal services, except services provided by the Attorney General
- ✓ Higher than projected probation monitoring reimbursements.

The total amount of these additional revenues and cost-savings are unlikely to be completely offset by lower than projected revenues, or greater than projected expenditures, in other areas (e.g., lower than projected interest earnings, higher than projected expenditures for temporary help and overtime for the Licensing Program, and higher than projected expenditures for professional services).

As shown by Exhibit III-3, end-of-year reserves were about \$24 million for the last two (2) years, after excluding a \$6 million loan to the General Fund, and reserves were projected to increase to \$26.2 million at the end of 2009/10, assuming a \$1.9 million surplus for that year. It is likely that reserves at the end of 2009/10 will be greater than \$26.2 million because it is likely that the 2009/10 surplus will be greater than the \$1.9 amount budgeted. An end-of-year reserve of \$26.2 million would be equivalent to nearly six (6) months of projected 2010/11 expenditures, assuming:

- ❖ Total fee and revenue collections are the same as budgeted for 2009/10 (\$50.3 million)
- ❖ \$3.2 million in additional salary and benefit costs related to the expected elimination of the Furlough Friday Program (assumes 17 percent higher salary and benefit costs than budgeted for 2009/10)
- ❖ \$0.9 million in additional salary and benefit costs for 17 new Enforcement Program positions included in DCA's Consumer Protection Enforcement Initiative BCP (assumes all positions start work on October 1, 2010, and an average annual cost of \$70,000 per position)
- ❖ \$0.5 million in additional salary and benefit costs for 7 new Licensing Program positions recently authorized by DCA (assumes all positions start work by July 1, 2010, and an average annual cost of \$70,000 per position)

III. License Fees, Expenditures, and Fund Condition

- ❖ \$0.5 million in additional operating expenditures (e.g., major equipment replacements, service contracts, etc.)
- ❖ \$1.1 million in cost-savings related to adoption of new salary and benefit cost containment programs (e.g., pay rate reductions)
- ❖ No offsetting reductions in expenditures for overtime or temporary help
- ❖ No new funding for six (6) new Operation Safe Medicine Unit positions and four (4) new Probation Program positions authorized during 2009/10.

With these assumptions total projected 2010/11 expenditures, net of reimbursement and cost recovery adjustments, would be about \$52.4 million (\$4.4 million per month). As has been the case for the past five (5) years, this level of reserves (\$26.2 million) significantly exceeds the maximum amount current set forth in Section 2435(h) of the *Medical Practice Act*. It is likely that reserves at the end of 2009/10 will be greater than \$26.2 million, and could approach a level equivalent to about 6.5 months of projected 2010/11 expenditures (\$28.6 million).

III. License Fees, Expenditures, and Fund Condition

E. Compliance with Section 2435(h) of the Medical Practice Act

Section 2435(h) of the *Medical Practices Act* requires that the Medical Board “maintain a reserve in the Contingent Fund of the Medical Board of California in an amount not less than two nor more than four months’ operating expenditures.” Current reserves significantly exceed the minimum requirement, as has occurred for the past several years. At 2009/10 budgeted expenditure levels, a two-month reserve would be about \$8 million, or \$18 million less than current reserves, excluding \$6 million loaned to the General Fund. However, results of our review show that, within 2 to 3 years, the Medical Board’s reserves are likely to decrease to a level equivalent to less than four (4) months’ operating expenditures.

As shown by Table III-2, below, even if total expenditures increase by about 8 percent during 2010/11 (to \$52.4 million), and increase by an additional \$1.6 million per year (3 percent) for the next several years, reserves at the end of 2012/13 will still exceed the minimum set forth in statute, excluding the \$6 million loan to the General Fund. The Medical Board’s proposed budget for 2010/11 assumes a similar \$4 million increase in total expenditures to \$52.4 million.

Table III-2. Projected End-of-Year Reserves

	2009/10	2010/11	2011/12	2012/13	2013/14
Total Fees and Revenues	\$50.3	\$50.3	\$50.3	\$50.3	\$50.3
Total Expenditures, Including Adjustments and Cost Recovery	48.4	52.4	54.0	55.6	57.0
Surplus/(Deficit)	\$1.9	(\$2.1)	(\$3.7)	(\$5.3)	(\$6.7)
End-of-Year Reserves	\$26.2	\$24.1	\$20.4	\$15.1	\$8.4
Estimated Months Reserve (based on subsequent year expenditures)	6.0	5.4	4.4	3.2	1.7

Regardless of whether expenditures increase by \$4.0 million in 2010/11, or a somewhat smaller amount, projected expenditures will likely exceed revenue collections during the year, and the resultant operating deficit will begin to deplete accumulated reserves. In subsequent years accumulated reserves will decrease further, assuming costs increase by several percent per year. It is likely that, at some point within the next two (2) to three (3) years, reserves will fall below the 4-month ceiling set forth in statute. However, in the absence of significant additional cost increases, reserves are unlikely to fall below the minimum 2-month level set forth in statute for at least several years. The \$6 million loan outstanding to the State’s General Fund is not expected to be repaid in the near future but, even if repaid, would not significantly impact the Medical Board’s fund condition because the amount is equivalent to less than 1.5 months’ expenditures.

Recommendation No. III-2. *Maintain the current \$783 initial and biennial fee structure. Reserves will likely fall below the 4-month ceiling set forth in statute within the next two to three years.*

IV. Overview of Complaint Workload, Workflows, and Performance

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IV. Profile of Complaints Opened and Dispositions

Complaint data reported historically by the Medical Board includes a mix of complaints and other types of matters that are captured and tracked in its Complaint Tracking System (CAS), including reports from law enforcement and criminal justice system agencies, reports from federal government agencies and physician licensing agencies in other states, probationary license certificates issued in lieu of full licensure, appeals of license application denials, referred to as statements of issues (SOIs), petitions for modification or termination of probation, petitions for reinstatement, and cases initiated based on audits of license compliance with Continuing Medical Education (CME) requirements.

In this section we identify some of the major differences in how these different types of complaints are handled by the Medical Board and related impacts on measures of Enforcement Program workload, workflow, and performance. Additionally, a summary of complaints received and dispositions by referral source is provided at the end of the section. The section is organized as follows:

Subsection	Title
A.	Overview of Complaint Workload, Workflows, and Performance
B.	Section 800 and 2240(a) Reports
C.	Disciplinary Action Reports Submitted by Other States
D.	Medical Board-Originated Complaints with District Office Identifiers
E.	Medical Board-Originated Complaints with Headquarters Unit Identifiers
F.	Medical Board-Originated Complaints with Probationer Identifiers
G.	Petitions for Modification or Termination of Probation
H.	Petitions for Reinstatement
I.	Other Complaints and Reports
J.	Complaint Workflows and Dispositions by Referral Source.

IV. Profile of Complaints Opened and Dispositions

A. Overview of Complaint Workload, Workflows, and Performance

Over the past eight (8) years, the number of complaints opened by the Medical Board declined by about 10 percent from an average of more than 8,000 complaints per year to about 7,200 complaints per year, excluding decreases attributable to changes implemented by the Medical Board to discontinue counting certain categories of complaints. Specifically, effective January 1, 2005, the Medical Board stopped counting complaints created when initiating change of address citations which, until recently, typically accounted for 250 to 350 complaints per year. Additionally, beginning in 2008/09 the Medical Board stopped opening complaints received that are determined during intake to be outside of the Board's jurisdiction. During 2008/09 about 800 non-jurisdictional complaints were not counted as received or closed. Excluding change of address citations and non-jurisdictional complaints identified during the CCU's initial intake process, 6,442 complaints were opened during 2008/09. This figure compares to an average of more than 7,400 complaints received per year during the early part of the decade, adjusted to exclude change of address citations and a comparable number of non-jurisdictional complaints.

Exhibit IV-1, on the next page, shows the number of complaints opened from 2000/01 through 2008/09 for each of the following 10 categories of matters:

- ❖ Mandated Section 800 and 2240(a) reports
- ❖ Disciplinary Action Reports Submitted by Other States
- ❖ Medical Board-Originated Complaints with District Office Identifiers
- ❖ Medical Board-Originated Complaints with Headquarters Unit Identifiers
- ❖ Medical Board-Originated Cases with CME Audit Failure Citation Identifier
- ❖ Medical Board-Originated Complaints with Probationer Identifier
- ❖ Medical Board-Originated Complaints with Other Identifiers
- ❖ Petitions for Modification or Termination of Probation
- ❖ Petitions for Reinstatement
- ❖ Other Complaints and Reports.

Exhibit IV-1 also shows, by year, the following aggregate output and performance measures:

- ❖ Number of complaints closed with no further action
- ❖ Number of complaints referred for investigation or prosecution
- ❖ Percent of cases referred for investigation or prosecution.
- ❖ Average elapsed time to close or refer cases for investigation or prosecution.

Overview of Complaints Opened and Dispositions - 2000/01 through 2008/09

Category of Complaints		2000/01 through 2002/03 (3-Year Avg.)	2003/04	2004/05 ¹	2005/06	2006/07	2007/08	2008/09 ²
Mandated Reports	Malpractice Reports from Insurers (Section 801 & 801.1)	888	787	722	726	676	597	605
	Malpractice Self-Reports (Section 801(c), 802, and 803.2)	328	228	212	185	187	150	204
	Malpractice Reports from Others (Section 803)	24	3	9	6	10	6	2
	Coroner Reports (Section 802.5)	32	18	23	11	22	16	16
	Health Care Facility Reports (Section 805)	146	157	110	138	127	138	122
	Surgical Death/Complication Self-Reports (Section 2240(a))	8	14	11	2	10	7	6
	Criminal Charge and Conviction Self-Reports (Section 802.1 and 803.5)	33	33	20	16	29	76	91
	Total Mandated Reports	1,459	1,240	1,107	1,084	1,061	990	1,046
Disciplinary Action Reports Submitted by Other States (IDENT 16)		323	371	448	385	279	288	258
Medical Board Originated Complaints with District Office Identifiers		286	212	202	216	216	161	113
Medical Board Originated Complaints with Headquarters Identifier ^{1 3} (IDENT 20, Excluding Petitions)		375	377	281	133	31	65	102
Medical Board Originated Complaints with CME Audit Failure Identifier (IDENT 21)		66	0	0	1	140	75	0
Medical Board Originated Complaints with Probationer Identifiers (IDENT 19)		6	13	22	23	9	11	34
Medical Board Originated Complaints with Other Identifiers ⁴ (IDENTs 22, 23, and 25)		32	12	7	9	10	6	10
Petitions for Modification or Termination of Probation (IDENT 26)		29	37	42	50	47	37	40
Petitions for Reinstatement (IDENT 27)		14	25	19	13	21	9	18
Other Complaints and Reports ^{1 2} Includes some NPDB reports (26 in 2008/09).		5,968	5,953	5,375	5,749	5,445	5,197	4,821
Total Complaints and Other Matters Opened^{1 2}		8,558	8,240	7,503	7,663	7,259	6,839	6,442
Complaints and Other Matters Closed		5,967	6,837	6,603	6,349	6,105	5,608	5,303
Complaints and Other Matters Referred for Investigation or Prosecution ^{1 3} Includes PLRs (31 in 2008/09).		2,355	1,887	1,443	1,331	1,182	1,133	1,123
Total Complaints and Other Matters Closed or Referred for Investigation or Prosecution^{1 2 3}		8,322	8,724	8,046	7,680	7,287	6,741	6,426
Percent of Cases Referred for Investigation or Prosecution^{1 3}		28%	22%	18%	17%	16%	17%	17%
Reported Average Days to Close or Refer Cases for Investigation or Prosecution ^{1 2 3}		55 Days	76 Days	66 Days	54 Days	54 Days	61 Days	75 Days
Reported Open Complaints and Petitions (End of Period)		2,019	1,566	1,011	1,086	1,133	1,283	1,323

¹ Effective in January 2005, change of address citations were no longer counted as complaints or investigations.

² Effective in 2008/09, some complaints received and determined by CCU to be outside of the Medical Board's jurisdiction were no longer counted as received or closed, thereby increasing CCU's reported average elapsed time to process complaints.

³ Includes probationary license certificates, SOIs, and criminal conviction notifications, advertising violations, and cite and fine non-compliance cases. Also includes change of address citation cases (through December 2004).

⁴ Includes Operation Safe Medicine, Internet Crimes Unit, and probation violation citation cases.

IV. Profile of Complaints Opened and Dispositions

Since the early part of the decade the number of complaints opened decreased significantly in both of the following areas:

Medical Malpractice Reports – The number of Medical Malpractice Reports submitted to the Medical Board decreased by 37 percent from an average of 1,240 reports per year during the early part of the decade to an average of 782 reports per year during the past two (2) years.

Out-of-State Disciplinary Action Reports – The number of Disciplinary Action Reports submitted to the Medical Board by medical/osteopathic boards in other states decreased by 27 percent from an average of about 350 reports per year during the early part of the decade to an average of 273 reports per year during the past two (2) years.

All complaints are opened by CCU, but are assigned different identifiers to distinguish the District office to which they are assigned. Additionally, CCU opens complaints on behalf of other Medical Board business units to track various matters that are not usually assigned to the District offices for investigation, including:

- ❖ Probationary License Certificates (issued in lieu of full licensure)
- ❖ Appeals of license application denials, referred to as statements of issues (SOIs)
- ❖ Continuing Medical Education (CME) audit failure citations
- ❖ Operation Safe Medicine (OSM) investigations
- ❖ Internet Crime investigations
- ❖ Probation violation citations
- ❖ Advertising violation citations
- ❖ Cite and fine non-compliance cases
- ❖ Petitions for modification or termination of probation
- ❖ Petitions for reinstatement.

In some years there have been significant changes in the number of complaint records opened by Headquarters Units for these matters. Since the early part of the decade the total number of complaint records opened for these matters has decreased by 60 percent (from more than 500 “records” opened per year to about 200 “records” opened per year).

Since the beginning of the decade the number of complaints submitted by patients, family members, other licensees, and numerous other similar external referral sources has fluctuated within a relatively narrow range (5,200 to 5,800 per year). There has been a significant increase in the number of complaints received since the beginning of the decade in only one category of complaints (criminal charge and conviction self-reports). The number of these reports recently increased primarily as a result of new requirements that licensees self-report misdemeanor charges and convictions in addition to previously required self-reporting of felony charges and convictions. This requirement became effective in January 2006 (SB 231, Figueroa).

Various changes that have occurred in the composition of complaints received since the early part of the decade (e.g., fewer medical malpractice reports, fewer Out-of-State reports, and fewer Medical Board-originated complaints). These changes appear to have

IV. Profile of Complaints Opened and Dispositions

had offsetting impacts on some aggregate complaint-handling performance measures. For example, over the past five (5) years the Medical Board consistently closed about 83 to 84 percent of all complaints, and referred the remaining 16 to 17 percent for investigation or prosecution.

Since 2004/05 the number of complaints closed, adjusted for recent changes in the handling and reporting of non-jurisdictional complaints, decreased by about 10 percent. Concurrently, the number of complaints referred for investigation or prosecution decreased by about 15 percent, after adjustment for changes in the reporting of change of address citation cases. During the past two (2) years, an average of 1,128 complaints was referred for investigation or prosecution – about 200 fewer complaints than were referred for investigation or prosecution during 2004/05, after adjustment for changes in the reporting of change of address citations.

From 2004/05 through 2007/08, the Medical Board maintained an average processing timeframe for complaints of about two (2) months (60 days). The recent increase in the average complaint processing time to 75 days in 2008/09 is partially attributable to elimination of about 800 non-jurisdictional complaints from the calculation of this performance measure.

Finally, during the early part of the decade the Medical Board closed or referred for investigation or prosecution significantly more complaints than were opened, and reduced the backlog of open complaints by 50 percent (from 2,000 open complaints to 1,000 open complaints). However, in recent years fewer complaints have been closed or referred for investigation or prosecution than have been opened, resulting in continuous increases in the number of pending complaints. At the end of 2008/09 there were 1,323 pending complaints. This is 300 (30 percent) more pending complaints than existed at the end of 2004/05. Inevitably, the growing number of open complaints will soon translate into longer average processing times, particularly given the continuation of the Furlough Friday Program through June 2010. Ultimately, over a period of several years, these complaint-handling delays will adversely impact aggregate Enforcement Program performance measures (e.g., total elapsed time from receipt of complaint to disciplinary outcome).

In the remainder of this section we present additional profile information pertaining to each of the major categories of complaints shown in Exhibit IV-1. These profiles highlight (1) significant changes in the number of cases handled by the Medical Board, (2) substantive differences in the processes used to screen and investigate the different types of cases, and related differences in the level of involvement of CCU and the District offices in these processes, and (3) related impacts on the process output and performance measures presented above. Finally, a more detailed statistical profile of complaint-handling workflows and dispositions during 2008/09, by referral source, is presented at the end of the section.

IV. Profile of Complaints Opened and Dispositions

B. Section 800 and 2240(a) Reports

Since the early part of the decade, the number of Section 800 and 2240(a) reports submitted to the Medical Board has decreased by more than 400 complaints per year. The decrease is attributable primarily to a decrease in the number of medical malpractice reports submitted by insurers, licensees, and others. Since the early part of the decade the number of medical malpractice reports has decreased by 37 percent from an average of 1,240 reports per year to an average 782 reports per year during the last two (2) years. Secondly, there has been a small decrease in the number of Section 805 reports submitted. These decreases have been partially offset by recent increases in the number of criminal charge and conviction self-reports submitted. The increase in criminal charge and conviction reports is largely attributable to recently imposed requirements that licenses self-report misdemeanor charges and convictions (SB 231, Figueroa). Prior to 2006 licensees were only required to report felony charges and convictions.

Following screening by CCU, a relatively large proportion of these cases (about 30 percent) is usually referred for investigation, and these cases account for a significant proportion of all cases referred for investigation. Aggregate measures of CCU output and performance, such as measures of the total number and proportion of cases referred for investigation, have been impacted by the significant decrease that has occurred in the number of Section 800 and 2240(a) reports received.

IV. Profile of Complaints Opened and Dispositions

C. Disciplinary Action Reports Submitted by Other States

During 2008/09 the Medical Board received 258 Disciplinary Action Reports from medical/osteopathic boards in other states. The complaint records opened for these reports are assigned a unique Identifier (IDENT 16). Historically, there have been significant fluctuations in the number of Out-of-State (IDENT 16) Reports received per year. Out-of-State cases only screened by CCU staff to determine if the other state's action was based on a disciplinary action previously taken by the Medical Board, in which case the complaint is closed. Most reports are not based on prior Medical Board disciplinary actions. However, the reports are only referred to District offices for investigation in cases where the licensee is practicing in California, which rarely occurs. Instead the cases are opened by CCU and transferred directly to the Discipline Coordination Unit (DCU). Depending on the basis for the other state's disciplinary action, DCU may:

- ❖ Close the case (e.g., the grounds for the other state's disciplinary action are not grounds for discipline in California)
- ❖ Issue a public letter of reprimand (subject to mutual consent by the Medical Board and the Licensee)
- ❖ Refer the case to HQES for prosecution.

Historically, a significant portion of Out-of-State cases have been included in statistical data showing the number of complaints referred for investigation and number of completed investigations referred to HQES for prosecution. The inclusion of these records in statistical data regarding the investigation process distorts some complaint-handling and investigation-related performance measures. For example:

- ❖ Measures of the number of completed investigations are over-stated because these cases are not actually investigated (as the term is conventionally defined)
- ❖ Measures of the average time taken to complete investigations are under-stated because the dates posted for these cases usually show that the investigation was both opened and completed within just one, or a few, business days
- ❖ Measures of the proportion of completed investigations referred to HQES are over-stated because a large proportion of these cases are referred directly to HQES without investigation and, in cases where a public letter of reprimand (PLR) is issued, the cases are not actually referred to HQES for prosecution, but for tracking purposes, are shown as if they were.

IV. Profile of Complaints Opened and Dispositions

D. Medical Board–Originated Complaints with District Office Identifiers

During the early part of the decade Medical Board staff typically originated nearly 300 complaints per year with District office Identifiers (IDENTs 2 to 18, excluding 16). In contrast, during 2008/09, only 113 complaints were opened by Medical Board staff with District office Identifiers. Some of these complaints are opened by CCU in response to requests from the Medical Board’s Executive Office or other Headquarters Units. Additionally, District office Investigators sometimes initiate these complaints when information is obtained during an investigation regarding other patients of the Subject of the investigation or other physicians involved in treating the patient. In these circumstances a new complaint may be opened and concurrently referred for investigation to the originating District office.

Table IV-1, below, shows the dispositions of Medical Board-originated complaints with District office Identifiers by year from 2000/01 through 2007/08. As shown by Table IV-1, nearly all of the decrease in this category of complaints is accounted for by a decrease in the number of complaints closed following investigation (from 148 complaints per year during the early part of the decade to 55 complaints during 2007/08). Additionally, the number of cases referred for prosecution decreased from an average of 51 cases per year during the early part of the decade to an average of 35 cases per year during the past several years.

Table IV-1. Dispositions of Medical Board-Originated Complaints with District Identifiers

Disposition	2000/01 to 2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Closed by CCU without Citation	61	69	83	85	77	68
Closed by Investigation without Citation	148	100	73	86	79	55
Closed by CCU or Investigations with Citation	15	3	3	5	3	2
Referred to HQES for Prosecution	51	31	37	35	45	25
Referred to District Attorney for Prosecution	11	9	6	5	12	7
Not Yet Determined	0	0	0	0	0	3
Total Dispositions	286	212	202	216	216	160

As shown by Table IV-1, during the early part of the decade a small percent of these cases was closed by CCU without referral for investigation (25 percent). In contrast, CCU closed 75 to 80 percent of all other complaints without referral for investigation. Of the complaints referred for investigation, the proportion subsequently referred for prosecution has generally been comparable to the referral rates for other complaints (e.g., 25 to 35 percent referred for prosecution).

IV. Profile of Complaints Opened and Dispositions

The inclusion of these records in statistical data regarding the Medical Board's complaint-handling and investigation processes distorts some related performance measures. For example, until recently:

- ❖ Measures of the number and proportion of complaints referred by CCU for investigation are over-stated because many of the cases were concurrently opened and referred to the originating District office for investigation without screening by CCU
- ❖ Measures of the average time taken to complete complaint processing are under-stated because many of these cases were concurrently opened and referred to the originating District office for investigation without screening by the CCU
- ❖ Measures of the average time taken to complete investigations are under-stated because the average time to complete these investigations, most of which were closed and not referred for prosecution, is several months less than the average elapsed time to complete investigations of other complaints (i.e., an average of about 7 months for Medical Board-originated cases compared to more than 10 months for cases originated based on information provided by external sources).

However, as the number of these complaints has decreased, the magnitude of these distortions has diminished.

The decrease in number of Medical Board-originated complaints referred for prosecution that has occurred in recent years is a potential cause of concern. However, it is not known whether Investigators are less focused on identifying other potential cases or whether the change that has occurred has contributed to reductions in (1) the number of multiple complaint cases, or (2) the total number of cases prosecuted.

IV. Profile of Complaints Opened and Dispositions

E. Medical Board–Originated Complaints with Headquarters Unit Identifiers

During 2008/09 the Licensing Division and other Headquarters business units opened more than 100 complaint records with a series of unique Identifiers (IDENTS 20 to 25) for cases involving:

IDENT 20 – Headquarters, including probationary license certificates, SOIs, and cite and fine non-compliance cases

IDENT 21 – Continuing Medical Education (CME) audit failure citation cases

IDENT 22 – Operation Safe Medicine (OSM) cases

IDENT 23 – Internet crime cases

IDENT 25 – Probation violation citation cases.

Until recently some of these cases were not assigned unique Identifiers. Instead, most were assigned the same Identifier (IDENT 20). SOIs and Cite and Fine Non-Compliance cases are referred by the originating Headquarters Unit directly to HQES without involvement of either the CCU or a District office. Most of the remaining cases, including probationary license certificates, and CME and probation violation citation cases, are not referred for investigation or to HQES for prosecution, but for tracking purposes are posted in CAS as if they were. With respect to CME audit failure citation cases, since the early part of the decade the Medical Board has not regularly performed audits of compliance with CME requirements. When CME audits were last performed during 2007, more than 200 citations were issued.

Historically, IDENT 20 to 25 cases have been included in statistical data showing the number of complaints referred for investigation and in the number of completed investigations referred for prosecution. The inclusion of these records in statistical data regarding the Medical Board’s investigation process distorts some related performance measures. For example:

- ❖ Measures of the number of completed investigations are over-stated because, with the exception of a small number of OSM and Internet crime cases, the cases are not actually investigated (as this term is conventionally defined)
- ❖ Measures of the average time taken to complete investigations are under-stated because the dates posted to the Complaint Tracking System for these cases usually show that the investigation was both opened and completed within just one, or a few, business days
- ❖ Measures of the proportion of completed investigations referred for prosecution are over-stated because many of the cases are not investigated prior to referral for prosecution and also because a significant portion of the cases are not actually referred for prosecution, but for tracking purposes are posted in CAS as if they were. Additionally, where a referral for prosecution actually occurs, this most commonly occurs as a part of the process of handling appeals of denied license applications (SOIs), a Licensing Program activity.

IV. Profile of Complaints Opened and Dispositions

F. Medical Board–Originated Complaints with Probationer Identifier

Complaints involving Probationers may originate from either external or internal Medical Board sources but, in all cases, are assigned the same unique Identifier (IDENT 19). Historically, most Medical Board-originated complaints involving Probationers were opened by regional Probation Unit Investigators based on information obtained from their probation monitoring activities. In these circumstances a new complaint was usually opened and concurrently referred for investigation to the originating Probation Unit.

During 2008/09 the Probation Units were restructured and Probationer complaint investigations were reassigned to the District offices. Concurrently, the cases were incorporated into the VE Pilot Project. Within the District offices, the cases are generally investigated using the same approach as is used for investigations of Non-Probationers.

During 2008/09 the Medical Board initiated 34 complaints involving Probationers (IDENT 19). The inclusion of these records in statistical data regarding the Medical Board's complaint-handling and investigation process distorts some related performance measures. For example:

- ❖ Measures of the number of complaints referred by CCU for investigation are over-stated because some of these cases are concurrently opened and referred to the originating Probation Unit or, following the restructuring of the Probation Program, to the District offices, without screening by CCU
- ❖ Measures of the average time taken to complete complaint processing are under-stated because the dates posted to the Complaint Tracking System for these cases usually show that the complaint was both opened and referred for investigation within just one, or a few, business days.

IV. Profile of Complaints Opened and Dispositions

G. Petitions for Modification or Termination of Probation

Petitions for modification or termination of probation (IDENT 26) are required to be submitted by Probationers directly to DCU. Typically, about 40 to 50 petitions for modification or termination of probation are received per year, of which a portion is requests for early termination of probation. In some cases Probationers submit both a petition for modification and a petition for termination of probation. In these cases the Medical Board treats and accounts for these cases as a single case. According to Medical Board staff, Probationers are increasingly submitting requests for early termination of probation at the first possible opportunity permitted under the terms and conditions of their probation.

DCU reviews submitted petitions and, if needed, obtains additional supporting documentation from the Probationer. Until recently, DCU forwarded the petition and supporting documentation directly to one of the Medical Board's regional Probation Units. Then, an assigned Probation Unit Investigator completed related background research, interviewed references, prepared a report summarizing results of their investigation, and forwarded the completed case to HQES. Recently, the Probation Units were restructured and some functions previously performed by the Probation Units were reassigned to the District offices. Now, DCU forwards the petitions for modification or termination of probation to the Probation Unit Supervisor who screens the petitions and determines whether to have the petitions reviewed by Probation Unit staff or refer the petitions to District offices for investigation. If there is a pending investigation involving the Probationer or the Petitioner has a record of compliance deficiencies, the cases are referred to a District office. Otherwise the cases are assigned to Probation Unit Inspectors for review. Cases referred to the District offices for investigation are included in the VE Pilot Project. Hearings are required for all petitions for modification or termination of probation, irrespective of the Petitioner's compliance record or the nature of the requested modifications to the terms of their probation. Consequently, all of these cases are referred to HQES to represent the Medical Board at the hearing.

Historically, IDENT 26 cases have been included in statistical data showing the number of complaints referred for investigation and the number of completed investigations referred for prosecution. The inclusion of these records in statistical data regarding the investigation process distorts some related performance measures. For example:

- ❖ Measures of the average timeframe to complete investigations are over-stated because only a limited level of investigation activity is required to be completed.
- ❖ Measures of the proportion of completed investigations referred for prosecution are over-stated because, unless the petition is withdrawn, an administrative hearing is always required to be completed as a part of the petition review process.

IV. Profile of Complaints Opened and Dispositions

H. Petitions for Reinstatement

Petitions for Reinstatement (IDENT 27) are required to be submitted by the Petitioner directly to DCU. Typically, fewer than 20 Petitions for Reinstatement are received per year.

DCU reviews the petitions and, if needed, obtains additional supporting documentation from the Petitioner. Until recently, DCU forwarded the Petition directly to one of the Medical Board's regional Probation Units. Subsequently, as assigned Probation Unit Investigator completed related background research, interviewed references, prepared a report summarizing results of their investigation, and forwarded the completed case to HQES. During 2008/09 the Probation Units were restructured and the functions previously performed by the Probation Units were reassigned to the District offices. Concurrently, all of these cases were incorporated into the VE Pilot Project.

Historically, IDENT 27 cases have been included in statistical data showing the number of complaints referred for investigation and the number of completed investigations referred for prosecution to HQES. The inclusion of these records in statistical data regarding the investigation process distorts some related performance measures. For example:

- ❖ Measures of the average timeframe to complete complaint investigations are over-stated because only a limited level of investigation activity is required to be completed
- ❖ Measures of the proportion of completed investigations referred for prosecution are over-stated because, unless the petition is withdrawn, an administrative hearing is always required to be completed as a part of the petition review process.

IV. Profile of Complaints Opened and Dispositions

I. Other Complaints and Reports

This category accounts for about 75 percent of all complaint records opened. About two-thirds of these complaints are received from patients or a member of their family, a friend, or a patient advocate. Excluding mandated Section 800 and 2240(a) reports, disciplinary action reports from other states (IDENT 16), complaints originated by Headquarters Units (IDENTs 20 to 25), complaints involving Probationers (IDENT 19), petitions (IDENTs 26 and 27), and change of address citations, during the early part of the decade the Medical Board received an average of about 5,600 complaints per year. This compares to an average of about 5,400 complaints received per year during the past two (2) years – a decrease of about 200 complaints per year, adjusted for changes in the handling and reporting of non-jurisdictional complaints. During the past five (5) years, the number of “Other Complaints” fluctuated within a limited range between 5,200 and 5,600 cases per year (including all non-jurisdictional complaints).

Following screening by CCU, only a small proportion of these cases (about 10 percent) is referred to the District offices for investigation. Aggregate measures of CCU performance, such as the proportion of cases closed and referred for investigation, have not been significantly impacted by the small decrease in number of complaints received from patients and others that has occurred since the early part of the decade.

IV. Profile of Complaints Opened and Dispositions

J. Complaint Workflows and Dispositions by Referral Source

Exhibit IV-2, at the end of this section, provides a more detailed statistical profile of complaints received, closed, and referred for investigation or prosecution during 2008/09. Significant characteristics of the complaints handled during 2008/09, shown by the data presented in Exhibit IV-2, include the following:

Out-of-State Disciplinary Action Reports – Reports submitted by medical/osteopathic boards in other states represented less than 5 percent of all complaints received during 2008/09, but accounted for the largest single source of referrals for prosecution (18 percent). During 2008/09, 60 Out-of-State cases were referred to HQES. Nearly all of these cases were handled by HQES' San Francisco office. Additionally, DCU issued a PLR for 24 other Out-of-State cases. Out-of-State cases are rarely referred to District offices for investigation.

Complaints Submitted by Patients and Related Parties – During 2008/09 complaints submitted by patients, patient advocates, family members, and friends represented nearly 60 percent of all complaints received and about 32 percent of all complaints referred for investigation. Only about 2 percent of cases received from these sources were subsequently referred for prosecution. During 2008/09, 81 cases from these sources were referred prosecution, accounting for 17 percent of total referrals for prosecution. Thus, while only a small percent of these cases are referred for prosecution, they still account for a significant proportion of all cases referred for prosecution.

Mandated Reports – Insurance company medical malpractice reports, Section 805 reports, and notices of arrests and convictions received from the Department of Justice together accounted for about 14 percent of complaints received, about 25 percent of all cases referred for investigation, and about 20 percent of all cases referred for prosecution. About 10 percent of the cases from these referral sources are referred for prosecution. Section 805 reports have one of the highest prosecution referral rates (29 percent).

Medical Board Originated Complaints with Headquarters Unit or Petition Identifiers – About 18 percent of the Headquarters-originated cases (84 of 464 total cases) are shown in CAS as referred for prosecution. However, a significant portion of these cases (e.g., probationary license certificates and CME audit failure citation cases) are not actually referred for prosecution and nearly all of the remaining cases are SOIs, petitions for modification or termination of probation, or petitions for reinstatement. District offices are not involved with SOIs, do not handle all petitions for modification or termination of probation, and the scope of the review completed by District offices for petitions for modification or termination of probation and for petitions for reinstatement is limited. Unless withdrawn, SOIs and petitions are always forwarded to HQES. Currently, HQES' San Francisco office handles nearly all SOIs.

IV. Profile of Complaints Opened and Dispositions

Medical Board-Originated Complaints with District Office and Probationer Identifiers – These cases represent only about 2 percent of complaints opened during 2008/09, but account for about 10 percent of referrals for investigation. Most of these cases are originated when Medical Board Probation Monitors (Inspectors) or District office Investigators identify, during the course of conducting other probation monitoring or investigation activities, probable violations of the terms and conditions of probation, the *Medical Practice Act*, or other laws. Consequently, the cases tend to have relatively high prosecution referral rates.

Other Referral Sources – All of the other categories of complaint referral sources collectively represent nearly 20 percent of complaints opened, 26 percent of cases referred for investigation, and 15 percent of cases referred for prosecution. About 6 percent of complaints from all of these other sources are referred for prosecution.

Overview of 2008/09 Complaint Handling and Dispositions by Referral Source

Referral Source	Quality of Care Complaints and Reports										Other Types of Cases										Total						
	CCU and Other HQ Business Units					Closed by Investigation		Referred for Prosecution			Total INV Closures and Legal Referrals	CCU and Other HQ Business Units				Closed by Investigation		Referred for Prosecution		Total INV Closures and Legal Referrals	CCU and Other HQ Units				Closed by Investigations	Referred for Prosecution ⁵	Legal Referrals - Percent of Complaints Received
	Received	Reviewed by Medical Consultant	Closed	Referred to Investigation		No Cite	Cite	HQE	DA ⁶	Received		Reviewed by Medical Consultant	Closed	Referred to Investigation		No Cite	Cite	HQE	DA ⁶		Received	Reviewed by Medical Consultant	Closed	Referred to INV			
				No.	%						No.			%	Received					Reviewed by Medical Consultant					Closed	Referred to INV	
Patient, Patient Advocate, Family Member or Friend (including 801.01(E) Reports)	2,075	1,165	1,810	247	12%	130	10	58	1	199	1,681	52	1,567	75	5%	59	3	18	4	84	3,756	1,217	3,377	322	202	81	2%
Insurance Companies and Employers (including 801.01(B&C) and NPDB Reports)	597	428	468	105	18%	92	7	27	0	126	14	1	11	3	21%	4	0	2	0	6	611	429	479	108	103	29	5%
Health Facilities (805 and Non-805 Reports)	82	0	4	80	95%	40	3	28	0	71	49	0	22	23	51%	12	2	10	0	24	131	0	26	103	57	38	29%
California Department of Health Services (or Successor State Agency)	38	17	19	14	42%	9	1	6	0	16	22	4	12	7	37%	7	1	1	0	9	60	21	31	21	18	7	12%
M.D., Pharmacist, Allied Health or Healing Arts Licensee, or Medical Society or Association	52	27	32	26	45%	14	0	6	1	21	235	10	216	31	13%	20	1	3	1	25	287	37	248	57	35	11	4%
CII - Department of Justice, Criminal Identification and Information Bureau	0	0	0	0	NMF	0	0	0	0	0	186	0	166	45	21%	19	1	25	0	45	186	0	166	45	20	25	13%
Other Governmental Agencies, Including FDA, DEA, Other DCA Boards and Bureaus, and 801 Reports	51	32	37	20	35%	10	0	2	0	12	42	0	40	9	18%	9	1	11	0	21	93	32	77	29	20	13	14%
Other ¹	71	16	46	25	35%	11	1	7	0	19	286	9	252	53	17%	29	0	11	3	43	357	25	298	78	41	21	6%
Police/Sheriff Department, Coroner's Office, District Attorney, and Courts (803 Reports, Criminal Filings, Non-Felony and Felony Conviction Reports)	32	10	23	16	41%	9	0	3	0	12	35	1	10	16	62%	7	2	6	0	15	67	11	33	32	18	9	13%
Licensee Self-Reporting (2240(A), 801.01, 802.01, 802.1, and Misdemeanor Conviction Reports)	204	149	141	35	20%	22	1	6	0	29	85	1	77	7	8%	4	1	1	0	6	289	150	218	42	28	7	2%
California Attorney General and Department of Justice, Including Medi-Cal Fraud and Narcotics Enforcement Bureaus	6	0	1	1	50%	1	0	1	0	2	24	0	27	1	4%	1	0	1	0	2	30	0	28	2	2	2	7%
Total, Excluding Out of State and Medical Board Cases	3,208	1,844	2,581	569	18%	338	23	144	2	507	2,659	78	2,400	270	10%	171	12	89	8	280	5,867	1,922	4,981	839	544	243	4%
Out of State Medical/Osteopathic Boards ² (16)	21	0	0	0	NMF	N/A	0	20	0	20	237	0	161	1	1%	2	0	69	0	71	258	0	161	1	2	89	34%
Medical Board Cases with District Identifiers (2 to 18, except 16)	47	10	19	31	62%	19	0	16	2	37	66	0	40	35	47%	31	0	12	4	47	113	10	59	66	50	34	30%
Medical Board Cases with Probationer Identifier (19)	2	0	1	1	50%	3	0	0	0	3	32	0	1	24	96%	12	0	19	0	31	34	0	2	25	15	19	56%
Petitions for Modification or Termination of Probation and Petitions for Reinstatement ³ (26 or 27)	0	0	0	0	NMF	0	0	0	0	0	58	0	0	58	100%	2	0	37	0	39	58	0	0	58	2	37	64%
Medical Board Cases with Other Identifiers ⁴ (20 to 25)	4	2	2	2	50%	1	2	0	0	3	108	0	74	6	8%	2	2	46	1	51	112	2	76	8	7	47	42%
Total, Including Out of State and Medical Board Cases	3,282	1,856	2,603	603	19%	361	25	180	4	570	3,160	78	2,676	394	13%	220	14	272	13	519	6,442	1,934	5,279	997	620	469	7%

¹ Includes CA Medical Review Inc., 803.6, 364.1, and NPDB Reports, Jury Verdict Weekly, HEAL, MQRC District, WE Tip, Consumer or Industry Group, Employee, Co-worker, Witness, Informant, Anonymous, and Unknown.

² Out-of-State cases are researched by the DCU. As appropriate, cases are referred directly to HQES without involvement of the District offices. Cases are only assigned to District offices when the licensee is practicing in California.

³ Petitions are initially handled by DCU which forwards the petition and supporting documentation to the Probation Monitoring Unit Manager who screens the petitions and either assigns to Probation Monitoring Unit staff or refers to the District offices for investigation. Completed cases are referred to HQES for hearing.

⁴ Includes probationary license certifications, license application denials (SOIs), CME audit failures, cite and fine non-compliance cases, and Operation Safe Medicine (OSM) and Internet cases. These matters are nearly always referred by the originating Headquarters Unit directly to HQES or, if applicable, a local District Attorney without any District office involvement.

⁵ Includes 31 pre-filing public letter of reprimand (PLR) cases not actually referred to HQES (Patient = 1, Insurer = 4, MD = 1, Licensee Self-Report = 1, and Out-of-State = 24).

⁶ Referrals to DA shown do not include ten (10) dual referrals.

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V. Complaint Intake and Screening

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V. Complaint Intake and Screening

This section presents results of our assessment of the Medical Board's complaint intake and screening processes. The section is organized as follows:

Subsection	Title
A.	Overview of Complaint Intake and Screening
B.	2008/09 Complaint Workloads and Processing Times
C.	Medical Specialist Reviews and Processing Times
D.	Disposition of Complaints Following Medical Specialist Review
E.	In-Depth Review of Complaints Taking Longer than Six Months to Refer to Investigation
F.	Pending Complaints
G.	Recommendations for Improvements.

V. Complaint Intake and Screening

A. Overview of Complaint Intake and Screening

CCU continues to do an outstanding job of administering and operating the Medical Board's complaint intake and screening processes. However, in recent years CCU has struggled to prevent growth in the number of pending complaints which is beginning to adversely impact elapsed timeframes to close or refer complaints for investigation or prosecution. During 2008/09 the CCU closed about 85 percent of all complaints, and the average elapsed time to close or refer these complaints for investigation or prosecution was 78 days (about 2.5 months), after excluding more than 800 closed non-jurisdictional complaints. If the non-jurisdictional complaints were included, CCU's average processing time would be about 67 days. During the years preceding 2008/09, the processing time for complaints averaged about 60 days (1 week less). In recent years the number of pending complaints has increased by about 30 percent (from 1,000 at the end of 2004/05 to more than 1,300 at the end of the 2008/09).

CCU's average processing time to close or refer complaints reflects the impacts of efforts to complete a substantive screening of all complaints to identify those that require a field investigation. The processes used to screen complaints, including independent review of nearly all quality of care complaints by a Medical Specialist, increase the amount of time needed to complete screening, but reduce the number of complaints referred to the District offices for investigation. It is much more effective and efficient for CCU to screen complaints than to have District office staff investigate and close the cases, and the case dispositions are determined within an average of about 2.5 months. Nearly 95 percent of the cases handled by CCU are closed or referred for investigation within a maximum of six (6) months.

Only about 15 percent of all complaints, those considered most likely to involve a violation of the *Medical Practice Act*, are referred for investigation, and about one-third of the cases referred for investigation are subsequently referred for prosecution. Because of the filtering performed by CCU, the District offices receive few complaints that do not require a substantive investigation. District offices, in turn, are expected to perform substantive investigations of the cases, and not simply re-screen and triage the cases to limit the number of investigations performed.

The specialist reviews and CCU's post-closure review processes help to ensure that cases requiring investigation are not improperly closed. Conversely, only a small percent of cases referred by CCU to the District offices are rejected and returned. Returns are usually due to either (1) referral of a complaint that is redundant to a currently pending investigation, or (2) referral of a complaint related to a pending multi-patient case investigation where the new patient would not strengthen the case if added to it. These cases are properly referred to the District offices for these determinations and, if returned, are properly accounted for as CCU rather than District office closures.

CCU does not conduct satisfaction surveys of patients and others that submit complaints to the Medical Board. Consequently, time series historical data showing levels of customer satisfaction are not available to determine what level of satisfaction is achieved and how it compares to historical levels. The last Customer Satisfaction Surveys were completed more than 10 years ago, several years prior to implementation of Medical Specialist reviews. Results of these surveys showed generally poor, but improving, levels of satisfaction with the services provided. For agencies like the Medical Board, the timeframe needed to resolve the complaint and the quality of communications with the Complainant are oftentimes correlated with customer satisfaction levels. It is unknown how customers would assess the level of services currently provided by CCU in either of these areas.

V. Complaint Intake and Screening

B. 2008/09 Complaint Workloads and Processing Times

Page 1 of Exhibit V-1, on the next page, shows the total number of complaints closed and referred to investigation or prosecution during 2008/09, and the average elapsed time to close, or refer, the complaints. Additionally, statistical data is presented for complaints reviewed by a Medical Specialist and for complaints not reviewed by a Medical Specialist. During 2008/09:

- ❖ More than 6,100 complaints were either closed or referred for investigation or prosecution by CCU. About 30 percent of these complaints were reviewed by an outside Medical Specialist prior to closure or referral for investigation or prosecution. About 85 percent of the complaints handled by CCU were closed.
- ❖ The average elapsed time for CCU to close or refer complaints for investigation or prosecution was 78 days (about 2.5 months), after excluding more than 800 closed non-jurisdictional complaints. If all non-jurisdictional complaints were included, CCU's average processing time would be about 67 days. Prior to 2008/09, the average processing time for complaints, including all non-jurisdictional complaints, was about 60 days (1 week less).
- ❖ The average elapsed time to close or refer complaints not reviewed by a Medical Specialist was about two (2) months (54 days). This compares to an average time of more than four (4) months (127 days) to close or refer complaints that were reviewed by a Medical Specialist.
- ❖ The average time to refer complaints for investigation or prosecution for cases not reviewed by a Medical Specialist was about one (1) month (33 days), reflecting both the expedited referral of selected, high-priority cases to investigation and also the accelerated processing timeframes associated with DCU's handling of Out-of-State cases, most of which are referred directly to HQES for prosecution.

Page 2 of Exhibit V-1 shows the total number of quality of care complaints closed and referred for investigation or prosecution during 2008/09 and the average elapsed time to close, or refer, the complaints. **Page 3 of Exhibit V-1** shows the total number of other complaints closed and referred to investigation or prosecution during 2008/09 and the average elapsed time to close, or refer, the complaints. As shown by Exhibit V-1, quality of care complaints represented about one-half of all complaints closed or referred, and the average time to close or refer quality of care complaints was about three (3) months (96 days) compared to about 2 months (56 days) for other complaints. quality of care complaints reviewed by a Medical Specialist took an average of more than four (4) months to close or refer. Of more than 400 complaints that took longer than six (6) months to close or refer, nearly three quarters were quality of care complaints, and nearly all of these complaints were reviewed by a Medical Specialist.

Summary of 2008/09 CCU Processing Timeframes for All Complaints

Disposition	Months	Not Reviewed by Medical Specialist ¹		Reviewed by Medical Specialist		Total	
		Number	Percent	Number	Percent	Number	Percent
Closed	Less than 1 Month	1,479	41%	6	0%	1,485	29%
	1 to 2 Months	720	20%	107	7%	827	16%
	2 to 3 Months	598	17%	304	19%	902	17%
	3 to 4 Months	366	10%	415	26%	781	15%
	4 to 6 Months	315	9%	510	32%	825	16%
	Longer than 6 Months	112	3%	237	15%	349	7%
	Total	3,590	100%	1,579	100%	5,169	100%
	Average Days	58 Days		129 Days		80 Days	
Referred to Investigation or Prosecution ²	Less than 1 Month	391	62%	8	2%	399	41%
	1 to 2 Months	139	22%	43	12%	182	19%
	2 to 3 Months	37	6%	70	20%	107	11%
	3 to 4 Months	29	5%	82	24%	111	11%
	4 to 6 Months	23	4%	97	28%	120	12%
	Longer than 6 Months	8	1%	48	14%	56	6%
	Total	627	100%	348	100%	975	100%
	Average Days	33 Days		120 Days		65 Days	
Total	Less than 1 Month	1,870	44%	14	1%	1,884	31%
	1 to 2 Months	859	20%	150	8%	1,009	16%
	2 to 3 Months	635	15%	374	19%	1,009	16%
	3 to 4 Months	395	9%	497	26%	892	15%
	4 to 6 Months	338	8%	607	31%	945	15%
	Longer than 6 Months	120	3%	285	15%	405	7%
	Total	4,217	100%	1,927	100%	6,144	100%
	Average Days	54 Days		127 Days		78 Days	

¹ Excludes 13 closed records and 145 records referred by Medical Board Headquarters or Probation Units directly to the District offices or HQES. Nearly all of the excluded records were SOIs, petitions for modification or termination of probation, petitions for reinstatement, or probation violation matters originated by Medical Board Headquarters or Probation Units.

² Includes all Out-of-State (IDENT 16) cases, most of which are referred directly to HQES for prosecution.

2008/09 CCU Processing Timeframes for Quality of Care Complaints

Disposition	Months	Not Reviewed by Medical Specialist ¹		Reviewed by Medical Specialist		Total	
		Number	Percent	Number	Percent	Number	Percent
Closed	Less than 1 Month	317	30%	5	0%	322	12%
	1 to 2 Months	255	24%	94	6%	349	14%
	2 to 3 Months	280	27%	297	19%	577	22%
	3 to 4 Months	123	12%	405	26%	528	20%
	4 to 6 Months	65	6%	500	33%	565	22%
	Longer than 6 Months	13	1%	229	15%	242	9%
	Total	1,053	100%	1,530	100%	2,583	100%
	Average Days	60 Days		129 Days		101 Days	
Referred to Investigation or Prosecution ²	Less than 1 Month	209	74%	7	2%	216	36%
	1 to 2 Months	49	17%	29	9%	78	13%
	2 to 3 Months	14	5%	66	21%	80	13%
	3 to 4 Months	7	2%	79	25%	86	14%
	4 to 6 Months	2	1%	93	29%	95	16%
	Longer than 6 Months	3	1%	45	14%	48	8%
	Total	284	100%	319	100%	603	100%
	Average Days	25 Days		123 Days		77 Days	
Total	Less than 1 Month	526	39%	12	1%	538	17%
	1 to 2 Months	304	23%	123	7%	427	13%
	2 to 3 Months	294	22%	363	20%	657	21%
	3 to 4 Months	130	10%	484	26%	614	19%
	4 to 6 Months	67	5%	593	32%	660	21%
	Longer than 6 Months	16	1%	274	15%	290	9%
	Total	1,337	100%	1,849	100%	3,186	100%
	Average Days	52 Days		128 Days		96 Days	

¹ Excludes six (6) records referred by Headquarters Units directly to the District offices or HQES.

² Includes all Out-of-State (IDENT 16) cases, most of which are referred directly to HQES for prosecution.

2008/09 CCU Processing Timeframes for Other Complaints

Disposition	Months	Not Reviewed by Medical Specialist ¹		Reviewed by Medical Specialist		Total	
		Number	Percent	Number	Percent	Number	Percent
Closed	Less than 1 Month	1,162	46%	1	2%	1,163	45%
	1 to 2 Months	465	18%	13	27%	478	18%
	2 to 3 Months	318	13%	7	14%	325	13%
	3 to 4 Months	243	10%	10	20%	253	10%
	4 to 6 Months	250	10%	10	20%	260	10%
	Longer than 6 Months	99	4%	8	16%	107	4%
	Total	2,537	100%	49	100%	2,586	100%
	Average Days	57 Days		116 Days		58 Days	
Referred to Investigation of Prosecution ²	Less than 1 Month	182	53%	1	3%	183	49%
	1 to 2 Months	90	26%	14	48%	104	28%
	2 to 3 Months	23	7%	4	14%	27	7%
	3 to 4 Months	22	6%	3	10%	25	7%
	4 to 6 Months	21	6%	4	14%	25	7%
	Longer than 6 Months	5	1%	3	10%	8	2%
	Total	343	100%	29	100%	372	100%
	Average Days	41 Days		89 Days		45 Days	
Total	Less than 1 Month	1,344	47%	2	3%	1,346	42%
	1 to 2 Months	555	19%	27	35%	582	18%
	2 to 3 Months	341	12%	11	14%	352	11%
	3 to 4 Months	265	9%	13	17%	278	9%
	4 to 6 Months	271	9%	14	18%	285	9%
	Longer than 6 Months	104	4%	11	14%	115	4%
	Total	2,880	100%	78	100%	2,958	93%
	Average Days	55 Days		106 Days		56 Days	

¹ Excludes 13 closed records and 139 records referred by Headquarters or Probation Units directly to the District offices or HQES. Nearly all of the excluded records were SOIs, petitions for modification or termination of probation, petitions for reinstatement, or probation violation matters originated by Headquarters or Probation Units.

² Includes all Out of State (IDENT 16) cases, which are nearly always referred directly to the AG rather than to the District offices for investigation.

V. Complaint Intake and Screening

C. Medical Specialist Review Workloads and Processing Times

Exhibit V-2, on the next two pages, shows the number of Medical Specialist reviews completed during 2008/09, by medical specialty, and the average elapsed times to assign the cases and complete the reviews. As shown by Exhibit V-2, the average elapsed times to complete Medical Specialist reviews vary by specialty. For six (6) high volume specialties, which collectively account for nearly two-thirds of all reviews, the average elapsed time to complete the reviews is about one (1) month (31 days). This compares to an average elapsed time of about two (2) months for 14 moderate volume specialties that collectively account for most of the remaining reviews.

For nearly all of the moderate volume specialties, the Medical Board has available a pool of fewer than 10 Medical Specialists to perform the reviews. For nine (9) of the 14 moderate volume specialties, a pool of five (5) or fewer Medical Specialists is available to review the complaints. The small number of Medical Specialists available to perform reviews of moderate volume specialty complaints contributes to the longer time needed to complete the reviews. However, the moderate volume specialties represent less than one-third of all reviewed complaints, and the Medical Specialist review process accounts for only about one-half of the total elapsed time to process these complaints. Therefore, significantly reducing the average elapsed time to complete the reviews (e.g., to the same one-month average timeframe achieved for high volume specialties), will only marginally improve the Medical Board's overall average complaint processing performance.

Central Complaint Unit - 2008/09 Specialty Reviews

High Volume Specialties	Number	Average Days to Assign	Average Days to Complete	Total Days
Internal/General Medicine	546	10	15	25
Obstetrics & Gynecology	149	16	26	43
Plastic/Cosmetic Surgery	126	14	18	32
Orthopedic Surgery	123	15	13	27
Surgery	115	33	19	52
Emergency Medicine	100	10	14	24
Average - High Volume Specialties (6)	1,159	14	17	31
Moderate Volume Specialties	Number	Average Days to Assign	Average Days to Complete	Total Days
Ophthalmology	78	44	24	67
Urology	54	41	19	61
Radiology	53	42	38	80
Cardiology	49	23	21	44
Psychiatry	46	32	29	60
Orthopedics	44	12	12	25
Pediatrics	38	36	40	76
Gastroenterology	31	28	20	47
Anesthesiology	30	44	22	66
Dermatology	30	21	23	45
Neurology	28	47	34	80
Neurological Surgery	25	44	32	76
ENT/Otolaryngology	26	36	17	53
Hematology/Oncology	21	39	36	75
Average - Moderate Volume Specialties (14)	553	35	26	61

Central Complaint Unit - 2008/09 Specialty Reviews

Low Volume Specialties	Number	Average Days to Assign	Average Days to Complete	Total Days
Pulmonology	12	12	14	26
Thoracic Surgery	11	29	12	40
Pain Medicine	10	45	22	67
Cardiothoracic Surgery	5	34	10	44
Physical Medicine & Rehabilitation	5	9	22	31
Colon & Rectal Surgery	4	30	33	63
Family Medicine	4	26	25	50
Perinatal/Neonatal	4	26	17	43
Nephrology	3	8	10	18
Nuclear Medicine	3	42	47	89
Endocrinology	2	56	21	77
Pathology	2	42	12	54
Rheumatology	2	29	34	63
Spine Surgery	2	2	10	12
Vascular Surgery	2	45	34	79
Allergy & Immunology	1	4	22	26
Alternative Medicine	1	64	7	71
Gynecology Oncology	1	16	26	42
Hematology/Oncology - Pediatrics	1	46	23	69
Medicine/Pulmonology	1	75	34	109
Midwifery	1	14	25	39
Pain Management	1	27	24	51
Pathology - Forensic	1	42	44	86
Pediatric Surgery	1	22	21	43
Pediatric Cardiology	1	49	28	77
Radiology Oncology	1	60	38	98
Retinal Specialty	1	9	15	24
Total Low-Volume Specialty (27)	83	29	20	49
Total	1,795	21	20	41

V. Complaint Intake and Screening

D. Disposition of Complaints Following Medical Specialist Review

Table V-1, below, provides a profile of the dispositions of complaints following Medical Specialist review for periods immediate prior to, and concurrent with, implementation of Medical Specialist reviews. Additionally, a profile of the dispositions of complaints following Medical Specialist review is provided for 2008/09. As shown by Table V-1, 17 percent of complaints were referred for investigation during 2008/09 compared to 20 to 21 percent referred to investigation previously. Additionally, a higher proportion of complaints are Closed-Insufficient Evidence (which usually refers to cases involving a simple or minor departure) and a lower percent of complaints are Closed-No Violation (which usually refers to cases where no departure is identified).

Table V-1. Disposition of Complaints Following Medical Specialist Review

Disposition	CY2000 to CY2002		CY2003 to CY2004		FY2008/09	
	Average Number	Percent	Average Number	Percent	Number	Percent
Closed - No Violation (i.e., No Departure)	1,852	61%	1,331	59%	1,082	54%
Closed - Insufficient Evidence (i.e., Simple/Minor Departure)	486	16%	348	16%	456	23%
Closed - Information on File	49	2%	72	3%	80	4%
Closed - Other	29	1%	22	1%	33	2%
Total	2,416	80%	1,773	79%	1,651	83%
Referred to Investigation	596	20%	468	21%	348	17%
Total	3,012	100%	2,241	100%	1,999	100%

The primary purpose of enacting the Specialist Review requirements was to reduce unnecessary referral of cases for field investigation that occurred due to competency limitations of the assigned reviewer. The data presented in Table V-1 indicate that the Medical Specialist review requirement is, as was intended, marginally reducing the number of complaints referred for investigation (i.e., by about 50 complaints per year, assuming 20 percent of 1,999 complaints would otherwise have been referred to investigation). Additionally, significantly more complaints are now being closed with an Insufficient Evidence (Simple/Minor Departure) designation. These complaints can potentially serve to support future disciplinary actions against the licensee on the basis that the licensee performed repeated negligent acts.

V. Complaint Intake and Screening

E. In-Depth Analysis of Complaints Taking More than Six Months to Refer to Investigation

CCU staff researched each of 59 cases that took longer than six (6) months to review and refer for investigation during 2008/09. Common factors identified as contributing to the extended processing time associated with completing the reviews of these cases included delays associated with:

- ❖ Contacting and obtaining a release from the patient for their medical records (e.g., patient unavailable or not initially responsive)
- ❖ Obtaining medical records from the treating health care facility or physician (e.g., physician non-responsive or provides incorrect or incomplete records)
- ❖ Identifying a Medical Specialist capable of reviewing the medical records (e.g., case involves a highly specialized procedure)
- ❖ Completion of the Medical Specialist review (e.g., the Specialist took a long time to review the medical records, possibly due to the number of records involved or because additional records were needed by the Medical Specialist to complete the review).

Additionally, in some cases it appears that CCU staff failed to follow-up or complete the processing of the case on a timely basis. Finally, some cases were not referred for investigation until a post-closure audit review was completed. District office staff expressed concerns about the comparatively low quality of these latter cases and CCU recently modified its post-closure audit procedures to address problems in this area.

The most common sources of delay in referring cases for investigation were related, directly or indirectly, to obtaining and reviewing medical records. The delays become extended when problems surface at different points during the screening process (e.g., delayed getting patient cooperation and release of the records, then further delayed obtaining the records, then further delayed identifying a Medical Specialist to review the records, and then further delayed getting the completed review from the Medical Specialist). Some of these delays are within the control of CCU, or CCU can more effectively manage the process to reduce the length of such delays. In other cases the cause of the delay is outside CCU's control and CCU has limited capability to reduce the delay (e.g., waiting for a patient in recovery to provide a release).

V. Complaint Intake and Screening

F. Pending Complaints

Table V-2, below, shows the number of pending CCU complaints as of June 30, 2009, and December 31, 2009. As shown by Table V-2, the number of pending complaints increased significantly during this six-month period, from about 1,308 open complaints at the end of June 2009, to 1,443 at the end of the year. The 10 percent increase in open complaints during this brief period is primarily attributable to staffing reductions resulting from implementation of the closure of the Medical Board's offices during the first three Fridays of each month (Furlough Fridays). During 2004/05 and 2005/06 the Medical Board had fewer than 1,100 open complaints.

Table V-2. CCU Pending Complaints

Assigned To	As of June 30, 2009			As of December 31, 2009		
	Quality of Care	Other	Total	Quality of Care	Other	Total
Analyst	555	413	968	668	393	1,061
Medical Consultant	296	8	304	335	5	340
Supervisor	18	18	36	27	15	42
Total	869	439	1,308	1,030	413	1,443

Inevitably, the growing number of open complaints will soon translate into longer average processing times, particularly given the continuation of the Furlough Friday Program through June 2010. Ultimately, over a period of several years, these complaint-handling delays will adversely impact aggregate Enforcement Program performance measures (e.g., total elapsed time from receipt of complaint to disciplinary outcome).

V. Complaint Intake and Screening

G. Recommendations for Improvement

Below we present several key recommendations for improving complaint intake and screening. These recommendations concern (1) the pool of Medical Specialists available to review quality of care and selected other complaints, (2) CCU staffing, and (3) measurement and monitoring levels of customer satisfaction with CCU services.

1. Medical Specialist Reviews

There are only a relatively small number of Medical Specialists available to review complaints in a number of moderate volume specialty areas, and some of the specialty areas are the same as those that have some of the longest average elapsed times to complete complaint reviews. On average, these reviews take only a few hours of labor time, but a few months of calendar time, to complete. For example, there are only four (4) Neurologists available to review more than two (2) dozen complaints per year and the average time to review these complaints is nearly three (3) months. Similar situations exist with:

- ❖ Urologists (2 Specialists, 54 complaints, 61-day average review time)
- ❖ Radiologists (5 Specialist, 53 complaints, 80-day average review time)
- ❖ Pediatrics (8 Specialists, 38 complaints, 76-day average review time)
- ❖ Anesthesiologists (9 Specialists, 30 complaints, 66-day average review time)
- ❖ Neurological Surgeons (3 Specialists, 25 complaints, 76-day average review time)
- ❖ Oncologists (5 Specialists, 21 complaints, 75-day average review time).

It would be beneficial to increase the number of Medical Specialists available to CCU in these and other moderate volume specialty areas.

Recommendation No. V-1. *Augment the Specialist Reviewer pool in targeted medical specialties and counsel or replace Medical Specialists who consistently fail to complete reviews on a timely basis, or amend the governing statute to provide flexibility to refer complaints for investigation without review by a Medical Specialist.*

V. Complaint Intake and Screening

2. CCU Workforce Capability and Competency

Seven and one-half (7.5) new CCU positions, including one (1) SSM I position, five (5) AGPA positions, and 1.5 MST/OT positions, are expected to be authorized in the 2010/11 Budget. These positions will be used primarily to enhance intake and screening of physician and surgeon and AHLF cases, and to enhance management and administration of the Specialty Review process. Additionally, two (2) new AGPA positions are expected to be authorized for the Office of Standards and Training (OST). These positions are expected to focus their efforts on training programs for CCU staff. These additional positions would significantly enhance CCU workforce capabilities. To ensure anticipated benefits are actually realized, CCU management should develop a specific plan detailing the program development and performance improvement goals and objectives that will be achieved as a result of these significant increases in authorized CCU and OST staffing levels. As much as possible the program development and performance improvement goals and objectives should be stated in terms that will enable assessment of the extent to which the objectives are actually achieved.

Recommendation No. V-2. *Augment CCU's workforce capabilities. When authorized, fill the new CCU and OST positions. Develop a specific plan detailing the program development and performance improvement goals and objectives that will be achieved by increasing authorized CCU and OST staffing levels. Track progress relative to the plan and provide periodic reports to the Medical Board showing progress in achieving each of the plan's goals and objectives.*

3. Customer Satisfaction Metrics

CCU has not surveyed customers regarding the level of satisfaction with CCU services since the late-1990s. Such surveys provide an important measure of the impact of changes in CCU processes and service levels, such as implementation of Medical Specialist reviews, changes in the average elapsed time to screen complaints, time spent by staff discussing with the complainant the status and disposition of their complaint, etc. CCU should continuously survey customers regarding their level of satisfaction with CCU services. Monitoring customer satisfaction levels helps to maintain and improve the level of service provided to the public by linking changes in policies and procedures with measures of the impacts of these changes on the customer community. Other DCA-affiliated regulatory programs utilize a simple postcard survey for this purpose.

Recommendation No. V-3. *Resume surveys of CCU customer satisfaction levels and compile and publish the results of the surveys.*

VI. Investigations

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VI. Investigations

Our assessment of investigation process performance focused on determination of the numbers of investigations completed by the District offices concurrent with and following implementation of the VE during 2006, the disposition of the cases, and the elapsed time to complete the investigations. The assessment also encompassed analysis of time spent by HQES Attorneys on investigations and in-depth reviews of more than two (2) dozen cases with more than 40 hours of time charged by HQES Attorneys during 2008/09. Additionally, we completed analyses of Medical Consultant and Medical Expert services and expenditures.

Results of these analyses show that fewer investigations are being completed by the District offices, the investigations are taking significantly longer to complete, and fewer cases are being referred for prosecution. Also, performance levels have declined as much, or more, in the Los Angeles Metro region than in other regions of the State even though Los Angeles Metro region Attorneys are significantly more involved with investigations. For example, during 2008/09 Los Angeles Metro region Attorneys billed the Medical Board about 50 hours of time per completed investigation, compared to about 31 hours of Attorney time billed per completed investigation in the Other Southern California region, and 15 hours of Attorney time billed per completed investigation in the Northern California region. Yet, notwithstanding this much higher level of Attorney involvement in investigations, during 2008/09, and also during 2007/08, only about 75 cases per year were referred for prosecution by Los Angeles Metro region District offices. This compares to about 72 cases per year referred for prosecution in the Other Southern California region and more than 100 cases per year referred for prosecution in the Northern California region. During the past two (2) years, 25 percent of completed Los Angeles Metro region investigations were referred for prosecution. In the Northern California region, 28 percent of completed investigations were referred for prosecution and, in the Other Southern California region, 32 percent of completed investigations were referred for prosecution.

The remainder of this section is organized as follows:

Subsection	Title	Subsection	Title
A.	Overview of "Consolidated" Investigation Workload, Outputs, and Performance	F.	Investigations Closed with Citation Issued
B.	Dispositions of Completed Investigations by Business Group	G.	Investigations Referred for Prosecution
C.	Investigations Opened and Completed, by Identifier	H.	HQES Declined to File Cases
D.	Average Elapsed Times to Complete Investigations	I.	Pending Investigations
E.	Investigations Closed without Citation or Referral for Prosecution	J.	Expenditures for HQES Investigation Services
		K.	Medical Consultant and Outside Expert Services and Expenditures
		L.	Recommendations for Improvement.

VI. Investigations

A. Overview of “Consolidated” Investigation Workload, Outputs, and Performance

Exhibit VI-1, on the next page, provides an overview of consolidated investigation workflows and performance since the early part of the decade. The statistical data presented in Exhibit VI-1 includes cases handled by the District offices as well as cases involving Probationers, petitions for modification or termination of probation, and petitions for reinstatement that, until recently, were exclusively handled by regional Probation Units. Additionally, the consolidated statistical data includes cases handled primarily, or exclusively, by various Headquarters Units, including:

- ❖ Out-of-State disciplinary action reports
- ❖ Probationary license certificates
- ❖ Appeals of license application denials, referred to as statements of issues (SOIs)
- ❖ Change of address citation cases (through December 2004)
- ❖ Continuing Medical Education (CME) audit failure citation cases
- ❖ Probation violation citation cases
- ❖ Cite and fine non-compliance cases
- ❖ Internet Crime and Operation Safe Medicine (OSM) cases.

As shown by Exhibit VI-1, since the early part of the decade the number of investigations opened, the number of investigations closed, and the number of cases referred for prosecution decreased significantly. For example, from 2005/06 to 2008/09:

- ❖ The number investigations opened decreased by 16 percent (from 1,354 investigations opened during 2005/06 to 1,135 investigations opened during 2008/09)
- ❖ The number of cases closed or referred for prosecution decreased by 15 percent (from 1,281 cases closed or referred during 2005/06 to 1,092 cases closed or referred during 2008/09)
- ❖ The number of pending investigations increased by 15 percent (from 1,054 at the beginning of 2005/06 to 1,211 at the end of 2008/09)
- ❖ The average elapsed time to complete investigations increased by 26 percent (from 9.1 months during 2005/06 to 11.5 months during 2008/09).

As part of the investigation process, District office Investigators may interview the Complainant and usually must collect pertinent medical or other records. Additionally, particularly with quality of care cases, but oftentimes for other cases as well, the investigation oftentimes includes (1) an interview with the Subject, (2) a review of the case by a Medical Consultant, and (3) a review of the case by an outside Medical Expert. Exhibit VI-1 shows estimated numbers of completed Complainant interviews, Subject Interviews, Medical Consultant Reviews, and Expert Reviews by year for the past 3 to 5 years. As shown by Exhibit VI-1, in recent years the number of

Overview of "Consolidated" Investigation Workload, Outputs, and Performance

Workflow Measure		2000/01 through 2002/03 ¹ (3-Year Avg.)	2003/04	2004/05 ²	2005/06 ³	2006/07 ⁴	2007/08	2008/09
Investigations Opened (Excluding Re-Opened Cases)	Complaints Referred to, or Opened by, District Offices (Various IDENTs)				1,123	963	867	872
	Out-of-State Cases (IDENT 16)				105	50	132	93
	Complaints Involving Probationers Referred to Field Offices (IDENT 19)				39	48	50	54
	Cases Opened by Headquarters Units ⁵ (IDENTs 20 through 25)				87	95	59	58
	Petitions for Modification or Termination of Probation (IDENT 26)				Included in HQ Cases	1	11	40
	Petitions for Reinstatement (IDENT 27)				Included in Headquarters Cases		6	18
	Total Investigations Opened⁵	2,355	1,887	1,443	1,354	1,157	1,125	1,135
Interim District Office Activities	Complainant Interviews (Estimated - Volumes Shown May Be Understated)					418	373	337
	Subject Interviews (Estimated - Volumes Shown May Be Understated)			818	705	656	711	681
	Medical Consultant Reviews (Estimated - Volumes Shown May Be Understated)					528	540	480
	Expert Reviews (Estimated - Volumes Shown May Be Understated)			565	464	393	469	340
Case Dispositions ⁵	Cases Closed without Citation, PLR, or Referral for Prosecution				767	657	711	581
	Cases Closed with Citation				44	41	43	47
	Cases Closed with Public Letter of Reprimand (PLR)				46	31	11	21
	Cases Referred for Prosecution to HQES (Includes Dual Referrals)	531	580	521	456	410	438	449
	Cases Referred for Prosecution to District Attorney (Includes Dual Referrals)	62	37	34	31	27	28	27
	Total Cases Referred for Prosecution	550 to 600 per Year, Including Some PLRs			424	396	441	443
	Total Cases Closed or Referred for Prosecution	2,395	2,117	1,475	1,281	1,125	1,206	1,092
Pending Cases (End of Period, Including AHLP Cases)	1,251	1,060	1,054	1,111	1,146	1,147	1,211	
Reported Average Time to Close Cases or Refer for Prosecution		6.7 Months	7.2 Months	8.5 Months	9.1 Months	10.1 Months	10.7 Months	11.5 Months

¹ During 2002/03, 19 authorized Investigator positions were abolished.

² Effective January 1, 2005, CCU began implementing Medical Specialist reviews. Additionally, the Medical Board discontinued counting change of address citations as complaints or investigations.

³ Effective January 1, 2006, the Medical Board and HQES began implementing the Vertical Enforcement (VE) Pilot Project.

⁴ Effective July 1, 2006, eight (8) new positions were authorized for the Enforcement Program (4 Investigators and 4 Assistant Investigators). Subsequently, the Assistant Investigator positions were reclassified to Inspectors and assigned to Probation Units. Concurrently, Investigator positions assigned to the Probation Units were reassigned to the District offices.

⁵ Includes probationary license certificates, SOIs, CME audit cases, cite and fine non-compliance cases, probation violation citation cases, Internet and Operation Safe Medicine (OSM) cases, petitions for modification or termination of probation, and petitions for reinstatement. Also, includes change of address citation cases (through December 2004).

VI. Investigations

completed Complainant and Subject interviews, and the number of completed Medical Consultant and Expert reviews, have declined in parallel with decreases in (1) the number of investigations opened, and (2) the number of investigations closed or referred for prosecution.

On average over the past four (4) years, about 35 percent of cases referred for Investigation were subsequently referred for prosecution. During 2008/09 the percent of cases referred for prosecution was higher than average. However, the above-average referral rate during 2008/09 is attributable to an especially large (18 percent) decline in the number of cases closed without referral for prosecution as compared to 2007/08. There was no change in the number of cases referred for prosecution during 2008/09 compared to the prior year.

Since the early part of the decade, the reported average elapsed time to complete investigations increased by more than 70 percent (from an average of 6.7 months to an average of more than 11 months). Some of this is due to the exclusion of change of address citations when calculating this performance measure. Prior to January 1, 2005, change of address citations were counted as completed investigations, which reduced average elapsed investigation time measures. While the average elapsed time data shown for 2005/06 through 2008/09 are consistently presented without change of address citations, some other types of matters continue to be captured in the Medical Board's data systems as investigations for tracking purposes, but investigations are not actually performed (e.g., probationary license certificates, SOIs, CME audit failure citations, probation violation citations, and cite and fine non-compliance cases). The reported average elapsed time data also include (1) Out-of-State cases, which rarely require investigation, (2) petitions for modification or termination of probation, and (3) and petitions for reinstatement. Out-of-State cases and petitions are subject to different review requirements and generally take much less time to complete than investigations (as that term is conventionally defined). The inclusion of these other types of cases when determining the average elapsed time to complete investigations overstates the number of completed investigations and understates average elapsed time measures. More importantly, in recent years the consolidated data obscured the deterioration in Enforcement Program performance that actually occurred in terms of (1) the decline in number of investigations completed by the District offices, and (2) the increase in the average elapsed time to complete these investigations. Excluding cases involving Probationers, over the past three (3) years:

- ❖ The number of investigations completed by the District offices decreased by 24 percent (from 1,083 during 2005/06 to 828 during 2008/09)
- ❖ The average elapsed time to complete these investigations increased by 34 percent (from 10.2 months during 2005/06 to 13.7 months during 2008/09).

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In the remainder of this section we present investigation-related workload and performance data for fiscal years 2005/06 through 2008/09 that differentiate, to the extent practicable, cases consistently investigated exclusively by the District offices throughout this period from the following other types of cases which are included in the consolidated data presented previously in Exhibit VI-1 and in periodic statistical reports published by the Medical Board and Department of Consumer Affairs:

- ❖ Out-of State disciplinary action reports
- ❖ Probationary license certificates
- ❖ Statements of Issues (SOIs)
- ❖ CME audit failure citation cases
- ❖ Cite and fine non-compliance cases
- ❖ Cases involving Probationers
- ❖ Petitions for modification or termination of probation
- ❖ Petitions for reinstatement.

The above types of cases can be distinguished from cases consistently handled exclusively by the District offices based on the Identifier (IDENT) assigned to the case and, where appropriate, elapsed time data showing the duration of the investigations. With rare exceptions, cases with certain Identifiers, or with investigation durations of only one, or a few, business days, are not handled by the District offices, or were only recently transferred to the District offices in connection with the restructuring of the Probation Units.

VI. Investigations

B. Dispositions of Completed Investigations by Business Group

Exhibit VI-2, on the next page, shows dispositions of completed investigations for each of the past four (4) fiscal years, for each of the following:

Cases Handled by the District Offices – This category includes all cases assigned District office Identifiers plus a small number of Out-of-State (IDENT 16) cases that may have been handled by the District offices as determined from the duration of the investigations.

Cases Involving Probationers and Petitions – This category includes cases with Probationer Identifiers (IDENT 19), petitions for modification or termination of probation (IDENT 20 or 26), and petitions for reinstatement (IDENT 20 or 27). Until recently these cases were handled exclusively by regional Probation Units and were not included in the VE Pilot Project.

Cases Handled by Headquarters Units – This category includes nearly all cases involving Out-of-State disciplinary action reports (IDENT 16) and a mix of other cases usually handled by various Headquarters Units, including probationary license certificates, SOIs, cite and fine non-compliance cases (IDENT 20), CME audit failure citation cases (IDENT 21), and Operation Safe Medicine and Internet crime cases (IDENTs 22 and 23, respectively).

As shown by Exhibit VI-2, in recent years the number of investigations completed by the District offices declined by 24 percent (from 1,083 during 2005/06 to 828 during 2008/09, excluding cases involving Probationers or petitions which were only recently assigned to the District office). The decrease in the total number of District office investigations completed during this period was partially offset by increases in the total number of cases closed or referred for prosecution by various Headquarters Units. Additionally, there were small increases in the number of completed investigations involving Probationers, petitions for modification or termination of probation, and petitions for reinstatement. Until recently, cases involving Probationers and all petitions were handled by regional Probation Units.

In recent years the number of cases referred for prosecution by the District offices decreased by 12 percent (from about 285 cases per year to 250 cases per year). Additionally, the number of public letters of reprimand (PLRs) issued by the District offices decreased significantly (from 29 during 2005/06 to an average of five (5) per year during the past two (2) years). On average, about 28 percent of all investigations completed by the District offices were referred for prosecution. In contrast, about 73 percent of the cases handled by Headquarters Units or involving Probationers or petitions were referred for prosecution.

Disposition of Completed Investigations, by Business Group - 2005/06 through 2008/09

Case Dispositions			2005/06	2006/07	2007/08	2008/09	
Cases Handled by District Offices	Closed	No Cite	Cases with District Office Identifiers	723	619	670	534
			Out of State (IDENT 16)	9	5	2	2
		Cite	Cases with District Office Identifiers	39	41	26	39
			Out-of-State (IDENT 16)	1		2	
	PLR	Cases with District Office Identifiers (2003/04 PLR = 12, 2004/05 PLR = 19)	29	13	3	7	
	Referred for Prosecution		Cases with District Office Identifiers (excludes PLR cases)	276	281	244	245
			Out-of-State (IDENT 16)	6	7	9	1
			Total Cases Referred to the Attorney General or a District Attorney	282	288	253	246
	Total Closed or Referred to AG of DA (Cases Handled by District Offices)			1,083	966	956	828
	Cases Involving Probationers and Petitions	Closed	No Cite	Probation (IDENT 19)	29	20	31
			Petitions for Modification or Termination of Probation (IDENT 26)				2
Cite			Probation (IDENT 19)	2		1	
Referred for Prosecution			Probation (IDENT 19)	17	14	17	22
			Headquarters ¹ (IDENT 20)	39	45	53	14
			Petitions for Modification or Termination of Probation (IDENT 26)	Included in Headquarters Cases			29
			Petitions for Reinstatement (IDENT 27)	Included in Headquarters Cases			8
			Total Cases Referred to AG or DA	56	59	70	73
Total Closed or Referred to AG of DA (Cases Involving Probationers and Petitions)			87	79	102	104	
Cases Handled by Headquarters Units		Closed	No Citation	Out of State (IDENT 16)			1
			Headquarters ^a (IDENT 20)	2	5	3	5
			Internet (IDENT 23)	4	8	4	9
	Cite	Out of State (IDENT 16)	2		14	8	
	PLR	Out of State (IDENT 16)	17	18	8	14	
	Referred for Prosecution		Out of State, Excluding PLRs (IDENT 16)	65	27	98	71
			Probation (IDENT 19)				7
			Headquarters ^a (IDENT 20)	20	21	18	32
			CME Audit (IDENT 21)				4
			Internet (IDENT 23)	1	1	2	10
		Total Cases Referred for Prosecution (HQES and DA)	86	49	118	124	
Total Closed or Referred for Prosecution (Cases Handled by Headquarters Units)			111	80	148	160	
Total Cases Closed or Referred for Prosecution (HQES and DA)			1,281	1,125	1,206	1,092	

¹ May include probationary license certifications, SOIs, CME audit cases, cite and fine non-compliance cases, Internet and Operation Safe Medicine (OSM) cases, petitions for modification or termination of probation, and petitions for reinstatement.

VI. Investigations

C. Investigations Opened and Completed by Identifier

Exhibit VI-3, on the next page, shows the number of investigations opened and completed by Identifier, by fiscal year. As shown by Exhibit VI-3, in recent years the number of investigations with District office Identifiers that were opened, closed, and referred for prosecution decreased significantly. During this period there was little change in the overall percentage of cases referred for prosecution, which averaged 29 percent during this period. However, there were significant differences in performance between the three (3) regions to which District offices are assigned. For example:

- ❖ The number of cases referred for prosecution decreased significantly in the Los Angeles Metro and Other Southern California regions. In contrast, there was no decrease in the number of cases referred for prosecution by the Northern California region.
- ❖ During the past several years the Northern and Other Southern California regions both closed or referred more cases than were opened. In contrast, in the Los Angeles Metro region, fewer cases were closed or referred than were opened. However, during 2008/09 none of the three (3) regions closed or referred more cases than were opened.
- ❖ In the Los Angeles Metro region, the proportion of cases referred for prosecution decreased from 33 percent during 2005/06 to 25 percent during each of the past two (2) fiscal years. In contrast, the proportion of cases referred for prosecution by the Northern California region increased from 22 percent during 2005/06 to an average of 28 percent during the past several years. For the Other Southern California region, the proportion of cases referred for prosecution averaged about 35 percent during the past several years, a higher proportion than achieved by either of the other two regions.

In contrast to the workload trends at the District offices, the number of cases with Out-of-State, Probationer, and Headquarters Unit Identifiers that were opened, closed, and referred for prosecution increased during the past several years. About 76 percent of these cases were consistently referred for prosecution. These cases consistently have a comparatively high 76 percent referral rate, and typically account for 20 to 25 percent of all case closures and referrals. Consequently, the consolidation of these cases, for performance reporting purposes, with cases handled by the District offices, obscures changes occurring in District office performance.

Summary of Investigations Opened and Completed, by Identifier
2005/06 through 2008/09¹

Cases with District Office Identifiers		2005/06	2006/07	2007/08	2008/09	Cases with Other Identifiers		2005/06	2006/07	2007/08	2008/09
Opened	Northern California	398	379	324	344	Opened	Out of State (IDENT 16)	105	50	132	93
	Los Angeles Metro	343	338	350	306		Probation (IDENT 19)	39	48	50	54
	Other Southern California	382	246	193	222		Headquarters (IDENTs 20, 21, 22, 26, and 27)	72	88	61	108
	Total Investigations Opened	1,123	963	867	872		Internet (IDENT 23)	15	8	15	8
Closed or Referred for Prosecution	Northern California	399	389	383	330		Total Investigations Opened	231	194	258	263
	Los Angeles Metro	343	308	302	305	Closed or Referred for Prosecution	Out of State (IDENT 16)	18	13	13	9
	Other Southern California	325	257	258	190		Probation (IDENT 19)	48	34	49	51
	Total Investigations Closed or Referred	1,067	954	943	825		Headquarters (IDENTs 20, 21, 26, and 27)	41	50	55	56
Difference	Northern California	(1)	(10)	(59)	14		Internet (IDENT 23)	5	9	6	19
	Los Angeles Metro	0	30	48	1		Direct Referrals and Same-Day Closures (IDENTs 16 and 19 through 27)	102	65	105	132
	Other Southern California	57	(11)	(65)	32	Total Investigations Closed or Referred	214	171	228	267	
	Difference: Opened Less Closed or Referred	56	9	(76)	47	Difference: Opened Less Closed or Referred	17	23	30	(4)	
Referred for Prosecution	Northern California	89	107	100	103	Referred for Prosecution	Out of State (IDENT 16)	6	7	9	1
	Los Angeles Metro	112	86	76	75		Probation (IDENT 19)	17	14	17	22
	Other Southern California	104	101	71	74		Headquarters (IDENTs 20, 21, 26, and 27)	39	45	53	51
	Total District Office Legal Closures	305	294	247	252		Internet (IDENT 23)	1	1	2	10
Percent Referred for Prosecution	Northern California	22%	28%	26%	31%		Direct Referrals to AG or DA (IDENTs 16, 19, 20, and 21)	100	65	89	122
	Los Angeles Metro	33%	28%	25%	25%	Total Legal Closures - Other Identifiers	163	132	170	206	
	Other Southern California	32%	39%	28%	39%	Percent Referred for Prosecution - Other Identifiers	76%	77%	75%	77%	
	Total - District Office Identifiers	29%	31%	26%	31%						

¹ Excludes re-opened cases. Statewide, an average of about 30 cases are re-opened per year.

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D. Elapsed Time to Complete Investigations

Exhibit VI-4, on the next page, shows average elapsed times to investigate cases, by fiscal year, for quality of care and other cases. The data shown excludes cases closed or referred directly for prosecution by the originating Headquarters or Probation Unit without involvement of the District offices. During the past several years the average elapsed time to complete Quality of Care case Investigations increased by 35 percent (from 11.3 months during 2005/06 to 15.2 months during 2008/09). During 2008/09, it took longer than 18 months to complete 34 percent of Quality of Care case Investigations compared to only 11 percent of cases that took longer than 18 months to Investigate during 2005/06. For other cases, the average elapsed time to investigate the cases increased by 42 percent (from 7.4 months during 2005/06 to 10.5 months during 2008/09). During 2008/09 it took longer than 18 months to complete 17 percent of the other case investigations compared to only 3 percent of Other cases that took longer than 18 months to Investigate during 2005/06.

The 35 percent increase over the past several years in the average elapsed time to complete quality of care case Investigations is particularly surprising given the impacts that VE was expected to have on these types of cases. For example, HQES Attorneys were expected to provide assistance in significantly reducing the amount of time needed to obtain patient medical records needed to determine the viability of the cases. Additionally, it was anticipated that cases that were not viable would be closed more quickly, thereby enabling redeployment of Investigators to accelerate the processing of other cases.

Exhibit VI-5, following Exhibit VI-4, shows average elapsed times to investigate cases by District office Identifier, by fiscal year. The overall average elapsed time to investigate cases with District office Identifiers increased by 35 percent (from 10.2 months during 2005/06 to 13.7 months during 2008/09). Average elapsed times increased significantly in all three (3) regions. In the Other Southern California, the average elapsed time to complete investigations in this region reached nearly 16 months and the number of cases closed or referred for prosecution decreased by 42 percent (to fewer than 200 completed investigations compared to more than 300 completed investigations in both of the other regions). For cases with other Identifiers, the number of completed investigations decreased during the past several years and the average elapsed time to investigate these cases increased significantly. Some of these cases were handled by Headquarters Units, some were handled by Probation Units, and some were handled by the District offices.

**Summary of Completed Investigations, By Type of Case
2005/06 through 2008/09**

Case Type	Elapsed Time to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	6 Months or Less	128	17%	85	14%	90	15%	78	14%
	9 to 12 Months	323	43%	227	36%	212	35%	149	27%
	12 to 18 Months	213	28%	193	31%	161	26%	140	25%
	18 to 24 Months	59	8%	86	14%	102	17%	97	18%
	More than 24 Months	25	3%	31	5%	47	8%	86	16%
	Total	748	100%	622	100%	612	100%	550	100%
	Average Number of Months	11.3 Months		12.5 Months		13.1 Months		15.2 Months	
Other Cases	6 Months or Less ¹	206	48%	183	42%	162	36%	139	34%
	9 to 12 Months	145	34%	145	33%	139	31%	133	33%
	12 to 18 Months	63	15%	78	18%	74	16%	64	16%
	18 to 24 Months	13	3%	21	5%	54	12%	33	8%
	More than 24 Months	2	0%	10	2%	25	6%	35	9%
	Total	429	100%	437	100%	454	100%	404	100%
	Average Number of Months	7.4 Months		8.4 Months		10.3 Months		10.5 Months	
All Cases	6 Months or Less ¹	334	28%	268	25%	252	24%	217	23%
	9 to 12 Months	468	40%	372	35%	351	33%	282	30%
	12 to 18 Months	276	23%	271	26%	235	22%	204	21%
	18 to 24 Months	72	6%	107	10%	156	15%	130	14%
	More than 24 Months	27	2%	41	4%	72	7%	121	13%
	Total	1,177	100%	1,059	100%	1,066	100%	954	100%
	Average Number of Months	9.9 Months		10.8 Months		11.9 Months		13.1 Months	

¹ Data shown excludes cases closed by Headquarters and Probation Units, cases closed with a citation issued by DCU or Probation Units, and cases referred directly for prosecution without District office investigation, including nearly all Out-of-State (IDENT 16) cases, cases involving probation violations (IDENT 19), originated by the Medical Board), and SOI, CME audit failure, and citation non-compliance cases (IDENT 20 or 21, originated by the Medical Board).

Cases Closed or Referred Directly for Prosecution	Quality of Care Cases	3	3%	12	18%	47	34%	20	14%
	Other Cases	101	97%	54	82%	93	66%	118	86%
	Total	104	100%	66	100%	140	100%	138	100%

**Summary of Completed Investigations, By Identifier (8.01 to 8.03)
2005/06 through 2008/09**

Business Unit		Investigations Completed				Average Elapsed Time to Complete (Months)				Comments
		2005/06	2006/07	2007/08	2008/09	2005/06	2006/07	2007/08	2008/09	
Cases with District Office Identifiers	Fresno	72	67	87	55	12.3	13.1	15.1	18.6	Includes several aged Section 805 cases.
	Pleasant Hill	120	93	99	102	10.1	10.4	13.5	13.9	
	Sacramento	117	139	116	97	12.8	13.1	10.7	9.8	
	San Jose	90	90	81	76	9.8	10.8	11.1	12.6	
	Total - Northern California	399	389	383	330	11.2	11.9	12.5	13.2	
	Cerritos	100	86	115	118	10.2	8.7	10.1	10.9	
	Diamond Bar	83	54	60	64	8.6	11.9	12.7	17.0	
	Glendale	82	67	40	72	11.0	11.6	12.2	13.5	
	Valencia	78	101	87	51	11.1	8.9	10.9	12.2	Includes several 3-week AG cases.
	Total - Los Angeles Metro Area	343	308	302	305	10.2	9.9	11.1	13.0	
	Rancho Cucamonga	N/A	N/A	N/A	6	N/A	N/A	N/A	8.6	Prior to _____, Rancho Cucamonga was a Regional Probation Unit.
	San Bernardino	119	105	87	61	9.4	11.3	15.0	16.9	
	San Diego	102	68	106	69	9.6	12.6	12.8	15.1	
	Tustin	104	84	65	54	8.3	10.4	13.6	16.6	
	Total - Other Southern California	325	257	258	190	9.1	11.3	13.8	15.9	
Total - District Offices	1,067	954	943	825	10.2	11.1	12.4	13.7		
Cases with Other Identifiers ¹	Out of State (IDENT 16)	16	12	13	3	3.6	8.0	6.3	11.7	These cases are nearly always referred from the Disciplinary Unit directly to the AG. They are only assigned to District offices when the licensee is practicing in California.
	Probation (IDENT 19)	48	34	49	51	9.7	10.1	9.9	10.9	Prior to 2008/09, these cases were investigated by regional Probation Units. Subsequently, the investigations were performed by District offices.
	Headquarters (IDENT 20)	41	50	55	17	3.8	6.3	7.1	7.1	Includes SOIs and probationary license certifications which are not handled by the District offices.
	Petition for Modification/Termination of Probation (IDENT 26)	Included with Headquarters Cases			31	Included with Headquarters Cases			6.7	Prior to 2008/09 petitions were handled by regional Probation Units. Subsequently, petitions for modification/termination of probation were handled by Probation Monitoring Units and the District offices and petitions for reinstatement were handled exclusively by the District offices.
	Petition for Reinstatement (IDENT 27)	Included with Headquarters Cases			8	Included with Headquarters Cases			9.3	
	Internet (IDENT 23)	5	9	6	19	7.6	8.3	12.1	13.2	These cases are handled by a specialized Headquarters Unit. They are usually referred to DAs for prosecution without involvement of the District offices.
	Total - Other Identifiers	110	105	123	129	6.5	7.9	8.4	9.6	
Total	1,177	1,059	1,066	954	9.9	10.8	12.0	13.2		

¹ Data shown excludes closed Headquarters and Probation Unit cases, cases closed with a citation issued by DCU or Probation Units, and cases referred directly for prosecution without District office investigation, including nearly all Out-of-State (IDENT 16) cases, cases involving probation violations (IDENT 19, originated by the Medical Board), and all SOI, CME audit failure, and citation non-compliance cases (IDENT 20 or 21, originated by the Medical Board).

Cases Closed or Referred Directly for Prosecution by the Originating Headquarters or Probation Unit	104	66	140	138	Not Applicable			
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VI. Investigations

E. Investigations Closed without Citation Issued

Exhibit VI-6, on the next page, shows average elapsed times to investigate cases that were closed without a citation issued, by fiscal year, for quality of care and other cases. As shown by Exhibit VI-6, during the past several years the average elapsed time to complete quality of care case investigations increased by 29 percent (from 10.4 months during 2005/06 to 13.4 months during 2008/09). During 2008/09, it took longer than 18 months to complete 25 percent of the quality of care case investigations compared to only 8 percent of cases that took longer than 18 months to complete during 2005/06. For other cases, the average elapsed time to complete the investigations increased by 60 percent (from 7.3 months during 2005/06 to 11.7 months during 2008/09). During 2008/09 it took longer than 18 months to complete 20 percent of the investigations of other cases compared to only 2 percent of other cases that took longer than 18 months to investigate during 2005/06.

Exhibit VI-7, following Exhibit VI-6, shows average elapsed times to Investigate cases that were closed without a citation issued, by Identifier, by fiscal year. As shown by Exhibit VI-7, the average elapsed time investigate cases having a District office Identifier increased by 35 percent (from 9.5 months during 2005/06 to 12.8 months during 2008/09). The average elapsed times increased significantly in all three (3) regions. The Other Southern California region experienced the largest increase in average elapsed times and, in 2008/09 the average elapsed time to close investigations in this region without any further action reached 15 months. The Other Southern California Region also experienced an especially large 50 percent decrease in the number of cases closed without a citation issued and, in 2008/09, the region closed without a citation issued fewer than one-half as many cases as the other two regions (100 case closures compared to more than 200 case closures in the other two regions).

For cases with other Identifiers, the number of cases closed without a citation issued varied minimally during the past several years. However, the average elapsed times to investigate these cases increased significantly. Some of these cases were handled by Headquarters Units, some were handled by Probation Units, and some were handled by the District offices.

**Summary of Investigations Closed without Citation Issued, By Type of Case
2005/06 through 2008/09**

Case Type	Elapsed Time to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	6 Months or Less	102	20%	63	16%	73	17%	63	17%
	6 to 12 Months	233	46%	143	37%	161	38%	120	33%
	12 to 18 Months	136	27%	117	30%	109	26%	88	24%
	18 to 24 Months	32	6%	46	12%	62	15%	58	16%
	More than 24 Months	9	2%	17	4%	21	5%	32	9%
	Total	512	100%	386	100%	426	100%	361	100%
	Average Number of Months	10.4 Months		11.9 Months		12.1 Months		13.4 Months	
Other Cases	6 Months or Less ¹	118	46%	106	39%	93	33%	62	28%
	6 to 12 Months	98	38%	92	34%	83	29%	76	35%
	12 to 18 Months	33	13%	58	21%	53	19%	35	16%
	18 to 24 Months	6	2%	7	3%	34	12%	18	8%
	More than 24 Months	0	0%	8	3%	20	7%	27	12%
	Total	255	100%	271	100%	283	100%	218	100%
	Average Number of Months	7.3 Months		8.7 Months		10.9 Months		11.7 Months	
All Cases	6 Months or Less ¹	220	29%	169	26%	166	23%	125	22%
	9 to 12 Months	331	43%	235	36%	244	34%	196	34%
	12 to 18 Months	169	22%	175	27%	162	23%	123	21%
	18 to 24 Months	38	5%	53	8%	96	14%	76	13%
	More than 24 Months	9	1%	25	4%	41	6%	59	10%
	Total	767	100%	657	100%	709	100%	579	100%
	Average Number of Months	9.4 Months		10.6 Months		11.6 Months		12.7 Months	

¹ Data shown excludes cases closed without a citation issued by the originating Headquarters or Probation Unit.

Closed without Investigation	Quality of Care Cases	0	0%	0	0%	0	0%	0	0%
	Other Cases	0	0%	0	0%	2	100%	2	0%
	Total	0	0%	0	0%	2	100%	2	0%

**Summary of Investigations Closed without Citation Issued, By Identifier
2005/06 through 2008/09**

Business Unit		Cases Closed without Citation				Average Elapsed Time to Close (Months)				Comments
		2005/06	2006/07	2007/08	2008/09	2005/06	2006/07	2007/08	2008/09	
Cases with District Office Identifiers	Fresno	47	38	62	43	11.6	13.9	14.3	17.9	
	Pleasant Hill	94	74	71	68	9.6	10.3	12.6	12.4	
	Sacramento	92	99	96	63	12.3	14.0	10.4	9.4	
	San Jose	75	66	53	47	9.2	9.8	10.5	12.2	
	Total - Northern California	308	277	282	221	10.6	12.0	11.8	12.6	
	Cerritos	62	62	77	88	9.2	7.7	8.6	10.5	
	Diamond Bar	56	38	47	45	7.9	10.7	11.4	15.6	
	Glendale	49	35	22	41	8.1	9.6	10.6	11.6	
	Valencia	49	73	66	39	9.9	8.8	10.3	11.9	
	Total - Los Angeles Metro Area	216	208	212	213	8.8	9.0	10.0	12.0	
	Rancho Cucamonga	N/A	N/A	N/A	4	N/A	N/A	N/A	8.8	Prior to 2008/09, Rancho Cucamonga was a Regional Probation Unit.
	San Bernardino	71	60	63	39	9.0	10.7	15.2	15.9	
	San Diego	71	35	71	31	9.0	12.0	12.0	13.9	
	Tustin	57	39	42	26	8.0	10.0	14.4	15.8	
	Total - Other Southern California	199	134	176	100	8.7	10.8	13.7	15.0	
Total - District Offices	723	619	670	534	9.5	10.7	11.7	12.8		
Cases with Other Identifiers ¹	Out of State (IDENT 16)	9	5	2	2	4.4	7.9	2.8	15.7	These cases are nearly always referred from the Disciplinary Unit directly to the AG. They are only assigned to District offices when the licensee is practicing in California.
	Probation (IDENT 19)	29	20	31	29	8.5	9.3	10.4	11.3	Prior to 2008/09, these cases were investigated by Regional Probation Units. Subsequently, the investigations were performed by District offices.
	Headquarters (IDENT 20)	2	5	2	3	1.5	7.4	8.9	12.9	Includes Statement of Issue (SOI) cases and Probation Certifications which are not handled by the District Offices.
	Petition for Modification/Termination of Probation (IDENT 26)	Included with Headquarters Cases			2	Included with Headquarters Cases			14.7	Prior to 2008/09 petitions were handled by regional Probation Units. Subsequently, petitions for modification/termination of probation were handled by Probation Monitoring Units and the District offices and petitions for reinstatement were handled exclusively by the District offices.
	Petition for Reinstatement (IDENT 27)	Included with Headquarters Cases			0	Included with Headquarters Cases			N/A	
	Internet (IDENT 23)	4	8	4	9	7.2	8.0	9.4	11.8	These cases are handled by a specialized Headquarters Unit. They are usually referred to DAs for prosecution without involvement of the District offices.
	Total - Other Identifiers	44	38	39	45	7.2	8.6	9.8	11.9	
Total, Excluding Non-Referred Cases	767	657	709	579	9.4	10.6	11.6	12.7		

¹ Data shown excludes cases Closed without Citation Issued by the originating Headquarters or Probation Unit.

Cases Closed without Citation Issued by the Originating Headquarters or Probation Unit	0	0	2	2	Not Applicable				
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VI. Investigations

F. Investigations Closed with Citation Issued

Exhibit VI-8, on the next page, shows the number of citations issued, by violation, by year. As shown by Exhibit VI-8, since the early part of the decade the total number of citations issued decreased by more than 50 percent (from more than 400 per year to fewer than 200 per year). This decrease is attributable primarily to an especially large decrease in the number of citations issued for failure to report a change of address. During 2008/09, 60 change of address citations were issued compared to more than 300 change of address citations issued per year during the early part of the decade. For nearly all of the other categories of violations for which Citations are issued, there was little or no difference in the number of citations issued during the past several years compared to the number issued during the early part of the decade. Most citations are issued by Headquarters Units without any involvement of the District offices (e.g., citations for failure to report a change of address, failure to report a criminal charge or conviction, CME audit failures, and discipline by another state that supports issuance of a citation in California).

Exhibit VI-9, following Exhibit VI-8, shows average elapsed times to investigate cases closed with citation Issued, by fiscal year, for quality of care and other cases. As shown by Exhibit VI-9, during the past several years the average elapsed time to complete quality of care case Investigations increased by nearly 100 percent (from 10.0 months during 2005/06 to 19.7 months during 2008/09). For other cases, the average elapsed time to complete the investigations increased by 44 percent (from 9.5 months during 2005/06 to 13.7 months during 2008/09).

Exhibit VI-10, following Exhibit VI-9, shows average elapsed times to investigate cases closed with citation issued, by Identifier, by fiscal year. As shown by Exhibit VI-10, the average elapsed time to investigate cases with District office Identifiers increased by 70 percent (from 10.3 months during 2005/06 to 17.5 months during 2008/09). Citations were issued somewhat more frequently in the Los Angeles Metro and Other Southern California regions than in the Northern California region. Such differences may reflect regional variations in the Attorney General's acceptance of cases for prosecution. In the Los Angeles Metro region the average elapsed time to complete these investigations increased during the past several years by nearly 50 percent (from 12.9 months to 18.3 months). In the Other Southern California region the average elapsed time to complete these investigations increased by more than 100 percent (from 8.1 months to 18.6 months).

Citations Issued
2002/03 through 2008/09

Violation	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Failure to Report Address Change	336	324	248	263	214	77	60
Failure to Report Criminal Charge or Conviction ¹	13	15	10	14	5	7	52
Failure to Maintain Adequate Medical Records	32	32	18	29	19	29	24
Failure to Comply with CME Requirements	65	0	0	0	140	75	0
Discipline by Another State	0	0	1	2	0	14	8
Unlicensed Practice of Medicine, Including Internet Rx without an Examination, and Unlawful Representation as a Physician	12	12	7	6	7	5	7
False or Misleading Advertising	3	2	0	2	7	8	6
Failure to Give Records within 15 Days	0	0	0	2	4	4	3
Failure to Provide Patient with Records	13	8	0	2	6	8	3
Violation of Term or Condition of Probation	0	0	0	2	4	0	3
Violation of Professional Confidence	6	3	0	2	1	2	2
Aiding Unlicensed Practice of Medicine	10	9	3	0	3	2	1
Violation of Drug Statutes/Regulations	14	5	4	9	1	0	1
Failure to File Death Certificate	0	1	0	0	1	3	0
Improper Supervision of a Physician's Assistant	3	0	0	2	0	0	0
Failure to Provide Information to Board	4	3	0	1	2	1	0
Failure to Report Outpatient Death	1	1	2	0	0	0	0
Other Violations (Including Unknown)	20	8	15	6	13	12	15
Total	532	423	308	342	427	247	185

¹ Beginning during 2006, licensees were required to self-report misdemeanor charges and convictions in addition to felony charges and convictions, resulting in an increase in citations issued during 2008/09 for failure to report these events.

**Summary of Investigations Closed with Citation Issued, By Type of Case
2005/06 through 2008/09**

Case Type	Elapsed Time to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	6 Months or Less	6	19%	1	4%	0	0%	1	4%
	6 to 12 Months	18	58%	8	32%	4	25%	3	12%
	12 to 18 Months	6	19%	11	44%	8	50%	8	32%
	18 to 24 Months	0	0%	5	20%	4	25%	5	20%
	More than 24 Months	1	3%	0	0%	0	0%	8	32%
	Total	31	100%	25	100%	16	100%	25	100%
	Average Number of Months	10.0 Months		13.1 Months		14.9 Months		19.7 Months	
Other Cases	6 Months or Less ¹	4	36%	5	31%	3	23%	2	14%
	6 to 12 Months	4	36%	7	44%	2	15%	3	21%
	12 to 18 Months	1	9%	4	25%	4	31%	6	43%
	18 to 24 Months	2	18%	0	0%	3	23%	2	14%
	More than 24 Months	0	0%	0	0%	1	8%	1	7%
	Total	11	100%	16	100%	13	100%	14	100%
	Average Number of Months	9.5 Months		7.9 Months		13.7 Months		13.7 Months	
All Cases	6 Months or Less ¹	10	24%	6	15%	3	10%	3	8%
	6 to 12 Months	22	52%	15	37%	6	21%	6	15%
	12 to 18 Months	7	17%	15	37%	12	41%	14	36%
	18 to 24 Months	2	5%	5	12%	7	24%	7	18%
	More than 24 Months	1	2%	0	0%	1	3%	9	23%
	Total	42	100%	41	100%	29	100%	39	100%
	Average Number of Months	9.9 Months		11.0 Months		14.3 Months		17.5 Months	

¹ Data shown excludes cases closed with a citation issued by DCU or Probation Units.

Citation without Investigation	Quality of Care Cases	0	0%	0	0%	0	0%	0	0%
	Other Cases	2	100%	0	0%	14	100%	8	100%
	Total	2	100%	0	0%	14	100%	8	100%

**Summary of Investigations Closed with Citation Issued, By Identifier (8.02)
2005/06 through 2008/09**

Business Unit		Cases Closed with Citation Issued				Average Elapsed Time to Close (Months)				Comments
		2005/06	2006/07	2007/08	2008/09	2005/06	2006/07	2007/08	2008/09	
Cases with District Office Identifiers	Fresno									
	Pleasant Hill		1	1	1		6.2	24.1	21.8	
	Sacramento	1	2			13.6	5.9			
	San Jose	1	2		5	16.1	12.4		10.4	
	Total - Northern California	2	5	1	6	14.9	8.6	24.1	12.3	
	Cerritos	3	6	5	4	8.7	9.4	14.7	14.3	
	Diamond Bar	1		3	7	6.8		15.1	22.7	
	Glendale	6	4	4	5	15.9	15.2	13.5	16.4	
	Valencia	5	4	2	1	13.0	9.5	14.6	13.8	
	Total - Los Angeles Metro Area	15	14	14	17	12.9	11.1	14.4	18.3	
	Rancho Cucamonga	N/A	N/A	N/A		N/A	N/A	N/A		Prior to 2008/09, Rancho Cucamonga was a Regional Probation Unit.
	San Bernardino	4	6	5	7	10.0	8.1	12.5	19.3	
	San Diego	6	4	1	4	8.4	14.7	15.5	12.5	
	Tustin	12	12	5	5	7.4	12.2	17.4	22.6	
	Total - Other Southern California	22	22	11	16	8.1	11.5	15.0	18.6	
Total - District Offices	39	41	26	39	10.3	11.0	15.0	17.5		
Cases with Other Identifiers ¹	Out of State (16)	1		2		4.7		4.3		These cases are nearly always referred from the Disciplinary Unit directly to the AG. They are only assigned to District offices when the licensee is practicing in California.
	Probation (19)	2		1		6.3		14.9		Prior to 2008/09, these cases were investigated by Regional Probation Units. Subsequently, the investigations were performed by District offices.
	Headquarters (20)									
	Petitions for Modification/Termination of Probation (26)									
	Petitions for Reinstatement (27)									
	Internet (23)									
	Total - Other Identifiers¹	3	0	3	0	5.8		7.8		
Total¹	42	41	29	39	10.0	11.0	14.3	17.5		

¹ Data shown excludes cases Closed with Citation Issued by the Disciplinary or Probation Units.

Closed with Citation Issued by Originating HQ or Probation Unit	2	0	14	8	Not Applicable			
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VI. Investigations

G. Investigations Referred for Prosecution

Exhibit VI-11, on the next page, shows average elapsed times to complete investigations for cases referred for prosecution, by fiscal year, for quality of care and other cases. As shown by Exhibit VI-11, during the past several years the average elapsed time to complete Quality of Care case Investigations increased by 34 percent (from 13.7 months during 2005/06 to 18.4 months during 2008/09). During 2008/09 it took longer than 18 months to investigate nearly 50 percent of these cases compared to 20 percent of cases that took longer than 18 months to investigate during 2005/06. For other cases, the average elapsed time to complete the investigations increased by 16 percent (from 7.5 months during 2005/06 to 8.7 months during 2008/09). During 2008/09, it took longer than 18 months to investigate 12 percent of the other cases compared to 4 percent of other cases that took longer than 18 months to investigate during 2005/06. Overall, the average elapsed time to investigate cases referred for prosecution increased by 23 percent (from 10.9 months during 2005/06 to 13.4 months during 2008/09). Concurrently, the number of cases referred for prosecution decreased by 9 percent (from 368 cases during 2005/06 to 336 cases during 2008/09).

Exhibit VI-12, following Exhibit VI-11, shows average elapsed times to investigate cases referred for prosecution, by Identifier, by fiscal year. As shown by Exhibit VI-12, the average elapsed time to investigate cases with District office Identifiers increased by 27 percent (from 11.9 months during 2005/06 to 15.1 months during 2008/09). The average elapsed time to investigate these cases increased significantly in all three (3) regions. During 2008/09, the Other Southern California region experienced the largest increase and, in 2008/09, the average elapsed time to investigate cases reached 15 months for cases referred for prosecution. The Other Southern California region also experienced a relatively large 29 percent decrease in the number of cases referred for prosecution. In contrast, in the Northern California region, the number of cases referred for prosecution, and the average elapsed time to complete these investigations, increased by 10 percent. In each of the last two fiscal years the Northern California region referred at least 30 percent more cases for prosecution than either the Los Angeles Metro or Other Southern California regions (100 cases referred for prosecution by the Northern California region compared to 76 or fewer cases referred for prosecution by each of the other regions). For other cases, the number of cases referred for prosecution and the average elapsed time to complete the investigations increased during the past several years. Some of these cases were handled by Headquarters Units, some were handled by Probation Units, and some were handled by the District offices.

**Summary of Investigations Referred for Prosecution, By Type of Case
2005/06 through 2008/09**

Case Type	Timeframe to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	6 Months or Less ¹	20	10%	21	10%	17	10%	14	9%
	6 to 12 Months	72	35%	76	36%	47	28%	26	16%
	12 to 18 Months	71	35%	65	31%	44	26%	44	27%
	18 to 24 Months	27	13%	35	17%	36	21%	34	21%
	More than 24 Months	15	7%	14	7%	26	15%	46	28%
	Total	205	100%	211	100%	170	100%	164	100%
	Average Number of Months	13.7 Months		13.4 Months		15.6 Months		18.4 Months	
Other Cases	6 Months or Less ¹	84	52%	72	48%	66	42%	75	44%
	6 to 12 Months	43	26%	46	31%	54	34%	54	31%
	12 to 18 Months	29	18%	16	11%	17	11%	23	13%
	18 to 24 Months	5	3%	14	9%	17	11%	13	8%
	More than 24 Months	2	1%	2	1%	4	3%	7	4%
	Total	163	100%	150	100%	158	100%	172	100%
	Average Number of Months	7.5 Months		8.0 Months		9.0 Months		8.7 Months	
All Cases	6 Months or Less ¹	104	28%	93	26%	83	25%	89	26%
	6 to 12 Months	115	31%	122	34%	101	31%	80	24%
	12 to 18 Months	100	27%	81	22%	61	19%	67	20%
	18 to 24 Months	32	9%	49	14%	53	16%	47	14%
	More than 24 Months	17	5%	16	4%	30	9%	53	16%
	Total	368	100%	361	100%	328	100%	336	100%
	Average Number of Months	10.9 Months		11.1 Months		12.4 Months		13.4 Months	

¹ Data shown excludes cases referred directly to the Attorney General or a District Attorney without District office investigation, including nearly all Out of State (IDENT 16) cases, cases involving probation violations (IDENT 19, originated by the Medical Board), and SOI, CME Audit Failure, and Citation Non-Compliance cases (IDENT 20 or 21, originated by the Medical Board).

Direct Referrals for Prosecution	Quality of Care Cases	3	3%	12	18%	47	38%	20	16%
	Other Cases	99	97%	54	82%	77	62%	108	84%
	Total	102	100%	66	100%	124	100%	128	100%

Summary of Investigations Referred for Prosecution, By Identifier (8.01)
2005/06 through 2008/09

Business Unit		Cases Referred for Prosecution				Average Elapsed Time to Refer (Months)				Comments
		2005/06	2006/07	2007/08	2008/09	2005/06	2006/07	2007/08	2008/09	
Cases with District Office Identifiers	Fresno	25	29	25	12	13.5	12.0	17.2	21.3	Includes several aged Section 805 cases.
	Pleasant Hill	26	18	27	33	12.1	11.1	15.6	16.9	
	Sacramento	24	38	20	34	14.6	11.1	12.4	10.4	
	San Jose	14	22	28	24	12.6	13.7	12.2	13.8	
	Total - Northern California	89	107	100	103	13.2	11.9	14.4	14.5	
	Cerritos	35	18	33	26	12.0	11.8	13.0	11.8	
	Diamond Bar	26	16	10	12	10.2	14.6	18.1	18.7	
	Glendale	27	28	14	26	15.2	13.6	14.4	15.8	
	Valencia	24	24	19	11	13.1	8.9	12.4	12.9	Includes several 3-week HQES cases.
	Total - Los Angeles Metro Area	112	86	76	75	12.6	12.1	13.8	14.5	
	Rancho Cucamonga	N/A	N/A	N/A	2	N/A	N/A	N/A	8.1	Prior to 2008/09, Rancho Cucamonga was a Regional Probation Unit.
	San Bernardino	44	39	19	15	10.0	12.6	15.0	18.5	
	San Diego	25	29	34	34	11.4	13.0	14.5	16.5	
	Tustin	35	33	18	23	9.0	10.3	10.8	16.1	
	Total - Other Southern California	104	101	71	74	10.0	12.0	13.7	16.6	
Total - District Offices	305	294	247	252	11.9	12.0	14.0	15.1		
Cases with Other Identifiers ¹	Out of State (16)	6	7	9	1	2.2	8.0	7.5	3.6	These cases are nearly always referred from the Disciplinary Unit directly to the AG. They are only assigned to District offices when the licensee is practicing in California.
	Probation (19)	17	14	17	22	12.1	11.2	8.7	10.3	Prior to 2008/09, these cases were investigated by Regional Probation Units. Subsequently, the investigations were performed by District offices.
	Headquarters (20)	39	45	53	14	3.9	6.2	7.0	5.9	Includes Statement of Issue (SOI) cases and Probation Certifications which are not handled by the District Offices.
	Petitions for Modification/Termination of Probation (26)	Included with Headquarters Cases			29	Included with Headquarters Cases			6.1	Prior to 2008/09 petitions were handled by regional Probation Units. Subsequently, petitions for modification/termination of probation were handled by Probation Monitoring Units and the District offices and petitions for reinstatement were handled exclusively by the District offices.
	Petitions for Reinstatement (27)	Included with Headquarters Cases			8	Included with Headquarters Cases			9.3	
	Internet (23)	1	1	2	10	9.4	10.6	17.6	14.5	These cases are handled by a specialized Headquarters Unit. They are usually referred to DAs for prosecution without involvement of the District offices.
	Total - Other Identifiers¹	63	67	81	84	6.0	7.5	7.7	8.4	
Total, Excluding Direct Referrals¹	368	361	328	336	10.9	11.1	12.4	13.4		

¹ Data shown excludes closed Headquarters and Probation Unit cases, cases closed with a citation issued by DCU or Probation Units, and cases referred directly for prosecution without District office investigation, including nearly all Out-of-State (IDENT 16) cases, cases involving probation violations (IDENT 19, originated by the Medical Board), and all SOI, CME audit failure, and citation non-compliance cases (IDENT 20 or 21, originated by the Medical Board).

Cases Referred Directly for Prosecution from Headquarters or Probation Units	102	66	124	128	Not Applicable			
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VI. Investigations

H. HQES Declined to File Cases

With a greater level of HQES Attorney involvement in investigations, it might be expected that the number of cases that HQES declined to file would decrease. **Table VI-1**, below, shows the number of cases with District office Identifiers that HQES declined to file, by year, for the past five (5) fiscal years. During the past several years there were not any sustained changes in the number of cases that HQES declined to file. The average number of cases that HQES declined to file during the past two (2) years (20 cases per year) was about the same as the average number of cases that HQES declined to file during the preceding three (3) years (21 cases per year).

Table VI-1. HQES Declined to File Cases

Fiscal Year	Cases with District Office Identifiers			
	Northern California	Los Angeles Metro	Other Southern California	Total
2004/05	8	7	4	19
2005/06	4	13	1	18
2006/07	8	13	4	25
3-Year Average	7	11	3	21
2007/08	4	10	0	14
2008/09	10	6	9	25
2-Year Average	7	8	5	20

Implementation of VE has not reduced the number of cases that HQES declines to file, notwithstanding HQES' higher level of involvement in the investigation of the cases. During the past two (2) years there was little difference between geographic regions in the average number of cases that HQES declined to file. However, HQES' Los Angeles Metro office continues to decline to file as many, or more, cases than offices in other regions, notwithstanding the Los Angeles Metro office's much higher level of Attorney involvement in the investigation of cases in that region.

VI. Investigations

I. Pending Investigations

Exhibit VI-13, on the next page, shows the number of pending physician and surgeon Investigations, by District office and region, as of June 30, 2009, and December 31, 2009. As shown by Exhibit VI-13, the number of pending investigations was little changed during this period. Excluding petitions, and including investigations of Probationers, nearly 1,000 investigations were pending at the District offices on June 30, 2009. This compares to about 850 to 900 investigations opened and closed or referred by the District offices during 2008/09. The number of pending investigations is consistent with the 13 to 14-month average elapsed time to complete investigations experienced by the District offices during 2008/09. Over time, changes in the number of pending investigations correlate with changes in the average elapsed time to complete investigations (i.e., longer, or shorter, elapsed times to complete investigations parallel increases, or decreases, in the number of pending investigations).

Pending Investigations by Business Unit

Business Unit		June 30, 2009			December 31, 2009			
		Physician/ Surgeon Investigations	Petitions	Total	Physician Surgeon Investigations	Petitions	Total	
District Offices	Northern California	Sacramento	83	6	89	86	3	89
		Fresno	63	3	66	96	2	98
		Pleasant Hill	109	2	111	95	2	97
		San Jose	94	2	96	117	1	118
		Total	349	13	362	394	8	402
	Los Angeles Metro	Cerritos	76	1	77	76	1	77
		Diamond Bar	65	2	67	36	1	37
		Glendale	106	3	109	97	2	99
		Valencia	87	2	89	59	2	61
		Total	334	8	342	268	6	274
	Other Southern California	San Diego	100	0	100	75	0	75
		Tustin	81	3	84	91	2	93
		San Bernardino	79	0	79	83	1	84
		Rancho Cucamonga	42	1	43	60	1	61
		Total	302	4	306	309	4	313
Total - District Offices		985	25	1,010	971	18	989	
Headquarters Units	Operation Safe Medicine	58	1	59	59	1	60	
	Office of Standards and Training	16	0	16	18	1	19	
	Total - Headquarters Units	74	1	75	77	2	79	
Total Pending Investigations		1,059	26	1,085	1,048	20	1,068	

VI. Investigations

J. Expenditures for HQES Investigation Services

Concurrent with implementation of VE, during 2006 HQES began opening “Investigation Matters” for specific cases during the Investigation Stage, and HQES Attorneys began charging time to these matters when they worked on these cases. Additionally, many HQES Attorneys, and Lead Prosecutors in particular, began charging additional time to general “Client Service” matters reflecting time spent assisting with Investigations that was not charged to specific cases. In some cases the HQES Attorneys charged their time to “Section-Specific Tracking” matters rather than to general “Client Service” matters. Based on a review of individual Attorney time charges during 2008/09, most of the time charged by HQES Attorneys to general Client Service and Section-Specific Tracking matters, excluding time charged by Supervising DAGs, was for time worked on Investigation-related activities. Additionally, in the Northern California region, these charges include time providing assistance to CCU (i.e., several hours per week).

Exhibit VI-14, on the next page, summarizes HQES time charges to Investigation, Client Service, and Section-Specific Tracking matters by year from 2006 through 2009, excluding time charged by Supervising DAGs and HQES’ Senior Assistant Attorney General. As shown by Exhibit VI-14, during the past two years the number of hours charged by HQES DAGs to these matters increased by nearly 70 percent, from an average of 16,872 hours during 2006 and 2007 to more than 28,000 hours during 2009. Exhibit VI-14 also shows that time charges by Los Angeles Metro office Attorneys accounted for nearly all of this increase. During 2009, Los Angeles Metro office Attorneys charged more than 17,000 hours to Medical Board investigations, compared to fewer than 6,400 hours charged during 2006 and 2007. Additionally, during 2009 Los Angeles Metro office Attorneys charged about 11,000 more hours to Medical Board investigations than HQES’ San Diego office Attorneys, and nearly 12,000 more hours than charged by HQES’ Northern California offices.

HQES’ hourly billing rates for Attorney services during 2008/09 and 2009/10 were \$158 and \$170, respectively, or an average of \$164 per hour. Assuming a \$164 hourly billing rate for Attorney services, estimated billings during 2009 for investigation-related services for cases assigned to the Northern and Southern California regions were less than \$1 million each during 2009, compared to more than \$2.8 million for cases assigned to the Los Angeles Metro office.

As discussed previously, there are significant variations between regions in the number of investigations completed, as well as variations in other output and performance measures, such as the proportion of completed investigations referred for prosecution. **Table VI-2**, on page VI-28, shows the number of investigations completed by year, by region. Also shown are corresponding ratios of the number of HQES Attorney hours charged per completed investigation based on the Attorney hours charged during each fiscal year as shown in Exhibit VI-14.

**Hours Charged by HQES Staff to Investigation Matters - 2006 through 2009
Including Hours Charged to Section-Specific Tracking and Client Service Matters**

Classification	HQES Office(s)	Calendar Year (Actual)			
		2006	2007	2008	2009
Deputy Attorneys (DAGs)	Northern California ¹	6,610.25	6,084.50	5,007.25	5,167.75
	Los Angeles Metro	6,349.00	6,388.00	13,527.75	17,083.50
	San Diego (Other Southern California)	4,535.50	3,777.50	5,625.50	5,988.75
	Total	17,494.75	16,250.00	24,160.50	28,240.00
Paralegals, Analysts, and Special Agents	Northern California ¹	235.25	286.25	201.75	175.00
	Los Angeles Metro	189.50	739.00	1,166.75	1,193.75
	San Diego (Other Southern California)	1,391.25	1,369.25	1,847.25	1,386.00
	Total	1,816.00	2,394.50	3,215.75	2,754.75
Total	Northern California ¹	6,845.50	6,370.75	5,209.00	5,342.75
	Los Angeles Metro	6,538.50	7,127.00	14,694.50	18,277.25
	San Diego (Other Southern California)	5,926.75	5,146.75	7,472.75	7,374.75
	Total, Excluding Supervising DAGs	19,310.75	18,644.50	27,376.25	30,994.75

Classification	HQES Office(s)	Fiscal Year (Interpolated)		
		2006/07	2007/08	2008/09
Deputy Attorneys (DAGs)	Northern California ¹	6,347.38	5,545.88	5,087.50
	Los Angeles Metro	6,368.50	9,957.88	15,305.63
	San Diego (Other Southern California)	4,156.50	4,701.50	5,807.13
	Total	16,872.38	20,205.26	26,200.26
Paralegals, Analysts, and Special Agents	Northern California ¹	260.75	244.00	188.38
	Los Angeles Metro	464.25	952.88	1,180.25
	San Diego (Other Southern California)	1,380.25	1,608.25	1,616.63
	Total	2,105.25	2,805.13	2,985.26
Total	Northern California ¹	6,608.13	5,789.88	5,275.88
	Los Angeles Metro	6,832.75	10,910.76	16,485.88
	San Diego (Other Southern California)	5,536.75	6,309.75	7,423.76
	Total, Excluding Supervising DAGs	18,977.63	23,010.39	29,185.52

¹ Includes Fresno, Sacramento, Oakland, and San Francisco offices, including CCU support services.

VI. Investigations

Table VI-2. HQES Attorney Hours Charged to Investigations per Completed Investigation

Performance Indicator	2006/07				2007/08				2008/09			
	Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total
Estimated Hours Charged ¹ (see Exhibit VI-14)	6,347	6,369	4,157	16,872	5,546	9,958	4,702	20,205	5,088	15,306	5,807	26,200
Investigations Closed without Citation	221	213	100	534	282	212	178	672	221	213	100	534
Investigations Closed with Citation Issued	5	14	22	41	1	14	11	26	6	17	16	39
Investigations Referred for Prosecution	107	86	101	294	100	76	71	247	103	75	74	252
Total Investigations Closed or Referred for Prosecution²	333	313	223	869	383	302	260	945	330	305	190	825
HQES Attorney Hours Charged per Completed Investigation	19	20	19	19	14	33	18	21	15	50	31	32
Hourly Billing Rate for Attorney Services	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158
Average Attorney Cost per Case	\$3,002	\$3,160	\$3,002	\$3,002	\$2,212	\$5,214	\$2,844	\$3,318	\$2,370	\$7,900	\$4,898	\$5,056

¹ Data shown includes hours charged by Lead Prosecutors and other Deputy Attorneys to Investigation, Section-Specific Tracking, and Client Service matters.

² Data shown excludes cases involving licensees on probation, Petitions for Modification or Termination of Probation, and Petitions for Reinstatement. The excluded cases are assumed to be proportionately distributed throughout the State.

As shown by Table VI-2, during 2008/09 HQES Attorneys assigned to Los Angeles Metro region cases billed:

- ❖ 60 percent more hours per completed investigation as were billed by Attorneys assigned to Other Southern California region cases (50 hours per completed investigation compared to 31 hours per completed investigation)
- ❖ More than three times (3x) as many hours per completed investigation as were billed by Attorneys assigned to Northern California region cases (50 hours per completed investigation compared to 15 hours per completed investigation).

Assuming a \$158 per hour billing rate for Attorney services, on a per case basis Attorneys working on Northern California region cases billed the Medical Board an average of less than \$2,400 per investigation completed during 2008/09. This compares to an average of about \$4,900 billed per completed investigation for Other Southern California region cases, and an average of \$7,900 billed per completed investigation for Los Angeles Metro region cases.

If HQES had charged an average of \$2,400 in Attorney fees per completed investigation during 2008/09 for all completed investigations, statewide, HQES' billings to the Medical Board for Attorney services would have been about \$2.0 million, or about \$2.2 million less than the estimated amount actually billed (\$4.2 million). Conversely, if HQES had charged \$7,900 in Attorney fees per completed investigation for all completed investigations, statewide, billings to the Medical Board for Attorney services would have been about \$6.5 million or nearly \$2.35 million more than the estimated amount actually billed.

VI. Investigations

In an effort to better understand Los Angeles Metro office Attorney charges for Investigation-related services, we researched a sample of Los Angeles Metro office cases from HQES' June 2009 Invoice Report to the Medical Board. The Invoice Report shows time charges during the month for each matter that had time charged during the billing period, and also cumulative charges for the fiscal year-to-date, and cumulative charges for the matter including charges from prior fiscal years. We selected all cases that were included in the June 2009 billing with more than 40 hours billed during 2008/09, irrespective of the number of hours charged during June. Twenty-eight (28) cases were selected. Of the 28 cases, nine (9) were assigned to the Valencia office, 11 were assigned to the Cerritos office, three (3) were assigned to the Diamond Bar office, and 4 were assigned to the Glendale office. Within these offices, the cases were assigned to various Investigators. The cases involved a mix of medical malpractice reports, Section 805 reports, sexual misconduct and impaired physician complaints, prescribing violations, and other quality of care and physician conduct matters. Of the 28 cases, 7 were assigned to one HQES Attorney, 6 were assigned to another HQES Attorney, 3 were assigned to a third HQES Attorney, and the remaining 12 cases were assigned to 10 other HQES Attorneys. **Table VI-3**, below, summarizes the disposition and current status of these 28 cases, as of mid-June 2010 (1 year later).

**Table VI-3. Disposition and Status of Selected Los Angeles Metro Cases
with Attorney Time Charged During June 2009**

Pending or Closed	Number	Referred for Prosecution	Number
Pending Investigation	2	Referred for Prosecution, Accusation Not Yet Filed	3
Closed – Without Referral or Citation	12	Referred for Prosecution, Accusation Filed (Pending Settlement or Hearing)	4
Closed – Subject Passed Competency Exam	2	Referred for Criminal Prosecution and PC 23 (License Restricted)	1
Closed – Recommended for Citation	1	Referred for Prosecution, Disciplinary Action	2
Referred to Office of Safe Medicine (Pending OSM Investigation)	1		
Total	18	Total	10

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Exhibit VI-15, on the next two pages, provides summaries of twelve (12) of the 28 Los Angeles Metro office cases included in the scope of our review, including the eight (8) cases with hours charged during June 2009, that had the most hours charged during 2008/09. **Exhibit VI-16**, following Exhibit VI-15, provides a recap of the remaining sixteen (16) cases. Several of these case histories reflect the benefits of having HQES Attorneys working jointly with Medical Board Investigators during the Investigation Stage. For example, HQES Attorneys helped to issue and enforce subpoenas for records, assisted in interviewing parties involved with the matter, provided advice and direction on the course and direction of the investigations, promptly prepared and filed pleadings, and sought adoption of disciplinary actions. However, the case histories also highlight a number of significant, and troubling, problems with the services provided by HQES' Los Angeles Metro office. Some of these problems may also exist, to a lesser extent, at other HQES offices. These problems include:

Performing Detailed Document and Record Reviews and Analyses – These case histories show that some Los Angeles Metro office Attorneys are substantively involved in performing detailed document and record reviews and analyses during the Investigation Stage. These activities appear to go well beyond providing legal advice and direction to the Medical Board regarding the course and direction of the investigation as provided in Section 12529.6 of the Government Code and in the *Vertical Prosecution Manual* adopted by HQES and the Medical Board. Nothing in Section 12529.6 suggests or implies that HQES Attorneys should be as intensively involved as they are in performing these types of investigation activities. The *VE Manual* specifically defines the role of the Primary DAG as follows:

“Works closely with other team members and, in conjunction with Supervising Investigator I, directs Investigators in obtaining evidence. Also, provides legal advice to the Medical Board and prosecutes the case.”

Excessive Time Spent on Cases that are Closed – These case histories show that some Los Angeles Metro office Attorneys spend as much time on cases that close as on cases that are referred for prosecution. The theory that greater Attorney involvement during the Investigation Stage will enable faster identification and earlier closure of cases is not supported by actual experience.

Delayed Filing of Pleading – Even though Attorneys were substantively involved with all of these cases, accusations were not promptly prepared for 3 of 6 cases that were referred for prosecution. The three (3) cases were referred for prosecution 5 to 7 months ago and, as of late-June, 2010, the accusations were not yet prepared.

Delayed Prosecution – Rather than initiating prosecution of a single patient case involving sexual misconduct (with a patient) that was referred for prosecution, the Primary DAG directed that the Medical Board investigate a case involving a second potential victim. The Primary DAG was extensively involved with each step of this supplemental investigation, which took eight (8) additional months to complete. Another five (5) months elapsed before the accusation was filed. Several additional months elapsed before the Primary DAG requested a hearing, which was not scheduled for another six (6) months. Throughout this period the Subject continued to practice without restriction.

Summaries of Selected Cases Billed for Investigation Services

Case History VI-1 (Estimated Cumulative HQES Fees through June 2009 – \$50,000) – This case had the largest number of hours charged during 2008/09 (249) of all of investigation cases billed during June 2009. In total, 332 hours were billed to this matter through June 2009, and additional hours were billed in subsequent months. During this 3-year investigation, the Subject was placed on probation following completion of another investigation involving similar treatment issues. Just before expiration of the statutes of limitations, the case was transmitted to HQES' Los Angeles Metro office for prosecution. The submittal included two (2) Expert opinions concluding that there were extreme and simple departures involving two (2) separate patients. HQES' Primary DAG declined to file and recommended closure of the case. On the following day, or possibly the day after, the case was transferred to another HQES office which, by then, had already reviewed the matter and agreed to accept it. A pleading was filed the next day. Several months later a settlement was reached that imposed additional discipline.

Case History VI-2 (Estimated Cumulative Fees through June 2009 – \$20,400) – This multiple patient case involving failure to treat issues had the second largest number of hours charged during 2008/09 (122) of all investigation cases billed during June 2009. Problems were encountered obtaining records. Subpoenas for records were obtained, but not complied with, which required court-ordered enforcement. **After the records were obtained and reviewed, the case was closed.**

Case History VI-3 (Estimated Cumulative Fees through June 2009 – \$17,000) – This multiple patient case involving excessive prescribing and billing had the third largest number of hours charged during 2008/09 (95.75) of all investigation cases billed during June 2009. The accusation, which encompassed a large number of violations, was not filed until more than six (6) months after the case was referred for prosecution. **The case is currently pending settlement or hearing.**

Case History VI-4 (Estimated Cumulative Fees through June 2009 – \$13,500) – This case had the fifth largest number of hours charged during 2008/09 (87.00) of all investigation cases billed during June 2009. The case number shown on this matter was closed during November 2008 because it was "redundant" to another case that was previously referred for investigation. It appears that the hours charged by HQES to this investigation matter during June 2009, and possibly in some prior months during 2008/09, were actually related to the prior case. **The case is currently assigned to an outside Expert for review.**

Case Histories VI-5 through VI-11 (Estimated Cumulative Fees through June 2009 – \$70,000 for 7 cases) – These seven (7) cases include a case that had the fourth largest number of hours charged during 2008/09 (88.5) and another case that had the sixth largest number of hours charged during 2008/09, for all cases billed during June 2009. These cases also include five (5) other cases that had more than 40 hours billed during 2008/09 that had the same Primary DAG assigned. The billing records for these cases describe the types of investigation-related activities performed. These activities included:

- Reviewing investigation reports
- Corresponding with the Investigator and others
- Preparing for and meeting with the Medical Consultant
- Preparing for and interviewing the Subject
- Reviewing depositions from related litigation
- Reviewing patient medical records
- Reviewing transcripts from prior cases
- Determining needs for and selecting a Medical Expert.

These billing records also suggest that, in some cases, a significant portion of this Attorney's time is spent on activities that go beyond providing general legal advice and direction to the Medical Board regarding the course and direction of the investigation. Instead, the Primary DAG is also substantively involved in completing detailed reviews and analysis of case records. **Six (6) of these cases were subsequently closed "Insufficient Evidence" or "No Violation". One (1) case was referred for prosecution and is currently pending settlement or hearing.**

Case History VI-12 (Estimated Cumulative Fees – \$15,000) – This single patient case involving sexual misconduct (with a patient) had the eighth largest number of hours charged during 2008/09 (79.5) of all investigation cases with hours charged during June. The Subject was previously disciplined by the Medical Board for the same offense. Following referral of the case for prosecution, the Primary DAG directed completion of an investigation of a second patient, which took eight (8) months to complete. The accusation was not filed until five (5) months after the second investigation was completed, and more than a full year following initial transmittal of the case. Several additional months elapsed before the Primary DAG requested a hearing, which was not scheduled for another six (6) months. Throughout this period the Subject continued to practice without restriction. **The case is currently pending settlement or hearing, and the Subject is continuing to practice without restriction.**

Summary of Other Cases Billed During June 2009 with More than 40 Hours Billed During 2008/09

Disposition Category	Case Profile	Disposition	2008/09 Investigation Hours	Total Investigation Hours through June 2009 ¹	Estimated Total Fees ¹
Matters Not Referred for Prosecution	Multiple patient case involving physician impairment.	Closed - No Violation	42.75	60.00	\$9,300
	Section 805 case.	Closed - Insufficient Evidence	70.75	84.00	13,020
	Section 805 case involving multiple patients.	Closed - Insufficient Evidence	77.00	83.25	12,904
	Case involving Subject's failure to diagnose/treat.	Closed - Pending Criminal	44.75	44.75	6,936
	Complex case involving prescribing violations.	Closed - Pending Criminal	52.25	53.75	8,331
	DHS referred case involving patient care issues.	Closed - Recommended Citation	52.00	53.25	8,254
	Case involving aiding/abetting unlicensed practice.	Referred to Office of Safe Medicine (HQES no longer involved with matter)	41.75	41.75	6,471
	Average HQES Fees per Case - \$9,317		Total Hours/Fees	381.25	420.75
Referred for Competency Examination	Section 805 case.	Closed - Compelled to Take Competency Exam (Passed)	57.50	57.50	\$8,913
	Case involving alleged self-use of prescription medications.	Closed - Compelled to Take Competency Exam (Passed)	58.25	58.25	9,029
	Average HQES Fees per Case - \$8,970		Total Hours/Fees	115.75	115.75
Matters Referred for Prosecution	Cases involving failure to provide adequate care.	Referred to HQES - Not Yet Filed (Pending for 7 months)	44.25	44.25	\$6,859
	Section 805 case involving multiple patients.	Referred to HQES - Not Yet Filed (Pending for 5 months)	59.50	78.50	12,168
	Case involving Subject misrepresentation of procedure.	Referred to HQES - Not Yet Filed (Pending for 6 months)	63.25	63.25	9,804
	Section 805 case.	Referred and Filed (filed within 2 months of transmittal)	64.00	69.75	10,811
	Case involving alleged prescribing violations.	Closed - Subject Deceased (following Referral for PC 23)	48.50	52.75	8,176
	Multiple patient case involving sexual misconduct.	Referred for Criminal and PC 23 (License Restricted)	46.50	46.50	7,208
	Case involving Subject's arrest for spousal abuse.	Referred to HQES, Filed, Decided (Revocation Stayed, Probation - 5 Years)	56.50	56.50	8,758
	Average HQES Fees per Case - \$9,112		Total Hours/Fees	382.50	411.50
Average HQES Hours and Fees per Case - 59.25 Hours / \$9,184		Total Hours/Fees	879.50	948.00	\$146,940

¹ Additional hours may have been worked on some cases subsequent to June 2009. The estimated fees shown assume a weighted average billing rate of \$155 per hour.

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Completed Case Rejections – This investigation initially concerned more than two (2) dozen patients, but focused on six (6) selected cases. Two (2) Expert opinions found multiple extreme and simple departures involving two (2) of the patients. During this 3-year investigation, the Subject was placed on probation following investigation of another complaint involving similar treatment issues. Just before expiration of the statute of limitations, the Primary DAG issued a 6-page Decline to File Memorandum that recommended closure of the case. Following issuance of the Decline to File Memorandum:

- ✓ The District Office Supervisor conferred with their Regional Manager
- ✓ The Regional Manager conferred with the Deputy Chief of Enforcement
- ✓ The Deputy Chief of Enforcement conferred with the Chief of Enforcement
- ✓ The Chief of Enforcement conferred with the Senior Assistant Attorney General
- ✓ The Senior Assistant Attorney General met with the Supervising DAG of another office to review the matter
- ✓ The case was transferred to the second HQES office which had agreed to prosecute the case
- ✓ An Attorney from the second HQES office came into work early the next day to prepare the pleading which was filed the next day.

A period of only three (3) days elapsed from issuance of the Decline to File Memorandum by HQES' Los Angeles Metro office to filing of the pleading by the second HQES office. Several months later the Medical Board accepted a settlement agreement imposing additional discipline that was negotiated by the second HQES office.

The problems highlighted by the above case histories are not isolated cases. Additional analyses and case histories showing the prevalence of several of these problems, particularly in the Los Angeles Metro region, are presented in Section VII (*Prosecutions and Disciplinary Action*). Additionally, the case histories highlight various internal control problems with the posting of Attorney time charges (e.g., time charges are sometimes posted to Investigation matters that reference a different Medical Board complaint from the case actually being investigated).

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K. Medical Consultant and Outside Expert Services and Expenditures

Generally, each District office has 2 to 3 part-time Medical Consultants assigned, and most of the Medical Consultants usually work at their assigned office for several hours either 1 or 2 days a week. Total wages paid to Medical Consultants during 2008/09 were \$852,000 (\$71,000 per month) for a total of 13,991 paid hours of services (\$61 per hour). This is equivalent to an average of about 22 paid hours per week for each District office. However, due to paid holidays, vacation, sick leave, and other paid time off, the actual number of hours worked by the Medical Consultants was less than 13,991 hours, and the average number of hours worked per week per District office was less than 22 hours. **Table VI-4**, below, shows the actual distribution of paid Medical Consultant hours during 2008/09, by District office and region.

Table VI-4. 2008/09 Medical Consultant Expenditures

District/Region	Hours Paid				Total Hours Paid		Avg. Hours per Office per Week	Salaries Paid
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Number	Percent		
Sacramento	482.25	351.50	377.25	520.25	1,731.25	12%	33	\$105,031
Fresno	144.25	525.25	570.45	434.75	1,674.70	12%	32	101,746
San Jose	77.75	104.80	169.00	153.75	505.30	4%	10	29,384
Pleasant Hill	146.50	405.00	283.00	321.75	1,156.25	8%	22	69,879
Total Northern California	850.75	1,386.55	1,399.70	1,430.50	5,067.50	36%	24	\$306,041
Glendale	128.50	442.50	414.75	373.00	1,358.75	10%	26	\$84,119
Cerritos	251.00	823.00	789.00	589.00	2,452.00	18%	47	158,843
Diamond Bar	39.50	185.00	273.75	299.30	797.55	6%	15	46,087
Valencia	126.00	278.50	344.25	335.50	1,084.25	8%	21	63,213
Total Los Angeles Metro	545.00	1,729.00	1,821.75	1,596.80	5,692.55	41%	27	\$352,262
San Bernardino	81.00	155.00	208.00	217.00	661.00	5%	13	\$40,649
Tustin	118.50	355.00	404.00	434.50	1,312.00	9%	25	77,173
San Diego	85.00	252.00	345.25	354.75	1,037.00	7%	20	61,951
Rancho Cucamonga	64.00	60.00	56.50	40.00	220.50	2%	4	13,600
Total Other Southern California	348.50	822.00	1,013.75	1,046.25	3,230.50	23%	16	\$193,373
Statewide Total	1,744.25	3,937.55	4,235.20	4,073.55	13,990.55	100%	22	\$851,676

Source: State Controllers Office Blanket Reports.

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At the beginning of the 2008/09 the hours paid to Medical Consultants were restricted by Executive Order S-09-09 which temporarily suspended the use of all part-time staff by agencies throughout the State. Table VI-4 also shows that, during 2008/09, Medical Consultant availability varied significantly between District offices and regions. For example, during 2008/09 an average of 15 paid hours per week, or less, of Medical Consultant services was utilized by some District offices while, at other District offices, an average of 25 paid hours per week, or more, of Medical Consultant services was utilized. Only one (1) District office (Cerritos) utilized the equivalent of more than one (1) full-time Medical Consultant position.

During 2008/09 the District offices completed investigations of 550 quality of care cases and 404 other (physician conduct) cases. **Table VI-5**, below, summarizes available historical data regarding the estimated number of Subject interviews, Medical Consultant reviews, and Expert reviews completed by the District offices, by type of case. For cases involving quality of care issues, the Medical Consultants are usually substantively involved in the investigation, provided they are available. The Medical Consultants are usually much less frequently involved with other cases.

Table VI-5. Interim Investigation Activities¹

Type of Case	Interim Activity	2004/05	2005/06	2006/07	2007/08	2008/09
Quality of Care	Subject Interviews	614	505	429	470	453
	Medical Consultant Reviews	Sufficiently Complete Data Not Available		400	439	413
	Expert Reviews	504	403	336	404	290
Other	Subject Interviews	204	200	227	241	228
	Medical Consultant Reviews	Sufficiently Complete Data Not Available		128	101	67
	Expert Reviews	61	61	57	65	50
Total	Subject Interviews	818	705	656	711	681
	Medical Consultant Reviews	Sufficiently Complete Data Not Available		528	540	480
	Expert Reviews	565	464	393	469	340

¹ The volumes shown are estimates and may be understated in one or more years.

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Based on the data presented in Tables VI-4 and VI-5, the Medical Consultants spend an average of less than 25 hours working on the cases in which they are involved, assuming that (1) at least 10 percent of the hours paid to Medical Consultants are for paid time off, and (2) substantive involvement with only about 500 completed cases per year, which is possibly understated. The amount of time spent by the Medical Consultants on these cases includes performance of, or assistance with, all of the following activities:

- ❖ Ad-hoc consultations to Medical Board Investigators, HQES Attorneys, and District office Supervisors
- ❖ Preparation and attendance at Subject interviews, including pre-interview planning and post-interview debriefing meetings
- ❖ Reviews of medical records
- ❖ Identification of cases that should be closed without obtaining an Expert opinion
- ❖ Identification and selection of Medical Experts
- ❖ Preparation of Medical Expert packages
- ❖ Review of Medical Expert reports.

Depending of their availability and area(s) of specialization, Medical Consultants can potentially impact a District office's need for outside Medical Experts and the average timeframe to complete investigations. Although there are many factors that can significantly impact the timeframe needed to complete investigations, the two (2) District offices with the highest Medical Consultant expenditures during 2008/09 (Cerritos and Sacramento) also had comparatively low average elapsed times per completed investigation for that same year (an average of 11 months and 10 months, respectively, compared to a statewide average for all District offices of nearly 14 months).

As suggested by the data shown on Table VI-5, Medical Experts are involved in fewer cases than the Medical Consultants and, except for their possible involvement in hearings, provide a more limited scope of services. During 2008/09, \$598,570 was billed by Medical Experts for case review services. Some Medical Experts may not all fully charge the Medical Board for all time spent on Medical Board matters. The billing rate for case review services is currently \$150 per hour. During 2008/09 the Medical Experts charged the Medical Board an average of less than 12 hours of time per completed case review, or about one-half the average amount of time utilized by the Medical Consultants. While the Medical Experts charge an average of less than 12 hours of time to complete the case reviews and prepare their Expert opinion, available data suggests that the provision of these services oftentimes extends over a period of 2 to 3 months, or longer. On average, the Medical Board's cost for Expert opinions is less than \$1,800 per completed review.

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Table VI-6, below, shows the frequency distribution of elapsed times for Medical Experts to provide these services for reviews completed during 2008/09, by District office Identifier. As shown by Table VI-6, on a statewide basis only 38 percent of all Medical Expert reviews are completed within one (1) month, and 23 percent take longer than two (2) months. While there is some variability, the frequency distributions of elapsed times to complete these reviews at individual District offices are similar to the statewide distribution. More than 30 percent of the Medical Expert reviews took longer than two (2) months to complete at one District office in each of the three regions (Sacramento, Valencia, and San Diego). Overall, the average elapsed time to complete Medical Expert reviews was 48 days (about 7 weeks).

Table VI-6. Elapsed Time to Prepare Expert Opinions During 2008/09

Business Unit		30 Days or Less		31 to 60 Days		61 to 91 Days		More than 91 Days		Total	
		Completed Opinions	Percent								
Northern California	Sacramento	10	37%	7	26%	8	30%	2	7%	27	100%
	San Jose	11	32%	17	50%	4	12%	2	6%	34	100%
	Fresno	11	46%	10	42%	2	8%	1	4%	24	100%
	Pleasant Hill	23	45%	18	35%	4	8%	6	12%	51	100%
	Total	55	40%	52	38%	18	13%	11	8%	136	100%
Los Angeles Metro	Valencia	10	42%	6	25%	5	21%	3	13%	24	100%
	Cerritos	8	24%	18	55%	2	6%	5	15%	33	100%
	Diamond Bar	4	25%	8	50%	4	25%	0	0%	16	100%
	Glendale	10	48%	7	33%	3	14%	1	5%	21	100%
	Total	32	34%	39	41%	14	15%	9	10%	94	100%
Other Southern California	Tustin	14	47%	11	37%	5	17%	0	0%	30	100%
	San Bernardino	14	33%	21	50%	2	5%	5	12%	42	100%
	San Diego	4	21%	7	37%	2	11%	6	32%	19	100%
	Rancho Cucamonga	2	100%	0	0%	0	0%	0	0%	2	100%
	Total	34	37%	39	42%	9	10%	11	12%	93	100%
Total - District Office Identifiers		121	37%	130	40%	41	13%	31	10%	323	100%
Other Identifiers (19, 20, and 23)		5	38%	3	23%	2	15%	3	23%	13	100%
Total - All Identifiers		126	38%	133	40%	43	13%	34	10%	336	100%

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There are significant regional variations in the use of Medical Experts that impact the time needed to complete investigations. For example, in the Northern California and Other Southern California regions, only one (1) Medical Expert opinion with a finding that there was an “extreme departure” or “multiple simple departures” is usually required for HQES to accept the case prosecution. In contrast, HQES Attorneys in the Los Angeles Metro region generally require completion of two (2) Medical Expert opinions in all single patient cases. There are numerous adverse impacts of this requirement on Los Angeles Metro region investigations, including:

- ❖ The second opinion is only requested after the first opinion is completed as it would serve no purpose to seek a second opinion in cases where another opinion shows no violation occurred. Thus, the requirement to obtain a second opinion adds at least 1 to 2 months to the elapsed time to complete most single patient case investigations that are referred for prosecution. The timeframe to complete these investigations can become even more extended if there are inconsistencies between the two Medical Expert opinions, if the second opinion is not timely completed, or if there are deficiencies with the quality of the second Medical Expert’s review or with the report documenting results of the review.
- ❖ If the second opinion does not confirm the findings of the first opinion, it effectively kills the case, resulting in fewer cases referred for prosecution.
- ❖ The number of Medical Expert opinions is doubled for cases that are referred for prosecution, thus reducing the availability of Medical Experts to perform reviews of other cases. This can make it much more difficult and increase the time needed to complete investigations of other cases, particularly cases involving more specialized medical practice areas
- ❖ Investigator and Medical Consultant workloads are increased along with costs for Medical Expert review services.

It is our understanding that, during the 1990s, the Medical Board routinely obtained two (2) Medical Expert opinions for single patient cases, but that this practice was discontinued. However, it is evident that there have been ongoing disagreements regarding needs for obtaining more than one (1) Medical Expert opinion during the Investigation stage, particularly in the Los Angeles Metro region, and that the disagreements are not limited to single patient cases. For cases referred to investigation prior to 2006, some Los Angeles Metro region Attorneys sometimes required submission of a confirming second opinion prior to accepting a case for prosecution, or would request a second opinion before beginning preparation of the pleading. Subsequent to 2006, some Los Angeles Metro region Attorneys, in their capacity as Lead Prosecutor or Primary DAG, required second opinions as part of the investigation process. In some cases significant disputes with District office Supervisors and Investigators have arisen over this issue primarily because of concerns about increased risks of harm to patients and the general public (e.g., cases involving substance abuse), but also because of adverse impacts on workflow, caseloads, costs, and the availability of Medical Experts to perform reviews of other cases.

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In connection with requirements to obtain a second Medical Expert opinion, it should not be overlooked that nearly all quality of care cases, and many other cases, were previously reviewed by a Medical Specialist as part of CCU's complaint screening process, and that the Medical Specialist determined at that point that the departures warranted referral of the case for investigation. Additionally, the District office Medical Consultant completes a review of all of these same cases. Thus, the first Medical Expert's opinion is actually the second, or third, review of the case resulting in a determination that either an extreme departure or multiple simple departures, or both, occurred. The second Medical Expert's review would be the third, or fourth, medical review of the case. It is our understanding that, outside of the Los Angeles Metro region, second opinions are rarely requested unless the case involves a second medical specialty, or it is determined that a case will proceed to hearing, which isn't determined sometime after the pleading is filed and, even then, still might not be needed if the departure is obvious. The overwhelming majority of cases are settled without a hearing, thus avoiding the need to obtain a second Medical Expert opinion in most cases.

It is our understanding that Enforcement Program and HQES management recently conferenced during April 2010 and reached an agreement to require two (2) Medical Expert opinions for all single patient cases. According to Enforcement Program management, only applying this requirement in the Los Angeles Metro region, where it is strongly supported by HQES management and practiced by their staff, was "unfair" to Los Angeles Metro region Investigators because they "had to do more work in LA". In support of this policy, it was argued that problems had recently been experienced with single patient cases that had just one Medical Expert (e.g., "a lot of San Diego cases have been dismissed at hearing."). This approach also would promote statewide uniformity. While we support the effort to promote uniformity, it makes no sense, at least to us, to subject all of the Medical Board's District office Investigators, Medical Consultants, Supervisors, and clerical support staff, to an unnecessary additional workload requirement just because it is the practice in one region of the State. Additionally, we question the assumption that the dismissals of San Diego office cases occurred solely because the Medical Board had only one (1) Medical Expert. Even if this assumption is correct, we don't understand why San Diego's cases proceeded to hearing without a second Medical Expert opinion, or why requiring a second opinion for all cases during the Investigation Stage is a better approach to resolving this problem than waiting until after the accusation is filed and determining how likely it is that a the case will actually proceed to Hearing, before obtaining the second opinion. Finally, although Enforcement Program and HQES management apparently reached this agreement to universally require two (2) Medical Expert opinions for all single patient cases, the actual practice in the field has not changed. District office Supervisors and HQES Supervising DAGs outside the Los Angeles Metro region rarely second Medical Expert opinion for single patient cases, except when an opinion is needed in a second specialty area or it appears likely that the case will proceed to hearing and a second opinion is needed to strengthen presentation of the case.

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L. Recommendations for Improvement

Below we discuss several key recommendations for improving investigation process performance. These recommendations concern Medical Consultant staffing, the availability of outside Medical Experts, and retention of Investigators. Additional recommendations that would impact investigations are included in Section X (*Organizational and Management Structures*), including recommendations involving:

- ✓ Restructuring the handling of Section 801 cases
- ✓ Restructuring the management of District office investigations
- ✓ Scaling back and optimizing HQES involvement in District office investigations
- ✓ Developing new organizational structures and processes for managing cases following referral for prosecution and HQES expenditures
- ✓ Improving workload and performance reporting process.

1. Medical Consultant Staffing

As noted in the Enforcement Monitor's 2004/05 reports, "the medical consultant's (MC) function is central to the speed and quality of QC cases processing at the district office level; however problems regarding medical consultant availability, training, and proper use contribute significantly to lengthy investigations and inefficient operations. . . Shortages of medical consultant time have made it continuously difficult for investigators to obtain sufficient medical consultant assistance. . ." However, the Medical Consultant's function is not limited to quality of care cases. They are also involved in many physician conduct cases. Additionally, their availability is critical not just to the process of reviewing Expert opinion reports, as emphasized by the Enforcement Monitor. Rather, the Medical Consultants are critical during earlier stages of the investigation during which, for example, medical records are initially received and reviewed, the Subject is interviewed, a decision is made as to whether to obtain an Expert opinion, potential Experts are identified and a selection decision is made, and the Expert package and instructions are prepared for the Expert's review.

Perhaps most importantly, the Medical Consultant is a key (perhaps the key) participant in the process of assessing, prior to referral of a case to an outside Expert, whether the facts and circumstances of a case, particularly for quality of care cases, indicate that an extreme departure or multiple simple departures occurred and, hence, whether to close the case or continue the investigation. In fact, the Medical Consultant's involvement in reviewing the Expert's opinion, which is the last step in the investigation process, is only one of their many important responsibilities. If the Expert has clearly presented their opinion as to whether an extreme departure or multiple simple departures has occurred, and support for the opinion is clearly organized and presented, then subsequent involvement of the Medical Consultant will probably be minimal. However, if the

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Expert's opinion is not clearly stated or well-supported in their report, the Medical Consultant's role is key in assessing the Expert's report and determining whether, or how, to proceed from that point forward (e.g., collect additional evidence, obtain clarification of the opinion, close the case, refer the case for prosecution, etc.).

Additionally, the Medical Board's pool of Medical Consultants serves as a gatekeeper on the flow of cases to Experts. In many cases the Medical Consultants are sufficiently qualified in the specialties involved to determine whether a case should be closed, avoiding completely the need for review services from an outside Medical Expert. To the extent that the Medical Consultants are able to make such determinations, the flow of cases to, and the Medical Board's needs for, outside Medical Experts is reduced. This not only reduces the timeframes to complete these investigations, but enables redirection of District office resources to other cases. It also helps to preserve the availability of outside Medical Experts for use on other cases.

Since publication of the Enforcement Monitor's reports there has been very little change in the availability of Medical Consultants. Needs in this area have not been emphasized. Additional Attorney positions (10) were authorized for HQES, additional Sworn Investigator and Assistant Investigator positions (8) were authorized for the Medical Board, additional positions (6) were authorized to reestablish an OSM Unit, additional positions (4) were authorized for the Probation Program and, most recently, new Non-Sworn positions (6) and a number of other Enforcement Program positions are expected to be authorized as part of the 2010/11 Budget, but no additional funding for Medical Consultants was included in this package.

Recommendation No. VI-1. *Augment Medical Consultant staffing. Medical Consultants should be available to all District offices all of the time (e.g., the equivalent of at least one full-time position per office, although actual availability will be less than full time due to vacations, sick leave and other time off). Because the Medical Consultant positions are classified as Permanent Intermittent, work hours can be adjusted to accommodate fluctuating workload demands, assuming a sufficient pool of resources is available to provide the services and the physicians are willing to work the number of hours needed. Offset additional costs for Medical Consultant positions by reducing expenditures for HQES investigation-related services (e.g., in the Los Angeles Metro region).*

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2. Medical Expert Resources

Although Medical Experts are of vital importance to the success of investigations and prosecutions, the Expert Reviewer Program has suffered from chronic weaknesses inherent in the system. A major problem, perhaps the most critical, is the limitation on utilization of the most qualified Medical Experts. While the Medical Board has attempted to remedy some of these problems by increasing the billing rate for Medical Expert review services from \$100 to \$150 per hour, the rate increase did not address restrictions on the Board's use of its most qualified Medical Experts.

Under current Board policy, Medical Experts may not be used more than three (3) times per year. As with medical procedures, Medical Experts tend to become more qualified as they complete more reviews. However, under current policy, at the very point when the Medical Experts may become most qualified, and also faster and more effective, they must stop work until another year. As defense counsels are under no such restrictions, under the current system the Investigators and Prosecutors are severely handicapped.

Recommendation No. VI-2. *Eliminate the limitation on reutilization of Medical Experts and augment the Medical Expert pool and enhance capabilities. In addition to strengthening Expert Reviewer oversight and overall Expert Reviewer Program management and administration, consider redirecting some funding currently used for HQES investigation-related services toward establishing a new program under which the Medical Board would contract for the services of a pool of physicians to provide Expert Review services (e.g., through an Interagency Agreement with one or more University of California Medical Centers, although this model may have its own problems relating to conflicts of interest).*

3. Investigator Retention

It is unlikely that Enforcement Program performance will improve significantly unless Investigator workforce capability levels are stabilized. Medical Board management does not control pay and benefit levels, mandated furloughs, baby boomer retirements, or recruitment efforts by other agencies, but it can impact District office work environments in significant and meaningful ways that can help to minimize Investigator attrition. A strategy to retain experienced Investigators should include efforts to create a work environment to promote communication with staff to provide assurances that work problems will be addressed. This strategy should include the following initiatives:

- ✓ Reducing and simplifying Investigator caseloads
- ✓ Increasing the availability of Medical Consultants
- ✓ Targeting HQES Attorney involvement during investigations to those cases where such involvement is needed

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- ✓ Limiting HQES Attorney involvement to activities that are appropriately performed by an Attorney (e.g., providing legal advice and direction)
- ✓ Promoting uniformity in the use of requests for supplemental investigations and decline to file cases to ensure that such requests and handling are reasonable and defensible, and do not unnecessarily delay the filing of accusations or result in inappropriate case closures.

Additionally, needs exists for all appropriate members of the Medical Board's Executive Management Team, and their counterparts at the Department of Justice, to meet jointly with staff from each District office and communicate directly to them that they are important and that management is committed to addressing as many of their issues and concerns as they reasonably can. Additionally, a process should outlined for completing a structured diagnostic review of all of the factors contributing to excessive staff turnover during the past several years, and developing and implementing a plan to address related improvement needs.

Recommendation No. VI-3. *Develop and implement an Immediate Action Improvement Plan to address critical District office workload and work environment issues. Meet with staff at each District office to present the Improvement Plan and outline a process for identifying and implementing further improvements. Conduct a structured diagnostic review of factors contributing to excessive Investigator turnover during the past several years, and develop and implement a Longer-Term Improvement Plan to reduce Investigator attrition and rebuild the Enforcement Program's field investigation workforce capabilities and competencies.*

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VII. Prosecutions and Disciplinary Outcomes

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VII. Prosecutions and Disciplinary Outcomes

This section presents results of our assessment of the prosecutions and disciplinary outcomes. Following referral of cases from Medical Board Headquarters Units or the District offices, prosecutions are largely carried out by HQES which prepares the pleading, negotiates proposed settlements, and represents the Medical Board at administrative hearings. The assessment focused on determination of the numbers of prosecutions completed and related disciplinary outcomes prior to, concurrent with, and following implementation of VE during 2006, the average elapsed time to complete the prosecutions and disciplinary actions, and expenditures for related HQES services.

Results of the assessment show that the number of accusations filed, the number of proposed stipulations and proposed decisions received, and the number of disciplinary actions all declined. Several other secondary output and performance measures also have declined. Concurrently, the elapsed time to file accusations has decreased, but this decrease is largely attributable to a decrease in the Los Angeles Metro region from an abnormally high level in prior years. In the Los Angeles Metro region the average elapsed time remains higher than in other regions due, in part, to (1) mis-use of requests for supplemental investigations, and (2) extended periods of inactivity while cases are pending at HQES following referral of the cases for prosecution. The average elapsed time from filing to settlement (stipulation received) has also decreased. However, there are significant performance variations between regions. The decrease in composite elapsed times from filing to settlement during this period, to a statewide average of 11 months during the past two (2) years, is attributable to improved performance in the Los Angeles Metro and Other Southern California regions. However, even with this improvement, the average elapsed time for the Los Angeles Metro region during the past two (2) years lagged performance of the other two regions. For the Northern California region, the elapsed times from filing to stipulation received generally averaged about ten (10) months throughout the past six (6) years.

The remainder of this section is organized as follows:

Subsection	Title	Subsection	Title
A.	Overview of Prosecutions and Disciplinary Outcomes	F.	Administrative Hearings and Average Elapsed Times from Accusation Filed to Decision Received
B.	Prosecution Process Workload, Outputs, and Performance Measures	G.	Average Elapsed Times from Decision Received to Board Action
C.	Accusations Filed and Average Elapsed Times from Transmittal to HQES to Accusation Filed	H.	Disciplinary Outcomes
D.	Stipulations Prepared and Average Elapsed Times from Accusation Filed to Stipulation Received	I.	Expenditures for HQES Prosecution Services
E.	Average Elapsed Times from Stipulation Received to Board Action	J.	Recommendations for Improvement.

VII. Prosecutions and Disciplinary Outcomes

A. Overview of Prosecutions and Disciplinary Outcomes

Exhibit VII-1, on the next page, summarizes physician and surgeon prosecutions and disciplinary actions for the six-year period from 2003/04 through 2008/09. Exhibit VII-1 shows:

- ❖ Number of petitions to revoke probation filed
- ❖ Number of accusations filed
- ❖ Number of pending accusations
- ❖ Number of pending legal cases
- ❖ Number of case dispositions, by type (default, withdrawn or dismissed, stipulation, and proposed decision)
- ❖ Number of citations issued
- ❖ Number of adopted and non-adopted disciplinary decisions
- ❖ Number of disciplinary outcomes, by type (revocation, surrender, suspension, probation, post-filing public reprimand, and pre-filing public letter of reprimand)
- ❖ Percentage of total disciplinary actions requiring revocation, surrender, suspension, or probation
- ❖ Average elapsed times to file accusations and complete prosecutions.

Exhibit VII-1 also shows numbers of cases appealed to Superior Court, number of appeals upheld, and number of appeals reversed, remanded, or vacated.

As shown by Exhibit VII-1, in recent years the total number of filings declined by nearly 10 percent. During the past three (3) years total filings averaged 244 per year compared to an average of 268 filings per year during the preceding three (3) years. At the same time, the number of post-filing stipulations and the number of proposed decisions also decreased by about 10 percent. The number of post-filing stipulations decreased to an average of 183 per year for the past three (3) years, from 202 per year during the preceding three (3) years. The number of proposed decisions decreased to an average of 67 per year for the past three (3) years, from 74 per year during the preceding three (3) years. Consistent with these reduced outputs, the number of disciplinary actions also decreased. Some of these output measures show particularly large decreases during 2008/09 compared to the levels typically achieved during the preceding five (5) years. For example:

- ❖ During 2008/09, 156 stipulations were received compared to an average of about 190 or more stipulations received during each of the preceding five (5) years
- ❖ During 2008/09, 171 licenses were revoked, surrendered, or suspended, or the licensee was placed on probation, compared to 208 to 230 comparable disciplinary actions taken during the preceding five (5) years.

Physician and Surgeon Prosecutions and Disciplinary Actions

Workflow Measure		2003/04	2004/05	2005/06 ^a	2006/07	2007/08	2008/09
Filings	Petitions to Revoke Probation	26	26	27	24	13	25
	Accusations	262	235	227	218	240	213
	Total Filings	288	261	254	242	253	238
Reported Average Time to File Accusation (Months)		3.5 Months	3.8 Months	4.3 Months	4.2 Months	4.0 Months	3.4 Months
Pending Matters	Pending Accusations (End of Period)	126	133	152	132	126	149
	Pending Legal Cases (End of Period; Including AHLPI; Excluding Probation)	494	503	436	391	508	508
Case Dispositions	Default Decision (failure to appear)	21	24	23	18	23	30
	Accusation Withdrawn or Dismissed	64	33	27	18	40	26
	Petition to Revoke Probation Withdrawn or Dismissed	7	1	2	0	2	2
	Post-Filing Stipulation Submitted	200	219	187	200	193	156
	Proposed Decision Submitted - In-State Practitioner	48	38	33	39	38	40
	Proposed Decision Submitted - Out-of-State Practitioner (IDENT 16)	4	12	7	8	5	10
	Proposed Decision Submitted - Petition to Revoke Probation (IDENT 'D')	5	10	5	5	3	6
	Proposed Decision Submitted - License Application Denial Appeal (SOI - IDENT 20)	25	19	17	16	19	12
Total Disciplinary Submittals (Excludes Filings Withdrawn/Dismissed and SOI Decisions)		278	303	255	270	262	242
Medical Board Decisions	Decision Adopted (Includes SOIs)	81	77	76	78	81	60
	Decision Not Adopted	15	10	11	13	19	15
	Stipulation Approved	186	208	193	188	206	173
	Stipulation Rejected	11	12	16	8	8	4
	Total Medical Board Decisions	293	307	296	287	314	252
Disciplinary Actions	Citations and Administrative Fines Issued	423	307	342	426	248	185
	Revocation	36	42	39	34	33	45
	Surrender	65	82	66	67	70	35
	Suspension Only	2	0	0	1	0	0
	Suspension with Probation	31	17	20	21	14	13
	Probation Only	92	89	86	91	91	78
	Public Reprimands (Post-Filing)	35	71	72	50	74	66
	Public Letters of Reprimand (Pre-Filing)	29	38	37	27	35	31
	Total Disciplinary Actions (Excludes Citations)	290	339	320	291	317	268
Percent Revocation, Surrender, Suspension, or Probation		78%	68%	66%	74%	66%	64%
Reported Average Time to Complete Prosecutions (Months)		16.9 Months	15.6 Months	16.9 Months	14.7 Months	15.5 Months	12.5 Months
Appeals	Decisions Appealed to Superior Court	25	25	28	20	26	12
	Decisions Upheld by Superior Court	15	14	13	13	13	10
	Decisions Reversed, Remanded, or Vacated by Superior Court	15	13	10	8	6	9

^a On January 2, 2006, the Medical Board and HQES began implementing the VE Pilot Project.

Sources: Medical Board of California Annual Reports, California Department of Consumer Affairs Annual Reports, and MBC Complaint Tracking System data.

VII. Prosecutions and Disciplinary Outcomes

In recent years there was little or no change in the number of default decisions, accusations withdrawn or dismissed, or proposed decisions received for cases involving In-State practitioners. In comparison to prior years, the total number of proposed decisions and stipulations approved by the Medical Board has decreased (particularly during 2008/09).

The disciplinary action data presented in Exhibit VII-1 show a decrease in the proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation. During 2008/09 only 64 percent of disciplinary actions required license revocation, surrender, suspension, or probation. During the preceding five (5) years the percent of disciplinary actions requiring license revocation, surrender, suspension, or probation ranged from 66 percent to 78 percent. This decrease in the proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation may be attributable to a combination of factors including (1) variations in the composition of cases referred for prosecution, (2) shifts in settlement negotiation strategies, and (3) recent legislative changes enabling issuance of public reprimands, with conditions, in lieu of stronger types of discipline. Additional information regarding this variance is presented subsequently in Section VII-H (*Disciplinary Outcomes*).

In recent years, there was little change in the number of pending accusations or total pending legal cases. The number of pending accusations fluctuated between about 125 and 150 cases, and the number of pending legal cases, after declining to about 400 cases during 2006/07, from about 500 cases previously, increased again to a level of 500 cases during the next two (2) years. Recent decreases in the number of cases referred for prosecution from the District offices have not resulted in corresponding decreases in the number of pending legal action cases.

During 2008/09 there was a marginal improvement in the average elapsed time to file accusations, and a more substantive improvement in the average elapsed time to complete prosecutions. The average elapsed time to file accusations decreased by about three (3) weeks (to 3.4 months during 2008/09 from an average of about 4.0 months during the preceding four (4) years). The average elapsed time to complete prosecutions decreased by about three (3) months (to 12.5 months during 2008/09 from an average of 15.7 months during the preceding four (4) years).

Finally, Exhibit VII-1 shows a reduction in number of appeals to Superior Court during 2008/09 compared to levels experienced during prior years. It is unclear whether this one-year reduction in appeals will be sustained over time.

VII. Prosecutions and Disciplinary Outcomes

B. Prosecution Process Workload, Outputs, and Performance

Exhibit VII-2, on the next five (5) pages, provides time series statistical data for the past six (6) fiscal years for a broad range of prosecution process workload, output, and performance measures for (1) cases investigated and referred for prosecution by District offices in each of three (3) major geographic regions of the State, (2) cases originated and referred for prosecution by various Headquarters Units, usually without investigation by the District offices, and (3) cases involving petitions to revoke probation which, until recently, were investigated and referred for prosecution by the Probation Units, and were not included in the VE Pilot Project. Exhibit VII-2 presents data showing:

- ❖ Number of cases that HQES and the Medical Board declined to file
- ❖ Number of accusations and petitions to revoke probation filed
- ❖ Number of accusations withdrawn or dismissed
- ❖ Number of default decisions
- ❖ Number of ISOs/TROs sought and granted
- ❖ Number of PC 23 appearances and orders
- ❖ Number of automatic suspension orders and suspension orders issued by Chief of Enforcement
- ❖ Number of post-filing stipulations submitted, approved, and rejected
- ❖ Number of proposed decisions submitted, adopted, and not adopted
- ❖ Number of decisions appealed to Superior Court, appeals upheld, and appeals reversed, remanded, or vacated
- ❖ Number of Out-of-State suspension orders
- ❖ Number of pre-filing (surrender) stipulations
- ❖ Number of compelled examinations passed
- ❖ Number of practice restriction stipulations
- ❖ Number of pre-filing public letters of reprimand
- ❖ Ratio of stipulations received to proposed decisions received
- ❖ Ratio of appeals to adopted and non-adopted decisions
- ❖ Ratio of decisions upheld to total appealed dispositions.

Prosecution Process Outputs and Performance Measures¹
2003/04 through 2008/09

Fiscal Year	HQES Declined To File								Accusation Filed								Default Decision							
	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	
2003/04	3	8	6	1				18	63	73	72	42	3	4	5	262	2	2	2	12	2	1		21
2004/05	8	7	4	1	1	1		22	48	61	55	60	2	6	3	235	2	6	2	11	2	1		24
2005/06	4	13	1	5	1			24	52	53	63	53	2	1	3	227	1	2	3	12	4	1		23
2006/07	8	13	4	2	4			31	65	44	66	38		5		218	2		3	7	6			18
2007/08	4	10	0	5	1			20	67	69	48	52	2	2		240	5	3	2	9	3	1		23
2008/09	10	6	9	4	1		2	32	62	40	50	51	2	5	3	213	1	6	5	17	1			30

Fiscal Year	Medical Board Declined to File								Accusation Withdrawn								Accusation Dismissed							
	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	
2003/04	1	4	1		1			7	4	16	10	6	5	3		44	6	4	6	2	2			20
2004/05	1			4	4			9	5	5	8	6	1			25	1	5	2					8
2005/06				3	2			5	6	5	5	2	2	1		21		4	2					6
2006/07	3	1	1		1			6	4	3	4	3				14	1	1	2					4
2007/08				1	1			2	9	6	11	2	2			30	2		8					10
2008/09	5	1			1		1	8	6	2	2	1	2	1	1	15	2	6	2	1				11

¹ Based upon the Identifier assigned to the case when transmitted to HQES. In some cases, subsequent actions are handled by HQES offices in other regions.

Prosecution Process Outputs and Performance Measures¹
2003/04 through 2008/09

Fiscal Year	ISO/TRO Sought								PC 23 Appearance								Automatic Suspension Order Issued							
	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	
2003/04	5	4	15		1	1		26	4	8	3			1			16			1	1			3
2004/05	6	15	15	1	1	1		39	2	5	2						9		2		2	1		5
2005/06	10	3	10					23	1	3	1						5			1				1
2006/07	11	2	9					22	1	1	4					1	6			3				4
2007/08	6	8	4		2			20		7	3						10							0
2008/09	10	4	1		3			18	4	8	2		1	1		2	16							2

Fiscal Year	ISO/TRO Granted								PC 23 Order Issued								Suspension Order Issued by Chief of Enforcement								
	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total	
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		
2003/04	6	1	9	1	5			22	4	8	1		2			15	1	1							2
2004/05	8	5	7	1	8			29	1	4	2					7		2	1	1	1			5	
2005/06	10	1	9		4			24	1	3						4		4	1					5	
2006/07	10	2	4		2			18	2	2	2		1			7	1	1	1					3	
2007/08	5	6	2		2			15		2	3					5	1	1						2	
2008/09	9	2	1	1	3			16	2	9			1	1		13		1						1	

¹ Based upon the Identifier assigned to the case when transmitted to HQES. In some cases, subsequent actions are handled by HQES offices in other regions.

Prosecution Process Outputs and Performance Measures¹
2003/04 through 2008/09

Fiscal Year	Post-Filing Stipulation Submitted								Post-Filing Stipulation Approved								Post-Filing Stipulation Rejected									
	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total		
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)			
2003/04	53	63	37	30	17			200	36	52	40	33	16	9		186	4	4	1				2			11
2004/05	45	54	55	43	17	2	3	219	48	50	42	41	19	6	2	208	3	5	2			1	1			12
2005/06	38	61	44	21	20		3	187	45	50	47	26	16	5	4	193	4	7	4					1		16
2006/07	45	52	42	39	19		3	200	42	51	40	27	17	8	3	188	3	4	1							8
2007/08	41	46	58	31	14	2	1	193	47	41	55	36	16	9	1	205	1	5	1			1				8
2008/09	40	45	37	23	8	3		156	35	45	45	30	6	12		173		3	1							4

Fiscal Year	Proposed Decision Submitted								Proposed Decision Adopted								Proposed Decision Not Adopted									
	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total		
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)			
2003/04	12	16	19	4	5	25	1	82	12	15	16	3	5	16		67	5	4	3			1	3			16
2004/05	11	13	13	12	10	19	1	79	4	13	9	10	7	19	1	63	1	1	3			2	4			11
2005/06	4	18	11	7	5	27		72	6	17	10	6	4	20		63	2	3	1	2			3			11
2006/07	9	17	13	8	5	16		68	10	9	7	10	6	14		56	2	3	3				4			12
2007/08	9	14	15	5	3	19		65	6	10	15	3	2	17		53		5	6	1			4	1		17
2008/09	11	12	12	10	6	12	5	68	9	7	6	10	5	9	1	47	3	6	3			1	3			16

¹ Based upon the Identifier assigned to the case when transmitted to HQES. In some cases, subsequent actions are handled by HQES offices in other regions.

Prosecution Process Outputs and Performance Measures¹
2003/04 through 2008/09

Fiscal Year	Decision Appealed to Superior Court								Decision Upheld								Decision Reversed, Remanded, or Vacated							
	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	
2003/04	3	7	9	1	2	2	1	25	5	4	4	1		1		15	3	6	2	2	2			15
2004/05	1	7	7	1	4	4	1	25	2	2	7		1	2		14	2	7	2	2				13
2005/06	4	8	5	3	1	7		28	2	1	5		2	2	1	13		2	2	2	1	3		10
2006/07	1	4	6	5	1	3		20	1	2	3	1	2	4		13	1	1	1	5				8
2007/08	4	12	4	1		5		26		1	6	2	1	2	1	13	1	1	1	2		1		6
2008/09	3	3	3		3			12	2	3	1	1		3		10	1	4	1	2		1		9

Fiscal Year	Out of State Suspension Order								Pre-Filing (Surrender) Stipulation								Petition to Revoke Probation Filed								
	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total	District Office IDENTs			Other Identifiers				Total	
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)		
2003/04	1			16				17	2	2	4	4	1	2		15								26	26
2004/05				12	1	1		14	6	2	2	3	2		15									26	26
2005/06				14				14	3	3	5	2		1		14		1						26	27
2006/07				7	1			8	3	3	1	3		3		13		1						23	24
2007/08				9	1			10	3	1	2	7	2	1		16			1					12	13
2008/09	2			15	1			18				1	1			2								25	25

¹ Based upon the Identifier assigned to the case when transmitted to HQES. In some cases, subsequent actions are handled by HQES offices in other regions.

Prosecution Process Outputs and Performance Measures¹
2003/04 through 2008/09

Fiscal Year	Compelled Examinations Passed								Practice Restriction Stipulations								Pre-Filing Public Letters of Reprimand										
	District Office IDENTs			Other Identifiers					Total	District Office IDENTs			Other Identifiers					Total	District Office IDENTs			Other Identifiers					Total
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Northern California		Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Northern California	Los Angeles Metro		Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)				
2003/04	2	6	2	1				11							0	4	4	4	17					29			
2004/05	1	1	2					4	2						2	8	4	7	18			1		38			
2005/06	1						1	2	3		1				5	15	4	10	8					37			
2006/07		5						5	4						4	10		3	14					27			
2007/08		2	1					3		1	1				2	1	2		32					35			
2008/09	2	1	1					4	1	1	1				3	4	2	1	24					31			

Fiscal Year	Ratio: STIPs Submitted to PDs Submitted								Ratio: Appeals to Adopted/Non-Adopted Decisions								Ratio: Decisions Upheld to Total Dispositions										
	District Office IDENTs			Other Identifiers					Total	District Office IDENTs			Other Identifiers					Total	District Office IDENTs			Other Identifiers					Total
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Northern California		Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Northern California	Los Angeles Metro		Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)				
2003/04 to 2004/05	4.3	4.0	2.9	4.6	2.3	0.0	1.5	2.6	18%	42%	52%	15%	40%	14%	200%	32%	58%	32%	73%	20%	33%	100%	NMF	51%			
2005/06 to 2006/07	6.4	3.2	3.6	4.0	3.9	0.0	NMF	2.8	25%	38%	52%	44%	20%	24%	NMF	34%	75%	50%	73%	13%	80%	67%	100%	59%			
2007/08 to 2008/09	4.1	3.5	3.5	3.6	2.4	0.2	0.2	2.6	39%	54%	23%	7%	38%	15%	0%	29%	50%	44%	78%	43%	100%	71%	100%	61%			
2003/04 to 2005/06 (3 Years)	5.0	3.8	3.2	4.1	2.7	0.0	3.0	2.6	27%	42%	50%	24%	37%	20%	200%	34%	64%	32%	73%	14%	50%	63%	100%	53%			
2006/07 to 2008/09 (3 Years)	4.3	3.3	3.4	4.0	2.9	0.1	0.8	2.7	27%	48%	33%	25%	29%	16%	0%	29%	50%	50%	77%	31%	100%	82%	100%	61%			

¹ Based upon the Identifier assigned to the case when transmitted to HQES. In some cases, subsequent actions are handled by HQES offices in other regions.

VII. Prosecutions and Disciplinary Outcomes

Key output and performance variances between geographic regions, and significant changes that occurred during the past several years, include the following:

Accusations Filed – The number of accusations filed increased significantly in the Northern California region and, concurrently, decreased significantly in the Los Angeles Metro and Other Southern California regions. In the Northern California region more than 60 accusations were filed each of the past three (3) years compared to only 50 accusations filed per year during the preceding two (2) years. In contrast, during this same period the Los Angeles Metro and Other Southern California regions, each of which previously filed more than 60 accusations per year, filed an average of fewer than 55 accusations per year. During 2008/09 the Los Angeles Metro and the Other Southern California regions each filed only 40 accusations. The number of accusations filed for Out-of-State cases fluctuated between 40 and 60 cases per year throughout the past six (6) years, and consistently averaged about 50 cases per year. All (or nearly all) of these accusations are prepared and filed by HQES' San Francisco office.

Post-Filing Stipulations Received – During 2008/09, 156 post-filing stipulations were received, a significant decrease from the levels attained during prior years which averaged about 200 stipulations per year. The decrease during 2008/09 is attributable primarily to a large decrease in the number of post-filing stipulations submitted by the Other Southern California region. There were also decreases in the number of post-filing stipulations submitted for probation revocation and Out-of-State cases. The decline in post-filing stipulations submitted for Out-of-State cases may be inversely correlated with the comparatively high number of Out-of-State cases resolved by issuance of a pre-filing public letter of reprimand (PLR) during 2007/08 and 2008/09 (28 PLRs issued per year compared to an average of 14 PLRs issued per year during the preceding four (4) years).

Ratio of Stipulations Received to Proposed Decisions Received – Historically, the Northern California region has had a significantly higher ratio of stipulations received to proposed decisions received than either the Los Angeles Metro or Other Southern California regions. In recent years this differential narrowed somewhat, but the ratio for the Northern California region was still significantly higher than the ratio for either of the other two regions (4.3 stipulations per proposed decision for the Northern California region compared to 3.4 stipulations per proposed decision for the Los Angeles Metro region and 3.3 stipulations per proposed decision for the Other Southern California region).

Appeals to Superior Court – The number of appeals to Superior Court, and related outcome measures, are too small to provide a valid basis for drawing conclusions, except to note that, on average, a few more cases per year are usually appealed in the Los Angeles Metro and Other Southern California regions than are appealed in the Northern California region. However, the number of appeals in all three (3) regions is very low (e.g., during 2008/09, there were only three (3) appeals of cases that were investigated by each of the three (3) regions, plus three (3) additional appeals involving probation revocation cases).

VII. Prosecutions and Disciplinary Outcomes

C. Accusations Filed and Average Elapsed Times from Transmittal to HQES to Accusation Filed

Exhibit VII-3, on the next page, shows average elapsed times from transmittal of the case to HQES to accusation filed, by year, from 2004 through 2009, by Identifier. All (or almost all) Out-of-State cases are handled by HQES' San Francisco office and, as shown by Exhibit VII-3, accusations for these cases are consistently filed within an average elapsed time of not more than about two (2) months. For cases with District office Identifiers, the average elapsed times from transmittal to filing are longer and, for these cases, the average elapsed times from transmittal to filing decreased by about six (6) weeks since 2005, but are unchanged compared to 2004. The decrease since 2005 in the average elapsed time to file accusations is attributable nearly entirely to a decrease during the past four (4) years in the average elapsed time to file accusations in the Los Angeles Metro region. In the Los Angeles Metro region the average elapsed time to file accusations decreased from nearly eight (8) months during 2005 to about five (5) months during 2009. However, the average elapsed time shown for the Los Angeles Metro region for 2005 (7.8 months) was 3.4 months (77 percent) longer than the average elapsed time for the region during the prior year.

During 2005, just prior to implementation of the VE, the average elapsed time to file accusations in the Los Angeles Metro region suddenly spiked up, and continued to increase in subsequent years, eventually reaching a peak of more than nine (9) months during 2007, before decreasing to lower levels during 2008 and 2009. **Table VII-1**, below, shows average elapsed times from transmittal to filing for cases Investigated by each of the Los Angeles Metro region's District offices from 2004 through 2009. As shown by Table VII-1, the variances in the aggregate regional data are also evident at each of the Los Angeles Metro region's four (4) District offices.

**Table VII-1 Average Elapsed Time from Transmittal of Case to HQES to Accusation Filed
Los Angeles Metro District Offices**

District Office	2004		2005		2006		2007		2008		2009	
	Number of Filings	Average Time (Months)										
Valencia	14	4.4	14	8.3	10	8.1	15	6.4	13	6.8	11	7.8
Ceritos	23	5.2	21	7.7	16	9.2	18	7.6	20	4.0	17	4.4
Diamond Bar	10	1.9	9	7.3	9	7.3	13	16.4	7	4.5	12	2.5
Glendale	14	5.0	13	7.9	11	9.7	19	8.0	10	9.4	12	5.5
Total	61	4.4	57	7.8	46	8.7	65	9.2	50	5.9	52	4.9

**Average Elapsed Times from Transmittal of Case to HQES to Accusation Filed, by Identifier
2004 through 2009**

Including Cases with Timeframes Exceeding 18 Months

Excluding Cases with Timeframes Exceeding 18 Months

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	3.6	61	4.4	54	3.0	163	3.7
2005	56	4.6	57	7.8	71	4.0	184	5.4
2006	54	3.2	46	8.7	49	6.0	149	5.8
2007	66	4.1	65	9.2	67	3.1	198	5.4
2008	60	2.6	50	5.9	46	3.9	156	4.0
2009	72	4.0	52	4.9	63	3.0	187	3.9

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	3.6	61	4.4	52	2.7	161	3.6
2005	55	4.1	55	6.9	70	3.8	180	4.8
2006	54	3.2	43	8.0	48	4.8	145	5.2
2007	65	3.8	55	7.1	66	2.9	186	4.5
2008	60	2.6	49	5.5	44	3.1	153	3.7
2009	71	3.6	49	3.8	61	2.5	181	3.3

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		Other (IDENT 20, 21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	49	2.3	3	1.9	10	3.2	225	3.3
2005	52	1.1	0	0.0	8	9.5	244	4.6
2006	50	1.3	2	6.5	3	1.0	204	4.6
2007	38	1.4	0	0.0	4	2.9	240	4.8
2008	59	2.0	2	2.5	6	5.4	223	3.5
2009	48	2.2	1	0.6	6	4.7	242	3.6

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		Other (IDENT 20, 21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	47	0.8	3	1.9	10	3.2	221	3.0
2005	52	1.1	0	0.0	5	2.2	237	4.0
2006	50	1.3	2	6.5	3	1.0	200	4.1
2007	38	1.4	0	0.0	4	2.8	228	3.9
2008	59	2.2	2	2.5	5	1.4	219	3.2
2009	48	2.2	1	0.6	6	4.7	236	3.1

VII. Prosecutions and Disciplinary Outcomes

Exhibit VII-4, on the next two pages, provides frequency distributions of elapsed time from transmittal of the case to HQES to accusation filed, by Identifier. The data presented in Exhibit VII-4 show that, until recently, fewer than a dozen cases per year referred for prosecution to HQES' Los Angeles Metro office were filed within two (2) months of transmittal of the case. During 2007 only 15 Los Angeles Metro region cases were filed within four (4) months of transmittal of the case. In contrast, during this same year 43 accusations for Northern California region cases and 52 accusations for Other Southern California region cases were filed within four (4) months. More recently, during 2009, 32 Accusations were filed within four (4) months of transmittal for Los Angeles Metro region cases, a significant improvement for the Los Angeles Metro region. However, during 2009, much higher numbers of accusations were filed within four (4) months of transmittal in the other regions of the State (47 in the Northern California region and 54 in the Other Southern California region).

Among the most significant factors that appear to contribute to extended elapsed times from transmittal of a case to HQES to filing of the accusation are included:

- 1) Requests for supplemental investigations, *and*
- 2) Inactivity while the case is pending at HQES.

With the assistance of Medical Board staff we researched both of these sources of delay by researching the histories of nearly two (2) dozen individual cases. Results of this research illustrate the nature and magnitude of the problems and frustrations experienced during the past several years by Medical Board management and staff in the Los Angeles Metro region and, to a lesser extent, in other parts of the State. Furthermore, difficulties in handing off of cases for prosecution appear to be greatest in the Los Angeles Metro region where HQES Attorneys are most involved with investigations. These case histories also show that, in the Los Angeles Metro region, it is not at all unusual for cases to languish at HQES for periods of 6 to 8 months, or longer, before an accusation is filed.

Additionally, it is apparent from these case histories that neither HQES nor the Medical Board has developed effective processes for regularly tracking and following-up on filings that are not prepared on a timely basis. HQES does not provide the Medical Board with a planned filing date that could be used to ensure alignment of HQES and Medical Board expectations regarding the urgency of the case and then track whether the filings are past due. In the absence of effective status tracking processes, HQES Managers and Supervisors appear to operate under the false impression that a high percentage of accusations are prepared within 30 to 60 days, which is simply not true irrespective of how narrowly the measure is defined. The Medical Board distributes listings of all pending cases on a monthly basis to all Enforcement Program and HQES Managers and Supervisors, but Enforcement Program management does not regularly follow-up with HQES regarding pleadings that are past due (e.g., by specifically alerting HQES about cases where a pleading was not received within period of 45 to 60 days), and HQES does not provide the Medical Board with any reporting regarding the status of cases referred for prosecution where the pleadings have not yet been prepared or filed. Follow-ups on overdue pleadings, at least in the Los Angeles Metro region, appear to occur only when initiated by Los Angeles Metro region District office Investigators or Supervisors, and these follow-ups appear to occur on an ad-hoc, rather than regular, basis.

Frequency Distribution of Elapsed Times from Transmittal of Case to HQES to Accusation Filed
2005 to 2009

Case Identifier	Elapsed Time from Transmittal to Filing ¹	2005		2006		2007		2008		2009	
		Number	Percent								
Northern California District Offices	2 Months or Less	18	33%	30	56%	28	43%	31	52%	26	37%
	3 to 4 Months	15	27%	9	17%	15	23%	17	28%	21	30%
	5 to 6 Months	8	15%	7	13%	7	11%	5	8%	12	17%
	7 to 12 Months	13	24%	7	13%	11	17%	7	12%	10	14%
	More than 12 Months	1	2%	1	2%	4	6%	0	0%	2	3%
	Total	55	100%	54	100%	65	100%	60	100%	71	100%
	Average Elapsed Time	4.1 Months		3.2 Months		3.8 Months		2.6 Months		3.6 Months	
Los Angeles Metro District Offices	2 Months or Less	9	16%	6	14%	7	13%	12	24%	20	41%
	3 to 4 Months	11	20%	4	9%	8	15%	11	22%	12	24%
	5 to 6 Months	6	11%	6	14%	11	20%	10	20%	6	12%
	7 to 12 Months	19	35%	15	35%	20	36%	10	20%	9	18%
	More than 12 Months	10	18%	12	28%	9	16%	6	12%	2	4%
	Total	55	100%	43	100%	55	100%	49	100%	49	100%
	Average Elapsed Time	6.9 Months		8.0 Months		7.1 Months		5.5 Months		3.8 Months	
Other Southern California District Offices	2 Months or Less	18	26%	13	27%	28	42%	26	59%	32	52%
	3 to 4 Months	29	41%	11	23%	24	36%	9	20%	22	36%
	5 to 6 Months	11	16%	9	19%	7	11%	4	9%	3	5%
	7 to 12 Months	11	16%	12	25%	7	11%	3	7%	3	5%
	More than 12 Months	1	1%	3	6%	0	0%	2	5%	1	2%
	Total	70	100%	48	100%	66	100%	44	100%	61	100%
	Average Elapsed Time	3.8 Months		4.8 Months		2.9 Months		3.1 Months		2.5 Months	

¹ Excludes 33 cases taking longer than eighteen (18) months to file, including 19 Los Angeles Metro region cases (58 percent).

Frequency Distribution of Elapsed Times from Transmittal of Case to HQES to Accusation Filed
2005 to 2009

Case Identifier	Elapsed Time from Transmittal to Filing ¹	2005		2006		2007		2008		2009	
		Number	Percent								
All District Office Identifiers	2 Months or Less	45	25%	49	34%	63	34%	69	45%	78	43%
	3 to 4 Months	55	31%	24	17%	47	25%	37	24%	55	30%
	5 to 6 Months	25	14%	22	15%	25	13%	19	12%	21	12%
	7 to 12 Months	43	24%	34	23%	38	20%	20	13%	22	12%
	More than 12 Months	12	7%	16	11%	13	7%	8	5%	5	3%
	Total	180	100%	145	100%	186	100%	153	100%	181	100%
	Average Elapsed Time	4.8 Months		5.2 Months		4.5 Months		3.7 Months		3.3 Months	
Other Identifiers (IDENTS 16, 19, 20, 21, and 23)	2 Months or Less	48	84%	45	82%	33	79%	47	71%	38	69%
	3 to 4 Months	5	9%	8	15%	6	14%	8	12%	7	13%
	5 to 6 Months	3	5%	1	2%	3	7%	10	15%	4	7%
	7 to 12 Months	1	2%	1	2%	0	0%	1	2%	6	11%
	More than 12 Months	0	0%	0	0%	0	0%	0	0%	0	0%
	Total	57	100%	55	100%	42	100%	66	100%	55	100%
	Average Elapsed Time	2.2 Months		1.5 Months		1.5 Months		2.0 Months		2.5 Months	
Total Accusations Filed	2 Months or Less	93	39%	94	47%	96	42%	116	53%	116	49%
	3 to 4 Months	60	25%	32	16%	53	23%	45	21%	62	26%
	5 to 6 Months	28	12%	23	12%	28	12%	29	13%	25	11%
	7 to 12 Months	44	19%	35	18%	38	17%	21	10%	28	12%
	More than 12 Months	12	5%	16	8%	13	6%	8	4%	5	2%
	Total	237	100%	200	100%	228	100%	219	100%	236	100%
	Average Elapsed Time	4.0 Months		4.1 Months		3.9 Months		3.2 Months		3.1 Months	

¹ Excludes 33 cases taking longer than eighteen (18) months to file, including 19 Los Angeles Metro region cases (58 percent).

VII. Prosecutions and Disciplinary Outcomes

Below we present results of analyses we performed of both of these sources of delay in the filing of accusations.

1. Requests for Supplemental Investigations

Between 2004 and 2009, a total of 63 cases had one or more supplemental investigations completed by the District offices, statewide, but nearly 70 percent of these cases were assigned to Los Angeles Metro region offices. On average, the supplemental investigations took 3 to 4 months to complete. The total number of cases with supplemental investigations submitted by Los Angeles Metro region offices during 2005 (12) was more than double the number submitted during the prior year (5), and greater than the number of cases with supplemental investigations completed over the entire 6-year period in each of the other regions of the State. In subsequent years, the number of cases with supplemental investigations completed by Los Angeles Metro region offices remained at elevated levels, but gradually declined. During 2009, Los Angeles Metro District offices completed supplemental investigations for four (4) cases, more than completed by all other District offices throughout the rest of the State. The Diamond Bar and Cerritos District offices were responsible for most of these Los Angeles Metro region cases (15 and 13, respectively). Consequently, our review of supplemental investigations focused on Los Angeles Metro region cases.

Table VII-2, below, shows the number of supplemental investigations completed by each of the Los Angeles Metro region's four (4) District offices, by year. As shown by Table VII-2, the total number of completed supplemental investigations submitted by Los Angeles Metro region offices during 2005 (12) was more than double the number submitted during the prior year (5), and greater than the number of supplemental investigations completed over the entire 6-year period in each of the other regions of the State. In subsequent years the number of supplemental investigations completed by Los Angeles Metro region District offices remained at elevated levels, but gradually declined. During 2009 Los Angeles Metro District offices completed four (4) supplemental investigations, more than completed by all other District offices throughout the rest of the State. The Diamond Bar and Cerritos offices were responsible for completing most of the region's supplemental investigations.

**Table VII-2. Completed Supplemental Investigations
Los Angeles Metro District Offices**

District Office	2004	2005	2006	2007	2008	2009	Total
Valencia		2	1	2		1	6
Ceritos	1	7	4		1		13
Diamond Bar		2	1	4	5	3	15
Glendale	4	1	2	1			8
Total	5	12	8	7	6	4	42

VII. Prosecutions and Disciplinary Outcomes

With the assistance of Medical Board staff, we researched each of the 15 supplemental investigation cases assigned to the Diamond Bar office. These cases involved a mix of single and multiple-patient cases and various types of complaints, including cases involving quality of care issues, excessive testing or treatment, sexual misconduct, criminal violations, excessive prescribing, and fraud. With one exception, all of the supplemental investigations were requested and completed prior to the filing of an accusation. The scope of most of the supplemental investigations encompassed either (1) obtaining an additional Medical Expert opinion, or (2) obtaining an addendum to a Medical Expert opinion. Following completion of these supplemental investigation activities, HQES declined to file two (2) cases. In one of these cases the decline to file was issued after first requesting and obtaining a second Medical Expert opinion which found multiple extreme and simple departures. Accusations were filed for the remaining 11 cases. For these 11 cases, the average elapsed time from transmittal to filing of the accusation was 10 months. Nine (9) of these cases were settled without a hearing. None of the cases that had two (2) Medical Expert opinions went to hearing. Two (2) cases proceeded to hearing. One (1) of these cases was a single patient case and the other case was a multiple patient case. Both of these cases had just one (1) Medical Expert opinion. Both of the cases that proceeded to hearing were dismissed. It is not clear that either case was dismissed due to problems with the Medical Expert or with the quality of their opinion. However, in these cases the defense may have benefitted from have two (or possibly more) Medical Experts as compared to HQES' use of only a single Expert.

Key findings resulting from this research are presented below.

Overview of Expert Opinions Included with Transmittal – Of the 13 cases referred to HQES for prosecution, including two (2) consolidated cases, 12 included a Medical Expert opinion that supported referral of the case (e.g., one or more extreme departures, multiple simple departures, or a combination of extreme and simple departures). The one (1) exception was a criminal conviction case for which an Expert opinion was not required. Ten (10) cases had a single Medical Expert opinion and three (3) cases had two (2) Medical Expert opinions.

Cases Transmitted with a Single Expert Opinion – Of the 10 cases referred for prosecution with a single Expert opinion, in five (5) cases HQES deferred preparing and filing an accusation pending preparation and submission of a second Medical Expert opinion or, in one case, two (2) additional Medical Expert opinions. In three (3) of the five (5) cases, the second Medical Expert opinion was not requested by HQES until 7 to 9 months after the case was referred for prosecution. In three (3) other cases that initially had a single Medical Expert opinion, HQES deferred preparing and filing an accusation pending preparation of an addendum to the Medical Expert opinion. In two (2) of these cases, HQES did not request the Addendum until more than three (3) months after the case was referred for prosecution. HQES did not request either a second Medical Expert opinion or an addendum to the Medical Expert opinion in only two (2) of the 10 single Medical Expert cases.

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Cases Transmitted with Two Expert Opinions – HQES deferred preparing and filing an accusation pending preparation and submission of addendums to the Medical Expert opinions in two (2) of three (3) cases referred for prosecution that had two (2) Medical Expert opinions. In both cases the addendums were not requested until more than three (3) months after transmittal of the case.

Additional Interview and Record Requests – HQES requested additional records in five (5) cases and additional interviews with the subject, patients, witnesses, or others in three (3) cases. In several instances these are the same cases. In several cases HQES did not submit these requests until several months after transmittal of the case. In several cases the additional interviews and records collection activities occurred after a second Medical Expert opinion or addendum had already been completed.

Supplemental Investigation Planning – In several cases, over an extended period of time, HQES submitted a sequential series of requests for additional interviews, records, and modified or additional Expert opinions. With better planning, some of these activities could possibly have been completed in parallel, thereby reducing the amount of calendar time needed to complete all supplemental investigation activities.

These case histories reflect a pattern of post-transmittal activity by some Los Angeles Metro region Attorneys that differs from the approach used by most Attorneys at other HQES offices. Most HQES Attorneys rarely request a second Expert opinion, even for single patient cases, unless a second medical specialty is involved or it is determined that a case will likely proceed to hearing and the departure is not obvious. This determination is usually made at some point after the accusation is filed. Also, most HQES Attorneys usually begin working collaboratively with the Medical Expert upon transmittal of a case, and do not usually decline to file or return a case to the District office Investigator solely to obtain an addendum. Instead, most HQES Attorneys usually discuss the case directly with the Expert during the process of drafting the accusation, and then provide the Expert with a draft of the accusation for their review. If an Addendum is needed, it is usually requested at a later point in the process. Additionally, other HQES Attorneys do not normally defer drafting and filing an accusation pending receipt of better quality, or certified, copies of records.

Occasionally, supplemental investigations are needed in advance of drafting and filing the accusation, a process used by all HQES offices to a limited extent. However, in the case of the Diamond Bar office, it appears that this process was used more frequently than would have occurred if the same cases had been referred for prosecution to HQES Attorneys outside the Los Angeles Metro region. When requested, a supplemental investigation does not necessarily result in a suspension of the process of drafting and filing the Accusation, as appears to have occurred with most of these Diamond Bar cases. Even among the Diamond Bar cases, there was one (1) case where additional witness interviews were completed after the accusation was filed and another case where an addendum to a Medical Expert's opinion was completed after the filing. In one (1) case the accusation was amended to consolidate another case.

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These case histories show that HQES' use of the supplemental investigation process contributed to the extended elapsed times from transmittal to filing that occurred with Diamond Bar's cases beginning during 2005 and continuing, to a lesser extent, in subsequent years. The case histories also show that, in many instances, Diamond Bar's cases languished for an extended period following transmittal to HQES. It is unclear what, if any, consumer protection or other benefits were realized from HQES' requests for additional Medical Expert opinions and addendum reports, and associated delays in the drafting and filing of the accusations.

2. Extended Periods of Limited Activity While Cases are Pending at HQES

Enforcement Program Managers, Supervisors, and Investigators commented to us about persistent problems with cases languishing at HQES after referral for prosecution, especially in the Los Angeles Metro region. To substantiate their experience, Medical Board staff in the Los Angeles Metro region provided us with synopses of the following seven (7) cases which were recently transmitted to HQES' Los Angeles Metro office (mid- to late-2009). Accusations for six (6) these cases were not prepared by HQES until up to ten (10) months later in mid-2010 (one case is still pending). The cases involved two (2) District offices in the Los Angeles Metro region and several different Lead Prosecutors and Primary DAGs.

Case History VII-1 (9 Month Delay) – This case involved the Subject's failure to have a chaperone present when seeing children. The Subject was also on probation. The accusation was not filed until 9 months after transmittal of the case to HQES.

Case History VII-2 (7 + Month Delay) – This multiple patient case involved multiple extreme departures in connection with prescribing medications. After the District office Supervisor contacted the Lead Prosecutor to determine the status of the filing, HQES reassigned the case to a different Attorney. As of late-June 2010, the accusation had not yet been prepared (7 months after transmittal to HQES).

Case History VII-3 (6 Month Delay) – The Medical Expert in this case identified numerous extreme departures involving the Subject's care of patients. The accusation was expected to be filed about 6 months after transmittal of the case to HQES.

Case History VII-4 (9 Month Delay) – The Subject in this case was convicted twice of Driving Under the Influence (DUI). The accusation was not filed until nine (9) months after transmittal of the case to HQES.

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Case History VII-5 (7 Month Delay) – This case involved a patient that had unnecessary surgery. Following a follow-up by the District office Supervisor, the Supervising DAG replied by email that:

“Our investigation on this subject was closed on (date). The investigation matter was assigned to DAG [Jane Doe]. We have no open administrative matter on this subject.”

The District office Supervisor escalated the matter to the Medical Board’s Regional Manager. An accusation was filed seven (7) months after transmittal of the case to HQES.

Case History VII-6 (5 Month Delay) – This multiple patient case involved excessive prescribing, prescribing without an examination, and record-keeping issues. Following transmittal of the case for prosecution, at the request of the District office Supervisor, the Medical Expert was asked to expand a portion of their review to include additional treatment dates for one of the patients. The accusation was filed five (5) months after transmittal of the Medical Expert’s addendum report.

Case History VII-7 (9+ Month Delay) – This single patient case involved unnecessary surgery and related complications. Two Medical Expert opinions found an extreme departure, but used somewhat different wording. Following completion of the investigation, the Primary DAG notified the District office Supervisor that he was closing the case with a recommendation to issue a citation and fine. The District office Supervisor requested clarification from the Primary DAG and Lead Prosecutor regarding their reasons for their rejection of the case and suggested that they consider requesting an addendum from one of the Medical Experts to clarify their report. A few days later HQES’ Supervising DAG replied:

“Thank you for the update. Because we have closed our investigation matter, we are not in a position to provide input at this time.”

The District office Supervisor escalated the matter to their Area Manager and the Deputy Chief of Enforcement who directed the Supervisor to transmit the case to HQES. Four (4) months after transmittal of the case, HQES issued a Decline to File Memorandum and again recommended issuance of a citation and fine. Several months later an agreement was reached between the Medical Board and HQES to seek a clarification of the Medical Expert’s report, as suggested previously by the District office Supervisor. The Medical Expert issued an addendum clarifying their extreme departure finding. As of mid-July, the case is still pending.

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D. Stipulations Prepared and Average Elapsed Times from Accusation Filed to Stipulation Received

Exhibit VII-5, on the next page, shows average elapsed times from accusation filed to stipulation received, by year, by Identifier. The data shown in Exhibit VII-5 excludes Out-of-State (IDENT 16) cases transmitted by DCU directly to HQES, and cases involving petitions to revoke probation (IDENT 'D') which are believed to be distributed proportionately throughout the State.

As shown in VII-5, for cases with District office Identifiers the average elapsed time from accusation filed to stipulation received decreased during the last several years (from an average of about 15 months to an average of about 11 months). However, there were significant performance variations between the different geographic regions of the State. For the Northern California region, the elapsed times generally averaged about 10 months throughout the past six (6) years. The decrease in composite elapsed times during this period, to a statewide average of 11 months during the past two (2) years, is attributable to improved performance in the Los Angeles Metro and Other Southern California regions. However, even with this improvement, the average elapsed time for the Los Angeles Metro region during the past two (2) years lagged performance of the other two regions.

Exhibit VII-6 also shows average elapsed time data for cases with an Out-of-State Identifier that were settled, and one (1) case with a Headquarters Unit Identifier that was settled. As shown by Exhibit VII-5, only a few stipulations are received each year for these types of cases (or none at all).

Average Elapsed Times from Accusation Filed to Stipulation Received by Identifier - 2004 through 2009
Excludes Petitions to Revoke Probation and Nearly All Out of State Cases

Including Cases with Timeframes Exceeding 3 Years

Excluding Cases with Timeframes Exceeding 3 Years

Fiscal Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)
2004	50	10	64	19	39	14	153	15
2005	36	10	49	17	50	14	135	14
2006 ²	40	12	66	18	38	16	144	16
2007	48	7	33	12	55	16	136	12
2008	30	10	45	10	44	12	119	11
2009	52	10	45	14	34	10	131	11

Fiscal Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)
2004	48	8	63	18	39	14	150	14
2005	35	9	47	16	48	13	130	13
2006 ²	38	9	61	15	36	15	135	13
2007	48	7	32	11	52	14	132	11
2008	29	7	44	9	43	11	116	9
2009	50	9	42	11	33	9	125	10

Fiscal Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20, 22, and 23)			
	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)
2004					1	1	154	15
2005	2	6	4	29	7	13	148	14
2006 ²					2	14	146	16
2007	4	3	2	13	2	5	144	12
2008	3	3	1	0	3	33	126	11
2009	1	24	1	5	1	9	134	11

Fiscal Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20,22, and 23)			
	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)
2004					1	1	151	14
2005	2	6	2	14	7	13	141	13
2006 ²					2	14	137	13
2007	4	3	2	13	2	5	140	10
2008	3	3	1	0	3	33	123	10
2009	1	24	1	5	1	9	128	10

¹ Over the six-year period from 2004 through 2009, excludes 24 subsequent stipulation submissions related to the same complaint, 176 stipulations related to Out-of-State (IDENT 16) cases transmitted by DCU directly to HQES, and 82 cases involving petitions to revoke probation (IDENT 'D').

² The VE Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

VII. Prosecutions and Disciplinary Outcomes

E. Average Elapsed Time from Stipulation Received to Board Action

Table VII-3, below, shows the average elapsed time from stipulation received to the Board action, by year, for the past four (4) fiscal years. As shown by Table VII-3, this process takes an average of about three (3) months to complete for all stipulations, and also for just stipulations with a District office Identifier. In some cases this process can take as long as 5 to 6 years to complete. If extended cycle time cases are excluded, then the average elapsed time for the remaining cases decreases to about two (2) months.

Table VII-3. Average Elapsed Times from Stipulation Submitted to Board Action

Category	2005/06		2006/07		2007/08		2008/09	
	Number of STIPs	Average Elapsed Time (Months)	Number of STIPs	Average Elapsed Time (Months)	Number of STIPs	Average Elapsed Time (Months)	Number of STIPs	Average Elapsed Time (Months)
Total Stipulations with Board Action	191	2.9	198	2.9	190	3.3	159	2.7
Less: Stipulations with Out-of-State, Headquarters, and Probationer Identifiers (IDENTS 16, 19, 20, 23, and D)	54	1.4	63	2.2	61	3.6	43	1.1
Stipulations with District Identifiers (IDENTs 2 through 18, Excluding 16)	145	3.3	137	3.2	135	3.0	123	3.1
Less: Stipulations with Extended Elapsed Times (Longer than 1 Year)	8	22.1	2	70.7	6	26.7	7	18.0
Stipulations with District Identifiers, Excluding Extended Elapsed Time Cases	137	2.2	135	2.2	129	1.9	116	2.2

In some cases, Board action does not occur for an extended period following receipt of a proposed stipulation because the licensee is not available to attend the Board’s Hearing on the matter due to failing health. More frequently, the Medical Board rejects the proposed Stipulation and refers the case back to HQES for re-negotiation. If the licensee is not agreeable to the Board’s counter-proposal, the matter is re-scheduled for hearing. Prior to the Hearing a modified stipulation may be negotiated between HQES and the licensee. In these circumstances the elapsed time from receipt of the stipulation to Board action includes the elapsed time related to negotiating, preparing, submitting, and adopting the modified stipulation. Alternatively, the case proceeds to hearing and, following the hearing, a proposed decision is prepared and submitted to the Board. In these circumstances the elapsed time from receipt of the stipulation to Board action includes the elapsed time for conducting the hearing, and preparing, submitting, and adopting the proposed decision. If the licensee submits a petition for reconsideration or appeals the proposed decision, then the elapsed times from stipulation received to Board action will be further extended pending the outcome of these processes (see Section VII-G – *Average Elapsed Time from Proposed Decision Received to Board Action*).

VII. Prosecutions and Disciplinary Outcomes

F. Administrative Hearings and Average Elapsed Times from Accusation Filed to Decision Received

Exhibit VII-6, on the next page, shows the average elapsed times from accusation filed to proposed decision received, by year, by Identifier. The data shown in Exhibit VII-6 excludes cases involving petitions to revoke probation (IDENT 'D') which are believed to be distributed proportionately throughout the State. Only about 10 to 15 percent of cases proceed to hearing as most cases are settled prior to hearing. For cases with District office Identifiers, about 20 hearings are completed per year compared to an average of about 150 total case dispositions (stipulations plus proposed decisions).

For cases with District office Identifiers, during the past two (2) fiscal years (2007/08 and 2008/09) an average of 18 to 20 months elapsed from accusation filed to proposed decision received, about the same as the average for the preceding two (2) years (2005/06 and 2006/07). Also, the average elapsed times during the past two (2) years were about the same in all major geographic regions of the State (18 to 19 months). Due to the small numbers of cases involved (about a dozen cases per year for each region), it is unclear whether the average elapsed times have changed significantly in any of the three major geographic regions of the State.

**Average Elapsed Times from Accusation Filed to Proposed Decision Received, By Identifier
2005/06 through 2008/09**

Fiscal Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)
2005/06	4	22	18	23	11	21	33	22
2006/07 ²	9	9	17	20	13	19	39	17
2007/08	9	19	14	18	15	21	38	19
2008/09	11	17	12	20	12	16	35	18
Fiscal Year	Cases with Other Identifiers ¹						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		Headquarters (IDENT 20)			
	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)
2005/06	7	9					40	20
2006/07 ²	8	9			1	5	48	16
2007/08	5	11					43	18
2008/09	10	9			1	25	46	16

¹ Excludes cases also involving petitions to revoke probation (DAPF and DAVF Action Codes).

² The VE Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

VII. Prosecutions and Disciplinary Outcomes

G. Average Elapsed Time from Proposed Decision Received to Board Action

Table VII-4, below, shows the average elapsed times from proposed decision received to Board action, by year, for the past four (4) fiscal years. As shown by Table VII-4, this process takes an average of 4 to 6 months to complete for all proposed decisions, and also for just proposed decisions with a District office Identifier. In some cases the process can take as long as 5 to 6 years to complete. If extended cycle time cases are excluded, then the average elapsed time for the remaining cases decreases to or 2 to 4 months.

Table VII-4. Average Elapsed Times from Proposed Decision Received to Board Action

Category	2005/06		2006/07		2007/08		2008/09	
	Number of PDs	Average Elapsed Time (Months)	Number of PDs	Average Elapsed Time (Months)	Number of PDs	Average Elapsed Time (Months)	Number of PDs	Average Elapsed Time (Months)
Total Proposed Decisions with Board Action	71	4.7	71	6.7	70	5.6	63	4.4
Less: Proposed Decisions with Out-of-State, Headquarters, and Probationer Identifiers (IDENTS 16, 19, 20, 23, and D)	36	2.7	42	3.7	32	5.7	32	4.2
Proposed Decisions with District Identifiers (IDENTs 2 through 18, Excluding 16)	39	6.1	36	8.9	42	5.0	32	4.5
Less: Proposed Decisions with Extended Elapsed Times (Longer than 1 Year)	4	31.5	7	36.2	4	29.7	1	23.1
Proposed Decisions with District Identifiers, Excluding Extended Elapsed Time Cases	35	3.2	29	2.3	38	2.4	31	3.9

In some cases Board action does not occur for an extended period following receipt of a proposed decision because the licensee is not available to attend the Board's Hearing on the matter due to failing health. In other cases the Medical Board rejects the proposed decision and refers it back to OAH. In these circumstances the elapsed time from receipt of the proposed decision to Board action includes the elapsed time for preparing and resubmitting the modified proposed decision. Additionally, the licensee may elect to submit a petition for reconsideration or appeal the proposed decision to Superior Court. In these circumstances, the elapsed time from receipt of the proposed decision to Board action includes the elapsed time for these processes, during which action by the Board may be stayed, in some cases for a period of years.

VII. Prosecutions and Disciplinary Outcomes

H. Disciplinary Outcomes

Exhibit VII-7, on the next page, shows disciplinary actions, by type of discipline, by Identifier for (1) the 4-year period from 2003/04 through 2006/07, and (2) the 2-year period from 2007/08 through 2008/09. Additionally, Exhibit VII-8 shows the percentage of disciplinary actions requiring license revocation, surrender, suspension, or probation. As shown by Exhibit VII-7, during the past two (2) years there were significant variations in disciplinary outcomes between the different geographic regions of the State.

Northern California Region

Total Disciplinary Actions – The total number of disciplinary actions decreased by about 9 percent (from an average of 56 actions per year to an average of 51 actions per year).

Composition of Disciplinary Actions – The number of disciplinary actions requiring license revocation, surrender, suspension, or probation decreased by 7 percent (from an average of 40.25 actions per year to an average of 37.50 actions per year). The proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation increased marginally (from 72 percent to 74 percent).

Los Angeles Metro Region

Total Disciplinary Actions – The total number of disciplinary actions decreased by about 13 percent (from an average of 71 actions per year to an average of 62 actions per year).

Composition of Disciplinary Actions – The number of disciplinary actions requiring license revocation, surrender, suspension, or probation decreased by 20 percent (from an average of 52 actions per year to an average of 41.5 actions per year). The number of public reprimands issued changed very little. The proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation decreased from 74 percent to 67 percent.

Other Southern California Region

Total Disciplinary Actions – The total number of disciplinary actions increased by about 10 percent (from an average of 58 actions per year to an average of 66 actions per year).

Composition of Disciplinary Actions – There was a significant increase in the number of public reprimands issued (from an average of 15 per year to an average of 22 per year). The number of disciplinary actions requiring license revocation, surrender, suspension, or probation was unchanged. Due to the increase in number of public reprimands, the proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation decreased from 75 percent to 66 percent.

**Disciplinary Outcomes by Identifier
2003/04 through 2008/09**

2003/04 through 2006/07 (4 Years)

Disciplinary Outcome	Cases with District Office Identifiers								Cases with Other Identifiers						Total	
	Northern California		Los Angeles Metro		Other Southern CA		Total		Out of State (16)		Probation (19 & D's)		Other (20 to 23, 27)			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Revocation	11	5%	24	9%	23	10%	58	8%	46	22%	31	31%	7	13%	142	13%
Surrender	59	26%	46	16%	47	20%	152	21%	88	43%	33	33%	7	13%	280	26%
Suspension Only	0	0%	0	0%	3	1%	3	0%	0	0%	0	0%	0	0%	3	0%
Probation with Suspension	19	9%	35	12%	23	10%	77	10%	1	0%	9	9%	2	4%	89	8%
Probation Only	72	32%	103	37%	77	33%	252	34%	43	21%	27	27%	37	69%	359	33%
Public Reprimand	62	28%	74	26%	59	25%	195	26%	28	14%	1	1%	1	2%	225	20%
Total Disciplinary Outcomes	223	100%	282	100%	232	100%	737	100%	206	100%	101	100%	54	100%	1,098	100%
4-Year Average	56		71		58		184		52		25		14		275	
Revocation/Surrender/Probation %	72%		74%		75%		74%		86%		99%		98%		80%	

2007/08 through 2008/09 (2 Years)

Disciplinary Outcome	Cases with District Office Identifiers								Cases with Other Identifiers						Total	
	Northern California		Los Angeles Metro		Other Southern CA		Total		Out of State (16)		Probation (19 & D's)		Other (20 to 23, 27)			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Revocation	12	12%	14	11%	12	9%	38	11%	29	27%	10	27%	1	6%	78	15%
Surrender	19	19%	19	15%	21	16%	59	17%	31	28%	13	35%	2	13%	105	20%
Suspension Only	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Probation with Suspension	7	7%	10	8%	6	5%	23	6%	2	2%	2	5%	0	0%	27	5%
Probation Only	37	36%	40	32%	48	37%	125	35%	22	20%	12	32%	10	63%	169	33%
Public Reprimand	27	26%	41	33%	44	34%	112	31%	25	23%	0	0%	3	19%	140	27%
Total Disciplinary Outcomes	102	100%	124	100%	131	100%	357	100%	109	100%	37	100%	16	100%	519	100%
2-Year Average	51		62		66		179		55		19		8		260	
Revocation/Surrender/Probation %	74%		67%		66%		69%		77%		100%		81%		73%	

VII. Prosecutions and Disciplinary Outcomes

With respect to the Los Angeles Metro region, it is unclear whether there is a correlation between:

- ❖ The decreased proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation for Los Angeles Metro cases, *and*
- ❖ The improved average elapsed times to reach settlement achieved in the Los Angeles Metro region during the past several years.

Additionally, if there is a correlation between these findings, it is unclear whether the correlation is due to weaker or less well-prepared cases, a change in the composition of the cases, less effective prosecution of the cases, or a combination of these factors.

VII. Prosecutions and Disciplinary Outcomes

I. Expenditures for HQES Prosecution Services

HQES Attorneys post time charges for prosecution-related activities to “Administrative” matters that are opened for each individual case. **Exhibit VII-8**, on the next page, summarizes HQES time charges to Administrative matters by year from 2005 through 2009. As shown by Exhibit VII-8, in four (4) of the past five (5) years, HQES charged between 31,000 and 34,000 hours to Administrative matters. The number of hours charged by HQES to Administrative matters during 2007 (38,000) was significantly higher than any of the other years. On a calendar year basis, during the past five (5) years the number of hours charged by Deputy Attorneys to Administrative matters:

- ❖ Increased by about 20 percent in the Northern California region (from about 11,000 hours to about 13,000 hours)
- ❖ Increased by about 30 percent in the Los Angeles Metro region (from about 10,000 hours to about 13,000 hours) and then decreased by about 23 percent (to about 10,000 hours)
- ❖ Increased by about 20 percent in the Other Southern California region (from about 9,000 hours to about 11,000 hours) and then decreased by about 18 percent (from about 11,000 hours to less than 9,000 hours).

On a fiscal year basis, the trends are the same, although less pronounced.

On a fiscal year basis, the trends are the same, although less pronounced. HQES’ hourly billing rates for Attorney services during 2008/09 and 2009/10 were \$158 and \$170, respectively, or an average of \$164 per hour. Assuming a \$164 hourly billing rate for Attorney services, estimated billings during 2009 for prosecution-related services for cases assigned to the Northern California region were about \$2.1 million compared to less than \$1.6 million for cases assigned to the Los Angeles Metro and Other Southern California regions.

As discussed previously, there are significant variations between regions in the number of prosecutions completed, as well as variations in other output and performance metrics, such as the proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation. **Exhibit VII-9**, following Exhibit VII-8, shows the number of prosecutions completed by year, by region, for (1) cases with District office Identifiers, (2) SOI-related stipulations and decisions, and (3) cases with Out-of-State Identifiers. Separate performance ratios are shown excluding, and including, Out-of-State cases which, when included, are weighted to reflect HQES staff estimates that, on average, these cases take about 15 percent as much time to complete as SOIs and cases with District office Identifiers. As shown by Exhibit VII-9, including a 15 percent weighting of Out-of-State cases, the number of hours charged by HQES Attorneys per completed case was about the same for each of the three major geographic regions of the State during both 2006/07 and 2008/09 (an average of about 150 hours per completed case). During 2007/08 the number of hours charged per completed case was much higher than this average for the Los Angeles Metro region (179 hours charged per completed case), and much lower than this average for both the Northern California and the Other Southern California regions (132 hours per completed case and 103 hours per completed case, respectively).

Hours Charged by HQES Staff to Administrative Matters - 2005 through 2009¹

Classification	HQES Office(s)	Calendar Year (Actual)				
		2005	2006	2007	2008	2009
Deputy Attorneys	Northern California ¹	11,333	11,718	12,960	12,231	13,026
	Los Angeles Metro	10,150	9,696	12,937	11,820	9,823
	San Diego (Other Southern California)	9,220	8,290	11,265	8,144	8,923
	Total	30,703	29,704	37,161	32,195	31,772
Paralegals and Analysts	Northern California ¹	92	15	65	317	157
	Los Angeles Metro	579	835	463	514	1,191
	San Diego (Other Southern California)	151	98	81	133	263
	Total	822	947	608	964	1,610
Supervising DAGs	Northern California ¹	99	221	212	106	160
	Los Angeles Metro	36	7	127	0	0
	San Diego (Other Southern California)	343	207	43	113	198
	Total	477	436	382	219	358
Total	Northern California ¹	11,524	11,954	13,237	12,654	13,342
	Los Angeles Metro	10,765	10,538	13,527	12,334	11,014
	San Diego (Other Southern California)	9,713	8,595	11,388	8,391	9,384
	Total	32,002	31,086	38,151	33,378	33,740

Classification	HQES Office(s)	Fiscal Year (Interpolated)			
		2005/06	2006/07	2007/08	2008/09
Deputy Attorneys	Northern California ¹	11,525	12,339	12,596	12,628
	Los Angeles Metro	9,923	11,316	12,378	10,822
	San Diego (Other Southern California)	8,755	9,777	9,704	8,534
	Total	30,203	33,432	34,678	31,984
Paralegals and Analysts	Northern California ¹	54	40	191	237
	Los Angeles Metro	707	649	489	852
	San Diego (Other Southern California)	124	89	107	198
	Total	885	778	787	1,287
Supervising DAGs	Northern California ¹	160	217	159	133
	Los Angeles Metro	22	67	64	0
	San Diego (Other Southern California)	275	125	78	156
	Total	457	409	301	289
Total	Northern California ¹	11,739	12,596	12,946	12,998
	Los Angeles Metro	10,652	12,032	12,931	11,674
	San Diego (Other Southern California)	9,154	9,991	9,889	8,888
	Total	31,545	34,619	35,766	33,560

¹ Excludes hours charged to Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters

² Includes Fresno, Sacramento, Oakland, and San Francisco offices.

Estimated HQES Attorney Hours Charged per Completed Prosecution - 2006/07 through 2008/09

Output or Performance Indicator		2005/06 (Total)	2006/07				2007/08				2008/09			
			Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total
Hours Charged to Administrative Matters by HQES Deputy Attorneys ¹		30,203	12,339	11,316	9,777	33,432	12,596	12,378	9,704	34,678	12,628	10,822	8,534	31,984
Completed Cases with District Office Identifiers ²	Default Decisions	6	2	0	3	5	5	3	2	10	1	6	5	12
	Accusations Withdrawn or Dismissed	22	5	4	6	15	11	6	19	36	8	8	4	20
	Post-Filing Stipulations Submitted	143	45	52	42	139	41	46	58	145	40	45	37	122
	Proposed Decisions Submitted	33	9	17	13	39	9	14	15	38	11	12	12	35
	Total Completed Cases with District Office Identifiers	204	61	73	64	198	66	69	94	229	60	71	58	189
Statement of Issues (SOI) - Stipulations and Proposed Decisions Submitted (IDENT 20)		27	16	0	0	16	21	0	0	21	15	0	0	15
Completed Cases with Out-of-State Identifiers	Default Decisions	12	7	0	0	7	9	0	0	9	17	0	0	17
	Accusations Withdrawn or Dismissed	2	5	0	0	5	10	0	0	10	3	0	0	3
	Post-Filing Stipulations Submitted	21	39	0	0	39	31	0	0	31	23	0	0	23
	Proposed Decisions Submitted	7	8	0	0	8	5	0	0	5	10	0	0	10
	Total Completed Cases with Out-of-State Identifiers	42	59	0	0	59	55	0	0	55	53	0	0	53
Total Completed Cases, Including SOIs and Cases with Out-of-State Identifiers (IDENT 16)		273	136	73	64	273	142	69	94	305	128	71	58	257
Ratio	HQES Attorney Hours Charged per Completed Prosecution Cases with District Identifiers and SOIs Only	131	160	155	153	156	145	179	103	139	168	152	147	157
	HQES Attorney Hours Charged per Completed Prosecution Cases with District or Out-of-State Identifiers and SOIs - Weighted ³	127	144	155	153	150	132	179	103	134	152	152	147	151
Hourly Billing Rate for Attorney Services		\$146	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158	\$158
Average Attorney Cost per Case		\$20,066	\$22,752	\$24,490	\$24,174	\$23,700	\$20,856	\$28,282	\$16,274	\$21,172	\$24,016	\$24,016	\$23,226	\$23,858

¹ Data shown excludes hours charged for cases classified as Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters.

² Data shown excludes cases involving Probationers, petitions for modification or termination of probation, petitions for reinstatement, and CME audit failure, Operation Safe Medicine, and Internet cases. The excluded cases are believed to be proportionately distributed throughout the State.

³ Out-of-State cases which, on average, take substantially less Attorney time to complete, are weighted 15 percent.

VII. Prosecutions and Disciplinary Outcomes

During 2007/08, HQES' Los Angeles Metro office billed significantly more hours to Administrative matters than billed during both 2006/07 or 2008/09, but completed fewer prosecutions, resulting in a higher average number of hours billed per completed case. The especially low average number of hours billed during 2007/08 per completed case shown for HQES' San Diego office is partially attributable to withdrawal or dismissal of an unusually large number of cases (19) during 2007/08 (a non-positive outcome). However, due to the especially large total number of cases completed by the San Diego office, even if the performance ratio is adjusted to exclude most of the withdrawn/dismissed cases, the average number of hours billed per completed case would still be significantly lower than shown for both of the other regions.

In summary, a portion of the additional staffing resources authorized for HQES to support implementation of VE was utilized to provide higher levels of prosecution-related services. This is especially evident during 2007, and was concentrated primarily in HQES' Los Angeles Metro and San Diego (Other Southern California) offices. Subsequently, during 2008 and 2009, these HQES offices redirected some of these resources toward providing higher levels of Investigation-related services. There may also have been some shifting in the reporting of hours for the some prosecution-related activities (e.g., time spent on ISOs, TROs, and PC 23s and drafting accusations is sometime posted to Investigation matters). In contrast, in the Northern California region there were only minimal shifts during the past two (2) years in the allocation of Attorney resources between investigation and prosecution-related services. Additionally, although fewer hours were billed by the Los Angeles Metro office for prosecution services during 2008/09 compared to the prior two (2) years, the number of hours billed per completed case was still the same, or higher, than billed for cases handled in each of the other two geographic regions of the State (even without adjusting for time posted to Investigation matters for prosecution-related services, such as time spent on ISOs, TROs, and PC 23s and drafting accusations). Finally, during the past several years an average of less than 150 Attorney hours were billed per completed case (weighted) and the Medical Board's cost for these services averaged about \$23,000 per case (weighted).

VII. Prosecutions and Disciplinary Outcomes

J. Recommendations for Improvement

Below we discuss several key recommendations for improving prosecution process performance. These recommendations concern (1) Supplemental Investigations, (2) Decline to File cases, and (3) Out-of-State cases. Additional recommendations that would impact prosecutions are included in Section X (*Organizational and Management Structures*), including recommendations involving:

- ✓ Restructuring the handling of Section 801 cases
- ✓ Restructuring the management of District office investigations
- ✓ Scaling back and optimizing HQES Attorney involvement in District office investigations
- ✓ Developing new organizational structures and processes for managing HQES expenditures and tracking cases following referral for prosecution
- ✓ Improving workload and performance reporting processes.

1. Supplemental Investigations and Decline to File Cases

In some cases, particularly in the Los Angeles Metro region, the supplemental investigation process is over-utilized and, to some extent, misused, resulting in unnecessary extension of the elapsed time to complete investigations, and delayed filing of Accusations. HQES Attorneys also sometimes decline to file cases that other Attorneys at the same or other HQES offices would accept and prosecute. When either of these events occurs, it sometimes triggers a dispute between HQES and Medical Board staff that can consume enormous amounts of resources at all levels throughout both organizations. Sometimes these disputes become very contentious, poisoning relationships not only between the parties involved in the dispute, but throughout both organizations. Alternatively, Enforcement Program staff acquiesce to HQES direction and either perform whatever additional investigative activities are requested, or close the case, even though they may disagree with this disposition. It is surprising that these types of disagreements can arise in a system that jointly assigns an Investigator an Attorney to each case at the onset of each investigation, and continuing through to its conclusion, especially in the Los Angeles Metro region where HQES Attorneys are most involved with the investigations. As the same types of disputes continue to surface, and continue to surface most frequently in the Los Angeles Metro region, it appears that the underlying causes of these disputes are not being addressed. A better process is needed to quickly, and impartially, resolve these disputes in a manner that reduces conflict and helps to prevent similar disputes from surfacing in the future.

Recommendation No. VII-1. *Establish independent panels to review all requests for supplemental investigations and all decline to file cases. The reviews should be completed expeditiously (e.g., within 1 to 2 days of issuance of the request for supplemental investigation or Decline to File Memorandum). For Northern California cases, the panel*

VII. Prosecutions and Disciplinary Outcomes

members should include a Regional Manager and Supervising DAG from the Southern California region, plus the Medical Board's HQES Services Monitor (see Recommendation No. X-6). For Southern California cases, the panel members should include a Regional Manager and Supervising DAG from the Northern California region, plus the Medical Board's HQES Services Monitor. The panels should review all decline to file cases and all requests for supplemental investigations for any cases where preparation of the pleading will be delayed pending completion of the supplemental investigation, and then advise the Chief of Enforcement, the Senior Assistant Attorney General, and all Medical Board and HQES Managers and Supervisors involved in the matter as to the results of their review, including recommended disposition of the matter.

2. Out-of-State Cases

The processes used to prepare Accusations for Out-of-State cases are currently working reasonably well. Some Out-of-State cases are currently handled by Medical Board staff without HQES involvement, but most cases are referred to HQES, which prepares an Accusation and, in most cases, negotiates a surrender of the Subject's license. It is unclear why an HQES Attorney is needed to perform these services for all of these cases. Additional staffing for DCU is expected to be authorized through the 2010/11 Budget which could provide DCU with the capability to draft many of these accusations, file the pleading, and negotiate related license surrenders. HQES Attorney involvement could be limited to reviewing the draft accusation and stipulation (on-line) and handling a limited number of more complex cases. Use of Medical Board staff in lieu of HQES Attorneys would reduce costs for these services and enable redirection of HQES resources to other cases.

Recommendation No. VII-2. *Restructure the processes used for preparing accusations for Out-of-State cases to reduce the number of cases referred to HQES. Utilize DCU staffing resources to draft accusations and license surrender stipulations for Out-of-State cases.*

VIII. Probation Program

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VIII. Probation Program

This section presents results of our assessment of the Probation Program. Results of this assessment show that the investigations and prosecutions of Probationers are being adversely impacted by the same factors as are impacting investigations and prosecutions of Non-Probationers. Additionally, needs exist to improve the processes used to ensure that on-going probation monitoring functions are regularly and properly performed.

The section is organized as follows:

Subsection	Title
A.	Investigations of Probationers and Petitions to Revoke Probation
B.	Probationer Intake and Monitoring
C.	Petitions for Modification or Termination of Probation.

VIII. Probation Program

A. Investigations of Probationers and Petitions to Revoke Probation

As shown by Exhibit VI-5, in Section VI, the Medical Board typically investigates about 50 cases per year involving Probationers (IDENT 19). In recent years, the average elapsed time to complete these investigations increased by about one (1) month (from 10 months to 11 months). Typically, about 30 cases are closed (60 percent), and the remaining cases (40 percent) are referred for prosecution. There is not a significant difference between the average elapsed time to complete investigations of cases that are closed and the average elapsed time to complete investigations of cases that are referred for prosecution. On average, investigations of Probationers take less time than investigations of Non-Probationers, possibly reflecting differences in the nature of many of these cases (e.g., a higher proportion of cases involving a violation of the terms of Probation). Additionally, prior to 2008/09, investigations of Probationers were not included in the VE Pilot Project.

Following referral for prosecution, if a petition to revoke probation is recommended, the Identifier on the case is changed to a 'D'. In some cases only a petition to revoke probation is filed, in other cases an accusation and a petition for revocation of probation are filed and, in rare cases, only an accusation is filed (e.g., if the term of the probation has expired). The absence of a District office Identifier for these cases (both 19s and Ds) makes it more difficult to determine the distribution of these cases by office or geographic region. However, the geographic distribution of cases involving Probationers is believed to be proportionate to the geographic distribution of Probationers, which is believed to be consistent with the geographic distribution of licensees and complaints referred for investigation.

As with referrals of non-Probationer cases to HQES, problems are sometimes experienced with referrals of Probationer cases to HQES, particularly in the Los Angeles Metro region. The following case summaries illustrate the some of the types of problems experienced with cases referred for prosecution to HQES' Los Angeles Metro office.

Case History VIII-1 (10 Month Delay). The Subject in this case was required to have a chaperone present when examining female patients. An investigation was completed that determined that the Subject did not have a chaperone present on numerous occasions when examining minor female patients. An accusation and petition to revoke probation were not filed until 10 months after referral of the case for prosecution.

Case History VIII-2 (18+ Month Delay). The Subject in this case was non-compliant with multiple terms and conditions of their probation, including refusing to enroll in and attend PACE, failing to submit Quarterly Reports, and failing to attend quarterly meetings with the Probation Monitor. The Medical Board issued an automatic suspension order, which remains in effect, and referred the case for prosecution. HQES now claims that it does not have the package, which the Medical Board now plans to resubmit. The delay in this case has already exceeded 18 months.

Case History VIII-3 (8+ Month Delay). The Subject in this case was required to abstain from the use of alcohol, but tested positive for a controlled substance. More than eight (8) months after referral of the case for prosecution, HQES had not

VIII. Probation Program

declined to file the case or prepared an accusation/petition to revoke probation. There is a disagreement between HQES and the Medical Board regarding the District office's response to HQES' request for additional investigation of the case.

Case History VIII-4 (4+ Month Delay). The Subject in this case was non-compliant with payment of cost recovery and probation monitoring costs, which had not been paid for years. More than four (4) months after the case was referred for prosecution, and approaching the point at which the Medical Board could lose jurisdiction, HQES had not declined to file the case or prepared a petition to revoke probation.

Several recommendations for improvement that would impact the investigations and prosecutions of Probationers, and help to address the problems illustrated in these case histories, are included in Sections V (*Investigations*) and Section X (*Organizational and Management Structures*), including recommendations involving:

- ✓ Restructuring the management of District office investigations
- ✓ Scaling back and optimizing HQES Attorney involvement in District office investigations
- ✓ Developing new organizational structures and processes for managing HQES expenditures and tracking cases following referral for prosecution
- ✓ Improved workload and performance reporting processes.

VIII. Probation Program

B. Probationer Intake and Monitoring

The Medical Board's Probation Monitoring Unit is responsible for intake and monitoring of Probationers. The Probation Monitoring Unit is organized into three (3) regional business units, with 4 to 7 Inspectors and one (1) clerical support position allocated to each unit. The regional units are each supervised by an Inspector III who reports to the Probation Management Unit's Manager (an SSM I). Key activities performed by Probation Monitoring staff are summarized below.

1. Intake Interviews

Intake interviews are completed for all new Probationers. During the interview the Probation Monitor reviews all of the terms and conditions of probation with the Probationer. On an annual basis about 100 new Probations are assigned to the Probation Monitoring Program, plus about a dozen others who are based outside the State and are not monitored (referred to as "tolling"). Data are not currently captured regarding the number of Intake Interviews completed or the elapsed time from commencement of probation to completion of the Intake Interviews.

2. First Year Monitoring

During the first year of probation emphasis is typically placed on ensuring compliance with terms and conditions involving participation in PACE, education, obtaining a practice monitor, chaperones, biologic fluid testing, and other requirements. Typically, these terms and conditions are "front-loaded" by the Board's decision. Additionally, Probationers are required to submit Quarterly Reports and to meet on a quarterly basis with the Medical Board's Probation Monitor.

3. Subsequent Year Monitoring

Subsequent year monitoring is generally limited to reviewing Quarterly Reports submitted by the Probationer and meeting quarterly with the Probationer. Including first-year participants, about 450 In-State Probationers are currently monitored (an average of about 30 to 35 cases per position, depending on vacancies).

4. Performance Reporting

Probation Program performance reporting focuses exclusively on tracking the number of Probationers, and new assignments, reassignments, and terminations or completions. More recently, attention has begun to focus on the completion of Intake Interviews, and the elapsed time from commencement of probation to completion of the Intake Interview.

VIII. Probation Program

The Medical Board does not currently capture data regarding the scheduling and completion of Quarterly Reviews with Probationers. Consequently, data are not available, without reviewing individual case files regarding any of the following:

- ❖ The extent to which Quarterly Reviews are completed on a quarterly basis, as scheduled
- ❖ The number and proportion of Quarterly Reviews completed on-site at the Probationer's office
- ❖ The number and proportion of Quarterly Reviews completed at other locations
- ❖ The number and proportion of Quarterly Reviews completed without meeting with the Probationer
- ❖ The number of random visits completed (e.g., to the offices of sole practitioners).

Needs exist to improve the processes used ensure that Probationer monitoring functions are regularly and properly performed.

Recommendation No. VIII-1. *Develop systems for tracking and reporting completion of quarterly reviews, random office visits, and other key probation monitoring activities.*

VIII. Probation Program

C. Petitions for Modification or Termination of Probation

Petitions for modification or termination of probation are submitted to DCU which forwards the petitions and supporting documentation to the Probation Unit Manager who researches the cases and determines whether to assign the petitions to Probation Unit staff or refer to the District offices for investigation. Cases involving Probationers with compliance deficiencies or another active Investigation are referred to the District offices. Otherwise, the cases are assigned to staff within the Probation Units. Cases referred to the District offices are handled as VE cases, with joint assignment of an HQES Attorney and an Investigator to each case. Following investigation by either the Probation Unit or the District office, and irrespective of the Probationer's compliance record or the nature of the requested changes to the terms and conditions of their probation, the petitions are transmitted to HQES which presents the cases for hearing.

It is unclear why cases referred to the District offices are included in the VE Pilot Project as they are not complaints and the basic character of these cases, and the types of investigations performed, are completely different from complaints. It is also unclear why hearings are required for all of these matters. A Medical Board analyst could potentially review the cases prior to referral to HQES, and make a determination, in some cases, as to whether to accept the Petition and then present it directly to the Board, without any involvement of HQES and OAH. The remaining cases could still be referred to HQES for hearing.

Recommendation No. VIII-2. *Restructure the processes used for investigating petitions for modification or termination of probation. Exclude cases referred to the District offices from the VE Program, and screen out petitions from referral to HQES that do not need a hearing before an ALJ.*

IX. Integrated Assessment of Enforcement Program Performance

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IX. Integrated Assessment of Enforcement Program Performance

This section presents an integrated assessment of the performance of the Enforcement Program. The assessment highlights significant changes in outputs and performance that occurred during the past several years following implementation of VE. Key statistical measures of overall Enforcement Program performance are presented, including:

- ✓ Number of ISOs/TROs sought and granted
- ✓ Number of accusations filed and average elapsed time from referral for Investigation to accusation filed
- ✓ Number of stipulations received and average elapsed time from referral for Investigation to stipulation received
- ✓ Number of disciplinary actions, decomposed by level of discipline imposed.

Since implementation of VE during 2006 there has been a marked deterioration in overall enforcement process performance. Investigator turnover has increased, fewer interim suspension actions are taken, investigations take longer to complete, fewer cases are referred for prosecution, and there has not been any significant improvement in the the disciplinary outcomes achieved or the timeframe to achieve these outcomes. Concurrently, the Medical Board's costs for HQES legal services have increased due to rate increases and increased Attorney staffing authorized to support implementation of VE. Of particular concern is the increase in the amount of time needed to complete Quality of Care case investigations. These investigations already take an average of more than 18 months to complete for cases that are referred for prosecution.

The more intensive involvement of HQES Attorneys in investigations appears to be contributing to elevated attrition of seasoned Investigators and deteriorating Enforcement Program performance. These impacts are most apparent in the Los Angeles Metro region where HQES Attorney involvement is greatest (2 to 3 times higher than the level of involvement of HQES Attorneys in other regions of the State). Recently implemented policy changes requiring a second Medical Expert opinion for most (or all) single patient cases assigned to Los Angeles Metro District offices could further increase the amount of time needed to complete some quality of care case investigations, increase Investigator caseloads, reduce the availability of Medical Experts, particularly in specialized areas of practice, and increase Investigator turnover and Medical Board costs. Finally, as aged cases migrate from the Investigation Stage to the Prosecution Stage during 2009/10 and subsequent years, it is likely that average elapsed times from case referral for investigation to stipulation received will increase.

There are a number of factors over the past several years that have contributed to the Enforcement Program's inability to meet its goals. The loss of Investigators to a number of state agencies is likely to have contributed, although it is not possible to know whether or to what extent goals would have been met if fewer Investigators had separated from the Board. It is, however a fact that the Board has experienced a number of lateral transfers (non-promotional) to other State agencies subsequent to implementation of Vertical Enforcement. Some staff were disappointed that pay raises did not materialize, case levels did not decline as hoped, and the Investigators were not transferred to the Department of Justice. It is also a fact that there are tensions between Medical Board and HQES management, and a lack of consistency of VE implementation among regions. All parties involved are jointly responsible for ensuring stability and an

IX. Integrated Assessment of Enforcement Program Performance

employment environment conducive to productivity, and it would appear that significant and continuing problems in this area have not been sufficiently addressed. Although current Enforcement Program staffing levels are higher than they have been in several years and the workforce is stable, likely due to current economic conditions, as the economy improves the Medical Board may again experience high attrition and vacancy rates if improvements are not made.

The remainder of this section is organized as follows:

Subsection	Title
A.	Complaints Handled and Average Elapsed Times from Initiation to Referral for Investigation
B.	ISOs/TROs Sought and Granted
C.	Accusations Filed and Average Elapsed Times from Referral for Investigation to Accusation Filed
D.	Accusations Withdrawn or Dismissed
E.	Stipulations Prepared and Average Elapsed Times from Referral for Investigation to Stipulation Submitted
F.	Efficiency of Investigations and Prosecutions
G.	Disciplinary Outcomes.

Recommendations for improvements are separately presented in Section V (*Complaint Intake and Screening*), Section VI (*Investigations*), Section VII (*Prosecutions and Disciplinary Outcomes*), Section VIII (*Probation Program*), and Section X (*Organizational and Management Structures*).

IX. Integrated Assessment of Enforcement Program Performance

A. Complaints Handled and Average Elapsed Times from Initiation to Referral for Investigation or Prosecution

As discussed in Section V, during 2008/09 the average elapsed time to close or refer complaints for investigation or prosecution was about 2.5 months, excluding a significant number of non-jurisdictional complaints closed during the Intake Stage. For complaints not reviewed by a Medical Specialist, the average elapsed time to close or refer complaints for investigation or prosecution was about two (2) months. For complaints reviewed by a Medical Specialist, the average time to close or refer the complaints was about four (4) months. Some high priority complaints are referred for investigation or prosecution with only limited screening. Consequently, for complaints referred for investigation or prosecution, the average elapsed time was shorter than the average elapsed time for complaints that are closed and referred for investigation or prosecution (about 2.1 months for complaints that are referred for investigation or prosecution compared to 2.6 months for complaints that are closed or referred). Reflecting additional time requirements to obtain records and have a Medical Consultant review the cases, the average elapsed time to close or refer quality of care complaints, which account for about one-half of all complaints, was about three (3) months. The average elapsed time to close or refer other complaints was less than two (2) months. Following implementation of requirements for review of all quality of care complaints by a Medical Specialist, the proportion of complaints referred for investigation or prosecution decreased by about 15 percent (from 20 percent to 17 percent). In recent years only about 17 percent of complaints were referred for investigation or prosecution.

During the past several years, the number of complaints opened decreased by about 5 percent, the number of complaints closed decreased by about 10 percent, and the number of complaints referred for investigation or prosecution decreased by about 15 percent. Concurrently, the number of pending complaints and the average elapsed time to close or refer cases increased by about 25 percent. Recent growth in the number of pending complaints and increases in average elapsed times to close or refer complaints appear unrelated to implementation of Specialty Review requirements earlier in the decade. Rather, these increases, which are concentrated in the past two (2) years, appear to be primarily a result of:

- ❖ The reduced availability of staffing resources due to restrictions on the use of overtime, staff turnover and vacancies, and work furloughs
- ❖ Changes in the composition of complaints, including significant decreases in Out-of-State and Medical Board-originated cases which, on average, are closed or referred for investigation or prosecution much more quickly than other complaints.

IX. Integrated Assessment of Enforcement Program Performance

B. ISOs/TROs Sought and Granted

It was anticipated that, as a result of earlier involvement of HQES Attorneys in case investigations, increased numbers of ISOs and TROs would be sought and granted, which would enhance consumer protection by more quickly restricting the physician’s practice of medicine. **Table IX-1**, below, shows the number of ISOs and TROs sought and granted, by year, for the past six (6) fiscal years. During the past several years, significantly fewer ISOs and TROs were sought. Also, significantly fewer were granted.

Table IX-1. ISOs/TROs Sought and Granted

Fiscal Year	ISO/TRO Sought								ISO/TRO Granted									
	District Office Identifiers				Other Identifiers				Total	District Office Identifiers				Other Identifiers				Total
	Northern California	Los Angeles Metro	Other Southern California	Total	Out of State (16)	Probation (D's)	Headquarters (20)	Northern California		Los Angeles Metro	Other Southern California	Total	Out of State (16)	Probation (D's)	Headquarters (20)			
2003/04	5	4	15	24	0	1	1	26	6	1	9	16	1	5		22		
2004/05	6	15	15	36	1	1	1	39	8	5	7	20	1	8		29		
2005/06	10	3	10	23				23	10	1	9	20		4		24		
3-Year Average	7	7	13	28	1	1	1	29	8	2	8	19	1	6		25		
2006/07	11	2	9	22				22	10	2	4	16		2		18		
2007/08	6	8	4	18		2		20	5	6	2	13		2		15		
2008/09	10	4	1	15		3		18	9	2	1	12	1	3		16		
3-Year Average	9	5	5	18		3		20	8	3	2	14	1	2		16		

Implementation of VE has not increased the number of ISOs and TROs sought and granted, notwithstanding higher levels of Attorney involvement in the investigations. Instead, since implementation of VE, the number of ISOs and TROs sought and granted has decreased by more than 30 percent. This decrease significantly exceeds any decrease that could be attributed to reductions in the number of cases referred for investigation.

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C. Accusations Filed and Average Elapsed Times from Referral for Investigation to Accusation Filed

Another anticipated benefit of VE was a reduction in elapsed times from referral of a case for investigation to filing of the accusation. For example, it was expected that with HQES Attorneys more involved with investigations, that it would take less time to obtain medical and other records needed to determine the merits of a complaint. Also, cases that were not viable could be identified and closed more quickly, thereby enabling redirection of resources to other cases, and accelerating completion of the Investigations while concurrently improving the quality of the cases. Finally, because an HQES Attorney was already very familiar with their cases and had directed various investigative activities, including the gathering of evidence, interviewing patients, witnesses, and subjects, and selecting a Medical Expert, and reviewing the evidence and the Medical Consultant's and Medical Expert's reports, and the reports of investigation prepared by the Investigator, it would take them significantly less time to prepare the accusation, which provides notice to the public of alleged negligence or misconduct by a licensee

As shown by **Exhibit IX-1**, on the next page, these expected performance improvements have not been realized. For cases with District office Identifiers, the average elapsed time from referral for investigation to accusation filed increased by two (2) months during the past several years. Average elapsed times from referred for investigation to accusation filed increased in all three (3) geographic regions. However, there were significant performance variances between the regions. The Northern California and Other Southern California regions had much shorter average elapsed times than the Los Angeles Metro region (17 to 19 months for the Northern California and Other Southern California regions compared to 22 to 23 months for the Los Angeles Metro region, a difference of 5 to 6 months). From this data it is abundantly clear that the much higher level of involvement of HQES Attorneys in Los Angeles Metro region cases has not provided any differential benefit in terms of achieving lower average elapsed times from referral of a case for Investigation to filing of the accusation. The higher level of involvement of HQES Attorneys in Other Southern California region cases, as compared to the level of involvement of HQES Attorneys in Northern California region cases, also has not provided any differential benefit in terms of achieving lower average elapsed times from referral a case for Investigation to filing of the accusation.

**Average Elapsed Times from Referral to Investigation to Accusation Filed, by Identifier
2004 through 2009**

Including Cases with Transmittal to Filing Timeframes Exceeding 18 Months

Excluding Cases with Transmittal to Filing Timeframes Exceeding 18 Months

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	17	61	19	54	14	163	17
2005	56	19	56	22	71	16	183	19
2006 ²	54	17	45	21	50	17	149	18
2007	66	17	65	22	67	16	198	18
2008	60	18	50	21	45	18	155	19
2009	72	19	51	21	64	19	187	20

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	17	61	19	53	14	162	17
2005	55	18	55	21	71	16	181	18
2006 ²	54	17	43	21	48	16	145	18
2007	65	16	55	20	66	16	186	17
2008	60	18	49	20	43	18	152	19
2009	71	18	48	20	61	19	180	19

Year	Cases with Other Identifiers ¹						Total All Case Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ, CME Audit, and Internet (IDENT 20,21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	2	13	3	19	10	11	178	16
2005	2	8	0	0	5	27	190	19
2006 ²	3	9	1	35	0	0	153	18
2007	5	12	0	0	1	18	204	18
2008	4	10	2	23	0	0	161	19
2009	0	0	1	36	6	15	194	19

Year	Cases with Other Identifiers ¹						Total All Case Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ, CME Audit, and Internet (IDENT 20,21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	2	13	3	19	10	11	177	16
2005	2	8			2	17	185	18
2006 ²	3	9	1	35			149	18
2007	5	12			1	18	192	17
2008	4	10	2	23			158	18
2009			1	36	6	15	187	19

¹ Over the six-year period from 2004 through 2009, excludes 279 accusations filed related to Out-of-State (IDENT 16) cases transmitted by DUC directly to HQES, and 16 accusations filed related to Headquarters, CME audit failure, and Internet cases (IDENTs 20, 21, and 23) transmitted by various Headquarters Units directly to HQES. Also excludes five (5) cases involving petitions to revoke probation (IDENT 'D').

² The Vertical Enforcement Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

IX. Integrated Assessment of Enforcement Program Performance

D. Accusations Withdrawn or Dismissed

With greater HQES Attorney involvement in investigations, it might be expected that fewer accusations would be withdrawn or dismissed. However, the number of accusations withdrawn or dismissed is small in comparison to the total number of accusations filed (about 10 percent), and accusations may be withdrawn or dismissed due to changing circumstances and other factors that are outside of the control of both the Medical Board and HQES (e.g., successful completion of the Diversion Program, death of the Subject, etc.).

A review of the statistical data appears to show that dismissals and withdrawals have remained essentially constant over the past five years. Changes appear to be due to statistical spikes only, and do not reflect any continuous trend or pattern.

As shown by **Table IX-2**, below, during the past five (5) fiscal years there has not been any sustained change in the number of accusations withdrawn, and the number of accusations dismissed recently increased. Due to a one-year spike in accusations withdrawn and dismissed during 2007/08, the average number of accusations withdrawn or dismissed during the past two (2) years (29 cases per year) was significantly higher than the average number of accusations withdrawn or dismissed during the preceding three (3) years (21 cases per year).

Table IX-2. Accusations Withdrawn and Dismissed

Fiscal Year	Cases with District Office Identifiers Withdrawn or Dismissed			
	Northern California	Los Angeles Metro	Other Southern California	Total
2004/05	6	10	10	26
2005/06	6	9	7	22
2006/07	5	4	6	15
3-Year Average	6	8	8	22
2007/08	11	6	19	36
2008/09	8	8	4	20
2-Year Average	10	7	12	29

Most of the accusations that were withdrawn or dismissed during 2007/08 involved cases that were investigated by District offices in the Northern California or Other Southern California regions. During 2007/08, 26 accusations were withdrawn and 10 were dismissed. About a dozen cases were withdrawn after determining that there was not sufficient evidence to prevail at a hearing. Other causes for these withdrawals included:

- ❖ The Medical Expert changed their opinion (about a half-dozen cases)

IX. Integrated Assessment of Enforcement Program Performance

- ❖ The license was cancelled, the respondent died, or the statute of limitations ran (several cases)
- ❖ A citation or public letter of reprimand was issued in lieu of discipline (2 cases)
- ❖ The Subject successfully completed the Diversion Program (2 cases).

The unusually high number of accusations withdrawn during 2007/08 did not persist into 2008/09.

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E. Stipulations Prepared and Average Elapsed Times from Referral for Investigation to Stipulation Received

Implementation of VE was expected to reduce average elapsed times from referral of a case for investigation to stipulation received, which effectively represents completion of the prosecution phase of the enforcement process. It was anticipated, for example, that in addition to reducing the average elapsed time to complete investigations and to file accusations, that implementation of VE might (1) marginally increase the proportion of cases that are settled without a hearing, and (2) reduce the average elapsed time to negotiate a settlement and prepare the stipulation.

With respect to increasing the proportion of cases that settle rather than proceed to hearing, about 80 to 85 percent of cases usually settle without a hearing. Thus, it was considered unlikely that implementation of VE would significantly increase the proportion of cases that might settle without a hearing. On an annual basis for the past six (6) years, the proportion of cases that did not settle, and proceeded to hearing, fluctuated between 15 and 20 percent. There is no evidence that implementation of VE had any significant beneficial impact in terms of increasing the proportion of cases that settle without a hearing.

As shown by **Exhibit IX-2**, on the next page, for cases with District office Identifiers:

- ❖ The number of stipulations submitted decreased during the last several years, particularly in the Los Angeles Metro and Other Southern California regions
- ❖ The average elapsed times from referral for investigation to stipulation received changed very little and, for all regions, this performance measure was only marginally lower during the past three (3) years during the preceding three (3) years.

However, as aged cases migrate from the Investigation Stage to the Prosecution Stage during 2009/10 and subsequent years, it is likely that the average elapsed times from referral for investigation to stipulation received will increase. Additionally, as shown by Exhibit IX-2, there are significant performance variations between geographic regions of the State. For example, the Los Angeles Metro region consistently had significantly higher average elapsed times from referral for investigation to stipulation received than the other regions. During the past two (2) years the average elapsed time for the Los Angeles Metro region was about seven (7) months longer than the average elapsed time for the Northern California region, and about three (3) months longer than the average elapsed time for the Other Southern California region.

**Average Elapsed Times from Referral for Investigation to Stipulation Submitted, by Identifier
2004 through 2009**

Including Cases with Post-Investigation Elapsed Times Exceeding 3 Years

Excluding Cases with Post-Investigation Elapsed Times Exceeding 3 Years

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004	50	2.2	64	3.1	39	2.5	153	2.7
2005	36	2.4	49	3.1	50	2.4	135	2.7
2006 ²	40	2.4	66	3.1	38	2.7	144	2.8
2007	48	2.0	33	2.9	55	2.8	136	2.5
2008	30	2.1	45	2.6	44	2.4	119	2.4
2009	52	2.2	45	3.0	34	2.4	131	2.5

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004	48	2.1	60	3.0	39	2.5	147	2.6
2005	34	2.3	43	2.9	49	2.4	126	2.5
2006 ²	37	2.1	59	2.9	33	2.3	129	2.5
2007	48	2.0	32	2.8	51	2.5	131	2.4
2008	29	1.9	41	2.5	41	2.3	111	2.3
2009	50	2.1	41	2.8	33	2.4	124	2.4

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20, 22, and 23)			
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004					1	0.6	154	2.6
2005	2	1.3	4	4.0	7	2.4	148	2.7
2006 ²					2	4.0	146	2.8
2007	4	1.1	2	3.6	2	0.7	144	2.5
2008	3	1.4	1	1.3	3	2.8	126	2.4
2009	1	3.3	1	2.9	1	0.9	134	2.5

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20, 22, and 23)			
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004					1	0.6	148	2.6
2005	2	1.4	2	3.1	7	2.4	137	2.5
2006 ²					1	3.8	130	2.5
2007	4	1.1	2	3.6	2	0.7	139	2.3
2008	3	1.4	1	1.3	2	1.6	117	2.2
2009	1	3.2	1	2.9	1	0.9	127	2.4

¹ Over the six-year period from 2004 through 2009, excludes 24 subsequent submissions related to the same complaint, 176 stipulations related to Out-of-State (IDENT 16) cases transmitted by DCU directly to HQES, and 82 cases involving petitions to revoke probation (IDENT 'D').

² The Vertical Enforcement Pilot Project was jointly implemented by the Medical Board and HQES during January 2006.

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Finally, as shown by **Table IX-3**, below, during the past several years the average elapsed times from referral for investigation to stipulation received have changed very little for either quality of care or for other cases. It was anticipated that the elapsed times for quality of care cases would be impacted most by implementation of VE (e.g., by reducing the time taken to obtain medical and other records).

Table IX-3. Average Elapsed Times from Referral for Investigation to Stipulation Received, by Type of Case¹ - 2005 through 2009

Calendar Year	Quality of Care Cases		Other Cases		Total	
	Number of Stipulations	Average Elapsed Time	Number of Stipulations	Average Elapsed Time	Number of Stipulations	Average Elapsed Time
2005	102	2.8 Years	35	2.2 Years	137	2.6 Years
2006 ²	102	3.2 Years	42	1.9 Years	144	2.8 Years
2007	98	2.7 Years	42	2.2 Years	140	2.5 Years
2008	90	2.7 Years	32	1.7 Years	122	2.4 Years
2009	88	2.8 Years	44	2.1 Years	132	2.6 Years

¹ Over the five-year period from 2005 through 2009, excludes 24 subsequent stipulation submittals related to the same complaint, 141 stipulations related to Out-of-State (IDENT 16) cases transmitted by DCU directly to HQES, eight (8) cases involving probationers (IDENT 19), fifteen (15) cases originated by various Headquarters Units (IDENTs 20, 22, and 23), and 65 cases involving petitions to revoke probation (IDENT 'D').

² The Vertical Enforcement Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

Table IX-3 shows that the average elapsed time to investigate and prosecute quality of care cases remains at least eight (8) months longer than the average elapsed time for other cases (i.e., an average of about 2.7 years, or longer, for quality of care cases compared to an average of about 2.0 years for other cases).

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F. Efficiency of Investigations and Prosecutions

Expectations that implementation of VE would improve efficiency have not been realized. To support implementation of VE, eight (8) additional Investigator and Assistant Investigator positions and 10 additional HQES Attorney positions were authorized. These additional positions increased Investigator staffing by about 10 percent and increased HQES Attorney staffing by more than 20 percent. Following implementation of VE, the number of investigations completed, the number of cases referred for prosecution, the number of accusations filed, and the number of stipulations prepared have all declined by 15 percent or more. Additionally, during this period the number of pending investigations and the number of pending legal cases both increased by more than 15 percent. In summary, higher levels of resources are now being used to produce increasingly lower levels of output.

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G. Disciplinary Outcomes

Exhibit IX-3, on the next page, shows disciplinary outcomes by referral source for (1) a baseline period of four (4) years from 2003/04 through 2006/07, and (2) the most recent two (2) fiscal years. As shown by Exhibit IX-3, the total number of disciplinary actions decreased from an average of 312 per year during the 4-year baseline period to an average of 292 per year for the past two (2) years. Additionally, the decrease in numbers of disciplinary actions is even greater if Out-of-State cases, which are rarely handled by the District offices, are excluded. Disciplinary outcomes have not improved since implementation of VE.

As discussed previously in Section VII, there was no change in the number disciplinary actions requiring license revocation, surrender, suspension, or probation for Other Southern California region cases, and the number of public reprimands increased significantly (from an average of 15 per year, to an average of 22 per year). While the number of disciplinary actions taken involving Northern California region cases decreased by about 10 percent in recent years, there was only a minimal decrease in the number of disciplinary actions taken that required license revocation, surrender, suspension, or probation. In contrast, in recent years the number of disciplinary actions taken involving Los Angeles Metro cases decreased by 13 percent overall, and the number of disciplinary actions requiring license revocation, surrender, suspension, or probation decreased by 20 percent. The change in the number and types of disciplinary actions taken on cases investigated by Los Angeles Metro region offices was the largest contributor to the decreases that have recently occurred in (1) the overall number of disciplinary actions taken, and (2) the number of disciplinary actions taken requiring license revocation, surrender, suspension, and probation. These decreases were only partially offset by an increase in the number of public reprimand actions taken on cases investigated by District offices within the Other Southern California region.

In recent years the number of disciplinary actions taken involving cases investigated by Los Angeles Metro and Other Southern California region District offices each accounted for about 35 percent of all disciplinary actions taken on cases with District office Identifiers. In contrast, Northern California region cases accounted for only 28 percent of all disciplinary actions taken on cases with District office Identifiers. The comparatively lower proportion of disciplinary actions taken involving Northern California region cases reflects comparatively lower numbers of accusations filed in prior years. However, recent decreases in the number of accusations filed involving Los Angeles Metro and Other Southern California region cases will likely lead to fewer disciplinary actions taken in the future on cases investigated by District offices in both of these regions. In contrast, the number of accusations filed involving cases investigated by Northern California region offices increased in recent years, which will likely lead to an increase in disciplinary actions taken in the future.

HQES recently changed the geographic boundaries of its offices. Portions of the areas previously served by the Sacramento and San Diego offices were transferred to the Los Angeles Metro office. These shifts could complicate future efforts to compare regional performance over time.

Disciplinary Actions by Referral Source
(Average Annual Rate)

Referral Source	Conventional Enforcement - 2003/04 to 2006/07					Vertical Enforcement - 2007/08 to 2008/09					Change				
	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions
Patient, Patient Advocate, Family Member or Friend, Including 801.01(E) Reports	11.8	5.3	15.8	20.5	53.4	10.5	1.5	11.5	21.0	44.5	(1.3)	(3.8)	(4.3)	0.5	(8.9)
Insurance Companies and Employers, Including 801.01(B&C) Reports	5.1	1.8	11.0	18.3	36.2	2.0	0.5	11.5	19.0	33.0	(3.1)	(1.3)	0.5	0.7	(3.2)
Health Facilities (Section 805 and Non-805 Reports)	9.8	2.0	11.0	5.5	28.3	9.5	2.0	13.0	3.0	27.5	(0.3)	0.0	2.0	(2.5)	(0.8)
California Department of Health Services (or Successor State Agency)	3.8	2.3	7.3	3.0	16.4	4.5	1.0	7.5	3.5	16.5	0.7	(1.3)	0.2	0.5	0.1
M.D., Pharmacist, Allied Health or Healing Arts Licensee, or Medical Society or Association	5.8	1.3	5.3	3.3	15.7	5.0	0.5	2.0	4.5	12.0	(0.8)	(0.8)	(3.3)	1.2	(3.7)
CII - Department of Justice, Criminal Identification and Information Bureau	4.5	0.5	2.0	0.8	7.8	5.5	0.0	3.5	1.0	10.0	1.0	(0.5)	1.5	0.2	2.2
Other Governmental Agencies, Including FDA, DEA, Other DCA Boards and Bureaus, and 801 Reports	4.1	2.1	4.0	2.6	12.8	3.5	1.5	3.5	1.5	10.0	(0.6)	(0.6)	(0.5)	(1.1)	(2.8)
Other ¹	7.0	1.8	2.8	2.6	14.2	3.5	2.0	3.5	1.5	10.5	(3.5)	0.2	0.7	(1.1)	(3.7)
Police/Sheriff Department, Coroner's Office, District Attorney, and Courts (803 Reports, Criminal Filings, and Non-Felony and Felony Conviction Reports)	5.3	1.3	3.0	0.5	10.1	3.0	0.5	2.0	0.5	6.0	(2.3)	(0.8)	(1.0)	0.0	(4.1)
Licensee Self-Reporting (2240(A), 801.01, 802.01, 802.1 and Misdemeanor Conviction Reports)	0.3	1.0	0.8	4.5	6.6	0.5	0.5	1.0	2.5	4.5	0.2	(0.5)	0.2	(2.0)	(2.1)
California Attorney General and Department of Justice, Including Medi-Cal Fraud and Narcotics Enforcement Bureaus	0.8	0.3	0.8	0.3	2.2	2.0	0.0	1.0	0.5	3.5	1.2	(0.3)	0.2	0.2	1.3
Total, Excluding Out of State and Medical Board Originated Cases	58.3	19.7	63.8	61.9	203.7	49.5	10.0	60.0	58.5	178.0	(8.8)	(9.7)	(3.8)	(3.4)	(25.7)
Out of State Medical/Osteopathic Boards	34.1	0.5	11.0	20.8	66.4	31.0	1.0	11.0	40.0	83.0	(3.1)	0.5	0.0	19.2	16.6
Medical Board Originated Cases	16.0	3.3	15.0	7.6	41.9	11.0	2.5	13.5	4.5	31.5	(5.0)	(0.8)	(1.5)	(3.1)	(10.4)
Total, Including Out of State and Medical Board Originated Cases	108.4	23.5	89.8	90.3	312.0	91.5	13.5	84.5	103.0	292.5	(16.9)	(10.0)	(5.3)	12.7	(19.5)

¹ Includes CA Medical Review Inc., 803.6, 364.1, and NPDB reports, Jury Verdict Weekly, HEAL, MQRC District, WE Tip, Consumer or Industry Group, Employee, Co-worker, Witness, Informant, Anonymous, and Unknown.

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X. Organizational and Management Structures

This section presents results of our analysis of the Medical Board’s organizational and management structures. Our analyses focused primarily on Enforcement Program organizational structures and management issues. Organizational structure and management issues concerning the Licensing Program are addressed separately in Section XI (*Licensing Program*). The section is organized as follows:

Subsection	Title
A.	Organization of Section 801 Case Investigations
B.	Management of District Office Investigations
C.	Management of Cases Referred for Prosecution and HQES Expenditures
D.	Workload and Performance Reporting
E.	Government Code Section 12529.6(e) Requirements
F.	Oversight of HQES Services.

X. Organizational and Management Structures

A. Investigations of Section 801 Cases

The Medical Board is currently planning to establish a new Sacramento-based unit that will use non-sworn staff to investigate Section 801 and selected other cases. Section 801 cases are distinguished from other cases because they involve a reported settlement of a malpractice case, and a substantial portion of the investigative activity involves identifying, collecting, and reviewing medical and other records, such as transcripts of depositions or court proceedings. Medical Board management believe that investigations of many of these cases can be completed by non-sworn staff, working jointly with HQES Attorneys, without referring the cases to District offices for investigation by a sworn Investigator. Non-sworn staff and clerical support resources are expected to become available in stages during 2010/11 and 2011/12 as part of a currently pending BCP that is expected to be included in the State's 2010/11 Budget. Section 801 cases currently account for about 10 percent of all cases referred to the District offices for investigation.

Recommendation X-1. *Restructure the handling of Section 801 cases by establishing a centralized unit comprised of non-sworn staff to investigate Section 801 and selected other cases.*

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B. Management of District Office Investigations

The current management of field investigations differs among regions. Vertical Enforcement has been implemented differently in different offices with varied success. Conflicts have arisen among Board and HQES at all levels throughout the State, but particularly in the Los Angeles region. Conversely, in some offices staff are respectful of each other's roles in the process and there is greater productivity. The level of DAG involvement with investigators also varies, with the Los Angeles office by far having the most DAG involvement in investigations while referring fewer cases for prosecution.

While problems with some critical investigative activities have always been experienced, and are to be expected (scheduling of interviews), they appeared to have not been helped by the implementation of VE, and may have been made worse. Disagreements about the need for supplemental investigation activities and the need for second Medical Expert opinions create conflicts that have not been finally resolved, and continue to fuel disagreements. The conflicts need a final resolution based on best practices.

The statutes and policies governing VE should be amended to establish the best practices identified and as implemented in the Northern and Other Southern California regions. Currently, the statutes "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." Different regions have interpreted this code differently, giving rise to different investigation practices by MBC and HQES staff. This ambiguity should be addressed so that there is a uniform understanding of everyone's role in the process. Without such clarification, the Medical Board will continue to have responsibility for investigations while having little authority over their direction.

The Medical Board should be clearly identified in statute as the sole, final authority for purposes of determining whether to continue an investigation. HQES' responsibility regarding such decisions should be limited, as provided by current statutes, to providing advice to the Board. In cases where the Medical Board elects to continue an investigation, HQES Attorneys should be available and supportive of these efforts, irrespective of any prior advice or decision. If the case is again referred for prosecution after the investigation is completed, then HQES can always reject the case at that time.

Recommendation No. X-2. *Amend the statutes governing Vertical Enforcement to clarify the Medical Board's sole authority to determine whether to continue an investigation.*

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Another significant problem with the management of District office investigations involves the extent of HQES Attorney involvement with the investigations, irrespective of the nature or complexity of the case. A high level of Attorney involvement in some investigations is warranted and beneficial to many, but not all, investigations. Prior to implementation of VE, the availability of HQES Attorneys to provide substantive legal support services was limited to only a small percentage of cases. Now, in some cases, the pendulum has swung too far in the other direction. In some cases HQES Attorneys are now substantively involved in completing investigations where a lesser level of involvement would be just as beneficial while avoiding many of the communication and coordination problems that otherwise arise.

Currently, in some parts of the State the HQES Lead Prosecutor, who may also be a Supervising DAG, generally works collaboratively with the Medical Board's District office Supervisor, reviews incoming cases (usually only one or two cases per week per office), regularly attends Quarterly Case Review meetings, and spends a few hours one or two days per week at the District office providing general consultation services to District office staff. In consultation with the District office Supervisor, needs are jointly identified for assignment of a Primary DAG to provide more substantive legal support services for specific cases on an exception basis. For other cases, the HQES Lead Prosecutor or Supervising DAG, along with the District office Supervisor, continues to monitor the status and progress of the cases and provides ad-hoc legal advice and consultation regarding the course of the investigation. With this approach an HQES Attorney would, for example, attend a Subject interview in only selected cases.

In contrast with this approach, in some parts of the State a Primary DAG is usually assigned to each new case, and is then expected to be substantively involved throughout the investigation. In some cases this extends to participation, not just in Subject Interviews, but also to interviews with complainants, witnesses, and others, and not just for cases involving sexual misconduct. The activities of the Primary DAGs also can include conducting detailed reviews and analysis of medical and other records, review of the qualifications of potential Medical Experts, preparation of the instructions for the Medical Expert, review of the package submitted to the Medical Expert, and numerous other activities. With this approach, communications and coordination between all of the different team members, for all of the cases, necessarily becomes much more cumbersome and complex. With this approach, for example, a Subject interview generally would not be completed without the Primary DAG present, which complicates the process of just trying to schedule the interview, or, alternatively, the LP may attend the Subject Interview on behalf of the Primary, or the Medical Board may obtain the Primary DAG's or Lead Prosecutor's consent to conduct the Subject interview without an Attorney present. This type of continuous coordination activity continues throughout the course of the investigation, and can become especially complicated when the Primary DAG is focused primarily on other cases (e.g., preparing for or attending a hearing), is on vacation, or is otherwise either unavailable or non-responsive.

Another dimension of this problem involves conflicts related to the use of Lead Prosecutors (LPs). The statutes governing VE require that each investigation referred to a District office "be simultaneously and jointly assigned to an investigator and to the deputy attorney general in (HQES) responsible for prosecuting the case if the investigation results in the filing of an accusation." The interim assignment of the LP to most cases at some District offices does not appear to be fully consistent with this requirement. The use of LPs was not included in the VE model recommended by the Enforcement Monitor. It was created to address problems experienced after VE was

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implemented, including logistical, resource availability, and other problems associated with reviewing and assigning incoming cases and resolving communication problems and conflicts between District office and HQES staff.

In some cases a Supervising DAG has served as the LP. This approach can reduce communication and coordination problems because the Supervising DAG has direct supervising authority over subordinate Attorneys. However, Supervising DAGs are apparently not always sufficiently available to perform the LP role for all District offices. Consequently, the Supervising DAGs usually assign a subordinate Attorney to serve as the LP. The ability of the assigned Attorney to effectively perform some key LP duties appears to be highly dependent on (1) the authority delegated to the LP by their Supervising DAG, (2) the ability of the LP to exercise the authority delegated to them, and (3) the relationships between the LPs and their peers. Thus, the effectiveness of the LP appears to be highly dependent on the management style of their Supervising DAG and the individual personality characteristics and interpersonal skills of the LP.

To reduce these conflicts, the statutes should be modified to eliminate mandatory requirements for joint assignment of a DAG for all cases referred for investigation. As a practical matter it cannot usually be determined when a District office investigation is opened whether the case will proceed to prosecution (most do not). Additionally, it is completely unrealistic to expect that the assignment of a DAG to a case will exist “for the duration of the disciplinary matter”, although it is preferable to minimize such changes. While it is beneficial to have an Attorney regularly available to review new investigations, attend case review meetings, monitor the status of pending investigations, and provide ad-hoc legal advice and assistance to Investigators, the mandatory assignment of a Primary DAG to all investigations is excessive and results in a multi-million dollar waste of valuable resources that could be better utilized for other purposes. Every case referred for investigation should not have to be “double-teamed”.

The assignment of Primary DAGs to cases during the Investigation Stage should be permissive, based primarily on the complexity and needs of the case as jointly determined by the District office Supervisor and the Supervising DAG (or their designees). Assignment decisions should be made with due care, taking into consideration all of the other, sometimes conflicting, workload and resource demands of both the Medical Board and HQES. If not needed, a Primary DAG should not be assigned to a case. Management judgment should be exercised in making case assignment decisions, rather than mechanistically applying a one-size-fits-all approach to all investigations which results in higher Attorney caseloads, sub-optimal utilization of staffing resources, and poor overall performance. The assignment of a Primary DAG to all cases is as bad, or worse, than the pre-VE system where HQES Attorneys were largely unavailable to assist Medical Board Investigators during the Investigation Stage. There can, and should be, a more balanced approach between these two extremes that enables higher levels of Attorney support during the Investigation Stage when more intensive involvement is needed (not just because an Attorney is assigned, is available, and chooses to spend time working on the case).

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Recommendation No. X-3. *Implement the best practices, identified and as implemented in the Northern and Other Southern California regions, statewide to optimize effective HQES Attorney involvement in investigations. Amend the statutes and policies governing Vertical Enforcement to establish the best practices identified in the Northern and Other Southern California regions. It would be helpful to amend the statute to make primary DAG assignments permissive, allowing Medical Board and HQES supervisors to jointly review incoming investigations to identify which cases would benefit from VE. Clarifying the statute as to the agencies' roles, responsibilities, and authority over investigations would help assure greater uniformity of investigations among regions.*

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C. Management of HQES Expenditures and Cases Referred for Prosecution

There are significant deficiencies with both Medical Board and HQES management of cases referred for prosecution. The processes currently used for identifying and tracking the status of cases after they are referred for prosecution are frequently failing, particularly in the Los Angeles Metro region. These processes appear, particularly in the Los Angeles Metro region, to be largely dependent on individual District office Investigator or Supervisor detection and follow-up of past due cases. These follow-ups sometimes do not occur until several months after a case is referred for prosecution, or longer. Failures by the Medical Board to transmit cases and failures by HQES to acknowledge receipt of a referred case, and to communicate its acceptance or rejection of the case, exacerbates and further complicates this problem. However, even without these other problems, the absence of a planned completion date from HQES regarding when a pleading will be prepared makes it difficult for anybody to know which cases are being treated as urgent matters and whether the pleadings are past due. Similar problems sometimes occur after the pleading is filed (e.g., when several months elapse before a Request to Set is submitted on a case that the Medical Board considers urgent because the Subject poses a significant risk).

Recommendation No. X-4. *Require HQES to inform the Medical Board Regional Manager and HQES Services Monitor of the planned date for completing a pleading. The notice should be required to be provided within five (5) business days of referral of any case for prosecution. Also, require that all Medical Board Regional Managers meet (or conference) on a monthly basis with their HQES counterparts to review the status of all previously referred cases for which an accusation has not yet been filed.*

There also are significant deficiencies with both Medical and HQES oversight and management of HQES' expenditures for legal services (both investigation and prosecution). Currently, it appears that nobody at either HQES or the Medical Board closely reviews or analyzes the 700 to 900 page Invoice Report that the Attorney General provides to the Medical Board each month to support their charges (which are paid automatically by a funds transfer by the State Controller's Office from the Medical Board's fund to the Department of Justice). Instead, the Invoice Report appears to go directly from an administrative services unit in the Department of Justice to the Medical Board's fiscal unit, which maintains a cumulative tabulation of total expenditures for budget status tracking purposes and then files the report.

Needs exist to develop and implement a process that requires that the Supervising DAGs, Deputy Assistant Attorney General, District office Supervisors, and Regional Managers review and approve the reasonableness of HQES' charges to all matters billed each month. The scope of the review should include verification that the charges are posted to the correct cases. The Supervising DAGs should review and approve the time charges posted to Investigation and Administrative matters, or note exceptions that require correction, and then submit their portions of the Invoice Report to the Deputy Assistant Attorney General for final approval and submission to the Medical Board's HQES Services Monitor. Concurrently, District office Supervisors should confirm that the time charges posted to Investigation matters are consistent with the Investigation activities performed during the reporting period, note any exceptions that require correction or further evaluation, and then submit their portions of the Invoice Report to their Regional Manager. The Regional

X. Organizational and Management Structures

Managers should review the charges posted to pending Administrative matters as part of their responsibilities related to tracking the status of pending accusations (see Recommendation No. XII-4, above), note any exceptions that require correction or further research, and then submit their region's portion of the Invoice Report to the Medical Board's HQES Services Monitor. The Medical Board's HQES Services Monitor should monitor completion of all of the supervisory and management reviews and, in consultation with the Senior Assistant Attorney General, initiate corrective actions to address any exceptions or other problems identified as a result of completing the reviews.

Recommendation No. X-5. *Develop and implement an HQES Invoice Report review and approval process that provides for review of the reasonableness of HQES time charges. As necessary, require that HQES create new summary templates that display time charge data in a summary format that facilitates completion of these reviews.*

Recommendation No. X-6. *Establish a new HQES Services Monitor position within the Medical Board's Enforcement Program to coordinate the provision of services to the Medical Board by HQES, continuously monitor and evaluate HQES performance and costs, resolve conflicts that arise between the agencies, and prepare and provide regular reports to Executive Management, the Medical Board, and oversight and control agencies..*

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D. Management Reports

New monthly management reports should be developed and provided to Enforcement Program and HQES Managers and Supervisors, and Medical Board Executive Management. At a minimum, the reports should provide the following summary level output and performance measures for the reporting period, and for the preceding 12 months period:

- ✓ Number of investigations closed, by Identifier, and average elapsed time from referred for investigation to closure
- ✓ Number of investigations referred for prosecution, by Identifier, and average elapsed time from referred for investigation to referred for prosecution
- ✓ Total number of investigations closed or referred for prosecution, by identifier, and average elapsed time from referred for investigation to closed or referred for prosecution
- ✓ Number of accusations filed, by Identifier, average elapsed time from referred for prosecution to accusation filed, and average elapsed time from referred for investigation to accusation filed
- ✓ Number of stipulations received, by Identifier, average elapsed time from accusation filed to stipulation received, and average elapsed time from referred for investigation to stipulation received
- ✓ Number of proposed decisions received, by Identifier, average elapsed time from accusation filed to proposed decision received, and average elapsed time from referred for investigation to proposed decision received.

Additionally, the monthly performance reports should provide consolidated output and performance data by geographic region and for the State as a whole (Northern California, Los Angeles Metro, and Other Southern California). Quarterly summaries of this same information should be prepared and provided to the Medical Board. The quarterly summaries should also include fiscal year-to-date totals and time series data for the preceding three (3) fiscal years. Finally, all of the reports should possibly include a limited number of selected other output and performance measures, such as data regarding interim suspension activities (e.g., ISOs and PC 23s), petitions to revoke probation, compelled competency examinations, or disciplinary outcomes.

Recommendation No. X-7. *Develop new monthly management reports showing key output and performance measures by business unit and for the State as a whole. (Presently, data is provided to the Board on a statewide basis only). Provide the monthly reports to all Enforcement Program and HQES Managers and Supervisors and to designated Medical Board Executive Office Managers and staff. Develop and provide the Board with quarterly Enforcement Program Output and Performance Summary reports that include data for the most recently completed quarter and time series data for the preceding three (3) fiscal years.*

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E. Government Code Section 12529.6(e) Requirements

To carry out the Legislatures intent in requiring use of the Vertical Enforcement Model, and to enhance the Vertical Enforcement process, Section 12529.6 of the Government Code requires that the Medical Board:

- ❖ Increase its computer capabilities and compatibilities with HQES in order to share case information
- ❖ Establish and implement a plan to locate its Enforcement Program staff and HQES staff in the same offices, as appropriate
- ❖ Establish and implement a plan to assist in team building between its Enforcement Program staff and HQES staff to ensure a common and consistent knowledge base.

All of these requirements should be modified, or repealed. Each of these requirements is briefly discussed below.

Computer Capabilities and Case Information Sharing – The Medical Board is currently supporting DCA’s efforts to develop the BREEZE2 System which would completely replace the Medical Board’s legacy Application Tracking System (ATS) and also the Complaint Tracking System (CAS). The Medical Board should not invest additional resources in CAS to make it compatible with HQES’ ProLaw System. However, the Medical Board should provide HQES with standard reports available from CAS to enable HQES to monitor the status of pending investigations and prosecutions. Additionally, the Medical Board should provide HQES with summary level *Enforcement Program Output and Performance Reports* (see Recommendation No. X-7).

Co-location of District Office and HQES Staff – Co-location of District office and HQES staff would be inconsistent with our recommendations for more selective application of VE. Instead, as practiced currently, the Medical Board should be required to provide suitable space for Lead Prosecutors and Primary DAGs to work at its District offices, when needed (e.g., using “hoteling”).

Team Building and Development of a Common and Consistent Knowledge Base – The Medical Board and HQES should be jointly responsible for developing training programs and providing them to their respective staff as needed to provide staff in both agencies with a common and consistent knowledge base. Requirements related to team-building should be addressed as part of the structured diagnostic review of factors contributing to elevated attrition of Medical Board Investigators that is recommended in Section VI (See Recommendation No. VI-3).

Recommendation No. X-8. *Amend or repeal Subsection(e) of Section 12529.6 of the Government Code. The Medical Board should not invest in CAS to make it more compatible with HQES’ ProLaw System and should not permanently co-locate Medical Board Investigators and HQES Attorneys.*

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F. Oversight of HQES Services

When it was created during 1990, HQES was authorized 22 DAG positions. Following its formation, HQES also established a goal to file all accusations within 60 days of receipt of a completed investigation. The Legislation creating HQES also required that DAGs work on-site at the Medical Board's offices to assist with complaint handling and investigations. However, HQES determined that it was severely understaffed, and did not comply with this latter requirement. During 1992 and 1993 the Medical Board provided funding for 22 additional DAG positions (44 total Attorney positions). Subsequently, during the late-1990s, the Deputy in District Office (DIDO) Program was introduced whereby a DAG worked at each District office one or two days per week to provide prosecutorial guidance during investigations. However, the DIDO Program was not always consistently implemented at all District offices.

To support implementation of VE, an additional ten (10) Attorney positions were authorized for in 2006. In addition to the Senior Assistant Attorney General, HQES is currently authorized 53 Attorney positions, plus four (4) Analyst positions. HQES also has seven (7) filled Secretary positions. However, even with these resources, and notwithstanding declines in the number of cases referred for prosecution, HQES continues to experience significant delays in filing accusations and in performing post-filing prosecutorial activities. In recent years HQES has filed fewer accusations and the number of interim suspensions also has declined. Concurrently, the number of pending accusations and the number of pending legal actions have increased.

The results of this assessment show that issues concerning HQES' performance have persisted for the past 20 years, notwithstanding authorization and funding of significant staffing increases. Results of the assessment also show that output and performance levels of HQES' Los Angeles Metro office are significantly lower than in other regions of the State, even though available staffing resources are disproportionately allocated to that office. The types of performance problems occurring in HQES' Los Angeles Metro office, as illustrated by the various case histories reviewed as part of this assessment, are especially disturbing, and cannot be attributed to differences in the types of cases investigated by Los Angeles Metro District offices or differences in the quality of those offices' completed investigations. While HQES' Los Angeles Metro office presumably has many very competent and dedicated Attorney's on its staff, the problems identified, unfortunately, reflect poorly on the entire office. Also, the problems occurring at HQES' Los Angeles office should not color perceptions of the organization as a whole, although similar problems may sometimes occur at the other offices,

The Medical Board, and even the Department of Consumer Affairs, is limited in its ability to exercise oversight of HQES services because it is entirely dependent on HQES to provide legal support services and must work collaboratively with them on an ongoing basis. Periodic reviews of HQES' services, costs, and performance should be completed by an independent entity, and results of the review should be provided to Department of Justice and Medical Board management as well as to oversight and control agencies.

Recommendation No. X-9. *Conduct periodic performance reviews of the services, costs, and performance of HQES, including the performance of each HQES office. Provide results of the audits to Department of Justice and Medical Board management and to oversight and control agencies.*

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XI. Licensing Program

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XI. Licensing Program

This section presents results of our assessment of the Business Process Reengineering (BPR) study of the Licensing Program recently completed by Hubbert Systems Consulting, Inc. (HSC). The Medical Board contracted with HSC to perform the study during August 2009, nearly a year after determining that an evaluation of the Licensing Program was needed. Award of the contract was delayed by the State's General Fund fiscal crisis. The evaluation of the Licensing Program was intended to complement other improvement initiatives already undertaken or planned by Licensing Program management. HSC was expected to complete the study over a period of four (4) months. HSC submitted a draft *Final Report* to the Medical Board on January 19, 2010. The draft report was never finalized.

This section is organized as follows:

Subsection	Title
A.	HSC Study Purpose, Scope, and Approach
B.	Results of HSC's Analysis
C.	Analysis of HSC's Recommendations
D.	Recommendations for Improvements.

XI. Licensing Program

A. HSC Study Purpose, Scope, and Approach

The purpose of HSC's assessment was to identify improvements in the Licensing Program to increase efficiency, facilitate compliance with governing statutes and regulations, and improve customer service. The focus of the study was on the Licensing Program's license application processes. These services are largely provided by two Physician and Surgeon Licensing Sections within the Medical Board's Division of Licensing. The scope of the study also encompassed other Licensing Division business units that support these processes, including the Consumer Information Unit (CIU) Call Center and Cashiering Unit, both of which are organized within the Licensing Division's Licensing Operations Section. The study scope also encompassed support services provided by the Medical Board's Information Systems Branch (ISB) and Graduate Medical Education (GME) Outreach Unit, both of which report administratively to the Medical Board's Executive Office. The study scope excluded the Medical Board's Mailroom Unit and the DCA's Mailroom and Cashiering Units, all of which are involved in license application and renewal processing. The study scope also excluded other Licensing Program services generally provided by business units within the Licensing Operations Section, including services involving the issuance of Fictitious Name Permits, approval of Ambulatory Surgery Center Accrediting Agencies, licensing of Allied Health Licensing Program (AHL) professionals (Registered Dispensing Opticians, Research Psychoanalysts, and Midwives), and recognition of International Medical Schools. In total, the study scope encompassed more than 80 percent of the Licensing Division's authorized permanent positions, and all of the Licensing Division's Temporary Help (Retired Annuitant and Student Assistant) positions.

HSC's technical approach to performing the study included the following major tasks:

- ❖ Research and review of the Medical Board's licensing and renewal processes and related Internet applications
- ❖ Research and review of statistical data covering the period from 2002 through mid-2009, including data regarding numbers of applications received and reviewed, and elapsed times to complete the reviews
- ❖ Review of a *Policies and Procedures Manual* recently drafted by Medical Board staff
- ❖ Preparation of maps and flow diagrams of the licensing and renewal processes
- ❖ Research and review of staff roles and responsibilities and analysis of staffing levels
- ❖ Identification and definition of reports needed to effectively manage application review workload and workflows
- ❖ Development of a draft *Business Plan* to improve efficiency and performance
- ❖ Development of recommendations for organizational and staffing changes needed to support implementation of the *Business Plan*
- ❖ Development of an *Implementation Plan*, a *Communications Plan*, and a *Training Plan*. The *Training Plan* was developed by Medical Board staff.

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B. Results of HSC's Analysis

HSC's draft *Final Report* included 31 recommendations for improvement. The recommendations are grouped into three (3) major categories for (1) Infrastructure, (2) Information Technology, and (3) Resources.

Infrastructure (16 recommendations) – The Infrastructure recommendations are organized into eight (8) subcategories, as follows:

Processes and Procedures – Includes recommendations to continue development of *Policies and Procedures Manuals*, strengthen Quality Assurance processes, create a Staff Suggestion System, implement a Continuous Improvement Program, and increase uninterrupted time for application review staff.

Licensing Application – Includes recommendations to revise the license application and accompanying instructions, implement a new application set-up Sheet, revise the fee schedule and licensing invoice letter, and create a new application update form for use in lieu of the application form.

Forms – Includes recommendations to continue the use of eTranscripts and acceptance of FCVS documents, and to implement iPickup for FSCV documents. Also includes recommendations to assess the use of an alternative approach for obtaining credentialing verifications.

Postgraduate Training Authorization Letters (PTAL) – Recommends resolution of multiple PTAL issues, without specifying how the issues should be resolved.

Website – Recommends several specific modifications to the Medical Board's Web site content (e.g., separating the application from the instructions, adding a PTAL tab, and creating new email options for users)

Consumer Information Unit (CIU) Call Center – Recommends several specific enhancements of CIU services, such as conducting periodic reviews of outcomes and call tree activity.

Graduate Medical Education (GME) – Recommends assessment of the potential use of AMA's Physician Professional Database to obtain information on residents enrolled in GME programs.

Other – Recommends evaluation of the viability of a Postgraduate Training Permit Concept. References evaluations previously completed during 1997 and 2006.

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Information Technology (7 recommendations) – Includes recommendations to develop more than 20 new tracking reports and logs, and to modify the Application Tracking System (ATS) to enhance functionality and improve application workload and workflow tracking capabilities. Additionally, HSC recommended increasing eCommunications with applicants and others, in lieu of hard copy communications, and completing an assessment of the feasibility of developing a secured portal for submission of Certificate of Completion (L3A/B) data. Also recommends that the Medical Board actively support DCA’s development of the BREEZE2 System to replace ATS and evaluate the potential use of a Document Management System that would use imaging of application documents to improve workflow tracking and reporting.

Resources (8 recommendations) – Includes recommendations to fill four (4) additional proposed positions identified in a 2010/11 Budget Change Proposal (BCP) on an accelerated basis in 2009/10, and to obtain approval for seven (7) additional authorized positions through a future BCP. Also includes recommendations to reorganize the Licensing Division (e.g., separate US/CAN from International Medical School Graduate (IMG) applications, consolidate Infrastructure-related functions, and create two new sections and an additional level of management). Additionally, recommends changing the name of the CIU, realigning some tasks, continuing to create and deploy staff training programs, and establishing performance objectives and continuing to work toward achieving these objectives.

HSC assigned a “High” priority to recommendations involving:

- ❖ Continued development of *Policy and Procedures Manuals*
- ❖ Strengthening Quality Assurance processes
- ❖ Revising the Application form and accompanying Instructions
- ❖ Revising the Fee Schedule and Licensing Invoice Letter
- ❖ Implementing a PTAL/License Application Update form
- ❖ Resolving PTAL issues
- ❖ Updating content on the Medical Board’s Web site
- ❖ Implementing CIU Call Center enhancements
- ❖ Implementing new management reports
- ❖ Enhancing ATS
- ❖ Supporting DCA’s development of the BREEZE2 system
- ❖ Augmenting and reorganizing Licensing Division staff
- ❖ Changing the name of the CIU
- ❖ Establishing performance objectives and continuing to work toward achieving these objectives.

HSC identifies potential costs and performance improvement benefits associated with implementing each recommendation, and “metrics” that could be used to measure the benefits actually achieved. In most cases the identified costs and benefits are not quantified.

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C. Analysis of HSC's Recommendations

Many of HSC's High priority recommendations, and many lower priority recommendations, are focused improvements targeted on a narrow or limited improvement needs. Examples include recommendations for relatively minor changes or updates to business unit names, standard forms, procedures, and the Medical Board's Web site. Many of these recommendations, if implemented, would likely improve effectiveness, efficiency, or service levels, but would not have a substantive impact on overall Licensing Program performance. Several other High priority recommendations, and others with a lower priority, recommend continuation of ongoing Licensing Program management activities, such as developing a *Policy and Procedures Manual*, strengthening the Quality Assurance process, and supporting DCA's development of the BREEZE2 system. A few of the recommendations lack meaningful specificity, such as the recommendation to resolve PTAL issues.

In terms of potential impact on overall Licensing Program costs and performance, HSC's most substantive recommendations for improvement include the following:

- ✓ Evaluate use of a Document Management System (DMS)
- ✓ Augment, reorganize, and train staff
- ✓ Establish performance objectives and implement new management and performance reports.

Below we provide an analysis of HSC's recommendations in each of these areas.

1. Evaluate Use of a Document Management System (DMS)

HSC assigned this recommendation a Medium priority and discussed needs for significant planning, resources, and training, and a strong infrastructure, to support successful implementation. HSC did not find any prior reports or other documentation suggesting a DMS was ever previously considered for the Licensing Program. HSC indicated that, in the past, these types of systems were used exclusively for large, paper-intensive applications. HSC's report includes data showing that the Medical Board receives more than 6,200 applications per year and HSC stated that an average of about 50 different documents. Many of these documents are submitted over an extended period of time and, as received, each document must be physically married with each application file, potentially prompting needs for additional review of the application file at that time. However, the estimated total number of licensing application documents handled (300,000 per year) is characterized as "relatively small". Also, the wide variety of documents involved and the possibility that the documents will be submitted without reference to the applicant's license application number, or other unique identifier, could complicate DMS development and implementation. DMS would replace the Medical Board's current paper-based licensing processes, and would not necessarily impact the electronic ATS or successor BREEZE2 system, although there could be interfaces with these other systems. Potential benefits of DMS include (1) streamlined processes, (2) improved workflow, (3) enhanced tracking, and (4)

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reduced processing times. HSC's staffing recommendations include resources to assess the feasibility of a DMS. HSC did not provide any quantified estimates of the potential costs of DMS or the potential impacts of DMS on Licensing Program performance. In the California State Government environment, a period of several years (or longer) would likely be needed to fully implement a DMS solution, but such a system could help to reduce needs for additional staffing resources as license application workloads increase over time.

2. Augment, Reorganize, and Train Staff

HSC assigned these recommendations a High priority and recommended increasing the number of authorized permanent Licensing Section positions by 54 percent (from 26 positions to 41 positions, an increase of 15 positions). Partially offsetting this proposed increase, HSC also proposed eliminating four (4) half-time Retired Annuitant positions (equivalent to 2 full-time positions) and eight (8) part-time Student Assistant positions (equivalent to 6 full-time positions, assuming all of the Student Assistants work a maximum of 30 hours per week). With these offsets, a net increase of at least seven (7) full-time-equivalent positions was recommended (representing a 27 percent net increase in authorized staffing for the Licensing Section). With these recommendations, total authorized permanent positions for the Licensing Program would increase by 33 percent (from about 45 positions to 60 positions, excluding offsets for the elimination of Retired Annuitants and Student Assistants). The proposed new permanent positions include a new Assistant Division Chief (Staff Services Manager II) position and three (3) new Section Supervisor (Staff Services Manager I) positions (resulting in a total of 7 first level supervisor positions, including 1 Officer Service Supervisor II position). The eleven (11) remaining proposed new positions are classified as AGPAs (4 positions), SSAs (4 positions), and MSTs (3 positions). The four (4) proposed non-SSA positions were already filled. HSC also recommended upgrading two (2) Office Technician positions to MST. HSC's recommended replacement of part-time Student Assistants with permanent MST, SSA, and AGPA positions would represent a significant upgrading of the Licensing Program's workforce classifications and capabilities. Finally, HSC recommended significantly expanding training for all Licensing Program staff. HSC did quantify the potential costs or potential benefits of these recommended organizational and staffing changes.

In its study, HSC presented statistical data showing that the number of license applications received grew modestly from 2004/05 through 2008/09 (i.e., about 10 percent over 4 years, or less than 3 percent per year). During this period the number of US/CAN applications received was unchanged and the number of IMG applications received decreased. Concurrently, PTAL applications increased significantly, and accounted for all of the aggregate increase in applications received that occurred during this period. Also, as shown by HSC, there are recurring peaks in US/CAN application submissions during the third quarter of each fiscal year (January to March) which create a compression of activity during the following quarter (April to June). Finally, data presented by HSC showed that during 2004/05, and again during 2006/07, Licensing Program staff were largely able to keep pace with the flow of new applications, and backlog accumulations during both years were minimal. In contrast, during 2005/06 and, subsequently, during 2007/08 and 2008/09, large application

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backlogs accumulated. HSC did not present any historical data showing Licensing Program staffing levels or overtime expenditures from 2004/05 through 2008/09, or data showing whether there was any correlation between (1) the Licensing Program's staffing levels and expenditures for overtime, and (2) program performance in terms of backlogged work and the timeframes needed to process license applications.

Prior to 2004/05, total authorized Licensing Program staffing was reduced from about 43 permanent positions to about 37 permanent positions. Authorized staffing for the Licensing Program remained at this same level through 2006/07. From the data presented in HSC's report it appears that, with additional overtime (which increased from \$31,000 to \$77,000), Licensing Program staff were largely able to keep pace with the flow of new applications during 2006/07, and prevent significant backlogs from accumulating. Use of Retired Annuitants and Student Assistants throughout this period was limited (less than 0.5 positions).

During 2007/08, three (3) additional clerical support (Office Technician) positions were authorized for the Licensing Program. Additionally, overtime expenditures increased marginally (to \$88,000) and there was a small increase in the use of Retired Annuitants and Student Assistants. However, HSC's report shows a marked increase in license application backlogs during 2007/08. During the following year (2008/09), the Cashiering Unit, which consisted of six (6) authorized positions, was transferred to the Licensing Division. This transfer increased authorized Licensing Program staffing to about 45 total positions, but did not impact the number of staff available to process license applications. During 2008/09, license application backlogs increased further, to record levels, notwithstanding significant increases in expenditures for both overtime (to \$196,000) and for Temporary Help (to 1.2 positions, from 0.4 positions, previously).

The HSC study does not appear to provide any substantive analysis of why authorized Licensing Program staffing resources (about 45 total authorized permanent positions, plus significant expenditures for Temporary Help and Overtime) were insufficient to keep pace with the flow of new applications during 2008 and 2009. The absence of an analysis of historical staffing and performance reduces the level of support for HSC's recommendation to increase authorized staffing for the Licensing Program by 15 permanent positions (with a likely cost of about \$1 million per year, less offsetting savings from reductions in the use of Retired Annuitants and Student Assistants). HSC also did not provide any workload-based analysis supporting the need for the additional positions. Additionally, HSC based its recommendation for three (3) additional SSM I positions on the large number of subordinate positions reporting to the Licensing Section's current SSM Is (an average of about 20 subordinate staff per position). However, the subordinate positions included in this analysis included part-time Retired Annuitants and Student Assistants, and most of these positions would be eliminated. If part-time staff are excluded from the analysis, as they normally are for purposes of justifying new supervisory positions, then the spans of control of the Licensing Section's supervisors are much narrower (an average of about 12 subordinate staff per position). In the California State Government environment, this smaller span of control would still be considered high for this type of program.

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As noted by HSC, during 2009/10 the Medical Board began filling eight (8) new positions proposed in a 2010/11 BCP that was not yet approved. DCA provided the Medical Board with a special authorization to fill these positions on an accelerated basis. At the time of HSC's study, four (4) of the positions had already been filled. Currently, seven (7) of the positions are filled, including one (1) new SSM I position. However, all of the positions were filled on a two-year, limited-term basis, pending formal approval of the pending BCP. Approval was also obtained from DCA to over-expend the amount budgeted for Temporary Help, the budget account used to fund these limited-term positions as well as costs for Retired Annuitants and Students Assistants). With these eight (8) additional limited-term positions, staffing for the Licensing Program now exceeds 52 total positions, excluding Retired Annuitants and Student Assistants, or 46 positions if staff assigned to the Cashiering Unit are excluded. Total authorized staffing resources for the Licensing Division, excluding Retired Annuitants and Student Assistants, is now 10 to 20 percent greater than previously authorized at any point during the 8-year period from 2000/01 through 2007/08.

As is evident from the above analysis, there is not a clear rationale for HSC's recommendation to seek authorization for seven (7) additional positions beyond the eight (8) additional positions requested as part of the currently pending 2010/11 BCP. Also, HSC provided no analysis of the cost-benefit trade-offs of using Permanent Intermittant positions, Temporary Help, such as Retired Annuitants and Student Assistants, and Overtime in lieu of additional full-time permanent positions, to address recurring seasonal workload peaks. Additionally, HSC's recommendation to upgrade two (2) of the Licensing Section's remaining three (3) Office Technician positions, and to completely eliminate the use of Student Assistants, would necessarily shift additional clerical and administrative support activities and workload to higher level staff. Finally, without HSC's proposed increases in SSM I positions, the recommendation to establish a new Assistant Division Chief position (SSM II) is not supported. Even with the additional SSM I positions, caution should still be exercised in establishing such a position because this type of management structure can simply fragment and dilute authority and accountability for Division and Section performance, and create an additional layer of bureaucracy that hinders, rather than enhances, effective decision-making, management of operations, and supervision of subordinate staff.

3. Establish Performance Objectives and Implement New Management and Performance Reports

In its reports HSC discusses the need to establish performance objectives for (1) application processing staff, (2) application review staff, and (3) administrative support staff, and indicates that their team worked with Licensing Program staff to develop performance objectives for Application Review staff. However, no specific performance objectives are presented in the report. HSC also discussed the need for performance metrics regarding actual work completed and indicated that, prior to the start of the BPR study, the Licensing Program established performance metrics for Application Review staff, based on manual counts. HSC also identified significant deficiencies with the Licensing Program's management reports, and the near complete absence of timely information regarding the Licensing Division's workload, workflow, and performance.

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Additionally, some recently developed workload reports rely completely on manual counts of documents at various stages of processing.

HSC does not identify or define any specific performance objectives for Licensing Program staff that are not already largely set forth in governing statutes (i.e., elapsed times to complete the processing of license applications). To address the deficiencies with the Licensing Program's performance metrics and reporting, HSC recommended development of more than 20 new reports and logs. However, most of these reports and logs consist of only a single data element. HSC does not present in its report an integrated framework for planning and managing Licensing Program performance in terms of outputs produced, resources used, productivity and service levels achieved, and backlogs. However, many of the elements of such a framework appear to be contained within various recommendations for improvement presented by HSC.

4. Other Issues

It is apparent that the scope of HSC's review of the Licensing Program was limited, focusing largely on the License Application process. Thus, other components of the Licensing Program were not generally assessed. For example, there is no discussion in HSC's report of the processes used to ensure licensee compliance with Continuing Medical Education (CME) Program requirements. During the past seven (7) years, the Medical Board has completed very few audits of licensee compliance with CME requirements. More than 200 citations were issued the last time the Licensing Program audited compliance with CME requirements (2007). A minimum number of audits of compliance with CME requirements should be regularly completed to ensure that non-compliance rates remain low, with larger numbers of audits completed in areas where above-average levels of non-compliance are detected.

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D. Recommendations for Improvement

Below we present and briefly discuss seven (7) recommendations resulting from our review of HSC's study of the Licensing Program and other related analyses performed as part of our assessment.

Recommendation No. XI-1. Implement HSC's Recommended Business Process Improvements

Medical Board staff from the Licensing Program and other business units spent considerable time working with HSC to identify and assess the recommendations for improvement presented in HSC's report. Additionally, about \$40,000 was expended for the study. Potential benefits associated with implementing HSC's recommendations for improvement should be lost. As determined appropriate, the Licensing Program should implement HSC's recommended business process improvements. If implemented, many of the recommendations could marginally improve internal effectiveness or efficiency, or the level of service provided to applicants, without incurring any significant additional costs.

Recommendation No. XI-2. Conduct a Limited, High-Level Business Case Analysis of Potential Benefits, Costs, and Risks of a Document Management System (DMS)

The Medical Board should consider conducting a limited, high-level business case analysis of potential benefits and costs of a DMS. This analysis should include researching document management systems used by DCA or other California State Government agencies and departments, such as the Contractors State License Board. Additionally, the analysis should include obtaining information from potential vendors, but not necessarily development and issuance of a Request for Information (RFI) as suggested by HSC. The analysis should focus on identifying and quantifying, where practicable, potential efficiency and other improvements that might be achieved, developing order of magnitude estimates of costs to develop and maintain the system, and comparing the potential benefits with the estimated costs. Additionally, the analysis should include an analysis of significant risk factors associated with development and implementation of such a system. If supported, the Business Case Analysis can be used to support development of Feasibility Study Report (FSR), if needed.

Recommendation No. XI-3. Obtain Authorization to Convert Recently Established Limited-Term Positions to Permanent Status

Based on the limited, high-level analysis of historical Licensing Program workload and staffing levels completed as part of our assessment, it appears that the eight (8) new positions proposed in the 2010/11 BCP would fully restore positions lost earlier in the decade and also provide additional positions justified on the basis of increased workloads since that time. Additionally, given the nature of the medical profession and health care industry needs for additional licensed physicians, it is highly unlikely that application workloads will diminish over time. Finally, when positions are classified as limited-term, there is a greater risk of higher staff turnover as incumbents transfer to other positions rather than risk losing their job in the event the position expires. Therefore, we recommend obtaining authorization to convert the recently established limited-term positions to a permanent status as soon as practicable. We understand that these positions were converted to a permanent status effective July 1, 2010.

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Recommendation No. XI-3. Scale Back the Use of Retired Annuitants, Student Assistants, and Overtime, if Furloughs are Discontinued

As discussed above, the recent addition of eight (8) new limited-term positions appears to be sufficient to fully restore positions lost earlier in the decade and also provide additional capabilities to process the larger number of license applications now submitted. Therefore, the Licensing Program should be able to significantly reduce its use of retired annuitants and student assistants, and overtime. We understand that the Medical Board has begun implementation of this recommendation.

Recommendation No. XI-5. Conduct a Detailed Analysis of Licensing Program Workload and Staffing Requirements

The Licensing Program could potentially benefit from completion of a detailed analysis of Licensing Program workload and staffing requirements. Such an analysis could help Licensing Program management to (1) optimize the alignment of workload demands with available staffing capabilities and (2) determine how best to organize staff and needs for reclassification of existing positions, including determination of whether it would be beneficial to reclassify a rank and file position to the supervisory level to enhance management capabilities and further reduce supervisory spans of control. Implementation of this recommendation should be deferred pending appointment of a new Licensing Program Chief.

Recommendation No. XI-6. Develop an Integrated Framework for Planning and Managing Licensing Program Performance

Licensing Program management should develop an integrated framework for planning and managing Licensing Program performance that encompasses (1) establishing program goals and objectives, (2) developing plans, (3) monitoring operations, and (4) reporting results. The framework should be developed around a common set of quantified measures of outputs produced, resources used, service levels provided, and performance levels achieved.

Recommendation No. XI-7. Resume Audits of Licensee Compliance with CME Requirements

Audits of compliance with CME requirements are essential to ensure that licensee compliance levels do not deteriorate, and should be resumed as soon as practicable.

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October 12, 2010

Board Members
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

RE: Initial Response of the Health Quality Enforcement Section (HQE)
to the Medical Board Program Evaluation Conducted By Ben Frank
and HQE's Comprehensive Report to the Medical Board Regarding
Physician Discipline under the Vertical Enforcement Program

Dear Board Members:

Thank you for the opportunity to review the original Program Evaluation dated July 6, 2010, the draft Summary Report dated July 21, 2010, and the latest Summary Report dated August 2, 2010, prepared by Ben Frank, which document his findings, conclusions and recommendations following his review of the Medical Board's programs.¹

As you know, the Medical Board originally authorized its Executive Director "to undertake a comprehensive, independent evaluation of the Medical Board."² In this regard, the stated purpose of the evaluation was "to conduct an independent and unbiased review of the Medical Board's organizational structure and core programs to identify strengths and weaknesses of current operations and develop recommendations for improvements."³ That would soon change. Shortly after commencement of the evaluation, "it was jointly determined, in consultation with Medical Board management, that the primary focus of [the] assessment [would] be on (1) identifying and

¹ The original Program Evaluation dated July 6, 2010, will be referred to herein as "Frank Report I" followed by the page number. The draft Summary Report dated July 21, 2010, will be referred to herein as "Frank Report II" followed by the page number. Finally, the latest Summary Report dated August 2, 2010, will be referred to herein as "Frank Report III," followed by the page number. When referred to generally, all three reports will be referred to herein collectively as simply the "Frank Report."

² Frank Report I, at p. I-1; Frank Report II, at p. I-1; and Frank Report III, at p. I-1.

³ Frank Report I, at p. I-2; Frank Report II, at p. I-2; and Frank Report III, at p. I-2.

assessing the impacts of the VE Pilot Project^[4] on the Enforcement Program, (2) identifying and assessing the benefits provided from the increased expenditures for VE-related legal services, (3) identifying and assessing other factors contributing to deteriorating Enforcement Program performance, and (4) developing an *Enforcement Program Improvement Plan*.⁵

As a result of this joint determination, the *primary focus* of Mr. Frank's evaluation shifted away from the Medical Board's organizational structure and programs as specified in the original Request for Offers and, instead, centered on the Office of the Attorney General and, more specifically, on the Health Quality Enforcement Section (HQE). The joint determination of Mr. Frank and Medical Board management to conduct an evaluation of HQE, and its activities spanning over several years, was made without the knowledge, input or involvement of the Office of the Attorney General or HQE. Thereafter, Mr. Frank's evaluation of HQE was based on extremely limited information from HQE itself and, regrettably, the comprehensive, reliable statistical data provided by HQE to Mr. Frank at his request was virtually ignored. Additionally, notwithstanding representations that he would consult with me, as HQE's Senior Assistant Attorney General, at the conclusion of his evaluation, Mr. Frank did not do so. In short, the evaluation of HQE conducted by Mr. Frank was completed with little input from HQE, and reached the conclusion that the Medical Board's Enforcement Program is deteriorating largely for reasons attributed to HQE, with little or no assessment of the long-standing and unresolved problems within the Medical Board's Enforcement Program itself that continue to affect investigator performance and investigation completion timelines.⁶

The purpose of this response by HQE to the Frank Report is threefold. First, this response will identify and address some of the flaws in the Frank Report, demonstrating how some of its key findings, conclusions and recommendations are incorrect as a matter of fact, law or both. Had HQE been permitted to fully participate in the evaluation of its own activities, it is anticipated that these flaws could have been eliminated from the Frank Report before it was submitted to the Medical Board. Second, this response will present HQE's comprehensive report to the Medical Board, entitled "Physician Discipline under the Vertical Enforcement Program," based on the statistical data contained on the ProLaw database maintained by the Office of the Attorney General. As this report will demonstrate, while further improvement should definitely be pursued, the VE program has improved, and continues to improve, public protection of patients receiving medical services in California while, at the same time, protecting physicians from unwarranted or needlessly protracted investigations and prosecutions. Finally, this response will report on significant steps that HQE has already taken in its continuing efforts to further improve its own performance, and also present

⁴ "VE" refers to the "vertical enforcement and prosecution model" mandated by the Legislature in Government Code section 12529.6 which defines the manner in which allegations of unprofessional conduct by physicians and surgeons are to be investigated and, if warranted by the evidence, prosecuted by the Health Quality Enforcement Section. At this point, the VE program is not a "pilot program," having been repeatedly extended by the Legislature, nor is it referred to as such in Government Code section 12529.6.

⁵ Frank Report I, at p. I-3; italics original; footnote added; Frank Report II, at p. I-2; and Frank Report III, at p. I-2.

⁶ It should be noted that the Frank Report comes virtually on the heels of the Medical Board's Report to the Governor and the Legislature dated June 2009 (which was actually submitted later in 2009), wherein the Medical Board was statutorily required to "report and make recommendations . . . on the vertical enforcement and prosecution model created under Section 12529.6." (Gov. Code, § 12529.7.)

HQE's recommendations on important ways that the VE program can be further improved to address some of the long-standing, systemic problems within the Medical Board's Enforcement Program.

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- I. Flaws in the Frank Report;
- II. Physician Discipline under the Vertical Enforcement Program; and
- III. Important Steps HQE Has Taken to Improve its Own Performance, and HQE's Recommendations on How the Medical Board's Enforcement Program Can Be Further Improved.

I. Flaws in the Frank Report

1. The Statistical Basis of the Frank Report is Unreliable

The Frank Report relies almost entirely on information obtained from the Medical Board's Case Tracking System ("CAS"), which is a management information system shared by other agencies in the Department of Consumer Affairs. However, information regarding Medical Board investigations and prosecutions contained in the CAS system has long been criticized and continues, at times, to be unreliable. For example, almost six years ago, in November 2004, the Medical Board's Enforcement Monitor⁷ noted that the CAS system "suffers from numerous inadequacies and problems impeding MBC's licensing and enforcement programs, and undermining its public disclosure program."⁸ Later, in her Final Report in November 2005, the Enforcement Monitor specifically recommended that the Medical Board and HQE upgrade their information management systems, noting that "MBC is studying [management information systems] improvements with [the Department of Consumer Affairs]; ProLaw is now in use at HQE . . ."⁹ While HQE has fully implemented its ProLaw case management system, over the last six years the Medical Board continues to utilize the CAS system.

Indeed, the Frank Report itself specifically notes some of the significant problems that demonstrate the unreliability of information maintained by the Medical Board in the CAS system. For example, "it appears that some updates to CAS are not always consistently posted by District Office staff for various interim investigation activities, including activities involving: Medical records requests[,] Complainant and Subject interviews[,] [and] Medical

⁷ Business and Professions Code section 2220.1 provided for the appointment of a "Medical Board Enforcement Program Monitor" to monitor and evaluate "the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system." (Added by Stats. 2002, c. 1085, (Sen. Bill No. 1950), § 18; repealed by Stats. 2004, c. 909 (Sen. Bill No. 136), § 3, operative Jan. 1, 2006.)

⁸ Initial Report, Executive Summary, at p. ES-12.

⁹ Final Report, Conclusions and Recommendations for the Future, at p. 203.

Consultant case reviews.”¹⁰ There are other problems as well.¹¹ “In some cases CAS is updated to show when the activity commenced (e.g., requested medical records, requested or scheduled a Complainant or Subject interview, or submitted records for review by the Medical Consultant or a Medical Expert, but CAS is not updated to show when the activity was completed). In other cases CAS is updated only when the activity is completed, or not updated to show either initiation or completion of the activity.”¹² Notwithstanding these significant problems, the Frank Report relies, almost entirely, on information obtained from the CAS system.

On or about March 3, 2010,¹³ Mr. Frank requested statistical information from HQE covering multiple aspects and stages of Medical Board investigations and prosecutions covering the period of 2005 through and including 2009.¹⁴ On June 20, 2010, after much effort, HQE provided Mr. Frank with a comprehensive response to his requests for case specific information for each of the calendar years of 2005 through 2009.¹⁵ In total, HQE provided detailed case specific information to Mr. Frank on a total of 1,899 cases.¹⁶ Finally, the requested information was provided to Mr. Frank first in .pdf format, and then in Excel spreadsheets.

The Frank Report virtually disregards the reliable statistical information obtained from the ProLaw database, admitting that “with some isolated exceptions, [it] was not used.”¹⁷ The justifications offered for disregarding the information provided by HQE

¹⁰ Frank Report I, at p. I-8; see also Frank Report II, at p. I-4; and Frank Report III, at p. I-3 and I-4.

¹¹ For example, the Frank Report notes that the statistical measures of the average time elapsed to complete interim investigation activities “may not be representative of actual performance” and, further, that “[t]he measures related to obtaining [m]edical [r]ecords are especially limited.” (Frank Report I, at p. I-9.) With respect to procuring medical records, the Frank Report also notes that “[t]he Medical Board’s measures count the records as received irrespective of the completeness or quality of the records provided, and do not account for supplemental submissions.” (Frank Report I, at I-9; Frank Report II, at p. I-4; and Frank Report III, at p. I-4.)

¹² Frank Report I, at pp. I-8 and I-9.

¹³ The Frank Report states that a revised data request was submitted to HQE on March 9, 2010, but later claims the date was March 7, 2010. (Frank Report I, at p. I-11; Frank Report II, at p. I-5.) The date of this request is changed yet again in Frank Report III, this time to April 22, 2010. (Frank Report III, at p. I-6.)

¹⁴ Frank Report I, at p. I-10; Frank Report II, at p. I-5; and Frank Report III, at p. I-5.

¹⁵ The information for each case that was provided to Mr. Frank included: (1) the ProLaw matter number; (2) matter description; (3) investigation number; (4) type of administrative matter; (5) the date the matter was opened; (6) the date the matter was accepted for prosecution; (7) the date the pleading was sent to the Medical Board for filing; (8) the number of days between the date the matter was accepted for prosecution and the date the pleading was sent to the Medical Board of filing; (9) the date the pleading was signed by the Executive Director; (10) the number of days between the date the pleading was sent to the Medical Board for filing and the date the pleading was signed by the Executive Director; (11) the number of days between the date the pleading was sent the Medical Board for filing and the date the stipulated settlement was sent to the Medical Board; (12) where applicable, the date the matter was rejected for prosecution; and (13) if the case was rejected, the date it was returned to the Medical Board.

¹⁶ The 1,899 total cases are broken down per year as follows: CY 2005 - 409 cases; CY 2006 - 387 cases, CY 2007 - 354 cases, CY 2008 - 355 cases, and CY 2009 - 394.

¹⁷ Frank Report II, cover letter, at p. 3; see also Frank Report II, cover letter, at p. 3.

vary.¹⁸ Unfortunately, this is not the first time that reliable statistical information provided by HQE has been disregarded.

Accordingly, relying on the admittedly incomplete information obtained from the CAS system while, at the same time, disregarding the statistical information provided by HQE from the ProLaw database, calls into question the accuracy of the findings, conclusions and recommendations contained in the Frank Report.¹⁹

2. The Frank Report Does Not Assess the Single Most Important Cause for Investigation Completion Delays – Continuing High Investigator Vacancy Rates and Turnovers

The Frank Report documents, but does not assess in any meaningful fashion, the most significant flaw in the Medical Board's Enforcement Program, namely, the inability of the Medical Board's Enforcement Program to recruit and retain experienced investigators.²⁰ This long-standing, problem, which has been fully documented many times over the past decade, continues to have a significant negative impact on both investigator performance and investigation completion timelines.

In her Initial Report back in 2004, the Enforcement Monitor correctly observed that:

“Recruitment and retention problems plague personnel management at the Medical Board. Supervisors and field investigators uniformly report that valuable, experienced investigators are lost and well-qualified applicants go elsewhere because of salary disparities between the pay of the MBC and other agencies hiring peace officers. MBC regularly loses in competition with other agencies over highly qualified investigative personnel.”²¹

Later, in her Final Report in 2005, the Enforcement Monitor again noted that:

“Compounding the loss of 19 sworn investigator positions during the 2001–04 hiring freeze, MBC continues to lose highly trained and experienced investigators and well-qualified applicants to other agencies because of disparities between MBC investigator salaries and those at other agencies

¹⁸ Originally, the reasons for this decision were reportedly that “much of the data provided by HQE was not provided until near the conclusion of the assessment,” and “much of the data provided was incomplete and of limited utility . . .” (Frank Report II, cover letter, at p. 3.) Those reasons were later revised to add that “much of the data was *unavailable, incomplete and of limited utility.*” (Frank Report III, cover letter, at p. 3; italics added.) It is unclear how the statistical information provided by HQE to Mr. Frank was “unavailable.”

¹⁹ While the Frank Report states that “[w]e filtered, compiled, summarized, and analyzed the data provided as needed for purposes of this study” (Frank Report II, at p. I-3; Frank Report III, at p. I-3), there is no description of the methodology that was used to compile the statistics presented in the report.

²⁰ Frank Report I, at pp. VI-44 and VI-45; Frank Report II, at p. VI-19; Frank Report III, at p. VI-19 and VI-20.

²¹ Initial Report, Executive Summary, at p. ES-24.

hiring peace officers. The Monitor urged MBC to continue its efforts to reinstate its lost enforcement program positions and to upgrade the salaries of its investigators commensurate with the competition.

“ . . .

“The related problems of investigator recruitment and retention can ultimately be addressed by full implementation of the integrated vertical prosecution system envisioned in SB 231. Upon a showing of the success of the vertical prosecution system, and with the Legislature’s affirmative approval after review of the 2007 report, the transfer of the MBC investigators to HQE will eventually result in special agent status for MBC’s sworn personnel and a concomitant increase in pay and career recognition.^[22] Morale and productivity will be boosted, and MBC’s ability to recruit and retain highly qualified investigators will be dramatically improved.”²³

Very little has changed in the last five years. Simply stated, the Enforcement Monitor’s description of the inability of the Medical Board to successfully recruit and retain experienced investigators is as true today as it was in 2005.

The Enforcement Monitor’s Final Report in 2005 also clearly shows that the long-standing morale and productivity problems that have continually plagued the Medical Board Enforcement Program, and its inability to recruit and retain highly qualified investigators, unquestionably predate the January 1, 2006, implementation of the “vertical prosecution and enforcement model” mandated by the Legislature in Government Code section 12529.6. Less than one year ago, HQE identified the top three reasons for investigation completion delays as:

“Investigator vacancy rate of 14%.^[24] The absence of trained, experienced investigators appears to be the principal reason undermining the MBC’s ability to complete investigations on a timely basis.

“The constant turn-over of investigators at the MBC results in a significant loss of productivity as pending investigations are transferred from one investigator to another and, often, from one district office to another as well. This loss of productivity also continues for a considerable period of time as

²² At the last minute, Senate Bill 231 was changed to eliminate the contemplated transfer of Medical Board investigators to the Office of the Attorney General. As a result, the anticipated increase in pay and career recognition that would have accompanied the proposed transfer never happened.

²³ Final Report, Executive Summary, at p. ES-20; footnote added.

²⁴ As of late 2009, the investigator vacancy rate has now reportedly climbed to 16%. (Frank Report I, p. II-51; Frank Report II, at II-15; Frank Report III, at p. II-16.)

newly hired investigators go through the Academy and then complete their on-the-job training.

“Some of the most experienced and productive investigators have been reassigned to train new investigators, rather than having the Supervising Investigator I in each district office conduct this training for new hires. As a result, these experienced and productive investigators have carried a reduced investigation caseload, thus contributing to additional delays in the MBC’s timely completion of investigations.”²⁵

The vacancy rate of experienced investigators fluctuates but continues today. For example, two experienced and productive Medical Board investigators have recently indicated their intention to transfer to other state agency investigator positions in order to receive a promotion to the “senior investigator” classification. New investigators will ultimately have to be hired to fill those positions, then go through the Academy and finally complete their on-the-job training. Approximately one year after their hire date, they will become fully productive as Medical Board investigators, only to leave for desired promotions, or be recruited by other state agencies, which will start the process all over again.

The Frank Report correctly notes “[i]t is unlikely that Enforcement Program performance will improve unless Investigator workforce capability and competency levels are stabilized and, eventually restored to the levels that existed earlier in the decade.”²⁶ This is true, as it has been for almost a decade. At the same time, however, the Frank Report contains no statistical analysis of the continuing impact that the high investigator vacancy rate and turn-over continues to have on investigator performance and investigation completion timelines.²⁷ To better assess the impact of investigator vacancy rates on the completion of investigations, on May 3, 2010, HQE requested from MBC substantially the same data MBC provided to Mr. Frank. MBC staff is currently working to produce this data.

Recognizing that some investigations were simply taking too long to complete, in July 2009, the Enforcement Program’s Executive Management created a new “Case Aging Council” whose tasks include, among other things, the review of aging investigations in order to identify and resolve the various reasons for investigation completion delays in those matters.

²⁵ Response of the Health Quality Enforcement Section to the Medical Board of California’s Report to the Governor and Legislature (Second Draft 6-7-09), at p. 3; footnotes added.

²⁶ Frank Report I, at p. VI-44; Frank Report II, at p. VI-19. In Frank Report III, this finding was significantly changed to read as follows: “It is unlikely that Enforcement Program performance will improve significantly unless *Investigator workforce capability levels are stabilized.*” (Frank Report III, at p. VI-19; italics added.)

²⁷ For example, the Frank Report contains no analysis of the impact of the constant reassignment of investigations from one investigator to another, or of the more recent development of investigations being transferred by Medical Board management from one District Office to another. This latter practice is particularly disruptive to the orderly and timely completion of investigations since it requires an investigator remotely located from the event or incident to familiarize him/herself with the case, and then to complete the investigation. Such transfers of investigations are also routinely ordered without any advance notification to, or input from, HQE, which, in turn, results in corresponding shifts in HQE caseloads that are often inconsistent with HQE staffing.

Greater efficiency and productivity by investigators will not, however, directly address the root cause for aging investigations, namely, the inability of the Medical Board to recruit and retain experienced investigators.

While only the Medical Board can solve the high investigator vacancy and turnover problems that have plagued its Enforcement Program for almost a decade, HQE has offered assistance in an effort to ameliorate the effects of these problems. Beginning in 2006 and continuing to 2009, HQE has offered to provide investigator services to the Medical Board in order to help reduce investigation completion delays. While HQE's offer has not been accepted, HQE recommends that the Medical Board consider this option, especially if no reasonable alternative presents itself.

3. The Frank Report Does Not Assess the "Chronic Weakness" in the Medical Board's Enforcement Program – its Expert Reviewer Program

The Frank Report mentions, but again fails to analyze in any meaningful fashion, the second most significant flaw in the Medical Board's Enforcement Program, namely, the "chronic weakness in the Medical Board's Expert Reviewer Program . . ." ²⁸ The continuing debilitating effect of this "chronic weakness" in the Medical Board's Enforcement Program simply cannot be overstated.

Both Frank Report I and Frank Report II correctly state that "in recent years little attention has been given to chronic weaknesses in the Medical Board's Expert Reviewer Program, except to authorize an increase in the billing rate for review services from \$100 to \$150 per hour." ²⁹ Those chronic weaknesses are identified as "deficiencies involving the insufficient availability of Medical Experts, particularly in specialized areas, the extended timeframes needed by the Medical Experts to complete their reviews, the quality of the Medical Expert's reports, and the effectiveness of the Medical Experts providing testimony as an Expert Witness at a hearing (when needed)." ³⁰ However, Frank Report III deletes these stated deficiencies in their entirety and, instead, simply recommends that the Board's policy restricting the use of experts to no more than three times per year be eliminated. ³¹ While elimination of this board-imposed restriction, which does not similarly restrict defense counsel, will make the most qualified experts more readily available, it will not, standing alone, sufficiently address all of the deficiencies correctly noted in Frank Reports I and II.

Expert opinions rendered by a Medical Board expert, following his/her review of the evidence gathered during the investigation, are the very heart of a quality-of-care case. The decision to recommend the filing of an accusation against a physician in a quality-of-care

²⁸ Frank Report I, at p. VI-44.

²⁹ Frank Report I, at p. VI-44; Frank Report II, at p. VI-18.

³⁰ Frank Report I, at p. VI-44; Frank Report II, at p. VI-18.

³¹ Frank Report III, at p. VI-19.

case rests, in large part, on the expert opinions provided to the assigned HQE deputy attorney general. And, as has often been demonstrated in the past, these cases will stand, or fall, based on the quality and soundness of those expert opinions.

It must be remembered that HQE has as strong an interest in protecting physicians against the unwarranted filing of disciplinary charges against their medical licenses as it does in the fair prosecution of those cases where, based on the evidence, disciplinary charges are warranted. It is for this reason that the quality and soundness of expert opinions submitted to HQE in quality-of-care cases are so very important.

When meeting with an expert witness to prepare her or him for the hearing, HQE deputy attorneys general are often informed that the expert witness has never testified before and that the upcoming hearing will be their first time doing so. Following such meetings, HQE deputy attorneys general occasionally return to the Attorney General's Office following such meetings with serious concerns regarding the expert's understanding the case, ability to articulate the basis for his/her expert opinions, or willingness to testify at the upcoming hearing.

HQE has brought up with Medical Board executive staff the continuing problems that exist within the Medical Board's Expert Review Program. Years ago, it was reportedly the practice of the Medical Board to meet with prospective experts to review their qualifications and to determine whether, in addition to meeting the minimum requirements,³² they were sufficiently qualified to serve as an expert in the Medical Board's Expert Reviewer Program. Unfortunately, that procedure was discontinued long ago. In late 2009, HQE recommended that the Medical Board reinstate this procedure as part of the selection process for Medical Board experts and, further, offered to have a Supervising Deputy Attorney General participate on the interview panel.³³ To date, HQE's recommendation and offer have not been accepted.³⁴

³² The minimum requirements for a physician to participate as an expert in the Medical Board's Expert Reviewer Program are: (1) possession of a current California medical license in good standing with no prior discipline, no Accusation pending, and no complaint history within the last three years; (2) Board certification in one of the 24 ABMS specialties (the American Board of Facial Plastic & Reconstructive Surgery, the American Board of Pain Medicine, the American Board of Sleep Medicine and the American Board of Spine Surgery are also recognized) with a minimum of three years of practice in the specialty area after obtaining Board certification; and (3) have an active practice (defined as at least 80 hours a month in direct patient care, clinical activity, or teaching, at least 40 hours of which is in direct patient care). (See http://www.mbc.ca.gov/licensee/expert_reviewer.html)

³³ In addition to careful selection of only those qualified to serve as experts, the Medical Board should seriously consider two additional improvements to the program as well. First, consideration should be given to increasing the compensation (currently set at \$150 per hour for case review/consultation and \$200 for providing expert testimony) in order to attract more qualified expert reviewers. Simply stated, a physician should not have to suffer an economic penalty for agreeing to participate as a Medical Board expert. Second, before they are assigned to review any case, physicians accepted by the Medical Board's Expert Reviewer Program should be required to attend a comprehensive training conference to be conducted, in part, by HQE in order to ensure that they are adequately trained and prepared to fulfill their duties and responsibilities as an expert for the Medical Board.

³⁴ The Medical Board recently published an advertisement seeking applications from physicians who meet the minimum qualification and currently practice in California and are interested in providing expert reviewer services for the Board. (See Medical Board Newsletter, Vol. 115, July 2010, at p. 7.)

4. The Frank Report Does not Assess Another Leading Cause of Investigation Completion Delays – the Unavailability of Medical Consultants in the District Offices

The Frank Report mentions, but again fails to analyze in any meaningful fashion, another flaw in the Medical Board's Enforcement Program, namely, the unavailability of Medical Consultants in the District Offices.³⁵

In her Initial Report in 2004, the Enforcement Monitor observed that:

“Medical consultants play a vital and varied role in the Medical Board’s complaint handling and investigation process. The Monitor believes problems of medical consultant availability, training and proper use contribute significantly to lengthy investigations and inefficient operations.”³⁶

Unfortunately, as the Frank Report correctly notes, nothing has changed in the last six years. “Since publication of the Enforcement Monitor’s reports there has been very little change in the availability of Medical Consultants.”³⁷ The Frank Report also notes that “Needs in this area have not been emphasized.”³⁸ This leading cause for investigation completion delays simply must be addressed.

Medical consultants across the State continue to be unavailable in the District Office, often for the majority of the work week. Investigations are stalled, subject interviews delayed, medical records are unreviewed, medical consultant memorandums remain unwritten, and the whole process grinds to a halt as the entire VE team awaits the return of the Medical Consultant to the District Office. As noted by the Enforcement Monitor years ago, the unavailability of Medical Consultants contributes significantly to lengthy investigations and inefficient operations. Unfortunately, very little has changed in the last six years to correct this continuing cause of investigation completion delays.³⁹

³⁵ Frank Report I, at pp. VI-42 and VI-43; Frank Report II, at pp. VI-17 and VI-18; Frank Report III, at pp. VI-16 and VI-18.

³⁶ Initial Report, at p. 144; emphasis added.

³⁷ Frank Report I, at p. VII-43; Frank Report II, at p. VI-18; Frank Report III, at p. VI-18. The Frank Report states that “no additional funding for Medical Consultants was included in th[e] package [that established the VE program or in the 2010/11 budget].” (Frank Report I, at VI-43; Frank Report II, at p. VI-18; Frank Report III, at p. VI-18.) However, as far back as 2005, it was contemplated that a portion of the increased initial and biennial fees paid by licensees would be used for this purpose. Specifically, in her Final Report, the Enforcement Monitor noted that “SB 231 (Figueroa) increases initial and biennial renewal fees by 30%. MBC management staff plans to use some of these additional funds to increase medical consultant hours.” (Final Report, at p. 87.) It is unknown whether that was ever done.

³⁸ Frank Report II, at p. VI-18; Frank Report III, at p. VI-18.

³⁹ The Medical Board recently submitted a budget augmentation request to address this problem, but this request has not been approved.

5. The Frank Report Does Not Recognize HQE's Legislatively-Mandated Oversight Responsibility Over Investigations and Prosecutions of Medical Board Cases

HQE agrees that investigation completion delays continue to be a significant problem in the Medical Board's Enforcement Program. However, rather than analyzing the impact of the most significant reasons for those delays (i.e., the continuing high investigator vacancy rates and turnover, shortage of qualified experts, and unavailability of medical consultants), the Frank Report concludes that the higher level of involvement by HQE deputy attorneys general at the investigation stage, mandated by the Legislature in Government Code section 12529.6, is the real cause for these delays. Again, this is error.

At the outset it is important to recognize that the Legislature has created a partnership between the Medical Board's Enforcement Program and the HQE Section of the Office of the Attorney General. It is also important to recognize that HQE has a legislatively-mandated oversight responsibility over investigations and prosecution of Medical Board cases. Over the last two decades, the Legislature has increased HQE's oversight role, gradually shifting more and more responsibility to HQE in the process. In 1991, the Legislature created HQE within the Office of Attorney General and charged it with "primary responsibility" to prosecute administrative disciplinary proceedings before the Medical Board.⁴⁰ Later, in 2006, the Legislature expanded HQE's role by shifting primary responsibility for investigations of alleged misconduct by physicians and surgeons to HQE.⁴¹ At the same time, the Legislature also mandated that those investigations be conducted using the "vertical prosecution model"⁴² under which the assigned HQE deputy attorney general is required to direct⁴³ the investigator who is "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."⁴⁴

As part of its oversight responsibility, HQE is responsible for ensuring that no physician is charged with unprofessional conduct unless those charges are supported by clear and

⁴⁰ Gov. Code, § 12529, as added by Stats. 1990, c. 1597 (S.B. 2375).

⁴¹ Gov. Code, § 12529.5, as added by Stats. 2005, c. 674 (S.B. 231).

⁴² In 2008, the model was renamed the "vertical enforcement and prosecution model." (Gov. Code, § 12529.6, subd. (a), as amended by Stats. 2008, c. 33 (S.B. 797).

⁴³ HQE has long taken the position that the direction authority conferred under Government Code section 12529.6 does not include supervision authority. Said another way, while the assigned HQE deputy attorney general is statutorily authorized and required to direct the assigned investigator in the accumulation of the required evidence, he or she does not actually supervise the investigator which, instead, is the responsibility of the supervising investigator in the District Office. Consistent with HQE's position, in 2008, Government Code section 12529.6 was amended to clarify that the investigator works under "the direction but not the supervision" of the assigned HQE deputy attorney general.

⁴⁴ Gov. Code, § 12529.6., subd. (a), as added by Stats. 2005, c. 674 (S.B. 231).

convincing evidence to a reasonable certainty.⁴⁵ In exercising that responsibility, whenever an HQE deputy attorney general concludes that an investigation has not produced clear and convincing evidence of any violation of the Medical Practice Act, he/she issues a memorandum declining to accept the case and directs that the investigation be closed. This cannot be a shared responsibility between the assigned investigator and the HQE deputy attorney general. Rather, it is a legal determination, made as part of the practice of law which only a member of the State Bar of California can make, and part of HQE's oversight role over Medical Board investigations to ensure that only meritorious cases are filed. The prevention of unwarranted investigations and prosecutions is an important part of HQE's oversight role which is especially important today, since many of the Medical Board's new investigators lack significant experience in the investigation of Medical Board cases.

Apparently, without recognizing the foregoing, the Frank Report suggests that "the statutes governing Vertical Enforcement [be amended] to clarify the Medical Board's [investigators] sole authority to determine whether to continue an investigation."⁴⁶ The only manner by which that could be accomplished would be for the Legislature to overhaul the various statutes that currently govern the investigation and prosecution of Medical Board cases, and return the primary responsibility for investigations of allegations of misconduct by physicians and surgeons to the Medical Board investigators.

Additionally, the Frank Report also recommends that "independent panels [be established] to review all requests for supplemental investigations and all decline to file cases."⁴⁷ It is further recommended that the Chief of Enforcement and HQE Senior Assistant Attorney General be "advise[d] . . . as to the results of their review, including recommended disposition of the matter."⁴⁸ Again, this recommendation does not recognize that the legal determination that further evidence is required in order to properly evaluate a case, and the legal determination declining to file charges where not warranted by the evidence cannot be a shared responsibility between HQE and the Medical Board investigators. Rather, such legal determinations constitute the practice of law which only a member of the State Bar of California can make, and are a part of HQE's oversight role over Medical Board investigations to ensure that only meritorious cases are filed.

Finally, the Frank Report recommends the creation of a "new HQES Services Monitor" to, among other things, "continuously monitor and evaluate HQE's performance and costs, resolve conflicts that arise between the agencies, and prepare and provide regular reports to the Executive Management, the Medical Board, and oversight and control agencies."⁴⁹

⁴⁵ *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856 [holding that "the proper standard of proof in an administrative hearing to revoke or suspend a doctor's license should be *clear and convincing proof to a reasonable certainty* and not a mere *preponderance of the evidence*." (Italics original)].

⁴⁶ Frank Report I, at p. X-7; Frank Report II, at p. X-2; Frank Report III, at p. X-2.

⁴⁷ Frank Report I, at ES-3; Frank Report II, at p. VII-17; Frank Report III, at p. VII-21.

⁴⁸ Frank Report I, at ES-3; Frank Report II, at p. VII-17; Frank Report III, at p. VII-21.

⁴⁹ Frank Report I, at p. ES-4; Frank Report II, at p. X-5; Frank Report III, at p. X-5.

However, both HQE and the Medical Board have already developed policies and procedures for the timely resolution of any conflicts that may arise.⁵⁰ More importantly, as HQE's Senior Assistant Attorney General, it continues to be my responsibility within the Department of Justice to monitor and evaluate HQE's performance. Accordingly, issues, questions or concerns regarding the performance of any HQE deputy attorney general have been, and should continue to be, brought to my immediate attention for investigation and resolution.

6. The Frank Report Does Not Mention or Assess, the Significant Travel Burden Placed on HQE Deputy Attorneys General Under the VE Program

In 2005, Senate Bill 231 (Figueroa) originally contemplated the transfer of Medical Board investigators to Office of the Attorney General which would, in turn, would have brought about a consolidation of the investigators and HQE deputy attorneys general in the same offices in many parts of the state. However, the contemplated transfer of investigators to the Attorney General's Office never happened and, instead, both the Medical Board and HQE were left to implement the VE program with their respective personnel located in offices remotely located from each other.⁵¹

Originally, in late 2005/early 2006, it was agreed that both the Medical Board and HQE would share the travel burden created by the VE program. Under this agreement, investigators would travel to the Office of the Attorney General, as necessary, and HQE deputy attorneys general would travel to the District Office, as necessary. Unfortunately, since the very beginning of the program, the travel burden has fallen almost entirely on HQE deputy attorneys general who are required to travel to District Offices to meet with investigators, review evidence, participate in witness and subject interviews, and complete a myriad of other tasks and responsibilities.+

To illustrate the extent of the significant travel burden placed on HQE under the VE program, the following table lists the distance (in miles), driving time (in minutes), and cost per hour (based on a per hour cost of \$170.00) for travel by HQE deputy attorneys general from the Office of the Attorney General in Los Angeles to each of the five Medical Board District Offices within its geographical area of responsibility.⁵²

⁵⁰ See Vertical Prosecution Manual (Second Edition, November 2006) at Section XXII, page 12, entitled "Disagreements."

⁵¹ Recognizing the geographical obstacles, the Legislature has mandated that "[t]he Medical Board shall . . . [e]stablish an 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." (Gov. Code, § 12529.6, subd. (e)(3).)

⁵² Distances and times are based on data obtained from <http://www.mapquest.com> on August 9, 2010. The cost per hour for attorney services set by the Department of Justice for the fiscal year 2009/10 is \$170.00. (DOJ Administrative Bulletin No. 09-25, issued June 26, 2009.)

Travel By Office of the Attorney General

Destination: MBC District Office	Round trip distance (miles)	Round trip driving time (minutes)	Cost of Attorney Time for One Round Trip
Valencia	77.8	90	\$255
Glendale	22.48	32	\$90.67
Diamond Bar	53.16	66	\$187
Cerritos	41.04	56	\$158.67
Tustin	71.7	88	\$249.33

In order to save attorney hours, improve efficiency, and significantly reduce travel costs to the Medical Board, HQE has previously proposed the following solution to the geographical obstacles created by the VE program. In HQE’s response to the Medical Board’s 2009 Report to the Governor and Legislature, we recommended:

“Video Conferencing: Under the VE Model, HQE has assumed the burden of the majority of required travel statewide between the various Attorney General’s Offices and MBC district offices. As a result, DAGs spend hundreds of hours a year traveling on California freeways in order to confer with investigators, review documents and attend interviews. Implementation of a video conferencing network statewide would eliminate the necessity of some of this required travel, reduce the number of attorney hours expended driving rather than performing legal work, provide a convenient method for investigators and DAGs to readily confer when more than a simple telephone call is required and, from an environmental standpoint, would reduce the negative impact such travel places on the environment overall. HQE recommends that HQE and MBC work together to implement a video conferencing network statewide to further improve the VE program.”⁵³

To date, HQE’s video conferencing recommendation has not been accepted by the Medical Board. HQE recommends that the Medical Board consider accepting this recommendation, especially if no reasonable alternative presents itself.

⁵³ Response of the Health Quality Enforcement Section to the Medical Board of California’s Report to the Governor and Legislature (Second Draft 6-7-09), at p. 2.

7. The Frank Report's Allegation of "Potential Overcharges" by HQE is Unsupported by Evidence, and Raised Outside of the Established Procedure and Appropriate Forum for Addressing Such Questions, Concerns and Issues

The Frank Report claims to have "identified potential internal control issues involving HQES' billings to the Medical Board, and potential overcharges for HQES services."⁵⁴ The "evidence" for this serious allegation appears to be the Frank Report's identification of "two (2) cases in which HQE Attorneys appear to have misreported a significant portion of their time during 2008/09."⁵⁵ In both cases, the "evidence" consisted, in part, of a Medical Board supervising investigator expressing his/her opinion to Mr. Frank that "the time charges appeared to be significantly overstated."⁵⁶ It hardly seems necessary to state that the opinions of supervising investigators, one of whom has admitted "that she didn't have complete knowledge of other activities in which the Lead Prosecutor might have been involved during these periods," is not the type of evidence that responsible persons rely upon to make such a serious allegation. Also, in one of the two cases, an HQE Supervising Deputy Attorney General offered to research the issue for Mr. Frank "and provide additional information that would account for all the time charged."⁵⁷ However, Mr. Frank declined to ask for that research "because further investigation of this issue was outside of the scope of our assessment."⁵⁸

Notwithstanding the lack of evidence to support such a serious allegation, the Frank Report nevertheless states that "during 2008/09, and possibly in some prior years and subsequently, the Medical Board may have been charged for some time that was not spent on Medical Board matters."⁵⁹

Historically, any questions, concerns or inquiries regarding the billing of any HQE deputy attorney general has been brought to my attention by the Executive Director or Chief of Enforcement. The precise billing(s) that are under examination are identified and the matter is referred to the appropriate Supervising Deputy Attorney General to investigate the matter, review the case file, evaluate the billing, and report back to me. Once all the appropriate information has been gathered, and a determination has been made whether any adjustment is required, I contact the Executive Director or Chief of Enforcement to report my findings and the matter is appropriately resolved, with or without an adjustment to the identified

⁵⁴ Frank Report I, at p. III-1; Frank Report II, at p. III-4; Frank Report III, at p. III-4.

⁵⁵ Frank Report I, at p. III-8.

⁵⁶ Frank Report I, at p. III-9.

⁵⁷ Frank Report I, at p. III-9.

⁵⁸ Frank Report I, at p. III-9. It is difficult to understand how alleging potential overcharges to the Medical Board by HQE based on two cases is within the scope of the Frank Report's assessment but, at the same time, receiving additional information in one of those cases that would account for all the time charged is not.

⁵⁹ Frank Report I, at p. III-13.

billing. This process, which has been used successfully for years, continues to be the established procedure and the appropriate forum to address any billing questions, concerns or inquiries.⁶⁰ Indeed, the present executive director recently availed herself of this procedure to discuss and resolve a billing matter.

The speculation of “potential overcharges” by HQE contained in the Frank Report is both unfounded and inappropriately raised outside the established procedure and appropriate forum for addressing billing questions, concerns or inquiries. Accordingly, HQE requests that it be withdrawn from the Frank Report and, if there are any questions, concerns or inquires regarding any billing by any member of HQE, such matters should be brought to my immediate attention for investigation and resolution.

Lastly, it should be noted that, each month, the Case Management Section of the Division of Administrative Services of the Office of the Attorney General provides each HQE Supervising Deputy Attorney General with a report regarding the billing of each HQE deputy attorneys general under his or her supervision. Supervising Deputy Attorneys General are expected to review those billings in order to ensure appropriate billing. According to the Frank Report, surprisingly, HQE’s monthly billings to the Medical Board “are not reviewed by Medical Board staff, except at an aggregate level as needed for budget tracking purposes.”⁶¹ HQE urges Medical Board staff to review HQE’s monthly billing and, if there are any questions, concerns or inquiries regarding any of those billings, to bring the matter to my immediate attention in the appropriate forum for investigation and resolution.

In conclusion, in the section above, HQE identified and addressed some of the flaws in the Frank Report, explaining how some of its key findings, conclusions and recommendations are incorrect as a matter of fact, law or both. Turning now from the Frank Report, in the following section, HQE will present an accurate picture of “Physician Discipline under the Vertical Enforcement Program” for the years of 2005 through 2009, based on the reliable statistical information contained in the ProLaw database.

II. Physician Discipline under the Vertical Enforcement Program

In order to assess the actual state of physician discipline in California for the period of 2005 through 2009, it is important to first identify the key statistical measures that will provide the most accurate assessment, and then present those statistical measures in a format that the reader can quickly and easily review to obtain the necessary information. Accordingly, HQE’s report to the Medical Board on the state of physician discipline in California for the period of 2005 through 2009 will present statistical information on the following five key statistical measures:

⁶⁰ This is the same process utilized by Dave Thornton, in his capacity as Chief of Enforcement and Executive Director, to address billing questions.

⁶¹ Frank Report I, at p. III-13.

1. Average number of days from date of receipt of complaint at the Medical Board District Office to the date the investigation is closed, either for insufficiency of evidence, or because the case has been accepted for prosecution;
2. Average number of days from the date the case is accepted by HQE for prosecution to the date the accusation is sent to the Medical Board for filing;
3. Average number of days from the date the case is accepted for prosecution by HQE to the date the case is ultimately resolved at the administrative level, either by way of a stipulated settlement or decision following litigation;
4. Average number of days from date of receipt of complaint at the Medical Board District Office to the date the case is ultimately resolved at the administrative level by stipulated settlement or decision; and
5. Disciplinary outcomes under the VE Program.

The **first key statistical measure** is the average number of days from date of receipt of complaint at the Medical Board District Office to the date the investigation is closed, either for insufficiency of evidence, or because the case has been accepted for prosecution. This statistical measure allows the Medical Board to accurately determine the overall length of time it has taken for the Medical Board's Enforcement Program to complete investigations from the date the consumer complaint is first received at the District Office to the date the investigation is closed or accepted for prosecution for all Medical Board cases from 2005 to 2009.

Average Number of Days from "Received at District Office" to "Matter Closed"

Calendar Year	2006	2007	2008	2009
Statewide	430.55	419.12	392.66	259.60

This first key statistical measure shows that, since implementation of the VE program on January 1, 2006, to the end of the calendar year 2009, there has been an overall 39.7% statewide reduction in the average number of days from date of receipt of complaint at the Medical Board District Office to the date the investigation is closed, either for insufficiency of evidence, or because the case has been accepted for prosecution.⁶²

The **second key statistical measure** is the average number of days from the date the case is accepted by HQE for prosecution to the date the accusation is sent to the Medical Board for filing. This statistical measure allows the Medical Board to assess how long it has taken HQE, statewide, to prepare proposed accusations for the period of 2005 to 2009.

⁶² The methodology utilized for this first key statistical measure is as follows: Using the "Opened" date in Prolaw for each year, average number of days was calculated from the date the consumer complaint was "Received at District Office" to the date "Matter Closed." "Matter Closed" included cases that were: (1) Closed: No Violation; (2) Closed: Insufficient Evidence; (3) Accepted for Prosecution; or (4) Citation or PLR issued. The following cases were omitted from the calculations above: (1) Closed: pending criminal resolution; (2) Closed: subject entered into Diversion; (3) Closed: unlicensed individual; (4) Closed: statute of limitations expired; and Non-MBC cases. Calculations were done using matters that had been resolved.

**Average Number of Days from “Accepted for Prosecution” to “Pleading Sent”
 Accusations Only**

Calendar Year	2005	2006	2007	2008	2009
Los Angeles	76.98	106.2	87.74	48.28	60.42
San Diego	97.3	89.4	59.67	72.63	50.55
Sacramento	64.53	82.77	56.64	89	104.5
San Francisco	39.53	35.44	27.91	44.71	36.48
Statewide	69.79	75.36	54.87	58.5	53.19

As the above chart shows, since implementation of the VE program on January 1, 2006, through the end of the calendar year 2009, HQE has reduced its overall average filing time from 69.79 days to 53.19 days. This represents an overall 24% statewide reduction in filing times since implementation of the VE program.⁶³

When cases that involve a combined Accusation/Petition to Revoke Probation are reviewed for the period of 2005 through 2009, the statistical improvement is even greater.

**Average Number of Days from “Accepted for Prosecution” to “Pleading Sent”
 Accusations/Petitions to Revoke Probation Only**

Calendar Year	2005	2006	2007	2008	2009
Los Angeles	120	88.5	68.5	55.33	69.43
San Diego	61.54	93.67	104.4	23	25
Sacramento	137	131.5	22	19	49.5
San Francisco	8	33	2	55.4	18.75
Statewide	88.44	95.07	68.5	40.93	42.63

When cases that involve Accusations only are combined with the cases involving Accusations/Petitions to Revoke Probation for the period of 2005 through 2009, the statistical improvement is likewise clearly shown.

⁶³ The methodology utilized for this second key statistical measure is as follows: Using the “Opened” date in Prolaw for each year, the average number of days was calculated from the date the case was “Accepted for Prosecution” to the date “Pleading Sent” to the Medical Board for filing. Administrative cases that were initially “Accepted for Prosecution,” only to be reviewed and returned to the Medical Board District Office for additional investigation, have been calculated separately deleting the time period of investigation. The cases reflected in the chart include out-of-state discipline cases. Calculations were done using matters that had been resolved.

**Average Number of Days from “Accepted for Prosecution” to “Pleading Sent”
 Accusations and Accusations/Petitions to Revoke Probation Combined**

Calendar Year	2005	2006	2007	2008	2009
Statewide	71.54	76.51	55.47	57.5	52.45

Finally, when all of the various types of administrative cases are combined for the period of 2005 through 2009, the statistical improvement is again clearly shown.⁶⁴

**Average Number of Days from “Accepted for Prosecution” to “Pleading Sent”
 All Administrative Matters**

Calendar Year	2005	2006	2007	2008	2009
Los Angeles	72.7	97.8	76.95	45.11	54
San Diego	87.5	85.83	65.92	63.52	47.27
Sacramento	65	73.75	46.65	80.15	88.56
San Francisco	39	33.39	26.81	45.65	35.46
Statewide	67.5	71.03	54.28	54.7	49.48

The following **third key statistical measure** is the average number of days from the date the case is accepted for prosecution by HQE to the date the case is ultimately resolved at the administrative level, either by way of a stipulated settlement or decision following litigation. This statistical measure allows the Medical Board to accurately determine the overall length of time it has taken HQE to complete the prosecution of physician discipline cases at the administrative level, statewide, from 2005 to 2009.

**Average Number of Days from “Accepted for Prosecution” to “Decision Signed by Client”
 Accusations and Accusations/Petitions to Revoke Probation**

Calendar Year	2005	2006	2007	2008	2009
Statewide	496.82	455.22	403.61	341.51	263.90

As the above chart clearly shows, since implementation of the VE program on January 1, 2006, through the end of the calendar year 2009, there has been an overall 47% statewide reduction in the length of time it has taken to complete and entire investigation and, if warranted by the evidence, the entire administrative disciplinary process, for all Medical Board cases from 2005 to 2009.⁶⁵

⁶⁴ The administrative matters included in this calculation include the following: (1) Interim Order of Suspension cases; (2) Penal Code Section 23 appearances; (3) Business and Professions Code section 820 cases; (4) Petitions to Compel Competency Examination cases; (5) Accusation cases; (6) Accusation and Petition to Revoke Probation cases; (7) Petitions to Revoke Probation cases; and (8) Statement of Issues cases. Automatic suspension orders were not included in this calculation. Calculations were done using matters that had been resolved.

⁶⁵ The methodology utilized for this third key statistical measure is as follows: Using the “Opened” date in Prolaw for each year, the average number of days was calculated from date the case was “Accepted for Prosecution” to the date “Decision Signed by Client.” Every effort was made to delete duplicate cases and multiple administrative matters that were consolidated into one Decision signed by the client. In addition, administrative cases that were initially “Accepted

The **fourth key statistical measure** is average number of days from date of receipt of complaint at the Medical Board District Office to the date the case is ultimately resolved at the administrative level by stipulated settlement or decision. This statistical measure allows the Medical Board to accurately determine the overall length of time it has taken to complete the entire investigation and, if warranted by the evidence, the entire administrative disciplinary process for all Medical Board cases from 2006 to 2009.

**Average Number of Days from “Received at District Office” to “Decision Signed by Client
 Accusations and Accusations/Petitions to Revoke Probation**

Calendar Year	2006	2007	2008	2009
Statewide	906.57	795.47	586.65	327.38

As this statistical measure demonstrates, since implementation of the VE program, there has been a 63.88% overall reduction in the overall length of time it has taken to complete the entire investigation and administrative disciplinary process for all Medical Board cases from 2006 to 2009.⁶⁶

Finally, any assessment of the state of physician discipline in California necessarily requires an examination of **disciplinary outcomes**. Under the Medical Practice Act, disciplinary outcomes range from the most severe – outright revocation or surrender of licensure – to revocation stayed with a period of probation – and finally to lowest level of post-accusation discipline, a public reprimand with or without educational courses. The following statistical measure allows the Medical Board to accurately determine the overall effectiveness of the VE program in obtaining the most severe disciplinary penalties, outright revocation, license surrenders, and revocation, stayed, with probation.

Accusations Resulting in “Serious Discipline”

Calendar Year	2006	2007	2008	2009
Los Angeles	65.6%	68.1%	72.7%	82.4%
Sacramento	61.0%	72.7%	64.0%	75.0%
San Francisco	65.4%	61.3%	54.5%	80.0%
San Diego	59.3%	50.9%	72.3%	64.3%
State total	62.7%	61.1%	67.1%	73.5%

for Prosecution,” only to be reviewed and returned to the Medical Board District Office for additional investigation, have been calculated separately deleting the time period of investigation. The calculations for this statistical measure include out-of-state discipline cases. Calculations were done using matters that had been resolved.

⁶⁶ The methodology utilized for this fourth key statistical measure is as follows: Using the “Opened” date in Prolaw for each year, the average number of days was calculated from date the consumer complaint was “Received at District Office” to the date “Decision Signed by Client.” For multiple investigation matters resulting in a single administrative matter (by amendment to the existing Accusation and/or Accusation/Petition to Revoke Probation), the earliest date “Received at District Office” was used. The calculations used for this statistical measure include matters investigated under the VE program. Calculations were done using matters that had been resolved.

Significantly, during the past two years, imposition of the most serious disciplinary action in cases handled by HQE – Los Angeles, where attorneys presently have greater involvement during the investigation stage, has increased 14.3%. This statistic, standing alone, undermines a central premise of the Frank Report, namely, that greater attorney involvement under the VE program has not translated into greater public protection. As this final statistical measure clearly demonstrates, since implementation of the VE program, imposition of the most severe disciplinary outcomes has increased 10.8% statewide from the pre-VE time period, with the resulting increase in public protection.⁶⁷

In conclusion, notwithstanding the problems that continue to plague the Medical Board's Enforcement Program, implementation of the VE program has resulted in overall improvements in the four key statistical measures that provide the most accurate picture of the state of physician discipline in California. Disciplinary outcomes over the same time period have significantly improved as well.

While the VE program continues to represent a vast improvement over the prior "Deputy-In-The-District-Office" Program, there is still nevertheless room for further improvement. In the next and final section of this response, HQE will report on the significant steps it has already taken in its continuing efforts to further improve its own performance, and also present its recommendations on important additional ways that the VE program can be further improved.

III. Important Steps HQE has taken to Improve its own Performance, and Recommendations on How the Medical Board's Enforcement Program Can be Further Improved

The staff of HQE – Los Angeles presently consists of twenty-two deputy attorneys general, one paralegal, and two supervising deputy attorneys general. It is by far the largest section in HQE statewide. In order to increase the efficiency and productivity of HQE – Los Angeles, and further improve the quality of legal services provided to the Medical Board by that office, a third supervising deputy attorney general position has been transferred from HQE – San Diego to HQE – Los Angeles. That new position has been advertised, applications have been accepted, and it is anticipated that interviews will be conducted in the near future.

HQE has also recently published its new "HQE Section Manual" for use by all staff in HQE statewide. While the manual will not be disseminated outside the Office of the Attorney General, in summary, it provides all HQE staff with a comprehensive set of policies and procedures that govern the legal work of the section, along with departmental policies and procedures, and will also be a valuable training resource for new deputy attorneys general who join the section in the future. It is anticipated that the new "HQE Section Manual" will also help to further promote uniformity in the handling of various legal issues by HQE staff statewide as well.

⁶⁷ The methodology utilized to calculate serious discipline is as follows: "Serious discipline" is defined as: (1) outright revocation of licensure; (2) surrender of licensure; and (3) revocation of licensure, stayed, with a period of probation of at least one year. Using the "Opened" date in ProLaw for each calendar year, "serious discipline" was calculated using the above definition. In calculating each outcome, cases that were "declined to prosecute" and cases that did not reach an administrative outcome (i.e., Accusations filed but waiting administrative hearing) were omitted from the calculations. Out-of-state discipline cases were also omitted from the calculations.

In addition to these important steps that HQE has taken to improve its own performance, the following are HQE's recommendations on important ways that the VE program can be further improved to address some of the long-standing, systemic problems within the Medical Board's Enforcement Program.

1. Consider Entering into an Interagency Contract for the Attorney General's Office to Provide the Medical Board with Investigative Services

The inability of the Medical Board to retain experienced investigators is a well-documented, longstanding problem that predates implementation of the VE program. As of 2009, the investigator vacancy rate was 16%. That unacceptably high vacancy rate, together with the high rate of investigator turnover, continues to seriously undermine the VE program. Permitting the Attorney General's Office to provide investigative services to the Medical Board would help to resolve the principal reason undermining the Medical Board's Enforcement Program's ability to complete investigations on a timely basis by providing trained, experienced investigators to compliment the job currently being performed by Medical Board investigators. For this reason, the HQE strongly recommends that the Medical Board consider entering into an interagency contract for the Attorney General's Office to provide investigative services to the Board, in addition to the legal services it currently provides. Funds that would otherwise be used by the Medical Board to pay the salaries of the currently vacant investigator positions could be used for this purpose.

2. Take Concrete Steps to Improve the Medical Board's Expert Reviewer Program

Earlier this year, the Medical Board established the Enforcement Committee and one of its goals is to enhance the expert reviewer training program. The committee should consider developing an outreach program to attract more qualified expert reviewers to participate in its Expert Reviewer Program. The committee should also consider reinstating its prior procedure under which prospective experts were actually interviewed to review their qualifications and to determine whether, in addition to meeting the minimum requirements, they are sufficiently qualified to serve as an expert in the Expert Reviewer Program. The Medical Board should also accept HQE's offer to have a Supervising Deputy Attorney General participate on the interview panel as well.

Consideration should also be given to increasing the compensation (currently set at \$150 per hour for case review/consultation and \$200 for providing expert testimony) in order to attract more qualified expert reviewers. Simply stated, a physician should not have to suffer an economic penalty for agreeing to participate as a Medical Board expert. Finally, before they are assigned to review any case, physicians accepted by the Medical Board's Expert Reviewer Program should be required to attend a comprehensive training conference to be conducted, in part, by HQE in order to ensure that they are adequately trained and prepared to fulfill their duties and responsibilities as an expert for the Medical Board.

3. Increase Medical Consultant Availability in the District Offices

The unavailability of medical consultants in the District Offices continues to be one of the leading causes for investigation completion delays. The Medical Board should take immediate steps to significantly increase medical consultant availability in the District Offices in order to reduce these continuing delays.

4. Utilize Video Conferencing to Reduce Required Travel Under the VE Program

Under the VE program, HQE has assumed the burden of the majority of required travel statewide between the various Attorney General's offices and Medical Board District Offices. As a result, HQE deputy attorneys general spend hundreds of hours a year traveling on California freeways in order to confer with investigators, review documents and attend interviews. This travel burden should be shared equally between HQE and the Medical Board's Enforcement Program, especially since the Board provides investigators with motor vehicles to use for all required travel. In addition, implementation of a video conferencing network statewide would eliminate the necessity of some of this required travel, reduce the number of attorney hours expended driving rather than performing legal work, and provide a convenient method for investigators and deputy attorneys general to readily confer when more than a simple telephone call is required. From an environmental standpoint, it would also reduce the negative impact such travel places on the environment overall. HQE recommends that HQE and the Medical Board work together to implement a video conferencing network statewide to further improve the VE program.

5. Foster an Environment of Cooperation and Support for the VE Program within the Medical Board's Enforcement Program

In some areas of the state, the VE program is working well, with HQE deputy attorneys general and Medical Board investigators working cooperatively and productively, and investigations and prosecutions being completed expeditiously. In other parts of the state, however, the program is not working as well as it could. However, the Frank Report's statement that "[t]here is a high level of conflict between Medical Board and HQE management and staff throughout much of the State" (Frank Report I, at p. X-6; Frank Report II, at p. X-1) is an overstatement of the occasional disagreements that have arisen under the VE program. In Frank Report III, this statement was revised to state that: "[c]onflicts have arisen among Board and HQES at all levels throughout the state, but particularly in the Los Angeles region. Conversely, in some offices, staff is respectful of each other's roles in the process and there is greater productivity." (Frank Report III, at p. X-1.) The importance of courtesy and cooperation which, in turn, fosters greater teamwork and productivity, has already been addressed and emphasized by both HQE and the Medical Board in the *Joint Vertical Enforcement Guidelines* (JVEG) (First Edition, April 2008). (See JVEG, Section 10, p. 8, entitled "Courtesy and Cooperation.")

It is important to recognize that at any given time there are over one thousand investigations or cases in which deputy attorneys general and Medical Board investigators are collaborating. It is also important to understand that only a handful of disputes arise each year and that all of these disputes are resolved either informally or by the dispute resolution process set forth in the *Vertical Enforcement Manual*. Indeed, over the twelve months, the number of conflicts requiring the formal dispute resolution process has almost been completely eliminated.

HQE and Medical Board's Enforcement Program should renew their efforts to achieve consistency and uniform implementation of the VE program in all of its District Offices statewide. By fostering an environment of cooperation and support for the VE program within the Medical Board's Enforcement Program, the Medical Board would send a strong signal that it supports the program and fully expects that all those within its Enforcement Program do the same.

In conclusion, thank you for the opportunity to review the Frank Report, as well as the opportunity for HQE to present its comprehensive report entitled "Physician Discipline Under the Vertical Enforcement Program." HQE looks forward to working with the Medical Board to further improve the VE program assist the Medical Board to reduce investigation completion delays, and implement much needed improvements to its Enforcement Program.

Sincerely,



CARLOS RAMIREZ
Senior Assistant Attorney General

For EDMUND G. BROWN JR.
Attorney General

cc: David C. Chaney
Chief Assistant Attorney General
Civil Law Division
Los Angeles

Linda Whitney
Executive Director
Medical Board of California
Sacramento

LEGISLATIVE PACKET



MEDICAL BOARD MEETING

NOVEMBER 5, 2010
LONG BEACH, CA

A. 2010 TRACER

**Medical Board of California
Tracker - Legislative Bill File
10/26/2010**

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 526	Fuentes	Public Protection and Physician Health Program Act of 2009	Sen. Approps. - Dead	Oppose	8/19/2009
AB 583	Hayashi	Disclosure of Education and Office Hours	Chapter #436	Support	8/20/2010
AB 646	Swanson	Physician employment: district hospital pilot project	Sen. Health - Dead	Support in Concept	4/13/2010
AB 648	Chesbro	Rural Hospitals: physician employment	Sen. B&P - Dead	Support in Concept	5/28/2009
AB 933	Fong	Workers' Compensation: utilization review	Vetoed	Support (Ltr. 8/30)	8/17/2010
AB 977	Skinner	Pharmacists: immunizations	Sen. B&P - Dead	Support (ltr. 6/3)	6/1/2010
AB 1310	Hernandez	Healing Arts: database	Sen. Approps. - Dead	Support	6/29/2009
AB 1767	Hill	Expert Reviewers & HPEF Sunset Extension	Chapter #451	Sponsor/Support (Ltr. 8/19)	6/7/2010
AB 2148	Tran	Personal Income Tax: charitable deductions	Asm. Approps. - Dead	Support (ltr. 5/10)	5/18/2010
AB 2386	Gilmore	Armed Forces: Medical Personnel	Chapter #151	Neutral	5/28/2010
AB 2566	Carter	Cosmetic surgery: employment of physicians	Vetoed	Support (Ltr. 8/24)	
AB 2699	Bass	Healing Arts: Licensure Exemption	Chapter #270	Oppose (ltr. 8/4)	8/27/2010
SB 294	Negrete McLeod	DCA: Regulatory Boards - Sunset Dates	Chapter #695	No Position Required	8/17/2010
SB 700	Negrete McLeod	Peer Review	Chapter #505	Support (Ltr. 8/30)	8/20/2010
SB 726	Ashburn	Hospitals: employment of physician; pilot project revision	Sen. B&P - Dead	Support in Concept (ltr. 5/10)	8/20/2009
SB 1031	Corbett	Medical Malpractice Insurance	Asm. B&P - Dead	Sponsor/Support (ltr. 5/10)	5/28/2010
SB 1069	Pavley	Physician Assistants	Chapter #512	Support (Ltr. 8/30)	8/16/2010
SB 1111	Negrete McLeod	Regulatory Boards	Sen. B&P - Dead		4/12/2010
SB 1150	Negrete McLeod	Healing Arts: advertisements	Asm. Approps. - Dead	Support (ltr. 5/10)	
SB 1172	Negrete McLeod	Diversion Programs	Chapter #517	Support (Ltr. 8/24)	6/22/2010
SB 1410	Cedillo	Medicine: licensure examinations	Vetoed	Oppose (Ltr. 8/26)	6/23/2010
SB 1489	B&P Comm.	Omnibus	Chapter #653	Support MBC Provisions (Ltr. 8/25)	8/12/2010

Pink - Sponsored Bill; Green - Chaptered Bill; Peach - Vetoed Bill; Grey - Dead Bill

AIB

583

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 583
Author: Hayashi
Chapter: #436
Subject: Disclosure of Education and Office Hours
Sponsor: CA Medical Association and CA Society of Plastic Surgeons
Board Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require health care practitioners to disclose their license type and highest level of educational degree to patients and physicians would additionally be required to disclose their board certification. Physicians who supervise locations outside their primary office would be required to post the hours they are present at each location.

This bill was amended to require physicians to communicate to their patients the required information either in writing or to prominently display the information, instead of wearing the information on a name tag, as was previously one of the options. This bill now also exempts specified practitioners from the requirements of this bill if they satisfy specified requirements. The amendments no longer require physicians who supervise outside locations to post the hours they are present.

ANALYSIS:

Existing law requires health care practitioners to either wear a name tag or prominently display their license status in their office. This bill requires health care practitioners to disclose certain information to help the public better understand the qualifications of the health care practitioner they are considering.

This bill intends to make consumers aware of the exact educational level and particular specialty certifications of their health care practitioner. Providing the public with more complete information on health care practitioners will help to alleviate any confusion about the exact qualifications of health care practitioners.

These provisions can be satisfied by either wearing the required information on a name tag, prominently posting the information in the health care practitioner's office (diploma, certificate), or by giving the information to the patient in writing at the initial patient encounter.

This bill will also require a physician, when supervising more than one location, to post the hours the physician is present. In addition, the public may not know that when they seek care at a physician's office, the physician may not be present. By requiring physicians to post when they are present in the office it will help the patient better understand the physician's availability.

The amendments taken August 17th require physicians to communicate to their patients the required information either in writing or to prominently display the information, instead of wearing the information on a name tag, as was previously one of the options. This bill now also exempts specified practitioners from the requirements of this bill if they satisfy other requirements. The amendments no longer require physicians who supervise outside locations to post the hours they are present.

FISCAL: Minor and absorbable enforcement costs

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board Staff
- Add to cite and fine table via regulations

October 20, 2010

Assembly Bill No. 583

CHAPTER 436

An act to add Section 680.5 to the Business and Professions Code, relating to health care practitioners.

[Approved by Governor September 29, 2010. Filed with Secretary of State September 29, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

AB 583, Hayashi. Health care practitioners: disclosure of education.

Existing law requires a health care practitioner to disclose, while working, his or her name and practitioner's license status on a name tag in at least 18-point type or to prominently display his or her license in his or her office, except as specified.

This bill would require each of those health care practitioners to disclose the type of license and, except as specified, the highest level of academic degree he or she holds either in a prominent display in his or her office or in writing, in a specified format given to a patient on his or her initial office visit. The bill would require a physician and surgeon, and an osteopathic physician and surgeon, who is certified in a medical specialty, as specified, to also disclose, in either of those manners the name of the certifying board or association. The bill would exempt specified health care practitioners, including, without limitation, persons working in certain licensed laboratories and health care facilities, as specified, from these requirements.

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

SECTION 1. Section 680.5 is added to the Business and Professions Code, to read:

680.5. (a) (1) A health care practitioner licensed under Division 2 (commencing with Section 500) shall communicate to a patient his or her name, state-granted practitioner license type, and highest level of academic degree, by one or both of the following methods:

(A) In writing at the patient's initial office visit.

(B) In a prominent display in an area visible to patients in his or her office.

(2) An individual licensed under Chapter 6 (commencing with Section 2700) or Chapter 9 (commencing with Section 4000) is not required to disclose the highest level of academic degree he or she holds.

(b) A person licensed under Chapter 5 (commencing with Section 2000) or under the Osteopathic Act, who is certified by (1) an American Board of Medical Specialties member board, (2) a board or association with

requirements equivalent to a board described in paragraph (1) approved by that person's medical licensing authority, or (3) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in the person's specialty or subspecialty, shall disclose the name of the board or association by either method described in subdivision (a).

(c) A health care practitioner who chooses to disclose the information required by subdivisions (a) and (b) pursuant to subparagraph (A) of paragraph (1) of subdivision (a) shall present that information in at least 24-point type in the following format:

HEALTH CARE PRACTITIONER INFORMATION

- 1. Name and license.....
- 2. Highest level of academic degree.....
- 3. Board certification (ABMS/MBC).....

(d) This section shall not apply to the following health care practitioners:

(1) A person who provides professional medical services to enrollees of a health care service plan that exclusively contracts with a single medical group in a specific geographic area to provide or arrange for professional medical services for the enrollees of the plan.

(2) A person who works in a facility licensed under Section 1250 of the Health and Safety Code or in a clinical laboratory licensed under Section 1265.

(3) A person licensed under Chapter 3 (commencing with Section 1200), Chapter 7.5 (commencing with Section 3300), Chapter 8.3 (commencing with Section 3700), Chapter 11 (commencing with Section 4800), Chapter 13 (commencing with Section 4980), or Chapter 14 (commencing with Section 4990.1).

(e) A health care practitioner, who provides information regarding health care services on an Internet Web site that is directly controlled or administered by that health care practitioner or his or her office personnel, shall prominently display on that Internet Web site the information required by this section.

A B

9 3 3

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 933
Author: Fong
Chapter: VETOED (see attached veto message)
Subject: Workers' Compensation: medical treatment
Sponsor: American Federation of State, County, and Municipal Employees
California Society of Industrial Medicine and Surgery
California Society of Physical Medicine and Rehabilitation
Union of American Physicians and Dentists
Board Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill clarifies current law to provide that physicians performing utilization review for injured workers must be licensed in California.

Amendments recently taken do not impact the Medical Board.

ANALYSIS:

Current law does not require physicians who perform utilization reviews of workers' compensation claims to be licensed in California as long as the physicians are licensed in another state. However, current law does state that performing an evaluation that leads to the modification, delay, or denial of medical treatment is an act of diagnosing for the purpose of providing a different mode of treatment for the patient. Only a licensed physician is allowed to override treatment decisions.

The author and proponents of this bill believe that out-of-state physicians are making inappropriate decisions regarding these utilization reviews in part because there is no regulatory agency holding them accountable.

This bill would ensure that any physician performing a utilization review in California would be regulated by the Medical Board (Board) by requiring all physicians performing these reviews to be licensed by California state law.

This bill is similar to last year's AB 2969 (Lieber) which was vetoed. The Board has supported that legislation in the past.

Amendments to this bill taken June 14, August 2, and August 17, 2010 do not impact the Board's support position.

FISCAL: None to the Board

IMPLEMENTATION:

None

BILL NUMBER: AB 933
VETOED: 09/23/2010

To the Members of the California State Assembly:

I am returning Assembly Bill 933 without my signature.

This bill would require a physician conducting utilization review in the workers' compensation system to be licensed in California. Such a requirement would be inconsistent with how utilization review is conducted in other areas of medicine and not in line with best practices nationwide. The proponents of this measure have not demonstrated a need for this disparity in treatment.

For this reason, I am returning this bill without my signature.

Sincerely,

Arnold Schwarzenegger

Assembly Bill No. 933

Passed the Assembly August 24, 2010

Chief Clerk of the Assembly

Passed the Senate August 23, 2010

Secretary of the Senate

This bill was received by the Governor this ____ day
of _____, 2010, at ____ o'clock ____M.

Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 3209.3 and 4610 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 933, Fong. Workers' compensation: medical treatment.

Existing workers' compensation law generally requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, and in the course of, employment.

Existing law, for purposes of workers' compensation, defines "psychologist" to mean a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology, as specified, and who either has at least 2 years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

This bill would require the psychologist to be licensed by California state law.

Existing law requires every employer to establish a medical treatment utilization review process, in compliance with specified requirements, either directly or through its insurer or an entity with which the employer or insurer contracts for these services. Existing law provides that no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

This bill would require the physician to be licensed by California state law.

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

SECTION 1. Section 3209.3 of the Labor Code is amended to read:

3209.3. (a) "Physician" means physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.

(b) "Psychologist" means a psychologist licensed by California state law with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

(c) When treatment or evaluation for an injury is provided by a psychologist, provision shall be made for appropriate medical collaboration when requested by the employer or the insurer.

(d) "Acupuncturist" means a person who holds an acupuncturist's certificate issued pursuant to Chapter 12 (commencing with Section 4925) of Division 2 of the Business and Professions Code.

(e) Nothing in this section shall be construed to authorize acupuncturists to determine disability for the purposes of Article 3 (commencing with Section 4650) of Chapter 2 of Part 2, or under Section 2708 of the Unemployment Insurance Code.

SEC. 2. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the

schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a physician licensed by California state law who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of

Occupational and Environmental Medicine Occupational Medical Practice Guidelines.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements must be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the

employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4062. If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision (b) of Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4062, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees

shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be

deposited in the Workers' Compensation Administration Revolving Fund.

Approved _____, 2010

Governor

AB 1767

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1767
Author: Hill
Chapter: #451
Subject: Healing Arts: Expert Reviewers and HPEF sunset extension
Sponsor: Medical Board of California
Board Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board (Board) to provide representation to a licensed physician who provides expertise to the Board in the evaluation of the conduct of a licensee when, as a result of providing the expertise, the physician is subject to a disciplinary proceeding undertaken by a specialty board of which the physician is a member.

This bill was amended to specify that with Medical Board approval, the Attorney General would provide the representation to the expert reviewer in the disciplinary proceeding that is a direct result of providing expertise to the Board.

This bill was also amended to extend the sunset date of the two members of the Health Professions Education Foundation (HPEF) that are appointed by the Medical Board of California, from January 1, 2011, to January 1, 2016.

ANALYSIS:

The Board is currently required to provide legal representation to physicians who provide expertise to the Board if they are named as a defendant in a civil action arising out of the evaluation, opinions, or statements made while testifying on behalf of the Board.

When a professional grievance is filed with a specialty board of which the physician is a member, the Board is not able to protect the physician. This creates a disincentive for these reviewers who provide a critical consumer protection function for the Board.

This bill would give the Board a way to protect its expert witnesses in the case that their testimony for the Board brings about complaints or grievances with the specialty boards of which the physicians who participate as expert witnesses are members. This bill removes the disincentive for physicians to use their expertise to assist in the Board's enforcement cases, thus preserving the ease with which the Board is able to recruit physicians to participate as expert witnesses.

The amendments taken June 7, 2010, are clarifying amendments requested by the Department of Consumer Affairs. The amendments clarify that the Office of the Attorney General would provide the representation, if the Board approves them to do so, and that representation would only be provided for disciplinary proceedings that are a direct result of a

physician providing expertise to the Board.

The amendments taken June 7, 2010 also extend the sunset date of the two HPEF members appointed by the Medical Board for five years, until January 1, 2016. The Medical Board funds the Loan Repayment Program in the HPEF through a \$25 fee on physician initial licensure and renewals. The two members appointed by the Medical Board represent the 125,000 California physician licensees who help support the loan repayment program.

FISCAL: Minimal and Absorbable

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board Staff
- Notify Health Professions Education Foundation/OSHPD
- Notify Attorney General's Office
- Inform Expert Reviewers and provide information during their Board training

October 20, 2010

Assembly Bill No. 1767

CHAPTER 451

An act to add Section 2316 to the Business and Professions Code, and to amend Section 128335 of the Health and Safety Code, relating to healing arts.

[Approved by Governor September 29, 2010. Filed with
Secretary of State September 29, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1767, Hill. Healing arts.

Existing law requires a board under the Business and Professions Code, including the Medical Board of California, to provide legal representation to any person hired or under contract who provides expertise to the board in the evaluation of an applicant or the conduct of a licensee when that person is named as a defendant in a civil action arising out of the evaluation or any opinions rendered, statements made, or testimony given to the board. Existing law also provides immunity from civil liability to any person providing testimony to the Medical Board of California, the California Board of Podiatric Medicine, or the Department of Justice indicating that a licensee may be guilty of unprofessional conduct or may be impaired because of drug or alcohol abuse or mental illness.

This bill would require the Office of the Attorney General, with approval by the Medical Board of California, to provide representation to any licensed physician and surgeon who provides expertise to the board in the evaluation of the conduct of an applicant or a licensee when, as a result of providing that expertise, the physician and surgeon is subject to a disciplinary proceeding undertaken by a specialty board of which the physician and surgeon is a member.

Existing law requires the Office of Statewide Health Planning and Development to establish a nonprofit public benefit corporation known as the Health Professions Education Foundation to perform various duties with respect to implementing health professions scholarship and loan programs. Under existing law, the foundation is governed by 13 members, including, until January 1, 2011, 2 members of the Medical Board of California appointed by the board.

This bill would extend the 2 foundation board appointments to January 1, 2016.

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

SECTION 1. (a) The Legislature finds and declares that consumer protection is further strengthened when the Medical Board of California uses board-certified physicians and surgeons in the investigation of complaints and the prosecution of administrative disciplinary actions. The Legislature further finds and declares that the use of board-certified physicians and surgeons is consistent with the requirements of Section 2220.08 of the Business and Professions Code, and in conformity with existing case law that requires that the standard of care and any deviations from the standard of care be established by expert witnesses.

(b) The Legislature finds and declares that a disturbing trend may be emerging whereby board-certified physicians and surgeons may be subject to discipline from the very boards that certified them as expert witnesses for the Medical Board of California in administrative proceedings. Actual or threatened discipline against board-certified physicians and surgeons may chill participation in the board's expert reviewer program and may significantly impair and hamper the effective and timely resolution of complaints and licensure and disciplinary actions. The Legislature finds and declares that the enactment of legislation is necessary to prevent this occurrence and for the protection of California consumers.

SEC. 2. Section 2316 is added to the Business and Professions Code, to read:

2316. If a licensed physician and surgeon who provides expertise to the board in the evaluation of an applicant or a licensee is, as a result of providing that expertise, the subject of a disciplinary proceeding undertaken by a specialty board of which the physician and surgeon is a member, with board approval, the Office of the Attorney General shall represent the physician and surgeon in that disciplinary proceeding regarding any allegation brought against the physician and surgeon as a direct result of providing that expertise to the board.

SEC. 3. Section 128335 of the Health and Safety Code, as amended by Section 3 of Chapter 317 of the Statutes of 2005, is amended to read:

128335. (a) The office shall establish a nonprofit public benefit corporation, to be known as the Health Professions Education Foundation, that shall be governed by a board consisting of a total of 13 members, nine members appointed by the Governor, one member appointed by the Speaker of the Assembly, one member appointed by the Senate Committee on Rules, and two members of the Medical Board of California appointed by the Medical Board of California. The members of the foundation board appointed by the Governor, Speaker of the Assembly, and Senate Committee on Rules may include representatives of minority groups that are underrepresented in the health professions, persons employed as health professionals, and other appropriate members of health or related professions. All persons considered for appointment shall have an interest in health programs, an interest in health educational opportunities for underrepresented groups, and the ability and desire to solicit funds for the purposes of this article as

determined by the appointing power. The chairperson of the commission shall also be a nonvoting, ex officio member of the board.

(b) The Governor shall appoint the president of the board of trustees from among those members appointed by the Governor, the Speaker of the Assembly, the Senate Committee on Rules, and the Medical Board of California.

(c) The director, after consultation with the president of the board, may appoint a council of advisers comprised of up to nine members. The council shall advise the director and the board on technical matters and programmatic issues related to the Health Professions Education Foundation Program.

(d) Members of the board and members of the council shall serve without compensation but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the board or the council. Members appointed by the Medical Board of California shall serve without compensation, but shall be reimbursed by the Medical Board of California for any actual and necessary expenses incurred in connection with their duties as members of the foundation board.

(e) Notwithstanding any provision of law relating to incompatible activities, no member of the foundation board shall be considered to be engaged in activities inconsistent and incompatible with his or her duties solely as a result of membership on the Medical Board of California.

(f) The foundation shall be subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), except that if there is a conflict with this article and the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), this article shall prevail.

(g) This section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.

SEC. 4. Section 128335 of the Health and Safety Code, as added by Chapter 317 of the Statutes of 2005, is amended to read:

128335. (a) The office shall establish a nonprofit public benefit corporation, to be known as the Health Professions Education Foundation, that shall be governed by a board consisting of nine members appointed by the Governor, one member appointed by the Speaker of the Assembly, and one member appointed by the Senate Committee on Rules. The members of the foundation board appointed by the Governor, Speaker of the Assembly, and Senate Committee on Rules may include representatives of minority groups which are underrepresented in the health professions, persons employed as health professionals, and other appropriate members of health or related professions. All persons considered for appointment shall have an interest in health programs, an interest in health educational opportunities for underrepresented groups, and the ability and desire to solicit funds for the purposes of this article as determined by the appointing power. The chairperson of the commission shall also be a nonvoting, ex officio member of the board.

(b) The Governor shall appoint the president of the board of trustees from among those members appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules.

(c) The director, after consultation with the president of the board, may appoint a council of advisers comprised of up to nine members. The council shall advise the director and the board on technical matters and programmatic issues related to the Health Professions Education Foundation Program.

(d) Members of the board and members of the council shall serve without compensation but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the board or the council.

(e) The foundation shall be subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), except that if there is a conflict with this article and the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), this article shall prevail.

(f) This section shall become operative January 1, 2016.

A B 2 3 8 6

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2386
Author: Gilmore
Chapter: #151
Subject: Armed Forces: medical personnel
Sponsor: Author
Board Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a hospital to enter into an agreement with the Armed Forces of the United States to authorize a physician and surgeon, physician assistant (PA), or a registered nurse (RN) to provide medical care in the hospital under specified conditions.

ANALYSIS:

Current law allows physicians and surgeons who are not licensed in California to engage in the practice of medicine in a military health facility in California as part of their residency, fellowship, or clinical training program if they are a commissioned officer on active duty in the medical corps of any branch of the armed forces of the United States, if they meet specified conditions, including registering with the Medical Board of California (the Board).

This bill would allow non-military hospitals to enter into an agreement with the Armed Forces of the United States to authorize a physician, PA, or RN to provide medical care if the following applies:

- The physician, PA, or RN holds a valid license in good standing in any state or territory in the United States.
- The medical care is provided as part of a training or educational program designed to promote combat readiness.
- The agreement complies with federal law.

This bill also contains consumer protection provisions. This bill requires the physician, PA, or RN while working in the hospital to wear a name tag that includes, in at least 18 point type, his or her name and license status, his or her state of licensure, and a statement that he or she is a member of the Armed Forces of the United States. This bill also requires the physician, PA, or RN to register with the board that licenses his or her respective health care profession in California, on a form provided by that Board; the Medical Board already has this form available.

The author believes this bill will help military health care professionals to improve their skills prior to being deployed to war. The California Academy of Physician Assistants believes this bill will improve access to appropriately trained health care providers.

FISCAL: Minimal and absorbable

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board Staff
- Revise existing military form and create new form with added fields (i.e. state individual is licensed, license number, etc.) to implement this bill.
- Post new form on the Board's Website.
- Work with contact at U.S. military (provided by the author's office) to perform outreach.

October 20, 2010

Assembly Bill No. 2386

CHAPTER 151

An act to add and repeal Section 714 of the Business and Professions Code, relating to the Armed Forces.

[Approved by Governor August 17, 2010. Filed with
Secretary of State August 17, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2386, Gilmore. Armed Forces: medical personnel.

Existing federal law authorizes a health care professional, as defined, to practice his or her health profession in any state or territory without licensure by that state if he or she has a current license to practice the health profession and is performing authorized duties for the Department of Defense.

Existing state law provides that no board that licenses dentists, physicians and surgeons, podiatrists, or nurses may require a person to obtain a California license to practice his or her profession in this state if the person is employed by, or has a contract with, the federal government and is rendering services in a facility of the government or the person is practicing as part of a program or project conducted by the federal government which, by federal statute, exempts persons in the program from state licensure, as specified.

This bill, until January 1, 2016, would authorize a hospital to enter into an agreement with the Armed Forces of the United States to authorize a physician and surgeon, physician assistant, or registered nurse to provide medical care in the hospital if the health care professional holds a valid license in good standing in another state or territory, the medical care is provided as part of a training or educational program designed to promote the combat readiness of the health care professional, and the agreement complies with federal law. The bill would exempt those health care professionals from licensure or relicensure by the State of California while practicing under an agreement, but would require those health care professionals to register with the board that licenses that health care profession in this state and to wear a specified name tag while working.

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

SECTION 1. Section 714 is added to the Business and Professions Code, to read:

714. (a) A hospital may enter into an agreement with the Armed Forces of the United States to authorize a physician and surgeon, physician assistant,

or registered nurse to provide medical care in the hospital if all of the following apply:

(1) The physician and surgeon, physician assistant, or registered nurse holds a valid license in good standing to provide medical care in the District of Columbia or any state or territory of the United States.

(2) The medical care is provided as part of a training or educational program designed to promote the combat readiness of the physician and surgeon, physician assistant, or registered nurse.

(3) The agreement complies with Section 1094 of Title 10 of the United States Code and any regulations or guidelines adopted pursuant to that section.

(b) A physician and surgeon, physician assistant, or registered nurse who is authorized to practice pursuant to subdivision (a) shall disclose, while working, on a name tag in at least 18-point type, his or her name and license status, his or her state of licensure, and a statement that he or she is a member of the Armed Forces of the United States.

(c) (1) If an agreement is entered into pursuant to subdivision (a), no board under this division that licenses physicians and surgeons, physician assistants, or registered nurses may require a person under subdivision (a) to obtain or maintain any license to practice his or her profession or render services in the State of California.

(2) Notwithstanding paragraph (1), a physician and surgeon, physician assistant, or registered nurse who enters into an agreement pursuant to subdivision (a) shall register with the board that licenses his or her respective health care profession in this state on a form provided by that board.

(d) This section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.

AIB 2566

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2566
Author: Carter
Chapered: VETOED (see attached veto message)
Subject: Cosmetic Surgery: employment of physicians
Sponsor: American Society for Dermatological Surgery Association
Board Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would prohibit outpatient cosmetic surgery centers from violating the prohibition of the corporate practice of medicine. This bill defines “outpatient elective cosmetic procedures or treatments.”

ANALYSIS:

The intent of this bill is to elevate the penalties of violating the corporate practice of medicine prohibition in order to prevent further offenses and to convince consumers with business models that violate this law to reconsider and revise their business practices.

This bill would enhance the penalty for corporations violating the prohibition of the corporate practice of medicine to a public offense punishable by imprisonment for up to five years and/or by a fine not exceeding \$50,000. Current law states that this violation is punishable as a misdemeanor, a \$1,200 fine, and imprisonment for up to 180 days.

This bill would define “outpatient elective cosmetic procedures or treatments” as medical procedures or treatments that are performed to alter or reshape normal structures of the body solely in order to improve appearance.

The Board has previously supported similar legislation such as AB 252 (Carter) in 2009 that authorized the revocation of a physician’s license for knowingly practicing with an organization that is in violation of the corporate practice of medicine. This bill was vetoed for being “duplicative of existing law.” In 2008 AB 2398 (Nakanishi) contained very similar provisions to AB 252 and was held in the Senate.

The author requested the Board sponsor this legislation concept. The Board declined but stated it would likely support when the bill was in print.

FISCAL: None to the Board

IMPLEMENTATION:

None

BILL NUMBER: AB 2566
VETOED: 09/29/2010

To the Members of the California State Assembly:

I am returning Assembly Bill 2566 without my signature.

I vetoed a similar measure last year. The reason for the veto remains the same. Existing law already addresses the issues highlighted by the sponsors and author. The real problem is that the sponsors want enforcement of this issue moved up on the prioritization of enforcement issues pending with the Medical Board (Board). California currently ranks 41st in the country for taking serious disciplinary action against doctors and this bill attempts to move those serious disciplinary actions behind businesses that operate "medi-spas" providing skin peels, dermabrasion and laser hair removal.

Good doctors are the backbone of our health delivery system. I believe the members of the Board want to protect patients. I just don't agree that the Board's time is better spent on medi-spa enforcement when other physicians should be more quickly investigated and prohibited from practicing medicine when they have caused serious patient harm or death.

Sincerely,

Arnold Schwarzenegger

Assembly Bill No. 2566

Passed the Assembly April 29, 2010

Chief Clerk of the Assembly

Passed the Senate August 23, 2010

Secretary of the Senate

This bill was received by the Governor this _____ day
of _____, 2010, at _____ o'clock _____M.

Private Secretary of the Governor

CHAPTER _____

An act to add Section 2417.5 to the Business and Professions Code, relating to the practice of medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 2566, Carter. Practice of medicine: cosmetic surgery: employment of physicians and surgeons.

Existing law, the Medical Practice Act, establishes the Medical Board of California within the Department of Consumer Affairs, which licenses physicians and surgeons and regulates their practice.

The Medical Practice Act restricts the employment of licensed physicians and surgeons and podiatrists by a corporation or other artificial legal entity, subject to specified exemptions. Existing law makes it unlawful to knowingly make, or cause to be made, any false or fraudulent claim for payment of a health care benefit, or to aid, abet, solicit, or conspire with any person to do so, and makes a violation of this prohibition a public offense.

This bill would make a business organization that provides outpatient elective cosmetic medical procedures or treatments, that is owned and operated in violation of the prohibition against employment of licensed physicians and surgeons and podiatrists, and that contracts with or employs these licensees to facilitate the offer or provision of those procedures or treatments that may only be provided by these licensees, guilty of a violation of the prohibition against knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. Because the bill would expand a public offense, it would impose a state-mandated local program.

This bill would state that its provisions are declaratory of existing law.

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.

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

SECTION 1. The Legislature finds and declares that the Medical Practice Act restricts the employment of physicians and surgeons by a corporation or other artificial legal entity, as described in Article 18 (commencing with Section 2400) of Chapter 5 of Division 2 of the Business and Professions Code, and that the prohibited conduct described in Section 2417.5 of the Business and Professions Code, as added by this act, is declaratory of existing law.

SEC. 2. Section 2417.5 is added to the Business and Professions Code, to read:

2417.5. (a) A business organization that offers to provide, or provides, outpatient elective cosmetic medical procedures or treatments, that is owned or operated in violation of Section 2400, and that contracts with, or otherwise employs, a physician and surgeon to facilitate its offers to provide, or the provision of, outpatient elective cosmetic medical procedures or treatments that may only be provided by the holder of a valid physician's and surgeon's certificate is guilty of violating paragraph (6) of subdivision (a) of Section 550 of the Penal Code.

(b) For purposes of this section, "outpatient elective cosmetic medical procedures or treatments" means medical procedures or treatments that are performed to alter or reshape normal structures of the body solely in order to improve appearance.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Approved _____, 2010

Governor

AIB 2699

MEDICAL BOARD OF CALIFORNIA
DRAFT LEGISLATIVE ANALYSIS

Bill Number: AB 2699
Author: Bass
Chapter: #270
Subject: Healing Arts: Licensure Exemption
Sponsor: Los Angeles County Board of Supervisors
Board Position: Oppose

DESCRIPTION OF CURRENT LEGISLATION:

This bill exempts specified health care practitioners, who are licensed and certified in other states, from California state licensure, for the purposes of providing voluntary health care services to uninsured and underinsured Californians on a short-term basis.

This bill was amended to apply to any individual licensed under Division 2 of the Business and Professions Code, relating to healing arts. The amendments limit the sponsored event to 10 days and to require that the sponsoring entity be a non-profit entity or a community-based organization. This bill was amended to require each board to notify the sponsoring entity within 20 calendar days if the request is approved or denied (using specified requirements). The amendments require the health care practitioner to submit to the appropriate board, on a form prescribed by each board, a request for authorization to practice without a license. Each health care practitioner must pay a fee, which must be determined by each board by regulation. The amendments also require the participating practitioner to provide a copy of his or her license in each state where the individual is licensed and require that the license be in good standing in each state where the individual is licensed. The amendments also specify a termination process for each board to terminate authorization for a health care practitioner to provide health care services. Lastly, this bill was amended to include a sunset date of January 1, 2014

ANALYSIS:

Current law exempts health care practitioners that are licensed in other states from California licensure in a state of emergency. There are also reciprocity eligibility requirements for physicians, nurses and dentists who are licensed in other states.

This bill exempts health care practitioners (physicians, osteopathic physicians and surgeons, chiropractors, dentists, dental hygienists, nurses, vocational nurses, optometrists, physician assistants, or podiatrists) from California state licensure if they are licensed or certified in good standing in another state, district, or territory of the United States and if they provide health care services in California under the following requirements:

- They must submit to the respective board in California a valid copy of his or her license or certificate and a photo identification issued by the state that he or she is

licensed or certified.

- The services must be provided to uninsured or underinsured persons on a short-term voluntary basis (no longer than 10 days per sponsored event).
- The services must be provided in association with a sponsoring entity that complies with specified requirements.
- The services must be provided without charge to the recipient, or to a third party on behalf of the recipient.

The sponsoring entity, which may be a non-profit or community-based organization, must register with the appropriate licensing board on a form that includes the name of the sponsoring entity, its officers or organization officials, contract information, and any information required by the licensing board, and this information must also be provided to the county health department in the county where the health care services will be provided. Within 15 days of the provision of health care services, the sponsoring entity must file a report with the licensing board and the county health department that includes the date, place, type, and general description of the services provided, and a listing of the health care practitioners who participated in providing those services. The sponsoring entity must maintain a list of health care practitioners associated with providing health care services and maintain a copy of each practitioner's current license or certification. The sponsoring entity must require each health care practitioner to attest in writing that his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings. This bill allows a licensing board to revoke the registration of a sponsoring entity if they do not comply with these provisions.

According to the sponsor, there are thousands of individuals in California who are lacking basic health care services and preventive care. In August 2009, the Remote Area Medical (RAM) Volunteer Corps conducted an eight-day health event in Los Angeles County. Volunteer health care practitioners provided \$2.9 million in free services to over 14,000 patient encounters during this event. While this event was successful, RAM faced a shortage of volunteer health care professionals because of restrictions in California law that prohibit volunteer out-of-state licensed medical personnel from providing short-term services. Because of this shortage, thousands of residents were turned away. RAM conducted another event, which was held at the Los Angeles Sports Arena from April 27 to May 3, 2010, where over 6,600 uninsured and underinsured individuals received vision and dental services. RAM is a non-profit organization that has staged hundreds of medical clinics, both in the United States and worldwide.

The August 2, 2010 amendments change the bill to apply to any individual licensed under Division 2 of the Business and Professions Code, relating to healing arts. The amendments limit the sponsored event to 10 days and to require that the sponsoring entity be a non-profit entity or a community-based organization. These amendments also require each board to notify the sponsoring entity within 20 calendar days if the request is approved or denied (using specified requirements). The health care practitioner must submit to the appropriate board, on a form prescribed by each board, a request for authorization to practice without a license and must pay a fee (determined by each board by regulation). These amendments also include a process that each board must follow to terminate authorization for a health care practitioner to provide health care services in California.

The August 27, 2010 amendments require the participating practitioner to provide a copy of his or her license in each state where the individual is licensed and requires that the license be in good standing in each state where the individual is licensed. These amendments also added a sunset date to the bill of January 1, 2014

FISCAL:

The recent amendments place more requirements on each board, resulting in a fiscal impact to the Medical Board. The Board is assuming 10 events per year with approximately 20 out of state physicians participating in each event. The Board is also assuming that these events will result in two enforcement cases per year. The Medical Board will require .5 Associate Governmental Program Analyst (AGPA) to do the following: Create a new form for the health care practitioner to submit for authorization to practice medicine without a license; Develop regulations to establish the nominal fee, per the direction in the bill; Answer technical questions on the new registration program; Evaluate applications for authorization; Maintain the database; Work directly with professional entities, legislators, local elected officials (city and county), medical groups, and other regulatory Boards at the Department of Consumer Affairs.

IMPLEMENTATION:

- Submit legislative BCP to DCA.
- Newsletter Article
- Notify/Train staff
- Identify staff resources to manage program
- Work with DCA on uniform implementation plan
- Potential regulatory proposal to discuss at the January 2011 Board Meeting

Assembly Bill No. 2699

CHAPTER 270

An act to amend Section 900 of, and to add and repeal Section 901 of, the Business and Professions Code, relating to healing arts.

[Approved by Governor September 23, 2010. Filed with
Secretary of State September 24, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2699, Bass. Healing arts: licensure exemption.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which he or she is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.

This bill would also provide, until January 1, 2014, an exemption from the licensure and regulation requirements for a health care practitioner, as defined, licensed or certified in good standing in another state or states, who offers or provides health care services for which he or she is licensed or certified through a sponsored event, as defined, (1) to uninsured or underinsured persons, (2) on a short-term voluntary basis, (3) in association with a sponsoring entity that registers with the applicable healing arts board, as defined, and provides specified information to the county health department of the county in which the health care services will be provided, and (4) without charge to the recipient or a 3rd party on behalf of the recipient, as specified. The bill would also require an exempt health care practitioner to obtain prior authorization to provide these services from the applicable licensing board, as defined, and to satisfy other specified requirements, including payment of a fee as determined by the applicable licensing board. The bill would require the applicable licensing board to notify the sponsoring entity, as defined, of the sponsored event whether the board approves or denies a request for authorization to provide these services within 20 days of receipt of the request. The bill would also prohibit a contract of liability insurance issued, amended, or renewed on or after January 1, 2011, from excluding coverage of these practitioners or a sponsoring entity for providing care under these provisions.

Because this bill would expand the definition of certain crimes, the bill would create a state-mandated local program.

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.

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

SECTION 1. Section 900 of the Business and Professions Code is amended to read:

900. (a) Nothing in this division applies to a health care practitioner licensed in another state or territory of the United States who offers or provides health care for which he or she is licensed, if the health care is provided only during a state of emergency as defined in subdivision (b) of Section 8558 of the Government Code, which emergency overwhelms the response capabilities of California health care practitioners and only upon the request of the Director of the Emergency Medical Services Authority.

(b) The director shall be the medical control and shall designate the licensure and specialty health care practitioners required for the specific emergency and shall designate the areas to which they may be deployed.

(c) Health care practitioners shall provide, upon request, a valid copy of a professional license and a photograph identification issued by the state in which the practitioner holds licensure before being deployed by the director.

(d) Health care practitioners deployed pursuant to this chapter shall provide the appropriate California licensing authority with verification of licensure upon request.

(e) Health care practitioners providing health care pursuant to this chapter shall have immunity from liability for services rendered as specified in Section 8659 of the Government Code.

(f) For the purposes of this section, "health care practitioner" means any person who engages in acts which are the subject of licensure or regulation under this division or under any initiative act referred to in this division.

(g) For purposes of this section, "director" means the Director of the Emergency Medical Services Authority who shall have the powers specified in Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

SEC. 2. Section 901 is added to the Business and Professions Code, to read:

901. (a) For purposes of this section, the following provisions apply:

(1) "Board" means the applicable healing arts board, under this division or an initiative act referred to in this division, responsible for the licensure or regulation in this state of the respective health care practitioners.

(2) "Health care practitioner" means any person who engages in acts that are subject to licensure or regulation under this division or under any initiative act referred to in this division.

(3) "Sponsored event" means an event, not to exceed 10 calendar days, administered by either a sponsoring entity or a local government, or both, through which health care is provided to the public without compensation to the health care practitioner.

(4) "Sponsoring entity" means a nonprofit organization organized pursuant to Section 501(c)(3) of the Internal Revenue Code or a community-based organization.

(5) "Uninsured or underinsured person" means a person who does not have health care coverage, including private coverage or coverage through a program funded in whole or in part by a governmental entity, or a person who has health care coverage, but the coverage is not adequate to obtain those health care services offered by the health care practitioner under this section.

(b) A health care practitioner licensed or certified in good standing in another state, district, or territory of the United States who offers or provides health care services for which he or she is licensed or certified is exempt from the requirement for licensure if all of the following requirements are met:

(1) Prior to providing those services, he or she:

(A) Obtains authorization from the board to participate in the sponsored event after submitting to the board a copy of his or her valid license or certificate from each state in which he or she holds licensure or certification and a photographic identification issued by one of the states in which he or she holds licensure or certification. The board shall notify the sponsoring entity, within 20 calendar days of receiving a request for authorization, whether that request is approved or denied, provided that, if the board receives a request for authorization less than 20 days prior to the date of the sponsored event, the board shall make reasonable efforts to notify the sponsoring entity whether that request is approved or denied prior to the date of that sponsored event.

(B) Satisfies the following requirements:

(i) The health care practitioner has not committed any act or been convicted of a crime constituting grounds for denial of licensure or registration under Section 480 and is in good standing in each state in which he or she holds licensure or certification.

(ii) The health care practitioner has the appropriate education and experience to participate in a sponsored event, as determined by the board.

(iii) The health care practitioner shall agree to comply with all applicable practice requirements set forth in this division and the regulations adopted pursuant to this division.

(C) Submits to the board, on a form prescribed by the board, a request for authorization to practice without a license, and pays a fee, in an amount determined by the board by regulation, which shall be available, upon appropriation, to cover the cost of developing the authorization process and processing the request.

(2) The services are provided under all of the following circumstances:

(A) To uninsured or underinsured persons.

(B) On a short-term voluntary basis, not to exceed a 10-calendar-day period per sponsored event.

(C) In association with a sponsoring entity that complies with subdivision (c).

(D) Without charge to the recipient or to a third party on behalf of the recipient.

(c) The board may deny a health care practitioner authorization to practice without a license if the health care practitioner fails to comply with the requirements of this section or for any act that would be grounds for denial of an application for licensure.

(d) A sponsoring entity seeking to provide, or arrange for the provision of, health care services under this section shall do both of the following:

(1) Register with each applicable board under this division for which an out-of-state health care practitioner is participating in the sponsored event by completing a registration form that shall include all of the following:

(A) The name of the sponsoring entity.

(B) The name of the principal individual or individuals who are the officers or organizational officials responsible for the operation of the sponsoring entity.

(C) The address, including street, city, ZIP Code, and county, of the sponsoring entity's principal office and each individual listed pursuant to subparagraph (B).

(D) The telephone number for the principal office of the sponsoring entity and each individual listed pursuant to subparagraph (B).

(E) Any additional information required by the board.

(2) Provide the information listed in paragraph (1) to the county health department of the county in which the health care services will be provided, along with any additional information that may be required by that department.

(e) The sponsoring entity shall notify the board and the county health department described in paragraph (2) of subdivision (d) in writing of any change to the information required under subdivision (d) within 30 calendar days of the change.

(f) Within 15 calendar days of the provision of health care services pursuant to this section, the sponsoring entity shall file a report with the board and the county health department of the county in which the health care services were provided. This report shall contain the date, place, type, and general description of the care provided, along with a listing of the health care practitioners who participated in providing that care.

(g) The sponsoring entity shall maintain a list of health care practitioners associated with the provision of health care services under this section. The sponsoring entity shall maintain a copy of each health care practitioner's current license or certification and shall require each health care practitioner to attest in writing that his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The sponsoring entity shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.

(h) A contract of liability insurance issued, amended, or renewed in this state on or after January 1, 2011, shall not exclude coverage of a health care

practitioner or a sponsoring entity that provides, or arranges for the provision of, health care services under this section, provided that the practitioner or entity complies with this section.

(i) Subdivision (b) shall not be construed to authorize a health care practitioner to render care outside the scope of practice authorized by his or her license or certificate or this division.

(j) (1) The board may terminate authorization for a health care practitioner to provide health care services pursuant to this section for failure to comply with this section, any applicable practice requirement set forth in this division, any regulations adopted pursuant to this division, or for any act that would be grounds for discipline if done by a licensee of that board.

(2) The board shall provide both the sponsoring entity and the health care practitioner with a written notice of termination including the basis for that termination. The health care practitioner may, within 30 days after the date of the receipt of notice of termination, file a written appeal to the board. The appeal shall include any documentation the health care practitioner wishes to present to the board.

(3) A health care practitioner whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless and until a subsequent request for authorization has been approved by the board. A health care practitioner who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of the applicable provisions of this division, and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.

(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(l) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SB 294

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 294
Author: Negrete McLeod
Chapter: #695
Subject: Professions and Vocations: Regulation
Sponsor: Author
Board Position: None

DESCRIPTION OF CURRENT LEGISLATION:

This bill changes the sunset review dates on various Department of Consumer Affairs (DCA) regulatory boards and bureaus, including the Medical Board of California (the Board). This bill would change the sunset date for the Medical Board from 2013 to 2014.

ANALYSIS:

Existing law requires all boards and bureaus under DCA to go through the sunset review process, which is overseen by the Joint Legislative Sunset Review Committee. The purpose of the sunset review process is to routinely review the performance of these boards and bureaus.

This bill would change the sunset date for the Board from 2013 to 2014.

FISCAL: None

IMPLEMENTATION:

- Newsletter Article
- Notify Board Staff
- Prepare for performing a Sunset evaluation/report in late 2012, in anticipation of legislation in 2013.

Senate Bill No. 294

CHAPTER 695

An act to amend Sections 2001, 2020, 2531, 2569, 2570.19, 2701, 2708, 2920, 2933, 3010.5, 3014.6, 3504, 3512, 3685, 3686, 3710, 3716, 4620, 4928, 4934, 4990, 4990.04, 5000, 5015.6, 5510, 5517, 5552.5, 5620, 5621, 5622, 5810, 6510, 6710, 6714, 7000.5, 7011, 7200, 7303, 8000, 8005, 8520, 8528, 8710, 11506, 18602, 18613, 22259 of, to amend and repeal Section 2531.75 of, and to add Section 4614 to, the Business and Professions Code, and to amend Section 94950 of the Education Code, relating to professions and vocations.

[Approved by Governor September 30, 2010. Filed with
Secretary of State September 30, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

SB 294, Negrete McLeod. Professions and vocations: **regulation**.

(1) Existing law provides for the licensure and **regulation** of various healing arts licensees by various boards, as defined, within the Department of Consumer Affairs, including the California Board of Occupational Therapy and the Physician Assistant Committee of the Medical Board of California. Existing law requires the Physician Assistant Committee of the Medical Board of California to appoint an executive officer. Under existing law, those provisions regarding the California Board of Occupational Therapy will become inoperative on July 1, 2013, and will be repealed on January 1, 2014. Those provisions governing the Physician Assistant Committee of the Medical Board of California will become inoperative on July 1, 2011, and will be repealed on January 1, 2012.

Under this bill, the provisions relating to the California Board of Occupational Therapy would become inoperative and be repealed on January 1, 2014, and the provisions concerning the Physician Assistant Committee of the Medical Board of California would become inoperative and be repealed on January 1, 2013.

Existing law provides for the licensure and regulation of certain healing arts licensees by the Medical Board of California, the State Board of Optometry, and the Respiratory Care Board of California. Existing law authorizes these boards to employ or appoint an executive director or executive officer. Existing law repeals these provisions on January 1, 2013. Existing law makes the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board responsible for the licensure of speech-language pathologists, audiologists, and hearing aid dispensers and authorizes the board to appoint an executive officer. Existing law repeals these provisions on January 1, 2012. Under existing law, the Board of Psychology is responsible for the licensure and regulation of psychologists

and is authorized to employ an executive officer. Existing law repeals these provisions on January 1, 2011.

This bill would repeal these provisions on January 1, 2014.

Existing law provides for the regulation of registered dispensing opticians by the Medical Board of California and provides that the powers and duties of the board in that regard shall be subject to review by the Joint Committee on Boards, Commissions, and Consumer Protection as if those provisions were scheduled to become inoperative on July 1, 2003, and repealed on January 1, 2004.

This bill would make the powers and duties of the board subject to that review as if those provisions were scheduled to be repealed on January 1, 2014.

Existing law provides for the licensure and regulation of specified healing arts licensees by the Acupuncture Board and the Board of Behavioral Sciences (BBS). Existing law authorizes the Acupuncture Board to appoint an executive officer and requires BBS to appoint an executive officer. Under existing law, these provisions are repealed on January 1, 2011.

Under this bill, these provisions would be repealed on January 1, 2013.

Existing law provides for the licensure and regulation of registered nurses by the Board of Registered Nursing and requires the board to appoint an executive officer. Under existing law, these provisions are repealed on January 1, 2013.

This bill would instead repeal these provisions on January 1, 2012.

Existing law provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California. Existing law provides that these regulatory provisions are repealed on January 1, 2013.

This bill would provide that these regulatory provisions are repealed on January 1, 2014.

(2) Existing law provides for the licensure and regulation of various professions and vocations by boards within the department, including, the California Board of Accountancy, the California Architects Board, the Landscape Architects Technical Committee, Professional Fiduciaries Bureau, the Board for Professional Engineers and Land Surveyors, and the State Board of Guide Dogs for the Blind. Existing law requires or authorizes, with certain exceptions, these boards to appoint an executive officer or a registrar. With respect to the Professional Fiduciaries Bureau, existing law authorizes the Governor to appoint the chief of the bureau. Under existing law, these provisions will become inoperative on July 1, 2011, and will be repealed on January 1, 2012.

This bill would make these provisions, inoperative and repealed on January 1, 2012.

Existing law authorizes the California Architects Board to implement an intern development program until July 1, 2011.

This bill would authorize the board to implement that program until July 1, 2012.

Existing law establishes in the Department of Pesticide Regulation a Structural Pest Control Board and requires the board, with the approval of the director of the department, to appoint a registrar. These provisions shall become inoperative on July 1, 2011, and are repealed on January 1, 2012.

This bill would make those provisions inoperative and repealed on January 1, 2015.

Existing law provides for the certification and regulation of interior designers until January 1, 2013.

This bill would extend the operation of these provisions to January 1, 2014.

Existing law provides for the regulation of certified common interest development managers and tax preparers and repeals these provisions on January 1, 2012.

This bill would repeal these provisions on January 1, 2015.

Under existing law, there is the Contractors' State License Board within the department and it is responsible for the licensure and regulation of contractors and existing law requires the board to appoint a registrar. Under existing law, these provisions are repealed on January 1, 2011.

This bill would repeal these provisions on January 1, 2012.

Existing law provides for the licensure and regulation of barbering and cosmetology by the Board of Barbering and Cosmetology and existing law authorizes the board to appoint an executive officer. Under existing law, these provisions are repealed on January 1, 2012.

This bill would repeal these provisions on January 1, 2014.

Under existing law, the practice of shorthand reporting is regulated by the Court Reporters Board of California and existing law authorizes the board to appoint committees. These provisions are repealed on January 1, 2011.

This bill would repeal these provisions on January 1, 2013.

Under existing law, the State Athletic Commission is responsible for licensing and regulating boxing, kickboxing, and martial arts matches and is required to appoint an executive officer. Existing law repeals these provisions on January 1, 2011.

This bill would repeal these provisions on January 1, 2012.

(3) Existing law, the California Private Postsecondary Education Act of 2009, provides for the regulation of private postsecondary educational institutions by the Bureau for Private Postsecondary Education in the Department of Consumer Affairs. Existing law repeals that act on January 1, 2016.

This bill would repeal the act on January 1, 2015.

(4) Existing law, until January 1, 2016, provides for the voluntary certification of massage practitioners and massage therapists by a nonprofit Massage Therapy Organization that is governed by a board of directors, and imposes certain duties on that organization. Existing law prohibits a city, county, or city and county from enacting an ordinance that requires a certificate holder to obtain any other license, permit, or other authorization

to engage in the practice of massage in addition to the certificate issued by the organization.

This bill would repeal these provisions on January 1, 2015. The bill would specify that establishing a uniform standard of certification and regulation of massage practitioners and massage therapists is a matter of statewide concern, and the massage therapy provisions apply to all cities and counties, including charter cities and charter counties.

(5) This bill would incorporate additional changes in Section 2570.19 of the Business and Professions Code proposed by SB 999 and SB 1489, to be operative if SB 999 and SB 1489, or either of them, and this bill become effective on or before January 1, 2011, and this bill is enacted last.

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

SECTION 1. Section 2001 of the Business and Professions Code is amended to read:

2001. (a) There is in the Department of Consumer Affairs a Medical Board of California that consists of 15 members, seven of whom shall be public members.

(b) The Governor shall appoint 13 members to the board, subject to confirmation by the Senate, five of whom shall be public members. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.

(c) Notwithstanding any other provision of law, to reduce the membership of the board to 15, the following shall occur:

(1) Two positions on the board that are public members having a term that expires on June 1, 2010, shall terminate instead on January 1, 2008.

(2) Two positions on the board that are not public members having a term that expires on June 1, 2008, shall terminate instead on August 1, 2008.

(3) Two positions on the board that are not public members having a term that expires on June 1, 2011, shall terminate instead on January 1, 2008.

(d) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date. The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 2. Section 2020 of the Business and Professions Code is amended to read:

2020. (a) The board may employ an executive director exempt from the provisions of the Civil Service Act and may also employ investigators, legal counsel, medical consultants, and other assistance as it may deem necessary to carry this chapter into effect. The board may fix the compensation to be paid for services subject to the provisions of applicable state laws and regulations and may incur other expenses as it may deem

SB 700

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 700
Author: Negrete McLeod
Chapter: #505
Subject: Peer Review
Sponsor: Author
Board Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill adds a definition of peer review. In addition, it adds that the peer review minutes or reports may be obtained by the Board.

ANALYSIS:

This bill focuses on enhancements to the peer review system as it relates to the Medical Board (Board) and oversight by the California Department of Public Health (DPH).

Specifically, this bill does the following:

- Adds a definition of what peer review is by specifying that it is the process in which the basic qualifications, staff privileges, employment, outcomes and conduct of licentiates are reviewed to determine if licensees may continue to practice in the facility and if so, under what, if any, parameters.
- Rewrites for clarity the section that requires an 805 report to be filed within 15 days from the date when:
 1. A peer review body denies or rejects a licensee's application for staff privileges or membership for a medical disciplinary cause or reason;
 2. A licensee's staff privileges, membership, or employment are revoked for a medical disciplinary cause or reason;
 3. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a total of 30 days or more within any 12 month period for medical disciplinary reasons;
 4. A licensee resigns or takes a leave of absence from staff

- privileges, membership or employment;
5. A licensee withdraws or abandons his or her application for staff privileges, membership, or employment;
 6. A licensee withdraws or abandons his or her request for renewal of staff privileges, membership, or employment after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason after receiving notice that his or her application for staff privileges, membership, or employment is denied or will be denied for a medical disciplinary cause or reason.
 7. A summary suspension of staff privileges, membership, or employment is imposed for a period in excess of 14 days.

This is to ensure that the Medical Board is informed as soon as possible when a physician has had restrictions imposed or is involved in an investigation regarding medical discipline.

- Requires an 805 report to be maintained electronically for dissemination for a period of three years after receipt.
- Adds that minutes or reports of a peer review are included in the documents that the Board may inspect. This will give the Board faster access to information so the Board can address issues of quality of care in an expeditious manner.
- Prohibits the Board from disclosing to the public any peer review summaries completed by a hospital if a court finds that the peer review was not conducted in good faith. This makes reporting fair for licensees who have a bogus report filed against them.
- Entitles the Board to inspect and copy specified unredacted documents relating to any disciplinary proceeding resulting in an action that is required to be reported pursuant to Section 805 without subpoena. This will give the Board faster access to information so the Board can address issues of quality of care in an expeditious manner.
- Requires the Board to remove from the Internet Website any information concerning a hospital disciplinary action that is posted if a court finds that the peer review was not done in good faith. The licensee must notify the Board of that finding. This makes reporting fair for licensees who have a bogus report filed against them.
- Requires the Board to post a factsheet on the internet that explains and

provides information on 805 reporting. The will help consumers understand the process and what this reporting means.

The August 20, 2010 amendments delete the allowance, that was in the bill, for the Board to inspect and copy specified unredacted documents relating to any disciplinary proceeding resulting in an action that is required to be reported pursuant to Section 805 without a subpoena. The amendments also delete from the bill the reporting of a formal investigation to the Board by a peer review body within 15 days of investigations related to a physicians' ability to practice medicine safely, based upon information they may be suffering from a disabling mental or physical condition that poses a threat to patient care. These sections would have given the Board broader authority to obtain information.

FISCAL: Minimal and absorbable

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board Staff
- Develop and post the factsheet by 1/1/10

October 20, 2010

Senate Bill No. 700

CHAPTER 505

An act to amend Sections 800, 803.1, 805, 805.1, 805.5, 2027, and 2220 of, and to add Section 805.01 to, the Business and Professions Code, relating to healing arts.

[Approved by Governor September 29, 2010. Filed with Secretary of State September 29, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

SB 700, Negrete McLeod. Healing arts: peer review.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process.

This bill would define the term "peer review" for purposes of those provisions.

Under existing law, specified persons are required to file a report, designated as an "805 report," with a licensing board within 15 days after a specified action is taken against a person licensed by that board.

This bill would also require specified persons to file a report with a licensing board within 15 days after a peer review body makes a decision or recommendation regarding the disciplinary action to be taken against a licentiate of that board based on the peer review body's determination, following formal investigation, that the licentiate may have engaged in various acts, including incompetence, substance abuse, excessive prescribing or furnishing of controlled substances, or sexual misconduct, among other things. The bill would authorize the board to inspect and copy certain documents in the record of that investigation.

Existing law requires the board to maintain an 805 report for a period of 3 years after receipt.

This bill would require the board to maintain the report electronically.

Existing law authorizes the Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California to inspect and copy certain documents in the record of any disciplinary proceeding resulting in action that is required to be reported in an 805 report.

This bill would specify that the boards have the authority to also inspect, as permitted by other applicable law, any certified copy of medical records in the record of the disciplinary proceeding.

Existing law requires specified healing arts boards to maintain a central file of their licensees containing, among other things, disciplinary information reported through 805 reports.

Under this bill, if a court finds, in a final judgment, that the peer review resulting in the 805 report was conducted in bad faith and the licensee who

is the subject of the report notifies the board of that finding, the board would be required to include that finding in the licensee's central file.

Existing law requires the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine to disclose an 805 report to specified health care entities and to disclose certain hospital disciplinary actions to inquiring members of the public. Existing law also requires the Medical Board of California to post hospital disciplinary actions regarding its licensees on the Internet.

This bill would prohibit those disclosures, and would require the Medical Board of California to remove certain information posted on the Internet, if a court finds, in a final judgment, that the peer review resulting in the 805 report or the hospital disciplinary action was conducted in bad faith and the licensee notifies the board of that finding. The bill would also require the Medical Board of California to include certain exculpatory or explanatory statements in those disclosures or postings and would require the board to post on the Internet a factsheet that explains and provides information on the 805 reporting requirements.

Existing law also requires the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine to disclose to an inquiring member of the public information regarding enforcement actions taken against a licensee by the board or by another state or jurisdiction.

This bill would also require those boards to make those disclosures regarding enforcement actions taken against former licensees.

The bill would make related technical and nonsubstantive changes.

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

SECTION 1. Section 800 of the Business and Professions Code is amended to read:

800. (a) The Medical Board of California, the Board of Psychology, the Dental Board of California, the Osteopathic Medical Board of California, the State Board of Chiropractic Examiners, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians, the State Board of Optometry, the Veterinary Medical Board, the Board of Behavioral Sciences, the Physical Therapy Board of California, the California State Board of Pharmacy, the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, the California Board of Occupational Therapy, and the Acupuncture Board shall each separately create and maintain a central file of the names of all persons who hold a license, certificate, or similar authority from that board. Each central file shall be created and maintained to provide an individual historical record for each licensee with respect to the following information:

(1) Any conviction of a crime in this or any other state that constitutes unprofessional conduct pursuant to the reporting requirements of Section 803.

(2) Any judgment or settlement requiring the licensee or his or her insurer to pay any amount of damages in excess of three thousand dollars (\$3,000) for any claim that injury or death was proximately caused by the licensee's negligence, error or omission in practice, or by rendering unauthorized professional services, pursuant to the reporting requirements of Section 801 or 802.

(3) Any public complaints for which provision is made pursuant to subdivision (b).

(4) Disciplinary information reported pursuant to Section 805, including any additional exculpatory or explanatory statements submitted by the licensee pursuant to subdivision (f) of Section 805. If a court finds, in a final judgment, that the peer review resulting in the 805 report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, the board shall include that finding in the central file. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(5) Information reported pursuant to Section 805.01, including any explanatory or exculpatory information submitted by the licensee pursuant to subdivision (b) of that section.

(b) Each board shall prescribe and promulgate forms on which members of the public and other licensees or certificate holders may file written complaints to the board alleging any act of misconduct in, or connected with, the performance of professional services by the licensee.

If a board, or division thereof, a committee, or a panel has failed to act upon a complaint or report within five years, or has found that the complaint or report is without merit, the central file shall be purged of information relating to the complaint or report.

Notwithstanding this subdivision, the Board of Psychology, the Board of Behavioral Sciences, and the Respiratory Care Board of California shall maintain complaints or reports as long as each board deems necessary.

(c) The contents of any central file that are not public records under any other provision of law shall be confidential except that the licensee involved, or his or her counsel or representative, shall have the right to inspect and have copies made of his or her complete file except for the provision that may disclose the identity of an information source. For the purposes of this section, a board may protect an information source by providing a copy of the material with only those deletions necessary to protect the identity of the source or by providing a comprehensive summary of the substance of the material. Whichever method is used, the board shall ensure that full disclosure is made to the subject of any personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or threatening to a licensee's reputation, rights, benefits, privileges, or qualifications, or be used by a board to make a determination that would affect a licensee's rights, benefits, privileges, or qualifications. The information required to be disclosed pursuant to Section 803.1 shall not be considered among the contents of a central file for the purposes of this subdivision.

The licensee may, but is not required to, submit any additional exculpatory or explanatory statement or other information that the board shall include in the central file.

Each board may permit any law enforcement or regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes to inspect and have copies made of that licensee's file, unless the disclosure is otherwise prohibited by law.

These disclosures shall effect no change in the confidential status of these records.

SEC. 2. Section 803.1 of the Business and Professions Code is amended to read:

803.1. (a) Notwithstanding any other provision of law, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall disclose to an inquiring member of the public information regarding any enforcement actions taken against a licensee, including a former licensee, by the board or by another state or jurisdiction, including all of the following:

- (1) Temporary restraining orders issued.
- (2) Interim suspension orders issued.
- (3) Revocations, suspensions, probations, or limitations on practice ordered by the board, including those made part of a probationary order or stipulated agreement.

- (4) Public letters of reprimand issued.
- (5) Infractions, citations, or fines imposed.

(b) Notwithstanding any other provision of law, in addition to the information provided in subdivision (a), the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall disclose to an inquiring member of the public all of the following:

(1) Civil judgments in any amount, whether or not vacated by a settlement after entry of the judgment, that were not reversed on appeal and arbitration awards in any amount of a claim or action for damages for death or personal injury caused by the physician and surgeon's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(2) (A) All settlements in the possession, custody, or control of the board shall be disclosed for a licensee in the low-risk category if there are three or more settlements for that licensee within the last 10 years, except for settlements by a licensee regardless of the amount paid where (i) the settlement is made as a part of the settlement of a class claim, (ii) the licensee paid in settlement of the class claim the same amount as the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case where the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action. All settlements in the possession, custody, or control of the board shall be disclosed for a licensee in the high-risk category if there are four or more settlements for that licensee within the last 10 years except for settlements by a licensee regardless of

the amount paid where (i) the settlement is made as a part of the settlement of a class claim, (ii) the licensee paid in settlement of the class claim the same amount as the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case where the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action. Classification of a licensee in either a "high-risk category" or a "low-risk category" depends upon the specialty or subspecialty practiced by the licensee and the designation assigned to that specialty or subspecialty by the Medical Board of California, as described in subdivision (f). For the purposes of this paragraph, "settlement" means a settlement of an action described in paragraph (1) entered into by the licensee on or after January 1, 2003, in an amount of thirty thousand dollars (\$30,000) or more.

(B) The board shall not disclose the actual dollar amount of a settlement but shall put the number and amount of the settlement in context by doing the following:

(i) Comparing the settlement amount to the experience of other licensees within the same specialty or subspecialty, indicating if it is below average, average, or above average for the most recent 10-year period.

(ii) Reporting the number of years the licensee has been in practice.

(iii) Reporting the total number of licensees in that specialty or subspecialty, the number of those who have entered into a settlement agreement, and the percentage that number represents of the total number of licensees in the specialty or subspecialty.

(3) Current American Board of Medical Specialty certification or board equivalent as certified by the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine.

(4) Approved postgraduate training.

(5) Status of the license of a licensee. By January 1, 2004, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall adopt regulations defining the status of a licensee. The board shall employ this definition when disclosing the status of a licensee pursuant to Section 2027.

(6) Any summaries of hospital disciplinary actions that result in the termination or revocation of a licensee's staff privileges for medical disciplinary cause or reason, unless a court finds, in a final judgment, that the peer review resulting in the disciplinary action was conducted in bad faith and the licensee notifies the board of that finding. In addition, any exculpatory or explanatory statements submitted by the licensee electronically pursuant to subdivision (f) of that section shall be disclosed. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(c) Notwithstanding any other provision of law, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall disclose to an inquiring member of the public information received regarding felony convictions of a physician and surgeon or doctor of podiatric medicine.

(d) The Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine may formulate appropriate disclaimers or explanatory statements to be included with any information released, and may by regulation establish categories of information that need not be disclosed to an inquiring member of the public because that information is unreliable or not sufficiently related to the licensee's professional practice. The Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall include the following statement when disclosing information concerning a settlement:

"Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the State of California believes that consumers should have access to malpractice information. In these profiles, the State of California has given you information about both the malpractice settlement history for the doctor's specialty and the doctor's history of settlement payments only if in the last 10 years, the doctor, if in a low-risk specialty, has three or more settlements or the doctor, if in a high-risk specialty, has four or more settlements. The State of California has excluded some class action lawsuits because those cases are commonly related to systems issues such as product liability, rather than questions of individual professional competence and because they are brought on a class basis where the economic incentive for settlement is great. The State of California has placed payment amounts into three statistical categories: below average, average, and above average compared to others in the doctor's specialty. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high-quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make an individual doctor's history more meaningful.

This report reflects data only for settlements made on or after January 1, 2003. Moreover, it includes information concerning those settlements for a 10-year period only. Therefore, you should know that a doctor may have made settlements in the 10 years immediately preceding January 1, 2003, that are not included in this report. After January 1, 2013, for doctors practicing less than 10 years, the data covers their total years of practice. You should take into account the effective date of settlement disclosure as well as how long the doctor has been in practice when considering malpractice averages.

The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to settle. Some doctors work primarily with high-risk patients. These doctors may have malpractice settlement histories that are

higher than average because they specialize in cases or patients who are at very high risk for problems.

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the doctor. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information in this report and the general issue of malpractice with your doctor.”

(e) The Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall, by regulation, develop standard terminology that accurately describes the different types of disciplinary filings and actions to take against a licensee as described in paragraphs (1) to (5), inclusive, of subdivision (a). In providing the public with information about a licensee via the Internet pursuant to Section 2027, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall not use the terms “enforcement,” “discipline,” or similar language implying a sanction unless the physician and surgeon has been the subject of one of the actions described in paragraphs (1) to (5), inclusive, of subdivision (a).

(f) The Medical Board of California shall adopt regulations no later than July 1, 2003, designating each specialty and subspecialty practice area as either high risk or low risk. In promulgating these regulations, the board shall consult with commercial underwriters of medical malpractice insurance companies, health care systems that self-insure physicians and surgeons, and representatives of the California medical specialty societies. The board shall utilize the carriers’ statewide data to establish the two risk categories and the averages required by subparagraph (B) of paragraph (2) of subdivision (b). Prior to issuing regulations, the board shall convene public meetings with the medical malpractice carriers, self-insurers, and specialty representatives.

(g) The Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall provide each licensee, including a former licensee under subdivision (a), with a copy of the text of any proposed public disclosure authorized by this section prior to release of the disclosure to the public. The licensee shall have 10 working days from the date the board provides the copy of the proposed public disclosure to propose corrections of factual inaccuracies. Nothing in this section shall prevent the board from disclosing information to the public prior to the expiration of the 10-day period.

(h) Pursuant to subparagraph (A) of paragraph (2) of subdivision (b), the specialty or subspecialty information required by this section shall group physicians by specialty board recognized pursuant to paragraph (5) of subdivision (h) of Section 651 unless a different grouping would be more

valid and the board, in its statement of reasons for its regulations, explains why the validity of the grouping would be more valid.

SEC. 3. Section 805 of the Business and Professions Code is amended to read:

805. (a) As used in this section, the following terms have the following definitions:

(1) (A) "Peer review" means both of the following:

(i) A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following:

(I) Determine whether a licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, to determine the parameters of that practice.

(II) Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.

(ii) Any other activities of a peer review body as specified in subparagraph (B).

(B) "Peer review body" includes:

(i) A medical or professional staff of any health care facility or clinic licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code or of a facility certified to participate in the federal Medicare Program as an ambulatory surgical center.

(ii) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that contracts with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code.

(iii) Any medical, psychological, marriage and family therapy, social work, dental, or podiatric professional society having as members at least 25 percent of the eligible licentiates in the area in which it functions (which must include at least one county), which is not organized for profit and which has been determined to be exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code.

(iv) A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity.

(2) "Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, or dentist. "Licentiate" also includes a person authorized to practice medicine pursuant to Section 2113 or 2168.

(3) "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates listed in paragraph (2).

(4) "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges,

active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

(5) “Denial or termination of staff privileges, membership, or employment” includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

(6) “Medical disciplinary cause or reason” means that aspect of a licentiate’s competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

(7) “805 report” means the written report required under subdivision (b).

(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body:

(1) A licentiate’s application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.

(2) A licentiate’s membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

(3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

(c) If a licentiate takes any action listed in paragraph (1), (2), or (3) after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within 15 days after the licentiate takes the action.

(1) Resigns or takes a leave of absence from membership, staff privileges, or employment.

(2) Withdraws or abandons his or her application for staff privileges or membership.

(3) Withdraws or abandons his or her request for renewal of staff privileges or membership.

(d) For purposes of filing an 805 report, the signature of at least one of the individuals indicated in subdivision (b) or (c) on the completed form shall constitute compliance with the requirement to file the report.

(e) An 805 report shall also be filed within 15 days following the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.

(f) A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information, electronically or otherwise, pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report. The notice shall also advise the licentiate that information submitted electronically will be publicly disclosed to those who request the information.

The information to be reported in an 805 report shall include the name and license number of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter.

A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section 805.5, the agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report.

If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

(g) The reporting required by this section shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800 and Sections 803.1 and 2027, provided that a copy of the report containing the information required by this section may be disclosed as required by Section 805.5 with respect to reports received on or after January 1, 1976.

(h) The Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California shall disclose reports as required by Section 805.5.

(i) An 805 report shall be maintained electronically by an agency for dissemination purposes for a period of three years after receipt.

(j) No person shall incur any civil or criminal liability as the result of making any report required by this section.

(k) A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars (\$100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the

person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, "willful" means a voluntary and intentional violation of a known legal duty.

(l) Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that under no circumstances shall exceed fifty thousand dollars (\$50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars (\$50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

(m) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates.

SEC. 4. Section 805.01 is added to the Business and Professions Code, to read:

805.01. (a) As used in this section, the following terms have the following definitions:

(1) "Agency" has the same meaning as defined in Section 805.

(2) "Formal investigation" means an investigation performed by a peer review body based on an allegation that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) occurred.

(3) “Licentiate” has the same meaning as defined in Section 805.

(4) “Peer review body” has the same meaning as defined in Section 805.

(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file a report with the relevant agency within 15 days after a peer review body makes a final decision or recommendation regarding the disciplinary action, as specified in subdivision (b) of Section 805, resulting in a final proposed action to be taken against a licentiate based on the peer review body’s determination, following formal investigation of the licentiate, that any of the acts listed in paragraphs (1) to (4), inclusive, may have occurred, regardless of whether a hearing is held pursuant to Section 809.2. The licentiate shall receive a notice of the proposed action as set forth in Section 809.1, which shall also include a notice advising the licentiate of the right to submit additional explanatory or exculpatory statements electronically or otherwise.

(1) Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to Section 809.5.

(2) The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(c) The relevant agency shall be entitled to inspect and copy the following documents in the record of any formal investigation required to be reported pursuant to subdivision (b):

(1) Any statement of charges.

(2) Any document, medical chart, or exhibit.

(3) Any opinions, findings, or conclusions.

(4) Any certified copy of medical records, as permitted by other applicable law.

(d) The report provided pursuant to subdivision (b) and the information disclosed pursuant to subdivision (c) shall be kept confidential and shall not be subject to discovery, except that the information may be reviewed as provided in subdivision (c) of Section 800 and may be disclosed in any subsequent disciplinary hearing conducted pursuant to the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) The report required under this section shall be in addition to any report required under Section 805.

(f) A peer review body shall not be required to make a report pursuant to this section if that body does not make a final decision or recommendation regarding the disciplinary action to be taken against a licensee based on the body's determination that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) may have occurred.

SEC. 5. Section 805.1 of the Business and Professions Code is amended to read:

805.1. (a) The Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California shall be entitled to inspect and copy the following documents in the record of any disciplinary proceeding resulting in action that is required to be reported pursuant to Section 805:

- (1) Any statement of charges.
- (2) Any document, medical chart, or exhibits in evidence.
- (3) Any opinion, findings, or conclusions.
- (4) Any certified copy of medical records, as permitted by other applicable law.

(b) The information so disclosed shall be kept confidential and not subject to discovery, in accordance with Section 800, except that it may be reviewed, as provided in subdivision (c) of Section 800, and may be disclosed in any subsequent disciplinary hearing conducted pursuant to the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 6. Section 805.5 of the Business and Professions Code is amended to read:

805.5. (a) Prior to granting or renewing staff privileges for any physician and surgeon, psychologist, podiatrist, or dentist, any health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code, or any health care service plan or medical care foundation, or the medical staff of the institution shall request a report from the Medical Board of California, the Board of Psychology, the Osteopathic Medical Board of California, or the Dental Board of California to determine if any report has been made pursuant to Section 805 indicating that the applying physician and surgeon, psychologist, podiatrist, or dentist has been denied staff privileges, been removed from a medical staff, or had his or her staff privileges restricted as provided in Section 805. The request shall include the name and California license number of the physician and surgeon,

psychologist, podiatrist, or dentist. Furnishing of a copy of the 805 report shall not cause the 805 report to be a public record.

(b) Upon a request made by, or on behalf of, an institution described in subdivision (a) or its medical staff the board shall furnish a copy of any report made pursuant to Section 805 as well as any additional exculpatory or explanatory information submitted electronically to the board by the licensee pursuant to subdivision (f) of that section. However, the board shall not send a copy of a report (1) if the denial, removal, or restriction was imposed solely because of the failure to complete medical records, (2) if the board has found the information reported is without merit, (3) if a court finds, in a final judgment, that the peer review, as defined in Section 805, resulting in the report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, or (4) if a period of three years has elapsed since the report was submitted. This three-year period shall be tolled during any period the licensee has obtained a judicial order precluding disclosure of the report, unless the board is finally and permanently precluded by judicial order from disclosing the report. If a request is received by the board while the board is subject to a judicial order limiting or precluding disclosure, the board shall provide a disclosure to any qualified requesting party as soon as practicable after the judicial order is no longer in force.

If the board fails to advise the institution within 30 working days following its request for a report required by this section, the institution may grant or renew staff privileges for the physician and surgeon, psychologist, podiatrist, or dentist.

(c) Any institution described in subdivision (a) or its medical staff that violates subdivision (a) is guilty of a misdemeanor and shall be punished by a fine of not less than two hundred dollars (\$200) nor more than one thousand two hundred dollars (\$1,200).

SEC. 7. Section 2027 of the Business and Professions Code is amended to read:

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

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

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

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

(4) All current accusations filed by the Attorney General, including those accusations that are on appeal. For purposes of this paragraph, "current accusation" shall mean an accusation that has not been dismissed, withdrawn, or settled, and has not been finally decided upon by an administrative law

judge and the Medical Board of California unless an appeal of that decision is pending.

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

(6) Any hospital disciplinary actions that resulted in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason. The posting shall also provide a link to any additional explanatory or exculpatory information submitted electronically by the licensee pursuant to subdivision (f) of Section 805.

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

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

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

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

(2) The information described in paragraphs (3) and (6) of subdivision (a) shall not be removed from being posted on the board's Internet Web site.

(3) Notwithstanding paragraph (2) and except as provided in paragraph (4), if a licensee's hospital staff privileges are restored and the licensee notifies the board of the restoration, the information pertaining to the termination or revocation of those privileges, as described in paragraph (6) of subdivision (a), shall remain posted for a period of 10 years from the restoration date of the privileges, and at the end of that period shall be removed from being posted on the board's Internet Web site.

(4) Notwithstanding paragraph (2), if a court finds, in a final judgment, that peer review resulting in a hospital disciplinary action was conducted in bad faith and the licensee notifies the board of that finding, the information concerning that hospital disciplinary action posted pursuant to paragraph (6) of subdivision (a) shall be immediately removed from the board's Internet Web site. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(c) The board shall also post on the Internet a factsheet that explains and provides information on the reporting requirements under Section 805.

(d) The board shall provide links to other Web sites on the Internet that provide information on board certifications that meet the requirements of subdivision (b) of Section 651. The board may provide links to other Web

sites on the Internet that provide information on health care service plans, health insurers, hospitals, or other facilities. The board may also provide links to any other sites that would provide information on the affiliations of licensed physicians and surgeons.

SEC. 8. Section 2220 of the Business and Professions Code is amended to read:

2220. Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars (\$30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

SB 1069

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1069
Author: Pavley
Chapter: #512
Subject: Physician Assistants
Sponsor: California Academy of Physician Assistants
Board Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize physician assistants to perform physical examinations, order durable medical equipment, and certify disability for the purpose of unemployment insurance eligibility.

This bill was amended to delete the amending provision to authorize physician assistants to certify disability for the purpose of unemployment insurance eligibility.

ANALYSIS:

Physician Assistants practice medicine under the supervision of physicians and surgeons and the duties of physician assistants are determined by the supervising physician and by current law. Current California law authorizes physician assistants to perform and certify specified medical examinations; this bill will permit physician assistants to perform other similar examinations and certifications.

The author and the sponsor of this bill believe that allowing physician assistants to perform physical examinations and sign all corresponding forms, order durable medical equipment, and certify disability for the purpose of unemployment insurance eligibility will help to expand access to health care by furthering a physician's ability to delegate specified health care tasks.

This bill was amended on May 5, 2010 to make a minor, technical change.

This bill was amended on August 16, 2010 to delete authorization in the bill to allow physician assistants to certify disability for the purpose of unemployment insurance eligibility.

FISCAL: None

IMPLEMENTATION:

- Newsletter Article

October 20, 2010

Senate Bill No. 1069

CHAPTER 512

An act to amend Section 3501 of, and to add Sections 3502.2 and 3502.3 to, the Business and Professions Code, to amend Sections 44336, 49406, 49423, 49455, 87408, 87408.5, and 87408.6 of, and to add Section 49458 to, the Education Code, and to amend Section 2881 of the Public Utilities Code, relating to physician assistants.

[Approved by Governor September 29, 2010. Filed with
Secretary of State September 29, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1069, Pavley. Physician assistants.

Existing law, the Physician Assistant Practice Act, is administered by the Physician Assistant Committee of the Medical Board of California and provides for the licensure and regulation of physician assistants. Existing law provides that a physician assistant may perform the medical services that are set forth by the regulations of the board when the services are rendered under the supervision of a licensed physician and surgeon. Existing law requires a physician assistant and his or her supervising physician to establish written guidelines for the adequate supervision of the physician assistant. Existing law provides that those requirements may be satisfied by adopting protocols for some or all of the tasks performed by the physician assistant, as specified.

This bill would provide that a physician assistant acts as the agent of the supervising physician when performing authorized activities, and would authorize a physician assistant to perform physical examinations and other specified medical services, as defined, and sign and attest to any document evidencing those examinations and other services, as required pursuant to specified provisions of law. The bill would further provide that a delegation of services agreement may authorize a physician assistant to order durable medical equipment and make arrangements with regard to home health services or personal care services. The bill would make conforming changes to provisions in the Education Code and the Public Utilities Code with regard to the performance of those examinations and services and acceptance of those attestations. The bill would also authorize a physician assistant to perform a physical examination that is required for participation in an interscholastic athletic program, as specified.

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

SECTION 1. Section 3501 of the Business and Professions Code is amended to read:

3501. As used in this chapter:

- (a) "Board" means the Medical Board of California.
- (b) "Approved program" means a program for the education of physician assistants that has been formally approved by the committee.
- (c) "Trainee" means a person who is currently enrolled in an approved program.
- (d) "Physician assistant" means a person who meets the requirements of this chapter and is licensed by the committee.
- (e) "Supervising physician" means a physician and surgeon licensed by the board or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation for improper use of a physician assistant.
- (f) "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant.
- (g) "Committee" or "examining committee" means the Physician Assistant Committee.
- (h) "Regulations" means the rules and regulations as set forth in Chapter 13.8 (commencing with Section 1399.500) of Title 16 of the California Code of Regulations.
- (i) "Routine visual screening" means uninvaseive nonpharmacological simple testing for visual acuity, visual field defects, color blindness, and depth perception.
- (j) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.
- (k) "Delegation of services agreement" means the writing that delegates to a physician assistant from a supervising physician the medical services the physician assistant is authorized to perform consistent with subdivision (a) of Section 1399.540 of Title 16 of the California Code of Regulations.
- (l) "Other specified medical services" means tests or examinations performed or ordered by a physician assistant practicing in compliance with this chapter or regulations of the board promulgated under this chapter.
- (m) A physician assistant acts as an agent of the supervising physician when performing any activity authorized by this chapter or regulations promulgated by the board under this chapter.

SEC. 2. Section 3502.2 is added to the Business and Professions Code, to read:

3502.2. Notwithstanding any other provision of law, a physician assistant may perform the physical examination and any other specified medical services that are required pursuant to Section 2881 of the Public Utilities Code and Sections 44336, 49406, 49423, 49455, 87408, 87408.5, and

87408.6 of the Education Code, practicing in compliance with this chapter, and may sign and attest to any certificate, card, form, or other documentation evidencing the examination or other specified medical services.

SEC. 3. Section 3502.3 is added to the Business and Professions Code, to read:

3502.3. (a) Notwithstanding any other provision of law, in addition to any other practices that meet the general criteria set forth in this chapter or the board's regulations for inclusion in a delegation of services agreement, a delegation of services agreement may authorize a physician assistant to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in Section 3502 or the delegation of services agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) For individuals receiving home health services or personal care services, after consultation with the supervising physician, approve, sign, modify, or add to a plan of treatment or plan of care.

(b) Nothing in this section shall be construed to affect the validity of any delegation of services agreement in effect prior to the enactment of this section or those adopted subsequent to enactment.

SEC. 4. Section 44336 of the Education Code is amended to read:

44336. When required by the commission, the application for a certification document or the renewal thereof shall be accompanied by a certificate in such form as shall be prescribed by the commission, from a physician and surgeon licensed under the provisions of the Business and Professions Code or a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, showing that the applicant is free from any contagious and communicable disease or other disabling disease or defect unfitting the applicant to instruct or associate with children.

SEC. 5. Section 49406 of the Education Code is amended to read:

49406. (a) Except as provided in subdivision (h), no person shall be initially employed by a school district in a certificated or classified position unless the person has submitted to an examination within the past 60 days to determine that he or she is free of active tuberculosis, by a physician and surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code. This examination shall consist of either an approved intradermal tuberculin test or any other test for tuberculosis infection that is recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA), which, if positive, shall be followed by an X-ray of the lungs in accordance with subdivision (f) of Section 120115 of the Health and Safety Code.

The X-ray film may be taken by a competent and qualified X-ray technician if the X-ray film is subsequently interpreted by a physician and

surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

The district superintendent or his or her designee may exempt, for a period not to exceed 60 days following termination of the pregnancy, a pregnant employee from the requirement that a positive intradermal tuberculin test be followed by an X-ray of the lungs.

(b) Thereafter, employees who are test negative by either the tuberculin skin test or any other test for tuberculosis infection recommended by the CDC and licensed by the FDA shall be required to undergo the foregoing examination at least once each four years or more often if directed by the governing board upon recommendation of the local health officer for so long as the employee's test remains negative. Once an employee has a documented positive test for tuberculosis infection conducted pursuant to this subdivision which has been followed by an X-ray, the foregoing examination is no longer required, and a referral shall be made within 30 days of completion of the examination to the local health officer to determine the need for followup care.

(c) After the examination, each employee shall cause to be on file with the district superintendent of schools a certificate from the examining physician and surgeon or physician assistant showing the employee was examined and found free from active tuberculosis. The county board of education may require, by rule, that all their certificates be filed in the office of the county superintendent of schools or shall require their files be maintained in the office of the county superintendent of schools if a majority of the governing boards of the districts within the county so petition the county board of education, except that in either case a district or districts with a common board having an average daily attendance of 60,000 or more may elect to maintain the files for its employees in that district. "Certificate," as used in this section, means a certificate signed by the examining physician and surgeon or physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code or a notice from a public health agency or unit of the American Lung Association that indicates freedom from active tuberculosis. The latter, regardless of form, shall constitute evidence of compliance with this section. Nothing in this section shall prevent the governing board, upon recommendation of the local health officer, from establishing a rule requiring a more extensive or more frequent physical examination than required by this section, but the rule shall provide for reimbursement on the same basis as required in this section.

(d) This examination is a condition of initial employment and the expense incident thereto shall be borne by the applicant unless otherwise provided by rules of the governing board. However, the board may, if an applicant is accepted for employment, reimburse that person in a like manner prescribed in this section for employees.

(e) The governing board of each district shall reimburse the employee for the cost, if any, of this examination. The board may provide for the examination required by this section or may establish a reasonable fee for

the examination that is reimbursable to employees of the district complying with the provisions of this section.

(f) At the discretion of the governing board, this section shall not apply to those employees not requiring certification qualifications who are employed for any period of time less than a school year whose functions do not require frequent or prolonged contact with pupils.

The governing board may, however, require an examination described in subdivision (b) and may, as a contract condition, require the examination of persons employed under contract, other than those persons specified in subdivision (a), if the board believes the presence of these persons in and around school premises would constitute a health hazard to pupils.

(g) If the governing board of a school district determines by resolution, after hearing, that the health of pupils in the district would not be jeopardized thereby, this section shall not apply to any employee of the district who files an affidavit stating that he or she adheres to the faith or teachings of any well-recognized religious sect, denomination, or organization and in accordance with its creed, tenets, or principles depends for healing upon prayer in the practice of religion and that to the best of his or her knowledge and belief he or she is free from active tuberculosis. If at any time there should be probable cause to believe that the affiant is afflicted with active tuberculosis, he or she may be excluded from service until the governing board of the employing district is satisfied that he or she is not so afflicted.

(h) A person who transfers his or her employment from one school or school district to another shall be deemed to meet the requirements of subdivision (a) if that person can produce a certificate which shows that he or she was examined within the past four years and was found to be free of communicable tuberculosis, or if it is verified by the school previously employing him or her that it has a certificate on file which contains that showing.

A person who transfers his or her employment from a private or parochial elementary school, secondary school, or nursery school to a school or school district subject to this section shall be deemed to meet the requirements of subdivision (a) if that person can produce a certificate as provided for in Section 121525 of the Health and Safety Code that shows that he or she was examined within the past four years and was found to be free of communicable tuberculosis, or if it is verified by the school previously employing him or her that it has a certificate on file which contains that showing.

(i) Any governing board or county superintendent of schools providing for the transportation of pupils under contract authorized by Section 39800, 39801, or any other provision of law shall require as a condition of the contract the examination for active tuberculosis, as provided by subdivision (a), of all drivers transporting these pupils, provided that private contracted drivers who transport these pupils on an infrequent basis, not to exceed once a month, shall be excluded from this requirement.

SEC. 6. Section 49423 of the Education Code is amended to read:

49423. (a) Notwithstanding Section 49422, any pupil who is required to take, during the regular schoolday, medication prescribed for him or her by a physician and surgeon or ordered for him or her by a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, may be assisted by the school nurse or other designated school personnel or may carry and self-administer prescription auto-injectable epinephrine if the school district receives the appropriate written statements identified in subdivision (b).

(b) (1) In order for a pupil to be assisted by a school nurse or other designated school personnel pursuant to subdivision (a), the school district shall obtain both a written statement from the physician and surgeon or physician assistant detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken and a written statement from the parent, foster parent, or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the statement of the physician and surgeon or physician assistant.

(2) In order for a pupil to carry and self-administer prescription auto-injectable epinephrine pursuant to subdivision (a), the school district shall obtain both a written statement from the physician and surgeon or physician assistant detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken, and confirming that the pupil is able to self-administer auto-injectable epinephrine, and a written statement from the parent, foster parent, or guardian of the pupil consenting to the self-administration, providing a release for the school nurse or other designated school personnel to consult with the health care provider of the pupil regarding any questions that may arise with regard to the medication, and releasing the school district and school personnel from civil liability if the self-administering pupil suffers an adverse reaction as a result of self-administering medication pursuant to this paragraph.

(3) The written statements specified in this subdivision shall be provided at least annually and more frequently if the medication, dosage, frequency of administration, or reason for administration changes.

(c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses auto-injectable epinephrine in a manner other than as prescribed.

SEC. 7. Section 49455 of the Education Code is amended to read:

49455. Upon first enrollment in a California school district of a child at a California elementary school, and at least every third year thereafter until the child has completed the eighth grade, the child's vision shall be appraised by the school nurse or other authorized person under Section 49452. This evaluation shall include tests for visual acuity and color vision; however, color vision shall be appraised once and only on male children, and the results of the appraisal shall be entered in the health record of the pupil. Color vision appraisal need not begin until the male pupil has reached the first grade. Gross external observation of the child's eyes, visual performance, and perception shall be done by the school nurse and the classroom teacher. The evaluation may be waived, if the child's parents so

desire, by their presenting of a certificate from a physician and surgeon, a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, or an optometrist setting out the results of a determination of the child's vision, including visual acuity and color vision.

The provisions of this section shall not apply to any child whose parents or guardian file with the principal of the school in which the child is enrolling, a statement in writing that they adhere to the faith or teachings of any well-recognized religious sect, denomination, or organization and in accordance with its creed, tenets, or principles depend for healing upon prayer in the practice of their religion.

SEC. 8. Section 49458 is added to the Education Code, to read:

49458. When a school district or a county superintendent of schools requires a physical examination as a condition of participation in an interscholastic athletic program, the physical examination may be performed by a physician and surgeon or physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code.

SEC. 9. Section 87408 of the Education Code is amended to read:

87408. (a) When a community college district wishes to employ a person in an academic position and that person has not previously been employed in an academic position in this state, the district shall require a medical certificate showing that the applicant is free from any communicable disease, including, but not limited to, active tuberculosis, unfitting the applicant to instruct or associate with students. The medical certificate shall be submitted directly to the governing board by a physician and surgeon licensed under the Business and Professions Code, a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, or a commissioned medical officer exempted from licensure. The medical examination shall have been conducted not more than six months before the submission of the certificate and shall be at the expense of the applicant. A governing board may offer a contract of employment to an applicant subject to the submission of the required medical certificate. Notwithstanding Section 87031, the medical certificate shall become a part of the personnel record of the employee and shall be open to the employee or his or her designee.

(b) The governing board of a community college district may require academic employees to undergo a periodic medical examination by a physician and surgeon licensed under the Business and Professions Code, a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, or a commissioned medical officer exempted from licensure, to determine that the employee is free from any communicable disease, including, but not limited to, active tuberculosis, unfitting the applicant to instruct or associate with students. The periodic medical examination shall be at the expense of the district. The medical certificate shall become a part of the personnel

record of the employee and shall be open to the employee or his or her designee.

SEC. 10. Section 87408.5 of the Education Code is amended to read:

87408.5. (a) When a community college district wishes to employ a retirant who is retired for service, and such person has not been previously employed as a retirant, such district shall require, as a condition of initial employment as a retirant, a medical certificate showing that the retirant is free from any disabling disease unfitting him or her to instruct or associate with students. The medical certificate shall be completed and submitted directly to the community college district by a physician and surgeon licensed under the Business and Professions Code, a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, or a commissioned medical officer exempted from licensure. A medical examination shall be required for the completion of the medical certificate. The examination shall be conducted not more than six months before the completion and submission of the certificate and shall be at the expense of the retirant. The medical certificate shall become a part of the personnel record of the employee and shall be open to the employee or his or her designee.

(b) The community college district that initially employed the retirant, or any district that subsequently employs the retirant, may require a periodic medical examination by a physician and surgeon licensed under the Business and Professions Code, a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, or a commissioned medical officer exempted from licensure, to determine that the retirant is free from any communicable disease unfitting him or her to instruct or associate with students. The periodic medical examination shall be at the expense of the community college district. The medical certificate shall become a part of the personnel record of the retirant and shall be open to the retirant or his or her designee.

SEC. 11. Section 87408.6 of the Education Code is amended to read:

87408.6. (a) Except as provided in subdivision (h), no person shall be initially employed by a community college district in an academic or classified position unless the person has submitted to an examination within the past 60 days to determine that he or she is free of active tuberculosis, by a physician and surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code. This examination shall consist of an approved intradermal tuberculin test or any other test for tuberculosis infection recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA), that, if positive, shall be followed by an X-ray of the lungs.

The X-ray film may be taken by a competent and qualified X-ray technician if the X-ray film is subsequently interpreted by a physician and

surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

The district superintendent, or his or her designee, may exempt, for a period not to exceed 60 days following termination of the pregnancy, a pregnant employee from the requirement that a positive intradermal tuberculin test be followed by an X-ray of the lungs.

(b) Thereafter, employees who are skin test negative, or negative by any other test recommended by the CDC and licensed by the FDA, shall be required to undergo the foregoing examination at least once each four years or more often if directed by the governing board upon recommendation of the local health officer for so long as the employee remains test negative by either the tuberculin skin test or any other test recommended by the CDC and licensed by the FDA. Once an employee has a documented positive skin test or any other test that has been recommended by the CDC and licensed by the FDA that has been followed by an X-ray, the foregoing examinations shall no longer be required, and referral shall be made within 30 days of completion of the examination to the local health officer to determine the need for followup care.

(c) After the examination, each employee shall cause to be on file with the district superintendent a certificate from the examining physician and surgeon or physician assistant showing the employee was examined and found free from active tuberculosis. "Certificate," as used in this subdivision, means a certificate signed by the examining physician and surgeon or physician assistant, or a notice from a public health agency or unit of the American Lung Association that indicates freedom from active tuberculosis. The latter, regardless of form, shall constitute evidence of compliance with this section.

(d) This examination is a condition of initial employment and the expense incident thereto shall be borne by the applicant unless otherwise provided by rules of the governing board. However, the board may, if an applicant is accepted for employment, reimburse the person in a like manner prescribed for employees in subdivision (e).

(e) The governing board of each district shall reimburse the employee for the cost, if any, of this examination. The board may provide for the examination required by this section or may establish a reasonable fee for the examination that is reimbursable to employees of the district complying with this section.

(f) At the discretion of the governing board, this section shall not apply to those employees not requiring certification qualifications who are employed for any period of time less than a college year whose functions do not require frequent or prolonged contact with students.

The governing board may, however, require the examination and may, as a contract condition, require the examination of persons employed under contract, other than those persons specified in subdivision (a), if the board believes the presence of these persons in and around college premises would constitute a health hazard to students.

(g) If the governing board of a community college district determines by resolution, after hearing, that the health of students in the district would not be jeopardized thereby, this section shall not apply to any employee of the district who files an affidavit stating that he or she adheres to the faith or teachings of any well-recognized religious sect, denomination, or organization and in accordance with its creed, tenets, or principles depends for healing upon prayer in the practice of religion and that to the best of his or her knowledge and belief he or she is free from active tuberculosis. If at any time there should be probable cause to believe that the affiant is afflicted with active tuberculosis, he or she may be excluded from service until the governing board of the employing district is satisfied that he or she is not so afflicted.

(h) A person who transfers his or her employment from one campus or community college district to another shall be deemed to meet the requirements of subdivision (a) if the person can produce a certificate that shows that he or she was examined within the past four years and was found to be free of communicable tuberculosis, or if it is verified by the college previously employing him or her that it has a certificate on file that contains that showing.

A person who transfers his or her employment from a private or parochial elementary school, secondary school, or nursery school to the community college district subject to this section shall be deemed to meet the requirements of subdivision (a) if the person can produce a certificate as provided for in Section 121525 of the Health and Safety Code that shows that he or she was examined within the past four years and was found to be free of communicable tuberculosis, or if it is verified by the school previously employing him or her that it has the certificate on file.

(i) Any governing board of a community college district providing for the transportation of students under contract shall require as a condition of the contract the examination for active tuberculosis, as provided in subdivision (a), of all drivers transporting the students, provided that privately contracted drivers who transport the students on an infrequent basis, not to exceed once a month, shall be excluded from this requirement.

(j) Examinations required pursuant to subdivision (i) shall be made available without charge by the local health officer.

SEC. 12. Section 2881 of the Public Utilities Code is amended to read:

2881. (a) The commission shall design and implement a program to provide a telecommunications device capable of serving the needs of individuals who are deaf or hearing impaired, together with a single party line, at no charge additional to the basic exchange rate, to any subscriber who is certified as an individual who is deaf or hearing impaired by a licensed physician and surgeon, audiologist, or a qualified state or federal agency, as determined by the commission, and to any subscriber that is an organization representing individuals who are deaf or hearing impaired, as determined and specified by the commission pursuant to subdivision (c). A licensed hearing aid dispenser may certify the need of an individual to participate in the program if that individual has been previously fitted with

an amplified device by the dispenser and the dispenser has the individual's hearing records on file prior to certification. In addition, a physician assistant may certify the needs of an individual who has been diagnosed by a physician and surgeon as being deaf or hearing impaired to participate in the program after reviewing the medical records or copies of the medical records containing that diagnosis.

(b) The commission shall also design and implement a program to provide a dual-party relay system, using third-party intervention to connect individuals who are deaf or hearing impaired and offices of organizations representing individuals who are deaf or hearing impaired, as determined and specified by the commission pursuant to subdivision (e), with persons of normal hearing by way of intercommunications devices for individuals who are deaf or hearing impaired and the telephone system, making available reasonable access of all phases of public telephone service to telephone subscribers who are deaf or hearing impaired. In order to make a dual-party relay system that will meet the requirements of individuals who are deaf or hearing impaired available at a reasonable cost, the commission shall initiate an investigation, conduct public hearings to determine the most cost-effective method of providing dual-party relay service to the deaf or hearing impaired when using a telecommunications device, and solicit the advice, counsel, and physical assistance of statewide nonprofit consumer organizations of the deaf, during the development and implementation of the system. The commission shall phase in this program, on a geographical basis, over a three-year period ending on January 1, 1987. The commission shall apply for certification of this program under rules adopted by the Federal Communications Commission pursuant to Section 401 of the federal Americans with Disabilities Act of 1990 (Public Law 101-336).

(c) The commission shall also design and implement a program whereby specialized or supplemental telephone communications equipment may be provided to subscribers who are certified to be disabled at no charge additional to the basic exchange rate. The certification, including a statement of visual or medical need for specialized telecommunications equipment, shall be provided by a licensed optometrist, physician and surgeon, or physician assistant, acting within the scope of practice of his or her license, or by a qualified state or federal agency as determined by the commission. The commission shall, in this connection, study the feasibility of, and implement, if determined to be feasible, personal income criteria, in addition to the certification of disability, for determining a subscriber's eligibility under this subdivision.

(d) The commission shall establish a rate recovery mechanism through a surcharge not to exceed one-half of 1 percent uniformly applied to a subscriber's intrastate telephone service, other than one-way radio paging service and universal telephone service, both within a service area and between service areas, to allow providers of the equipment and service specified in subdivisions (a), (b), and (c), to recover costs as they are incurred under this section. The surcharge shall be in effect until January 1, 2014. The commission shall require that the programs implemented under this

section be identified on subscribers' bills, and shall establish a fund and require separate accounting for each of the programs implemented under this section.

(e) The commission shall determine and specify those statewide organizations representing the deaf or hearing impaired that shall receive a telecommunications device pursuant to subdivision (a) or a dual-party relay system pursuant to subdivision (b), or both, and in which offices the equipment shall be installed in the case of an organization having more than one office.

(f) The commission may direct any telephone corporation subject to its jurisdiction to comply with its determinations and specifications pursuant to this section.

(g) The commission shall annually review the surcharge level and the balances in the funds established pursuant to subdivision (d). Until January 1, 2014, the commission shall be authorized to make, within the limits set by subdivision (d), any necessary adjustments to the surcharge to ensure that the programs supported thereby are adequately funded and that the fund balances are not excessive. A fund balance which is projected to exceed six months' worth of projected expenses at the end of the fiscal year is excessive.

(h) The commission shall prepare and submit to the Legislature, on or before December 31 of each year, a report on the fiscal status of the programs established and funded pursuant to this section and Sections 2881.1 and 2881.2. The report shall include a statement of the surcharge level established pursuant to subdivision (d) and revenues produced by the surcharge, an accounting of program expenses, and an evaluation of options for controlling those expenses and increasing program efficiency, including, but not limited to, all of the following proposals:

(1) The establishment of a means test for persons to qualify for program equipment or free or reduced charges for the use of telecommunication services.

(2) If and to the extent not prohibited under Section 401 of the federal Americans with Disabilities Act of 1990 (Public Law 101-336), the imposition of limits or other restrictions on maximum usage levels for the relay service, which shall include the development of a program to provide basic communications requirements to all relay users at discounted rates, including discounted toll-call rates, and, for usage in excess of those basic requirements, at rates which recover the full costs of service.

(3) More efficient means for obtaining and distributing equipment to qualified subscribers.

(4) The establishment of quality standards for increasing the efficiency of the relay system.

(i) In order to continue to meet the access needs of individuals with functional limitations of hearing, vision, movement, manipulation, speech and interpretation of information, the commission shall perform ongoing assessment of, and if appropriate, expand the scope of the program to allow for additional access capability consistent with evolving telecommunications technology.

(j) The commission shall structure the programs required by this section so that any charge imposed to promote the goals of universal service reasonably equals the value of the benefits of universal service to contributing entities and their subscribers.

O

SB 1172

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1172
Author: Negrete McLeod
Chapter: #517
Subject: Regulatory Boards: Diversion Programs
Sponsor: Author
Board Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require all healing arts boards under the Department of Consumer Affairs (DCA) to order a licensee to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensee's probation or diversion program. This bill allows a healing arts board to adopt regulations authorizing the board to order a licensee to cease practice for major violations or when ordered to undergo a clinical diagnostic evaluation.

This bill was amended to remove the provision that allowed a licensee to petition to return to practice after being issued a cease and desist order.

Other amendments that were taken that do not impact the Board include deletion of the external audit requirements, deletion of the provisions that prohibited the Board from disclosing to the public that a licensee is participating in a diversion program, and deletion of the provisions that prohibited waiving confidentiality for records pertaining to substance abuse treatment services. Lastly, this bill was amended to exempt the Board of Registered (BRN) nursing from the provisions in this bill.

ANALYSIS:

Senate Bill 1441 (Ridley-Thomas, 2008) established the Substance Abuse Coordination Committee within the DCA. This committee was responsible for formulating uniform and specific standards in specified areas for each healing arts board must use in dealing with substance-abusing licensees. These sixteen standards are required whether or not a board chooses to have a formal diversion program.

Many of the uniform standards established under SB 1441 do not require statutes for implementation; however, current law does not give all boards the authority to order a cease practice. Therefore this authority needs to be codified in law in order to fully implement the uniform standards established by the Substance Abuse Coordination Committee.

This bill would require all healing arts boards to order a licensee to cease practice if he or she tests positive for alcohol or any dangerous drugs. This bill also allows a healing arts board to adopt regulations authorizing the board to order a licensee to cease practice for major violations

or when ordered to undergo a clinical diagnostic evaluation. The requirement to order a licensee to cease practice is regardless of whether or not the board has a diversion program.

The April 27, 2010 amendments remove the provisions allowed a licensee to petition to return to practice after being issued a cease and desist order. They also removed the provisions that prohibited a licentiate from waiving confidentiality for records pertaining to substance abuse treatment services and that

The May 11, 2010 amendments delete the provisions that required an external audit of DCA's services relating to the treatment and rehabilitation of impaired physicians and other board's licensees that would have been required to be performed once every three years, along with the report of the audit that would have been required to be submitted to the legislature by June 30 of each year.

The June 22, 2010 amendments remove the provisions that prohibit the Board from disclosing to the public that a licensee is participating in a board diversion program unless participation was ordered as a term of probation. The amendments also exempt the BRN from the requirements of this bill.

FISCAL: None

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board Staff
- Update disciplinary guidelines regulations

Senate Bill No. 1172

CHAPTER 517

An act to amend Section 156.1 of, and to add Sections 315.2 and 315.4 to, the Business and Professions Code, relating to regulatory boards.

[Approved by Governor September 29, 2010. Filed with Secretary of State September 29, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1172, Negrete McLeod. Regulatory boards: diversion programs.

(1) Existing law provides for the regulation of specified professions and vocations by various boards, as defined, within the Department of Consumer Affairs. Under existing law, individuals or entities contracting with the department or any board within the department for the provision of services relating to the treatment and rehabilitation of licentiates impaired by alcohol or dangerous drugs are required to retain all records and documents pertaining to those services for 3 years or until they are audited, whichever occurs first. Under existing law, those records and documents are required to be kept confidential and are not subject to discovery or subpoena.

This bill would specify that those records and documents shall be kept for 3 years and kept confidential and are not subject to discovery or subpoena unless otherwise expressly provided by law.

(2) Existing law provides for the licensure and regulation of various healing arts by boards within the Department of Consumer Affairs. Under existing law, these boards are authorized to issue, deny, suspend, and revoke licenses based on various grounds and to take disciplinary action against their licensees.

Existing law establishes diversion and recovery programs to identify and rehabilitate dentists, osteopathic physicians and surgeons, physical therapists, physical therapy assistants, registered nurses, physician assistants, pharmacists and intern pharmacists, veterinarians, and registered veterinary technicians whose competency may be impaired due to, among other things, alcohol and drug abuse.

The bill would require a healing arts board to order a licensee to cease practice if the licensee tests positive for any prohibited substance under the terms of the licensee's probation or diversion program. The bill would also authorize a board to adopt regulations authorizing it to order a licensee on probation or in a diversion program to cease practice for major violations and when the board orders a licensee to undergo a clinical diagnostic evaluation, as specified. The bill would provide that these provisions do not affect the Board of Registered Nursing.

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

SECTION 1. Section 156.1 of the Business and Professions Code is amended to read:

156.1. (a) Notwithstanding any other provision of law, individuals or entities contracting with the department or any board within the department for the provision of services relating to the treatment and rehabilitation of licentiates impaired by alcohol or dangerous drugs shall retain all records and documents pertaining to those services until such time as these records and documents have been reviewed for audit by the department. These records and documents shall be retained for three years from the date of the last treatment or service rendered to that licentiate, after which time the records and documents may be purged and destroyed by the contract vendor. This provision shall supersede any other provision of law relating to the purging or destruction of records pertaining to those treatment and rehabilitation programs.

(b) Unless otherwise expressly provided by statute or regulation, all records and documents pertaining to services for the treatment and rehabilitation of licentiates impaired by alcohol or dangerous drugs provided by any contract vendor to the department or to any board within the department shall be kept confidential and are not subject to discovery or subpoena.

(c) With respect to all other contracts for services with the department or any board within the department other than those set forth in subdivision (a), the director or chief deputy director may request an examination and audit by the department's internal auditor of all performance under the contract. For this purpose, all documents and records of the contract vendor in connection with such performance shall be retained by such vendor for a period of three years after final payment under the contract. Nothing in this section shall affect the authority of the State Auditor to conduct any examination or audit under the terms of Section 8546.7 of the Government Code.

SEC. 2. Section 315.2 is added to the Business and Professions Code, to read:

315.2. (a) A board, as described in Section 315, shall order a licensee of the board to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensee's probation or diversion program.

(b) An order to cease practice under this section shall not be governed by the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) A cease practice order under this section shall not constitute disciplinary action.

(d) This section shall have no effect on the Board of Registered Nursing pursuant to Article 3.1 (commencing with Section 2770) of Chapter 6 of Division 2.

SEC. 3. Section 315.4 is added to the Business and Professions Code, to read:

315.4. (a) A board, as described in Section 315, may adopt regulations authorizing the board to order a licensee on probation or in a diversion program to cease practice for major violations and when the board orders a licensee to undergo a clinical diagnostic evaluation pursuant to the uniform and specific standards adopted and authorized under Section 315.

(b) An order to cease practice under this section shall not be governed by the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) A cease practice order under this section shall not constitute disciplinary action.

(d) This section shall have no effect on the Board of Registered Nursing pursuant to Article 3.1 (commencing with Section 2770) of Chapter 6 of Division 2.

S B 1410

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1410
Author: Cedillo
Chapter: VETOED (see attached veto message)
Subject: Medicine: licensure examinations
Sponsor: Author
Board Position: Oppose

DESCRIPTION OF CURRENT LEGISLATION:

This bill would delete the limitation that an applicant for licensure may only make four attempts to obtain a passing score on Step III of the United States Medical Licensing Examination (USMLE).

This bill has an urgency clause and would take effect immediately upon passage. This bill also contains provisions to make the removal of the limitation of attempts retroactive to January 1, 2007.

This bill was amended to require the Medical Board of California (Board) to adopt a resolution at a public meeting every time it adopts a passing score, prohibits the Board from delegating the responsibility to adopt the passing score to any other entity, and requires the passing score to be a numerical score and not a percentage. The amendments state the intent of the Legislature that the Board complies with the court's holding in *Marquez v. Medical board of California*. The amendments also remove the urgency clause and the retroactive provision, so this bill will now take effect on January 1, 2011 and will no longer make the removal of limitation attempts retroactive to January 1, 2007.

ANALYSIS:

Currently, applicants for licensure are required to pass Step III within four attempts in order to be eligible to be licensed as a physician in California. This bill would give applicants an unlimited number of attempts to take and pass the examination.

The limitation was established in 2006 by AB 1796 (Bermudez, Chapter 843) which was sponsored by the Board. In the interests of furthering the Board's mission of consumer protection, this limitation was deemed necessary to allow the Board to better assess applicants' ability to practice medicine safely. The requirement to pass Step III within four attempts was designed to assure that physicians who are issued full and unrestricted licenses are current in their medical knowledge at the time they receive their initial license.

Subsequent legislation, SB 1048 (Chapter 588, 2007), included provisions to allow an applicant who obtains a passing score on Step III of the USMLE in more than four attempts to be considered for licensure if the applicant has been licensed in another state for at least four years.

This bill would repeal these provisions as well as they would be unnecessary if applicants have unlimited attempts to pass the exam.

Previous study of the issue of physicians' ability to practice medicine safely with regard to the number of attempts needed to pass Step III of the USMLE indicate that there is a correlation between the number of times a physician has to take the exam to obtain a passing score and his or her competency as a physician. Of the physicians found to have taken Step III of the USMLE more than four times in order to pass, there were a large number found to be substandard by the report submitted to the Federation of State Medical Boards (FSMB).

Allowing applicants for licensure unlimited attempts to pass Step III of the USMLE allows for substandard physicians to be practicing in California and puts patients at risk. The number of attempts needed to pass required exams is not disclosed to the public. Consumers do not know they are being treated by a physician who had to take the very exam that indicates their ability and readiness to treat them multiple times before they were considered adequate for licensure. In the interests of patient protection, the competency of a physician should be evaluated and questioned when that physician continues to retake Step III of the USMLE without any limitation. The current requirement of licensure in another state for four years with a clear record and board certification provides this consumer protection.

The May 19, 2010 amendments continue to repeal the four attempt limit for licensing applicants to pass the USMLE Step III and now require the Board to adopt a resolution at a public meeting every time it adopts a passing score. The amendments also prohibit the Board from delegating the responsibility to adopt the passing score to any other entity and require the passing score to be a numerical score and not a percentage. The Board re-adopted the FSMB's passing score at the April Board Meeting by resolution; however this bill is contrary to FSMB's passing score, which is a percentage, not a numerical score. The amendments also state the intent of the Legislature that the Board comply with the court's holding in Marquez v. Medical board of California, which the Board believes it has already done.

The June 23, 2010 amendments remove the urgency clause and the retroactive provision, so this bill will now take effect on January 1, 2011 and will no longer make the removal of limitation attempts retroactive to January 1, 2007.

The Department of Consumer Affairs is also opposed to this bill, attached is their letter of opposition.

FISCAL: None

IMPLEMENTATION:
None

October 20, 2010

BILL NUMBER: SB 1410
VETOED: 09/29/2010

To the Members of the California State Senate:

I am returning Senate Bill 1410 without my signature.

This measure weakens California's existing licensing requirements for California physicians and potentially puts patients at risk by giving substandard physicians an unlimited number of attempts to pass the final step of the United States Medical Licensing Examination. In addition, physicians are able to eventually obtain licensure in California if they can be licensed in another state for at least four years without any adverse licensure action.

For these reasons, I am unable to sign this bill.

Sincerely,

Arnold Schwarzenegger

Senate Bill No. 1410

Passed the Senate August 25, 2010

Secretary of the Senate

Passed the Assembly August 19, 2010

Chief Clerk of the Assembly

This bill was received by the Governor this _____ day
of _____, 2010, at _____ o'clock ____M.

Private Secretary of the Governor

CHAPTER _____

An act to amend Section 2177 of, and to add Sections 2177.5 and 2177.7 to, the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

SB 1410, Cedillo. Medicine: licensure examinations.

Existing law, the Medical Practice Act, requires the Medical Board of California to issue a physician's and surgeon's certificate to a qualified applicant. Under the act, an applicant for a physician's and surgeon's certificate is required to include specified information with his or her application and to obtain a passing score on an entire examination or on each part of an examination. Existing law authorizes applicants to take the written examinations conducted or accepted by the board in separate parts, and requires the board to adopt by resolution the passing score for each examination or each part of an examination. Existing law requires an applicant to obtain a passing score on Step III of the United States Medical Licensing Examination within not more than 4 attempts of taking that part of the examination.

This bill would delete the prohibition on taking Step III of the United States Medical Licensing Examination more than 4 times. The bill would also require the board to accept as a passing score from an applicant the passing score that was adopted by the board and in effect on the date the applicant registered for that examination or part of the examination. The bill would further require the board to act by passing a resolution every time it adopts a passing score for an entire examination or for each part of an examination that is required for certification, subject to specified requirements and in conformity with the court's holding in *Marquez v. Medical Board of California* (2010) 182 Cal.App.4th 548.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) Under Section 2177 of the Business and Professions Code, an applicant who is seeking a physician's and surgeon's certificate in California must obtain a passing score on Step III of the United States Medical Licensing Examination (USMLE) within not more than four attempts in order to be eligible for a certificate. The examination has three steps. However, only Step III has a limit on the number of times that an applicant may attempt to pass the step.

(b) The USMLE is administered by the Federation of State Medical Boards (FSMB), a national nonprofit entity. Periodically, the FSMB recommends passing scores to the various state medical boards. It is left to the discretion of each state board to determine whether to adopt the recommended score. Historically, the Medical Board of California (MBC) has not had a formal procedure regarding adoption of the FSMB recommended passing score.

(c) When an applicant registers for the USMLE, he or she has an eligibility period of three months in which to take the examination. Multiple examination dates are available within the three-month period. The lack of a formal adoption process within the MBC, combined with a three-month window to take the examination after registration, has created some confusion as the MBC may increase the accepted passing score at any time without public record, input, or notification to applicants who have already registered for the examination.

(d) Furthermore, prior to the enactment of Chapter 843 of the Statutes of 2006 (AB 1796), California did not limit the number of times an applicant may take any part of the USMLE. Under the new law, which places an arbitrary limit of attempts on Step III of the examination, highly qualified and much needed physicians and surgeons are being denied a license to practice medicine in California. Their only option is to move to another state, become licensed and practice there, and return four years later.

(e) Failing to pass the USMLE under an arbitrary cap on the number of attempts does not translate into a lack of competency in providing high-quality medical care. Furthermore, existing law does not take into consideration learning disabilities, a history of poor performance on standardized tests, hardships, or other variables that may impede the ability of an individual to pass the examination, essentially discriminating against certain applicants.

(f) Twenty-seven states in the United States and two territories have more lenient policies regarding the USMLE, which may

include having no cap or allowing for more attempts than California. Those states and territories include AL, AZ, CO, CT, DE, FL, GU, HI, IA, IL, KS, MA, MI, MN, MS, MT, NM, NV, NJ, NY, NC, ND, OH, OK, PA, TN, VA, VI, and WY. In fact, AZ, CO, CT, DE, GU, HI, IA, KS, MA, MI, MN, MS, MT, NJ, NY, NC, ND, OH, PA, TN, VI, VA, and WY have no limit on the number of times an applicant may take the examination.

(g) Lastly, even though Assembly Bill 1796 was signed by the Governor, he expressed concerns with the measure. The Governor issued a signing message stating that Assembly Bill 1796 failed to provide the appropriate exceptions to the requirement that physicians and surgeons applying for licensure pass Step III of the USMLE within four attempts, and that Assembly Bill 1796 may have unintended consequences. The Governor requested that the MBC address his concerns. Subsequently, the MBC requested that language be added to Section 2177 of the Business and Professions Code that would cross-reference Section 2135.5 of the Business and Professions Code to exempt from the four-attempt limitation an applicant who holds an unlimited and restricted license as a physician and surgeon in another state and who has held that license continuously for a minimum of four years prior to the date of application. This amendment was added by Chapter 588 of the Statutes of 2007 (SB 1048), which was an omnibus bill for the Senate Committee on Business and Professions.

(h) The inclusion of those changes by Senate Bill 1048 has proven to be an inadequate approach to addressing the need for flexibility and consideration of other factors that may contribute to an individual failing to pass Step III of the USMLE within four attempts. It is now viewed by the Legislature as unreasonable to require an individual to leave the state, go through all the steps necessary to obtain licensure in another state, and then return to California after four years to obtain a license to practice medicine.

(i) It is further unreasonable for the MBC to change the passing score for an examination once an applicant has registered for that examination without any formal procedure or notification to the applicant.

SEC. 2. Section 2177 of the Business and Professions Code is amended to read:

2177. (a) A passing score is required for an entire examination or for each part of an examination, as established by resolution of the board.

(b) Applicants may elect to take the written examinations conducted or accepted by the board in separate parts.

(c) An applicant shall have obtained a passing score on Step III of the United States Medical Licensing Examination in order to be eligible for a physician's and surgeon's certificate.

SEC. 3. Section 2177.5 is added to the Business and Professions Code, to read:

2177.5. Notwithstanding subdivision (a) of Section 2177, the board shall accept as a passing score on an examination or part of an examination from an applicant the passing score that was adopted by the board and in effect on the date the applicant registered for that examination or part of the examination.

SEC. 4. Section 2177.7 is added to the Business and Professions Code, to read:

2177.7. (a) Pursuant to Sections 2177 and 2184, the board shall adopt a resolution every time the board adopts a passing score for an entire examination or for each part of an examination that is required for certification under this article.

(b) The resolution required pursuant to subdivision (a) shall be adopted or readopted at a public meeting of the board, and subject to public input and an affirmative vote of a majority of board members present at the meeting constituting at least a quorum.

(c) The board shall not delegate to any other entity, whether by contract or resolution, the responsibility to adopt the passing score described in this section. If the board adopts the recommended passing score of another entity as its passing score for an examination or any part of an examination and that entity subsequently changes that recommended passing score, the board's passing score shall not be changed unless the board readopts that recommended passing score, or adopts some other score, by resolution pursuant to this section.

(d) The passing score to be adopted pursuant to this section shall be stated as a numerical score and shall not be stated as a percentage of correct answers.

SEC. 5. (a) It is the intent of the Legislature in enacting Section 4 of this act that the Medical Board of California comply with the

court's holding in *Marquez v. Medical Board of California* (2010) 182 Cal.App.4th 548.

(b) Sections 2177 and 2184 of the Business and Professions Code unambiguously require the Medical Board of California to establish a passing score for Step III of the United States Medical Licensing Examination and to do so by resolution.

(c) The board shall adopt a passing score by means of a formal, memorialized public vote. This single, unambiguous statutory requirement is intended to keep the board accountable to the Legislature, the medical professions, medical license applicants, and the public, and to prevent the board from delegating this responsibility to anyone else.

Approved _____, 2010

Governor



SB 1489

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1489
Author: Senate Business, Professions and Economic Development
Committee
Chapter: #653
Subject: Omnibus
Sponsor: Committee
Board Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried by the Senate Business and Professions Committee. Some provisions, although non-substantive, impact statutes governing the Medical Practices Act.

The provisions relating to the Medical Board (the Board) are in the Business and Professions Code and are as follows (only these sections of the bill are attached):

- **2065 & 2177** – Deletes and corrects obsolete references related to the Board's Division of Licensing and exams.
- **2096 & 2102** – Reinstates postgraduate training requirement for licensure.
- **2184** – Allows the Board to consider good cause or reason, time spent in various training programs, and current and active practice in another state or Canadian province, when addressing the period of validity of the written examination scores required for licensure.
- **2516** – Clarifies provisions related to the reporting requirements for licensed midwives.

This bill was amended to include the reporting requirements for midwives and to provide clarifying amendments to Section 2184.

FISCAL: None to the Board

IMPLEMENTATION:

- Newsletter Article
- Notify/Train Board Staff

October 20, 2010

Senate Bill No. 1489

CHAPTER 653

An act to amend Sections 2065, 2096, 2102, 2103, 2177, 2184, 2516, 2530.2, 2539.1, 2539.6, 2570.19, 3025.1, 3046, 3057.5, 3147, 3147.6, 3147.7, 3365.5, 4013, 4017, 4028, 4037, 4052.3, 4059, 4072, 4076.5, 4101, 4119, 4127.1, 4169, 4181, 4191, 4196, 4425, 4426, 4980.40.5, 4980.43, 4980.80, 4982.25, 4984.8, 4989.54, 4990.02, 4990.12, 4990.18, 4990.22, 4990.30, 4990.38, 4992.36, 4996.17, 4996.23, 4999.46, 4999.54, 4999.58, and 4999.90 of, to add Section 4200.1 to, to add and repeal Sections 4999.57 and 4999.59 of, to repeal Sections 2026, 4980.07, 4982.2, and 4984.6 of, and to repeal Article 3 (commencing with Section 4994) of Chapter 14 of Division 2 of, the Business and Professions Code, relating to healing arts.

[Approved by Governor September 30, 2010. Filed with
Secretary of State September 30, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1489, Committee on Business, Professions and Economic Development. Healing arts.

(1) 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 an applicant for a physician's and surgeon's certificate whose professional instruction was acquired in a country other than the United States or Canada to provide evidence satisfactory to the board of, among other things, satisfactory completion of at least one year of specified postgraduate training.

This bill would require the applicant to instead complete at least 2 years of that postgraduate training.

Existing law requires an applicant for a physician's and surgeon's certificate to obtain a passing score on the written examination designated by the board and makes passing scores on a written examination valid for 10 years from the month of the examination for purposes of qualification for a license. Existing law authorizes the board to extend this period of validity for good cause or for time spent in a postgraduate training program.

This bill would apply this 10-year period of validity to passing scores obtained on each step of the United States Medical Licensing Examination and would also authorize the board to extend that period for an applicant who is a physician and surgeon in another state or a Canadian province and who is currently and actively practicing medicine in that state or province.

Existing law requires a licensed midwife who assists in childbirths that occur in out-of-hospital settings to annually report specified information to the Office of Statewide Health Planning and Development in March and requires the office to report to the Medical Board of California licensee

compliance with that requirement every April and the aggregate information collected every July.

This bill would require those annual reports to be made by March 30, April 30, and July 30, respectively, and would make additional changes to the information required to be reported by a midwife with regard to cases in California.

(2) Existing law provides for the licensure and regulation of speech-language pathologists, audiologists, and hearing aid dispensers by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board. Existing law requires a licensed audiologist who wishes to sell hearing aids to meet specified licensure and examination requirements, and to apply for a dispensing audiologist certificate, pay applicable fees, and pass a board-approved hearing aid examination, except as specified. Existing law authorizes a licensed audiologist with an expired hearing aid dispenser's license to continue to sell hearing aids pursuant to his or her audiology license.

This bill would require the board to issue a dispensing audiology license to a licensed audiologist who meets those requirements or whose license to sell hearing aids has expired. The bill would also waive the licensure, examination, and application requirements described above as applied to a licensed hearing aid dispenser who meets the qualifications for licensure as an audiologist.

Existing law requires hearing aid dispensers and audiologists to inform a customer, in writing, that he or she should consult with a physician based upon an observation, or being informed by the customer, that certain problems of the ear exist.

This bill would additionally require that written notification upon observing or being informed by the customer of pain or discomfort in the ear or of specified accumulation or a foreign body in the ear canal.

(3) Existing law, the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. Existing law authorizes the renewal of an expired license within 3 years after its expiration if the licensee files an application for renewal and pays all accrued and unpaid renewal fees and the delinquency fee prescribed by the board.

This bill would also require the licensee to submit proof of completion of the required hours of continuing education for the last 2 years.

Existing law authorizes the restoration of a license that is not renewed within 3 years after its expiration if the holder of the expired license, among other requirements, passes the clinical portion of the regular examination of applicants, or other clinical examination approved by the board, and pays a restoration fee equal to the renewal fee in effect on the last regular renewal date for licenses.

This bill would instead require the holder of the expired license to take the National Board of Examiners in Optometry's Clinical Skills examination or other clinical examination approved by the board, and to also pay any delinquency fees prescribed by the board.

Existing law alternatively authorizes the restoration of a license that is not renewed within 3 years after its expiration if the person provides proof that he or she holds an active license from another state, files an application for renewal, and pays the accrued and unpaid renewal fees and any delinquency fee prescribed by the board.

This bill would also require the person to submit proof of completion of the required hours of continuing education for the last 2 years and take and satisfactorily pass the board's jurisprudence examination. The bill would also require that the person not have committed specified crimes or acts constituting grounds for licensure denial.

(4) Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy and requires an applicant for a license to pass a national licensure examination and the board's jurisprudence examination. Existing law prohibits boards in the Department of Consumer Affairs from restricting an applicant who failed a licensure examination from taking the examination again, except as specified.

This bill would authorize an applicant for a pharmacist license to take the licensure examination and the jurisprudence examination 4 times each. The bill would also authorize the applicant to take those examinations 4 additional times each if additional pharmacy coursework is completed, as specified.

Existing law requires a facility licensed by the board to join the board's e-mail notification list within 60 days of obtaining a license or at the time of license renewal.

This bill would allow an owner of 2 or more facilities to comply with the e-mail notification requirement through the use of one e-mail address under specified circumstances.

Existing law requires the California State Board of Pharmacy to promulgate regulations that require, on or before January 1, 2011, a standardized, patient-centered, prescription drug label on all prescription medicine dispensed to patients in California.

This bill would exempt from those standardized, prescription drug label requirements prescriptions dispensed to a patient in a health facility and administered by a licensed health care professional, as specified.

(5) Existing law provides for the licensure and regulation of marriage and family therapists, licensed clinical social workers, educational psychologists, and professional clinical counselors by the Board of Behavioral Sciences. Existing law authorizes a licensed marriage and family therapist, licensed clinical social worker, or licensed educational psychologist whose license has been revoked, suspended, or placed on probation to petition the board for reinstatement or modification of the penalty, as specified. Existing law also authorizes the board to deny an application or suspend or revoke those licenses due to the revocation, suspension, or restriction by the board of a license to practice as a clinical social worker, marriage and family therapist, or educational psychologist.

This bill would make those provisions apply with respect to licensed professional clinical counseling, as specified.

Existing law requires an applicant applying for a marriage and family therapist license to complete a minimum of 3,000 hours of experience during a period of at least 104 weeks. Existing law requires that this experience consist of at least 500 hours of experience in diagnosing and treating couples, families, and children, and requires that an applicant be credited with 2 hours of experience for each hour of therapy provided for the first 150 hours of treating couples and families in conjoint therapy.

This bill would instead require that an applicant receive that 2-hour credit for up to 150 hours of treating couples and families in conjoint therapy, and would only allow an applicant to comply with the experience requirements with hours of experience gained on and after January 1, 2010.

Existing law requires an applicant for a professional clinical counselor license to complete a minimum of 3,000 hours of clinical mental health experience under the supervision of an approved supervisor and prohibits a supervisor from supervising more than 2 interns.

This bill would prohibit the board from crediting an applicant for experience obtained under the supervision of a spouse or relative by blood or marriage, or a person with whom the applicant has had or currently has a personal, professional, or business relationship that undermines the authority or effectiveness of the supervision. The bill would also delete the provision prohibiting a supervisor from supervising more than 2 interns.

Existing law requires an associate clinical worker or an intern to receive an average of at least one hour of direct supervisor contact for every 10 hours of client contact in each setting and authorizes an associate clinical worker or an intern working in a governmental entity, a school, college, or university, or a nonprofit and charitable institution to obtain up to 30 hours of the required weekly direct supervisor contact via two-way, real time videoconferencing.

This bill would delete that 30-hour limit and would require an associate clinical worker or an intern to receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy, as defined, is performed in each setting in which experience is obtained.

Existing law imposes specified requirements with respect to persons who apply for a professional clinical counselor license between January 1, 2011, and June 30, 2011, inclusive. Existing law imposes specified unit requirements on applicants who hold degrees issued prior to 1996.

This bill would include within those requirements specified units of supervised practicum or field study experience.

Existing law imposes specified requirements with respect to persons who apply for a professional clinical counselor license between January 1, 2011, and December 31, 2013, inclusive. With respect to those applicants, existing law authorizes the board to accept experience gained outside of California if it is substantially equivalent to that required by the Licensed Professional Clinical Counselor Act and if the applicant has gained a minimum of 250

hours of supervised clinical experience in direct counseling in California while registered as an intern with the board.

This bill would eliminate that 250-hour requirement with respect to persons with a counseling license in another jurisdiction, as specified, who have held that license for at least 2 years immediately prior to applying with the board.

Existing law authorizes the board to refuse to issue or suspend or revoke a professional clinical counselor license or intern registration if the licensee or registrant has been guilty of unprofessional conduct, as specified.

This bill would specify that unprofessional conduct includes (1) engaging in conduct that subverts a licensing examination, (2) revocation, suspension, or restriction by the board of a license to practice as a clinical social worker, educational psychologist, or marriage and family therapist, (3) conduct in the supervision of an associate clinical social worker that violates the profession's governing professional clinical counseling or regulations of the board, and (4) failing to comply with required procedures when delivering health care via telemedicine.

The bill would make other technical, nonsubstantive changes in various provisions governing the healing arts and would delete certain obsolete and duplicative language.

(6) This bill would incorporate additional changes in Section 2177 of the Business and Professions Code proposed by SB 1410, to be operative if SB 1410 and this bill become effective on or before January 1, 2011, and this bill is enacted last.

(7) This bill would incorporate additional changes in Section 2570.19 of the Business and Professions Code proposed by SB 294 and SB 999, to be operative if SB 294 and SB 999, or either of them, and this bill become effective on or before January 1, 2011, and this bill is enacted last.

(8) This bill would incorporate additional changes in Section 4980.43 of the Business and Professions Code proposed by AB 2435, to be operative if AB 2435 and this bill become effective on or before January 1, 2011, and this bill is enacted last.

(9) This bill would incorporate additional changes in Section 4996.17 of the Business and Professions Code proposed by AB 2167, to be operative if AB 2167 and this bill become effective on or before January 1, 2011, and this bill is enacted last.

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

SECTION 1. Section 2026 of the Business and Professions Code is repealed.

SEC. 2. Section 2065 of the Business and Professions Code is amended to read:

2065. Unless otherwise provided by law, no postgraduate trainee, intern, resident, postdoctoral fellow, or instructor may engage in the practice of medicine, or receive compensation therefor, or offer to engage in the practice

of medicine unless he or she holds a valid, unrevoked, and unsuspended physician's and surgeon's certificate issued by the board. However, a graduate of an approved medical school, who is registered with the board and who is enrolled in a postgraduate training program approved by the board, may engage in the practice of medicine whenever and wherever required as a part of the program under the following conditions:

(a) A graduate enrolled in an approved first-year postgraduate training program may so engage in the practice of medicine for a period not to exceed one year whenever and wherever required as a part of the training program, and may receive compensation for that practice.

(b) A graduate who has completed the first year of postgraduate training may, in an approved residency or fellowship, engage in the practice of medicine whenever and wherever required as part of that residency or fellowship, and may receive compensation for that practice. The resident or fellow shall qualify for, take, and pass the next succeeding written examination for licensure, or shall qualify for and receive a physician's and surgeon's certificate by one of the other methods specified in this chapter. If the resident or fellow fails to receive a license to practice medicine under this chapter within one year from the commencement of the residency or fellowship or if the board denies his or her application for licensure, all privileges and exemptions under this section shall automatically cease.

SEC. 3. Section 2096 of the Business and Professions Code is amended to read:

2096. (a) In addition to other requirements of this chapter, before a physician's and surgeon's license may be issued, each applicant, including an applicant applying pursuant to Article 5 (commencing with Section 2100), except as provided in subdivision (b), shall show by evidence satisfactory to the board that he or she has satisfactorily completed at least one year of postgraduate training.

(b) An applicant applying pursuant to Section 2102 shall show by evidence satisfactory to the board that he or she has satisfactorily completed at least two years of postgraduate training.

(c) The postgraduate training required by this section shall include at least four months of general medicine and shall be obtained in a postgraduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC).

(d) The amendments made to this section at the 1987 portion of the 1987-88 session of the Legislature shall not apply to applicants who completed their one year of postgraduate training on or before July 1, 1990.

SEC. 4. Section 2102 of the Business and Professions Code is amended to read:

2102. An applicant whose professional instruction was acquired in a country other than the United States or Canada shall provide evidence satisfactory to the board of compliance with the following requirements to be issued a physician's and surgeon's certificate:

(a) Completion in a medical school or schools of a resident course of professional instruction equivalent to that required by Section 2089 and issuance to the applicant of a document acceptable to the board that shows final and successful completion of the course. However, nothing in this section shall be construed to require the board to evaluate for equivalency any coursework obtained at a medical school disapproved by the board pursuant to this section.

(b) Certification by the Educational Commission for Foreign Medical Graduates, or its equivalent, as determined by the board. This subdivision shall apply to all applicants who are subject to this section and who have not taken and passed the written examination specified in subdivision (d) prior to June 1, 1986.

(c) Satisfactory completion of the postgraduate training required under subdivision (b) of Section 2096. An applicant shall be required to have substantially completed the professional instruction required in subdivision (a) and shall be required to make application to the board and have passed steps 1 and 2 of the written examination relating to biomedical and clinical sciences prior to commencing any postgraduate training in this state. In its discretion, the board may authorize an applicant who is deficient in any education or clinical instruction required by Sections 2089 and 2089.5 to make up any deficiencies as a part of his or her postgraduate training program, but that remedial training shall be in addition to the postgraduate training required for licensure.

(d) Passage of the written examination as provided under Article 9 (commencing with Section 2170). An applicant shall be required to meet the requirements specified in subdivision (b) prior to being admitted to the written examination required by this subdivision.

(e) Nothing in this section prohibits the board from disapproving a foreign medical school or from denying an application if, in the opinion of the board, the professional instruction provided by the medical school or the instruction received by the applicant is not equivalent to that required in Article 4 (commencing with Section 2080).

SEC. 5. Section 2103 of the Business and Professions Code is amended to read:

2103. An applicant who is a citizen of the United States shall be eligible for a physician's and surgeon's certificate if he or she has completed the following requirements:

(a) Submitted official evidence satisfactory to the board of completion of a resident course or professional instruction equivalent to that required in Section 2089 in a medical school located outside the United States or Canada. However, nothing in this section shall be construed to require the board to evaluate for equivalency any coursework obtained at a medical school disapproved by the board pursuant to Article 4 (commencing with Section 2080).

(b) Submitted official evidence satisfactory to the board of completion of all formal requirements of the medical school for graduation, except the applicant shall not be required to have completed an internship or social

service or be admitted or licensed to practice medicine in the country in which the professional instruction was completed.

(c) Attained a score satisfactory to an approved medical school on a qualifying examination acceptable to the board.

(d) Successfully completed one academic year of supervised clinical training in a program approved by the board pursuant to Section 2104. The board shall also recognize as compliance with this subdivision the successful completion of a one-year supervised clinical medical internship operated by a medical school pursuant to Chapter 85 of the Statutes of 1972 and as amended by Chapter 888 of the Statutes of 1973 as the equivalent of the year of supervised clinical training required by this section.

(1) Training received in the academic year of supervised clinical training approved pursuant to Section 2104 shall be considered as part of the total academic curriculum for purposes of meeting the requirements of Sections 2089 and 2089.5.

(2) An applicant who has passed the basic science and English language examinations required for certification by the Educational Commission for Foreign Medical Graduates may present evidence of those passing scores along with a certificate of completion of one academic year of supervised clinical training in a program approved by the board pursuant to Section 2104 in satisfaction of the formal certification requirements of subdivision (b) of Section 2102.

(e) Satisfactorily completed the postgraduate training required under Section 2096.

(f) Passed the written examination required for certification as a physician and surgeon under this chapter.

SEC. 6. Section 2177 of the Business and Professions Code is amended to read:

2177. (a) A passing score is required for an entire examination or for each part of an examination, as established by resolution of the board.

(b) Applicants may elect to take the written examinations conducted or accepted by the board in separate parts.

(c) (1) An applicant shall have obtained a passing score on Step 3 of the United States Medical Licensing Examination within not more than four attempts in order to be eligible for a physician's and surgeon's certificate.

(2) Notwithstanding paragraph (1), an applicant who obtains a passing score on Step 3 of the United States Medical Licensing Examination in more than four attempts and who meets the requirements of Section 2135.5 shall be eligible to be considered for issuance of a physician's and surgeon's certificate.

SEC. 6.5. Section 2177 of the Business and Professions Code is amended to read:

2177. (a) A passing score is required for an entire examination or for each part of an examination, as established by resolution of the board.

(b) Applicants may elect to take the written examinations conducted or accepted by the board in separate parts.

(c) An applicant shall have obtained a passing score on Step III of the United States Medical Licensing Examination in order to be eligible for a physician's and surgeon's certificate.

SEC. 7. Section 2184 of the Business and Professions Code is amended to read:

2184. (a) Each applicant shall obtain on the written examination a passing score, established by the board pursuant to Section 2177.

(b) (1) Passing scores on each step of the United States Medical Licensing Examination shall be valid for a period of 10 years from the month of the examination for purposes of qualification for licensure in California.

(2) The period of validity provided for in paragraph (1) may be extended by the board for any of the following:

(A) For good cause.

(B) For time spent in a postgraduate training program, including, but not limited to, residency training, fellowship training, remedial or refresher training, or other training that is intended to maintain or improve medical skills.

(C) For an applicant who is a physician and surgeon in another state or a Canadian province who is currently and actively practicing medicine in that state or province.

(3) Upon expiration of the 10-year period plus any extension granted by the board under paragraph (2), the applicant shall pass the Special Purpose Examination of the Federation of State Medical Boards or a clinical competency written examination determined by the board to be equivalent.

SEC. 8. Section 2516 of the Business and Professions Code is amended to read:

2516. (a) Each licensed midwife who assists, or supervises a student midwife in assisting, in childbirth that occurs in an out-of-hospital setting shall annually report to the Office of Statewide Health Planning and Development. The report shall be submitted no later than March 30, with the first report due in March 2008, for the prior calendar year, in a form specified by the board and shall contain all of the following:

(1) The midwife's name and license number.

(2) The calendar year being reported.

(3) The following information with regard to cases in California in which the midwife, or the student midwife supervised by the midwife, assisted during the previous year when the intended place of birth at the onset of care was an out-of-hospital setting:

(A) The total number of clients served as primary caregiver at the onset of care.

(B) The total number of clients served with collaborative care available through, or given by, a licensed physician and surgeon.

(C) The total number of clients served under the supervision of a licensed physician and surgeon.

(D) The number by county of live births attended as primary caregiver.

(E) The number, by county, of cases of fetal demise, infant deaths, and maternal deaths attended as primary caregiver at the discovery of the demise or death.

(F) The number of women whose primary care was transferred to another health care practitioner during the antepartum period, and the reason for each transfer.

(G) The number, reason, and outcome for each elective hospital transfer during the intrapartum or postpartum period.

(H) The number, reason, and outcome for each urgent or emergency transport of an expectant mother in the antepartum period.

(I) The number, reason, and outcome for each urgent or emergency transport of an infant or mother during the intrapartum or immediate postpartum period.

(J) The number of planned out-of-hospital births at the onset of labor and the number of births completed in an out-of-hospital setting.

(K) The number of planned out-of-hospital births completed in an out-of-hospital setting that were any of the following:

(i) Twin births.

(ii) Multiple births other than twin births.

(iii) Breech births.

(iv) Vaginal births after the performance of a cesarean section.

(L) A brief description of any complications resulting in the morbidity or mortality of a mother or an infant.

(M) Any other information prescribed by the board in regulations.

(b) The Office of Statewide Health Planning and Development shall maintain the confidentiality of the information submitted pursuant to this section, and shall not permit any law enforcement or regulatory agency to inspect or have copies made of the contents of any reports submitted pursuant to subdivision (a) for any purpose, including, but not limited to, investigations for licensing, certification, or regulatory purposes.

(c) The office shall report to the board, by April 30, those licensees who have met the requirements of subdivision (a) for that year.

(d) The board shall send a written notice of noncompliance to each licensee who fails to meet the reporting requirement of subdivision (a). Failure to comply with subdivision (a) will result in the midwife being unable to renew his or her license without first submitting the requisite data to the Office of Statewide Health Planning and Development for the year for which that data was missing or incomplete. The board shall not take any other action against the licensee for failure to comply with subdivision (a).

(e) The board, in consultation with the office and the Midwifery Advisory Council, shall devise a coding system related to data elements that require coding in order to assist in both effective reporting and the aggregation of data pursuant to subdivision (f). The office shall utilize this coding system in its processing of information collected for purposes of subdivision (f).

(f) The office shall report the aggregate information collected pursuant to this section to the board by July 30 of each year. The board shall include this information in its annual report to the Legislature.

(g) Notwithstanding any other provision of law, a violation of this section shall not be a crime.

SEC. 9. Section 2530.2 of the Business and Professions Code is amended to read:

2530.2. As used in this chapter, unless the context otherwise requires:

(a) "Board" means the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board. As used in this chapter or any other provision of law, "Speech-Language Pathology and Audiology Board" shall be deemed to refer to the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board or any successor.

(b) "Person" means any individual, partnership, corporation, limited liability company, or other organization or combination thereof, except that only individuals can be licensed under this chapter.

(c) A "speech-language pathologist" is a person who practices speech-language pathology.

(d) The practice of speech-language pathology means all of the following:

(1) The application of principles, methods, instrumental procedures, and noninstrumental procedures for measurement, testing, screening, evaluation, identification, prediction, and counseling related to the development and disorders of speech, voice, language, or swallowing.

(2) The application of principles and methods for preventing, planning, directing, conducting, and supervising programs for habilitating, rehabilitating, ameliorating, managing, or modifying disorders of speech, voice, language, or swallowing in individuals or groups of individuals.

(3) Conducting hearing screenings.

(4) Performing suctioning in connection with the scope of practice described in paragraphs (1) and (2), after compliance with a medical facility's training protocols on suctioning procedures.

(e) (1) Instrumental procedures referred to in subdivision (d) are the use of rigid and flexible endoscopes to observe the pharyngeal and laryngeal areas of the throat in order to observe, collect data, and measure the parameters of communication and swallowing as well as to guide communication and swallowing assessment and therapy.

(2) Nothing in this subdivision shall be construed as a diagnosis. Any observation of an abnormality shall be referred to a physician and surgeon.

(f) A licensed speech-language pathologist shall not perform a flexible fiberoptic nasendoscopic procedure unless he or she has received written verification from an otolaryngologist certified by the American Board of Otolaryngology that the speech-language pathologist has performed a minimum of 25 flexible fiberoptic nasendoscopic procedures and is competent to perform these procedures. The speech-language pathologist shall have this written verification on file and readily available for inspection upon request by the board. A speech-language pathologist shall pass a flexible fiberoptic nasendoscopic instrument only under the direct authorization of an otolaryngologist certified by the American Board of Otolaryngology and the supervision of a physician and surgeon.

TRACCKER II

**Medical Board of California
Tracker II - Legislative Bills
10/12/2010**

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 52	Portantino	Umbilical Cord Blood Collection Program	Chapter #529	08/30/10
AB 159	Nava	Perinatal Mood and Anxiety Disorders: task force	Dead	03/25/09
AB 417	Beall	Medi-Cal Drug Treatment Program: buprenorphine	Dead	03/15/10
AB 445	Salas	Use of X-ray Equipment: prohibition: exemptions	Dead	
AB 452	Yamada	In-home Supportive Services: CA Independence Act of 2009	Dead	
AB 456	Emmerson	Dentistry Diversion Program	Dead	05/28/09
AB 497	Block	Vehicles: HOV lanes: used by physicians	Dead	05/14/09
AB 520	Carter	Public Records: limiting requests	Dead	
AB 542	Feuer	Adverse Medical Events: expanding reporting	Vetoed	08/17/10
AB 718	Emmerson	Health Care Coverage	Dead	05/20/10
AB 721	Nava	Physical Therapists: scope of practice	Dead	04/13/09
AB 832	Jones	Ambulatory surgical clinics: workgroup	Dead	05/05/09
AB 834	Solorio	Health Care Practitioners: peer review	Dead	04/14/09
AB 867	Nava	California State University: Doctor of Nursing Practice Degree	Chapter #416	08/20/10
AB 877	Emmerson	Healing Arts: DCA Director to appoint committee	Dead	04/14/09
AB 950	Hernandez	Hospice Providers: licensed hospice facilities	Dead	07/15/10
AB 1162	Carter	Health Facilities: licensure	Dead	
AB 1168	Carter	Professions and Vocations (spot)	Dead	
AB 1194	Strickland	State Agency Internet Web Sites: information	Dead	
AB 1235	Hayashi	Healing Arts: peer review	Vetoed	02/16/10
AB 1458	Davis	Drugs: adverse effects: reporting	Dead	05/05/09

**Medical Board of California
Tracker II - Legislative Bills
10/12/2010**

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1478	Ammiano	Written Acknowledgment: medical nutrition therapy	Dead	
AB 1487	Hill	Tissue Donation	Chapter #444	08/10/10
AB 1518	Anderson	State Government: Boards, Commissions, Committees, repeal	Dead	04/08/10
AB 1542	Jones	Medical Homes	Dead	08/27/10
AB 1659	Huber	State Government: agency repeals	Chapter #666	07/15/10
AB 1916	Davis	Pharmacies: prescriptions: reports	Dead	04/08/10
AB 1937	Fletcher	Pupil Health: Immunizations	Chapter #203	06/23/10
AB 1938	Fletcher	Dentistry	Dead	
AB 1940	Fletcher	Physician Assistants	Dead	04/05/10
AB 1994	Skinner	Hospital employees: presumption	Dead	03/23/10
AB 2028	Hernandez	Confidentially of Medical Information: disclosure	Chapter #540	08/09/10
AB 2093	V. Manual Perez	Immunizations for Children: reimbursement of physicians	Vetoed	08/20/10
AB 2104	Hayashi	California State Board of Pharmacy	Chapter #374	06/24/10
AB 2130	Huber	Professions and Vocations: sunset review	Chapter #670	08/18/10
AB 2254	Ammiano	Marijuana Control, Regulation, and Education Act	Dead	
AB 2268	Chesbro	Alcohol and Drug Abuse	Chapter #93	04/20/10
AB 2292	Lownethal	Pharmacy: clinics	Dead	
AB 2382	Blumenfield	California State University: Doctor of Physical Therapy	Chapter #425	07/15/10
AB 2500	Hagman	Professions & Vocations: licenses: military service	Chapter #389	06/22/10
AB 2548	Block	CURES: Prescription Drug Monitoring Program	Dead	
AB 2551	Hernandez	Pharmacy Technicians: scholarship and loan repayment	Dead	08/02/10
AB 2707	Berryhill	Department of Consumer Affairs: regulatory boards	Dead	

**Medical Board of California
Tracker II - Legislative Bills
10/12/2010**

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 58	Aanestad	Physicians and Surgeons: peer review	Dead	05/19/09
SB 92	Aanestad	Health care reform	Dead	03/11/09
SB 238	Calderon	Prescription drugs	Dead	04/23/09
SB 341	DeSaulnier	Pharmaceuticals: adverse drug reactions	Dead	05/14/09
SB 389	Negrete McLeod	Professions and Vocations	Dead	06/01/09
SB 395	Wyland	Medical Practice	Dead	
SB 442	Ducheny	Clinic Corporation: licensing	Chapter #502	08/12/10
SB 484	Wright	Ephedrine and Pseudoephedrine: classification as Schedule V	Dead	05/12/09
SB 502	Walters	State Agency Web Sites: information posting: expenditures	Dead	
SB 638	Negrete McLeod	Regulatory boards: operations	Dead	
SB 719	Huff	State Agency Internet Web Sites: information searchability	Dead	
SB 761	Aanestad	Health Manpower Pilot Projects	Dead	05/06/09
SB 810	Leno	Single-Payer Health Care Coverage	Dead	01/13/10
SB 953	Walters	Podiatrists: liability for emergency services	Chapter #105	05/19/10
SB 1050	Yee	Osteopathic Medical Board of California: Naturopathic Medicine	Chapter #143	04/22/10
SB 1051	Huff	Emergency Medical Assistance: administration of disasters	Dead	05/12/10
SB 1083	Correa	Health Facilities: licensure	Dead	04/28/10
SB 1094	Aanestad	Healing Arts: peer review	Dead	
SB 1106	Yee	Prescribers: dispensing of samples	Dead?	04/05/10
SB 1132	Negrete McLeod	Healing Arts	Dead	
SB 1171	Negrete McLeod	Regulatory boards: operations	Dead	04/05/10

**Medical Board of California
Tracker II - Legislative Bills
10/12/2010**

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1246	Negrete McLeod	Naturopathic Medicine	Chapter #523	08/02/10
SB 1281	Padilla	Emergency Medical Services: defibrillators	Dead	
SB 1390	Corbett	Prescription drug labels	Dead	06/15/10
SB 1490	B&P Comm.	Professions and Vocations	Chapter #298	04/12/10
SB 1491	B&P Comm.	Professions and Vocations	Chapter #415	08/20/10
SBX8 53	Calderon	Medical Marijuana Act	Dead	
SJR 14	Leno	Medical Marijuana	Dead	
SJR 15	Leno	Public Health Laboratories	Chapter #46	08/17/09

B. 2011 PROPOSALS

The following are legislative proposals staff would like to develop for 2011 Legislation.

Medical Board Staff Proposals

1. Authorize staff to seek legislation to require physicians to cooperate/attend physician conferences with the Board and to consider non-compliance unprofessional conduct.

Reason: Similar and consistent with the State Bar of California requirements for attorneys, this proposal would require physicians to cooperate with the Medical Board, which will expedite the closure of cases.

Pro:

- Will help to expedite the closure of cases and no longer require the Medical Board to subpoena physicians who do not cooperate, which adds time to the cases.

Con:

- Will impose a new legal requirement on physicians.

2. Authorize staff to seek legislation to automatically temporarily suspend a physician and surgeon's certificate when a physician is incarcerated after a misdemeanor conviction during the period of incarceration.

Reason: Incarcerated physicians should not be treating or prescribing to patients, including other inmates.

Pro:

- This proposal would prohibit incarcerated physicians from treating and prescribing to patients, including other inmates. There is a similar provision for felony incarceration (B&P Code Section 2236.1).

Con:

- Incarcerated physicians would not be allowed to prescribe to patients, even those that were patients before the time of incarceration.

3. Omnibus - Authorize staff to develop proposed technical "fixes" to the Licensing laws (including midwifery) and place as many as possible in an omnibus bill. This will include some midwifery clean up language on reporting requirements and adding clinical training to be listed as one of the ways the period of validity for passing scores may be extended.

Board Evaluation Report Recommendations

1. Per the Board Evaluation (Ben Frank) Report, authorize staff to seek legislation to amend the statutes governing Vertical Enforcement (VE) to clarify the Medical Board's sole authority to determine whether to continue an investigation.

Pro:

- Per the report, will promote efficiency in the Enforcement Program by clarifying the Medical Board and Attorney General (AG) Office's roles, per the report.

Con:

- Legislative clarification will most likely not make a practical difference; instead revising the VE manual will allow the Medical Board and the AG to work together to implement VE.

2. Per the Board Evaluation Report, authorize staff to seek legislation to amend current law to no longer require Medical Board Investigators and HQES Attorneys to be permanently co-located.

Pro:

- Co-location has been found to be impractical, repealing existing law would legislatively mirror current practice.

Con:

- Co-location is not in existence in current practice, as such, legislation is not needed. An option would be to include this language in an omnibus bill if it is non-controversial.

3. Per the Board Evaluation Report, authorize staff to seek legislation to amend current law to no longer require the Medical Board to invest in the Complaint Tracking System (CAS) to make it more compatible with HQES' ProLaw System.

Pro:

- Repealing this requirement would no longer require the Medical Board to invest funds into CAS.

Con:

- With the approval of DCA's BreZE computer system, this legislative change is no longer needed. BreZE will completely replace CAS and the Boards Application Tracking System.

C. 2011 OTHER

AGENDA ITEM 26 C.

2011 Legislation – Other

This will be a verbal report

**MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations**

Subject	Current Status	Date Approved by Board	Date Notice Published by OAL	Date of Public Hearing	Date of Final Adoption	Date to DCA (and other control agencies) for Review *	Date to OAL for Review **	Date to Sec. of State***
Disciplinary Guidelines - 2009	File discontinued by MBC (process ended before adoption could be finalized)	7/24/09	9/11/09	10/30/09	11/30/09	To DCA 3/18/10; Approved by DCA 4/28/10; To Agency 4/29/10; approved by SCSA 6/1/10	6/3/10, discontinued by MBC 8/9/10	Will not be submitted
Written Exam for Physician licensure	Staff is Finalizing the File	1/29/10	3/12/10	4/30/10	4/30/10			
Abandonment of Application Files	Staff is Finalizing the File	4/30/10	6/4/10	7/30/10	7/30/10			
Polysomno-graphy Program	Hearing Scheduled 11/5/2010	7/30/10	9/10/10	11/5/10				
Limited Practice License	Hearing Scheduled 11/5/2010	7/30/10	9/10/10	11/5/10				
Disciplinary Guidelines - 2010	Hearing Scheduled 11/5/2010	7/30/10	9/17/10	11/5/10				
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations pending Summer 2011							

* - DCA is allowed 30 calendar days for review

** - OAL is allowed 30 working days for review

*** - Regs usually take effect 30 days after filing with Sec. of State

Prepared by Kevin A. Schunke
Updated October 11, 2010
For questions, call (916) 263-2368



State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

AGENDA ITEM 28

Memorandum

Date: October 16, 2010
To: Members of the Board
From: Reginald Low, M.D.
Subject: Status Update of International Medical School Recognition

International Medical Schools are subject to review pursuant to Title 16, Section 1314.1 (a)(2), of the California Code of Regulations (CCR).

Attached for your information is the list of the six International Medical Schools that have submitted applications for recognition by the Board. This list provides both the timelines and the current status of the application.

Currently, we have four medical consultants reviewing applications. One consultant serves as the trainer for the new consultants, one is an experienced consultant; and two are still fairly new to our review process. However, one of the medical consultants appointment term expires at the end of October 2010. The Board is still seeking to expand its staff of part-time Medical Consultants and is looking for two to four additional consultants to review the new applications that are arriving. However, there is currently a hiring freeze, which prevents us from hiring new consultants or extending current appointment terms at this time. We are anticipating meeting with the Department of Consumer Affairs, Examination Unit soon to put together the examination for medical consultants. Although, there is no timeline at this point as to when the examination will be given we are hopeful it will be done by the end of the year.

We have one school on our agenda for review and consideration.

AMERICAN UNIVERSITY OF ANTIGUA	
DATE	DISCRIPTION/COMMENT
3/23/2008	Received application
6/30/2008	Staff transmitted application to Medical Consultant
11/26/2008	Staff mailed Medical Consultant deficiency letter to school
8/20/2009	Staff mailed "due diligence" letter to school
9/24/2009	Staff received information from school
10/22/2009	Staff transmitted school's reply to Medical Consultant
1/4/2010	Medical Consultant requested additional information
2/3/2010	Staff mailed Medical Consultant deficiency letter to school
4/30/2010	Staff received information from school
6/4/2010	Staff transmitted school's reply to Medical Consultant
6/21/2010	Staff mailed staff deficiency letter to school
6/22/2010	Staff and Medical Consultant discussed questions, obtained information and clarified additional informational needs with school officials from AUA via teleconference
7/12/2010	Staff e-mailed school a summary of questions from 6/22/10 discussion
7/15/2010	Staff e-mailed school a copy of Consultant's preliminary report
7/21/2010	Staff received information from school dated July 20, 2010
7/29/2010	Staff received information from school dated July 28, 2010
7/30/2010	Board voted to begin site visit process after school submits all requested information
8/11/2010	Staff e-mailed analysis of AUA's 7/28/10 binder to management and Medical Consultant
8/12/2010	Staff e-mailed Medical Consultant's reply to management
9/16/2010	Meeting with Medical Consultant at MBC -update on status of review
10/12/2010	Draft out of state/country travel request to management
10/14/2010	Staff mailed and e-mail letter to school requesting additional informatior

16 CCR § 1314.1(f)

Cal. Admin. Code tit. 16, § 1314.1(f)

Barclays Official California Code of Regulations
 Title 16. Professional and Vocational Regulations
 Division 13. Medical Board of California
 Chapter 1. Division of Licensing
 Article 4. Schools and Colleges of Medicine

For disposition of former Sections 1370-1375.45, see Table of Parallel Reference, Chapter 13.2, Title 16, California Code of Regulations.

§ 1314.1 (f). International Medical Schools.

(f) If an institution wishes to retain the board's determination that its resident course of instruction leading to an M.D. degree is equivalent to that required by Sections 2089 and 2089.5 of the code, or if it is currently being evaluated for such equivalency, it shall do the following:

(1) It shall notify the board in writing no later than 30 days after making any change in the following:

(A) Location including addition or termination of any branch campus;

(B) Mission, purposes or objectives;

(C) Change of name;

(D) Any major change in curriculum, including but not limited to, a change that would affect its focus, design, requirements for completion, or mode of delivery, or other circumstance that would affect the institution's compliance with subsections (a) and (b).

(E) Shift or change in control. A "shift or change in control" means any change in the power or authority to manage, direct or influence the conduct, policies, and affairs of the institution from one person or group of people to another person or group of people, but does not include the replacement of an individual administrator with another natural person if the owner does not transfer any interest in, or relinquish any control of, the institution to that person.

(F) An increase in its entering enrollment above 10% of the current enrollment or 15 students in one year, whichever is less, or 20% or more in three years.

(2) Every seven years, it shall submit documentation sufficient to establish that it remains in compliance with the requirements of this section and of Sections 2089 and 2089.5 of the code.

(g) The documentation submitted pursuant to subsection (f)(2) shall be reviewed by the board or its designee to determine whether the institution remains in compliance with the requirements of these regulations and of Sections 2089 and 2089.5 of the code. The board may require a site visit as part of this review. It may also require a site visit at any other time during the seven-year period if it becomes aware of circumstances that warrant a site visit, including any change described in subsection (f).

(h) The board may at any time withdraw its determination of equivalence when any of the following occur:

(1) An institution is no longer in compliance with this section;

(2) The institution submits false or misleading information or documentation regarding its compliance with this section;

(3) Institution officials submit fraudulent documentation concerning a former student's medical curriculum; or

(4) The institution permits students to engage in clinical training in California facilities that do not satisfy the requirements of section 2089.5(c) and (d) of the code and, where applicable, section 1327 of Title 16 of the California Code of Regulations.

Prior to withdrawing its determination of equivalence, the board shall send the institution a written notice of its intent to withdraw its determination of equivalence, identifying those deficiencies upon which it is proposing to base the withdrawal and giving the institution 120 days from the date of the notice within which to respond to the notice. The board shall have the sole discretion to determine whether a site visit is necessary in order to ascertain the institution's compliance with this section. The board shall notify the institution in writing of its decision and the basis for that decision.

(i) The board may evaluate any institution described in subsection (a)(1) to determine its continued compliance with Sections 2089 and 2089.5 of the code if, in its sole discretion, the board has reason to believe that the institution may no longer be in compliance.

Note: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2018, 2089, 2089.5, 2102 and 2103, Business and Professions Code.

HISTORY

1. New section filed 11-13-2003; operative 12-13-2003 (Register 2003, No. 46).
2. Amendment filed 12-9-2009; operative 1-8-2010 (Register 2009, No. 50).

16 CCR § 1314.1, **←16 CA ADC § 1314 →. ←1 →**

This database is current through 10/1/10 Register 2010, No. 40

END OF DOCUMENT

DATE REPORT ISSUED: October 27, 2010
ATTENTION: Medical Board of California
SUBJECT: Periodic Compliance Requirements for Previously
Recognized International Medical Schools per
California Code of Regulations Section 1314.1
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

- Determine if Board should delegate duties to the Task Force on International Medical Schools with a final recommendation on the reevaluations coming to the full Board.

If the Board opts for this recommendation from staff, then the Task Force will need to consider the following as its task assignments:

- Evaluate the current workload of the Board and current staffing, including the number of and availability of medical consultants.
- Review and evaluate the current Self-Assessment Report for possible changes. This will require several meetings with the medical consultants to provide recommendations and evaluations of the changes.
- Determine if there is a need for two different Self-Assessment Reports: one for initial evaluations and one for reevaluations.
- Recognize and consider the difficulty in obtaining out of country and/or out state travel for site visits.
- Recognize and consider the costs to the Board for the site visits for reevaluations of currently recognized medical schools.
- Determine the order of which medical schools are to be reevaluated and development of a new timeline for the reevaluations. Ross and AUC may need to update the 2008 self-assessments.

BACKGROUND AND ANALYSIS:

Currently there are 14 international medical schools that are recognized by the Board within the jurisdiction of California Code of Regulations (CCR) Section 1314.1. All of these medical schools and any future medical schools that receive recognition per CCR Section 1314.1 are to be reevaluated every seven years and the Board may require a

site visit at any other time during the seven-year period if it becomes aware of circumstances that warrant a site visit.

On February 3, 2006, the Division of Licensing (Division) adopted the following schedule for conducting reevaluations of these schools. The Division selected American University of the Caribbean (AUC), Ross, St. George's and Saba universities to be reevaluated in the first group:

<u>Name of school</u>	<u>Last inspected</u>	<u>Reevaluation due</u>
AUC	1985, 1998	2010
Ross University	1985	2010
St. George's University	1985	2010
Saba University	2004	2011

Ross University and AUC submitted their completed Self Assessment Reports in October and December 2008, respectively. Subsequent events and workload priorities prevented staff and the Medical Consultants from following the adopted timeline for reevaluating these medical schools.

The Division previously reached consensus on some, but not all, aspects of the reevaluation process that should be followed when reevaluating medical schools. In 2005, the members agreed that their reevaluation process should be modeled after the Liaison Committee on Medical Education's (LCME) and that they should seek the statutory authority to recover the full costs of reevaluation and site visit expenses. However, the subsequent search for a legislative sponsor was unsuccessful. In terms of the survey instrument that the Division should use to reevaluate previously-recognized medical schools, the members agreed that either the existing Self Assessment Report or a modified document could be used for data-collection purposes. However, no decision was reached. As late as the Division's February 2, 2007 meeting, the members planned to have the Medical Consultants review the schools' Self Assessment Reports and express their opinions as to whether site inspections should be conducted. The regulation leaves the requirement for site inspections to the Board's discretionary.

Comparison with LCME's process for reevaluating accredited schools:

LCME reviews accredited medical schools every eight years. California's regulations mandate reevaluations every seven years.

With the opening of Florida State University's new medical school in 2002, the first new U.S. medical school in 20 years, the LCME developed a process for accrediting new medical schools that involves two site inspections, two years apart during the first accreditation review. California's regulations allow for one site inspection during the review process.

The LCME's process for re-accrediting existing medical schools is just as rigorous as its process for evaluating new medical schools. Both groups of schools receive site inspections. The final site inspection for a new medical school lasts one additional day. The California Board has no experience yet with its reevaluation process.

If you have any questions concerning this memorandum, please telephone me at (916) 263-2382

**Reevaluations of Previously
Reviewed International Medical Schools
Mandated pursuant to CCR Section 1314.1 (f)(2)**

Name of School	Recognition Date*	7-Year Reevaluation Date
American Univ. of Caribbean (St. Maarten, N.A.)	9/15/1989	December 2010**
Ross University (Dominica)	6/30/1990	December 2010**
St. George's Univ. (Grenada)	9/15/1989	December 2010**
Semmelweis University (Hungary)	5/30/2002	December 2010**
Szeged University (Hungary)	9/22/2003	December 2010**
Charles University (Czech. Republic)	12/29/2003	December 2010
Saba University (Saba, N.A.)	11/5/2004***	November 2011
Debrecen University (Hungary)	4/28/2005	April 2012
Pecs Univ. (Hungary)	5/3/2005	May 2012
Jagiellonian Univ. (Hungary)	7/27/2007	July 2014
Med. Univ. of Poznan (Poland)	7/27/2007	July 2014
ELAM (Cuba)	7/27/2007	July 2014
Med. Univ. of Lublin (Poland)	7/25/2008	July 2015
St. George's UK campus	7/24/2009	July 2016

*This is the date used to calculate the seven-year reevaluation period.

**The recognition date of these schools predated December 13, 2003, the effective date of Section 1314.1. Therefore, their reevaluation date is calculated as seven years after December 13, 2003.

*** Recognition extended only to those students who matriculate at Saba on or after January 1, 2002.

Medical Board of California International Medical School Self-Assessment Report



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I. Introduction:

The purpose of this institution self-assessment report is to assess institutions, in the recognition and update phases, in the areas of institution function, structure, and performance. Included are detailed and objective analysis questions that are required for institutional recognition by the Medical Board of California.

If an institution meets the requirements set forth in Title 16 California Code of Regulations section 1314.1 (a)(1), then that institution is exempt from this process. Those requirements of Title 16 California Code of Regulations section 1314.1 (a)(1) are as follows:

- ⇒ The institution is owned and operated by the government of the country in which it is located.
- ⇒ The country is a member of the Organization for Economic Cooperation and Development.
- ⇒ The institution's primary purpose is to educate its own citizens to practice medicine in that country.

All other institutions seeking recognition from the Medical Board of California that do not fulfill the requirements of Title 16 California Code of Regulations section 1314.1 (a)(1), will be evaluated based upon this self-assessment report. A site inspection may be required by the Medical Board of California. If a site visit is requested of an institution seeking recognition from the Medical Board of California, the school must pay all site visit fees. See Title 16, California Code of Regulations, section 1314.1(e).

II. Instructions:

All responses and information provided in this self-assessment report must be accurate and applicable to the institution in question. No additional information may be included by the medical institution aside from that which is required by this self-assessment report. **If this self-assessment report is incomplete or inaccurate at the time it is submitted, it will be returned to the institution without any further review by the Medical Board of California.**

Each section of this self-assessment report shall be completed by the person(s) most knowledgeable about the topic. Care shall be taken to ensure the accuracy and consistency of data across sections of the self-assessment report (for example, by using a consistent base year for data). The institution shall ensure that the completed self-assessment report undergoes a comprehensive review to identify any missing items or inconsistencies in reported information.

A final self-assessment report should include a statement of institutional strengths and issues that require attention either to assure compliance with recognition standards or to improve institutional quality.

The self-assessment report shall reflect the participation of all constituent components of the institution: administrators of the institution, department chairs and heads of sections, junior and senior faculty members, medical students, representatives of clinical affiliates, and trustees of the institution.

The dean of the institution shall submit the self-assessment report and shall certify under penalty to the truth of its contents.

III. Mission and Objectives:

1. Provide the institution's written purpose or mission statement and objectives that include: the institution's broad expectations concerning the education students will receive; the role of research as an integral component of its mission, including the importance, nature, objectives, processes and evaluation of research in medical education and practice; and the teaching, patient care, and service to the community.
2. Describe how the institutional objectives are consistent with preparing graduates to provide competent medical care.
3. Describe how students learn how medical research is conducted.
4. Provide an assessment of how students evaluate and apply medical research results to their patient population.
5. Describe how students participate in ongoing faculty research projects.
6. Describe the breadth of the research involvement of basic science and clinical departments.
7. Describe the infrastructure supporting research including departmental or individual research incentives.
8. Describe the written objectives for all courses; explain how the objectives are used as part of program planning and evaluation; and describe how students are made aware of these objectives.
9. Complete the attached Student Status Information Chart (page 6). (Please do not submit any additional information other than what is requested by this chart.)

IV. Organization:

1. Describe the manner in which the institution is organized and provide appropriate documentation to support the description. Please include a listing of the owners and the percentage of interest of each owner.
2. If applicable, provide a list of the names of the board of directors, their qualifications, their financial interests in the institution, and their curricula vitae.
3. Attach a list of the names of all officials, other than faculty members and board of directors, along with the titles of their positions. Please do not provide any further information other than the names and titles of positions.
4. Attach a graphic representation of the organizational structure of the medical institution (e.g. organizational charts etc.) Please limit the attachments to three pages.
5. Attach a copy of the charter from the jurisdiction in which the institution is domiciled.

V. Curriculum:

1. Can students receive a certificate of completion without passing either step 1 or step 2 of the USMLE?
2. Describe how the structure and content of the educational program provides an adequate foundation in the basic and clinical sciences and enables students to learn the fundamental principles of medicine, to acquire critical judgment skills, and to use those principles and skills to provide competent medical care.
3. Describe how the institution is fostering the ability of students to learn through self-directed independent study.
4. Describe the mechanisms used for curriculum planning, implementation, evaluation, management, and oversight, including the roles of faculty committees, the departments, and the central institution administration.
5. How many academic years or months of actual instruction is your program?
6. What is the total number of hours of all courses required to obtain a medical degree?
7. What is the percent of actual attendance that is required?
8. Describe how attendance is monitored.
9. Describe the formal processes for making changes to the curriculum.
10. Describe how the curriculum for all applicants provides for adequate instruction in each of the following subjects. Please limit yourself to approximately one page per subject.
 - alcoholism and other chemical substance dependency (detection and treatment)
 - anatomy (including embryology, histology and neuroanatomy)
 - anesthesia
 - bacteriology
 - biochemistry
 - child abuse detection and treatment
 - dermatology
 - family medicine
 - geriatric medicine
 - human sexuality
 - immunology
 - medicine (including all sub-specialties)
 - neurology
 - obstetrics and gynecology
 - ophthalmology

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- otolaryngology
 - pain management and end-of-life care
 - pathology
 - pharmacology
 - physical medicine
 - physiology
 - preventive medicine (including nutrition)
 - psychiatry
 - radiology (including radiation safety)
 - spousal or partner abuse detection and treatment
 - surgery (including orthopedic surgery)
 - therapeutics
 - tropical medicine
 - urology
11. Discuss where all the subjects listed above can be found in the curriculum.
 12. Complete the following curriculum tables. List only the one main principle course objective where required. If necessary, add tables for any additional years required by the institution.
 13. Complete the following tables related to performance on the USMLE. If the data is not available, please explain why.

Year One

Course	Length In Weeks	Number Of Lecture Hours	Number Of Lab Hours	Number Of Small Group Discussion Hours*	Number Of Patient Contact Hours	Total Hours	Principle Course Objective
Total							

* Includes case-based or problem solving sessions

Year Two

Course	Length in weeks	Number Of Lecture Hours	Number Of Lab Hours	Number Of Small Group Discussion Hours*	Number Of Patient Contact Hours	Total Hours	Principle Course Objective
Total							

* Includes case-based or problem solving sessions

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Year

Clerkship	Total Weeks	% Ambulatory	Number Of Sites Used*	Typical Weekly Length Of Time For Formal Instruction	Average Number Of New Patients Per Week	Average Number Of Continuity Patients Per Week

*Include the number of sites used for inpatient teaching and the number of sites used for outpatient teaching in the clerkship in the following format: #inpatient/ #outpatient

Year

Clerkship	Total Weeks	% Ambulatory	Number Of Sites Used*	Typical Weekly Length Of Time For Formal Instruction	Average Number Of New Patients Per Week	Average Number Of Continuity Patients Per Week

*Include the number of sites used for inpatient teaching and the number of sites used for outpatient teaching in the clerkship in the following format: #inpatient/ #outpatient

USMLE Step 1

Year	Number Of Students Who Took USMLE Step 1	Number Of Students Who Passed On First Attempt	Number Of Students Who Passed On Second Attempt	Number Of Students Who Passed On Or After Third Attempt	Number Of Students Who Never Passed

USMLE Step 2

Year	Number Of Students Who Took USMLE Step 2	Number Of Students Who Passed On First Attempt	Number Of Students Who Passed On Second Attempt	Number Of Students Who Passed On Or After Third Attempt	Number Of Students Who Never Passed

VI. Governance:

1. Describe how the institution's administrative and governance systems allow the institution to accomplish its objectives.
2. Describe the faculty's formal role in the institution's decision-making process and where it is documented.
3. Are students enrolled in the program permitted to serve as instructors, administrators, officers, or directors of the institution? If yes, explain.
4. Describe the mechanisms that exist for periodic review of departments and heads of departments.
5. Are there any departments experiencing significant problems? If yes, please identify which department, the nature of the problem(s), and any potential solutions the institution has identified.
6. Provide a list of the deans' names, responsibilities, credentials, date of appointment, and relationship to university officials.
7. Attach a copy of the institution's contingency plan for addressing disasters (hurricanes, earthquakes, floods, military conflict, etc.).

VII. Faculty:

1. List all faculty members and their length of employment at the institution.
2. Describe how the faculty is qualified and sufficient in number to achieve the objectives of the institution. (A "qualified" faculty member is a person who possesses either a credential generally recognized in the field of instruction or a degree, professional license, or credential at least equivalent to the level of instruction being taught or evaluated.)
3. Describe and explain the institution's formal ongoing faculty development process. Attach the institution's written policy.
4. Describe the process by which faculty participate and document their activities in continuing medical education.
5. Describe the role of faculty in the admissions process.
6. Is there any anticipated decrease in the number of faculty in the near future (for example, through a significant number of retirements)? If yes, when, why, and to what extent?
7. Does the course and clerkship review include a review of the faculty who taught the course? If yes, please describe how and who does the review?
8. Describe how the clinical faculty participates in the institution's educational program.
9. Describe how clinical faculty are involved in curriculum development.
10. List any other responsibilities the faculty have aside from teaching (e.g. research, administrative duties, etc.).

VIII. Admissions and Promotion Standards:

1. Describe the institution's standards governing admission requirements and student selection and promotion to the next semester or academic year. How are the standards consistent with the institution's mission and objectives? How does the institution adhere to these standards?
2. Describe the admissions process, including the organization and operation of the admissions committee.
3. Who makes the initial and then the ultimate decision regarding admission?
4. For students experiencing academic or other difficulties, describe how a decision is made whether to permit a student to remediate or to repeat a course.
5. Describe all the educational prerequisites for admission, including any courses or topics that are recommended but not required.
6. Describe the academic advisory system, including any programs designed to assist potentially high-risk students in the entering class or students who experience academic difficulty throughout the curriculum.
7. Describe the system for counseling students on career choice and residency application.
8. Describe any background screening process that the institution performs on potential students, including any factors that might result in a potential student being unable to obtain licensure (e.g. criminal convictions, history of disciplinary action in undergraduate education, physical or mental disabilities, etc.).
9. Describe the institution's policies for evaluating applications for transfer from students enrolled in other medical schools. Do you accept medical education from medical schools that are not approved or recognized by California? Are there criteria that describe the schools from which you will grant transfer credit? Is there a maximum limit on the amount of advanced placement credit that you will grant? Do you accept basic sciences coursework completed in schools other than medical schools? Do you accept coursework that the student completed over the Internet or in schools that require little or no attendance in classrooms and laboratories? How is the student's previous course work evaluated for academic equivalence with your curriculum? How is the student's medical knowledge tested to determine placement in the appropriate academic year?
10. Complete the following evaluation charts.

Year One

		Grading Formula (percent contribution to final grade)						
Course	Number Of Exams	Written Exams	Lab/ Practical Exams	USMLE Subject Exams	OSCE/ SP* Exams	Oral Pres. Or Paper	Faculty/ Resident Evals**	Other***

* Objective Structured Clinical Examination/Standardized Patient
 ** Include evaluations by faculty members or residents in clinical experiences and also in small group sessions (for example, a facilitator evaluation in small group or case-based teaching).
 *** Describe the specifics in the report narrative

Year Two

		Grading Formula (Percent Contribution To Final Grade)						
Course	Number Of Exams	Written Exams	Lab/ Practical Exams	USMLE Subject Exams	OSCE/ SP* Exams	Oral Pres. Or Paper	Faculty/ Resident Evals**	Other***

* Objective Structured Clinical Examination/Standardized Patient
 ** Include evaluations by faculty members or residents in clinical experiences and also in small group sessions (for example, a facilitator evaluation in small group or case-based teaching).
 *** Describe the specifics in the report narrative

Year

Grading Formula (Percent Contribution To Final Grade)

Clerkship	Who Contributes To Clinical Evaluation*	Written Exams	USMLE Subject Exams	OSCE/ SP Exams	Oral Pres. Or Paper	Faculty/ Resident Evals	Other**	Clinical Skills Observed***

* Use the following key to indicate who contributes to the final evaluation of the clerk: F (full-time faculty), V (volunteer or community clinical faculty), R (residents), O (other [describe in report narrative])

** Describe the specifics in the report narrative

*** Are all students observed performing core clinical skills? (Yes or No)

Year

Grading Formula (Percent Contribution To Final Grade)

Clerkship	Who Contributes To Clinical Evaluation*	Written Exams	USMLE Subject Exams	OSCE/ SP Exams	Oral Pres. Or Paper	Faculty/ Resident Evals	Other**	Clinical Skills Observed***

* Use the following key to indicate who contributes to the final evaluation of the clerk: F (full-time faculty), V (volunteer or community clinical faculty), R (residents), O (other [describe in report narrative])

** Describe the specifics in the report narrative

*** Are all students observed performing core clinical skills? (Yes or No)

IX. Financial Resources:

This section applies to all institutions except those that are solely owned and operated by the government of the country in which the institution is located.

1. Show evidence that the institution possesses sufficient financial resources to accomplish its mission and objectives.
2. Provide the institution's current year financial budget.
3. Describe all monetary allocations allotted to research activity.
4. Is the institution planning or engaged in any major construction or renovation projects, or other initiatives that require substantial capital investment? If yes, how will capital needs be addressed?
5. List the amount of tuition and fees, and the overall cost of attending this institution.
6. Is there anything pending that might negatively affect the institution's financial resources (e.g. existing litigation, lawsuits, etc.)? If yes, explain.
7. Include the institution's annual financial statements prepared in accordance with standards of the International Accounting Standards Board and the independent auditor's or accountant's report issued. The reports must have been prepared within one year from the date the self-assessment report is submitted.

X. Facilities:

1. Describe the institution's facilities, laboratories, equipment and library resources and how they are sufficient to support the educational programs offered by the institution and how they enable the institution to fulfill its mission and objectives.
2. Indicate whether the institution owns, leases or has other arrangements for use of the property and buildings. Describe any other arrangements aside from ownership.
3. If an institution utilizes affiliated institutions to provide clinical instruction, describe how the institution is fully responsible for the conduct and quality of the educational program at those affiliated institutions.
4. Excluding anatomy, describe the amount and nature of student performance in actual lab experience (i.e. actual specimens).
5. Explain how the institution is using computer-assisted instruction in required or optional learning experiences and/or in the evaluation of students.
6. Explain how the library's hours, services, holdings, staff, and facilities meet the needs of the faculty, residents, students, and the institution's mission and objectives.
7. Describe the library's automated databases and bibliographic search, computer and audiovisual capabilities.

XI. Medical Students:

1. Does the acceptance of transfer students, or visiting students, in the institution's teaching hospitals (including affiliates) affect the educational program of regular students (i.e., in the context of competition with the institution's own students for available resources, patients, educational venues, etc.)? If yes, explain.
2. Is the curriculum and student training educating medical students to provide sound medical care or is it focused primarily upon passing the USMLE (or some other licensing examination)? Provide specific evidence.
3. If the institution provides patient care, describe the formal system of quality assurance for its patient care program.
4. Describe how students have access to Internet and/or Intranet databases?
5. What is the general student opinion of the institution and the educational experience it provides as reflected in student surveys, evaluations, polls or other sources of information provided by students?
6. Describe how all students are systematically observed performing core clinical skills, behaviors, and attitudes.
7. Do students believe that they have adequate representation in decision-making bodies that directly affect their education? Please explain.
8. Explain the housing arrangement at affiliated locations provided by the institution, if any.

XII. Records:

1. What is the retention period for student transcripts?
2. How long will/does the institution maintain and make available for inspection any records that relate to the institution's compliance with requirements for recognition by the Medical Board of California?
3. Is there a central location where records are kept? Where are the records maintained? In what form? For how long?
4. Describe the back-up system for both paper and electronic records.
5. Describe how student records are made accessible to students who wish to review them.
6. Where and how does the institution maintain for each student a permanent, complete, accurate, and up-to-date transcript of student achievement including clinical and transfer units?
7. Describe how the institution plans to store and make available records if the institution ceases to operate.

XIII. Branch Campuses:

1. If the institution has more than one campus, describe the written policies and procedures governing the division and sharing of administrative and teaching responsibilities between the central administration and faculty, and the administration and faculty at the other locations.
2. Describe how the policies are consistent with the institution's mission and objectives.
3. Describe how the institution is fully responsible for the conduct and quality of the educational program at these sites.
4. Describe processes that are in place to ensure standardization of course content and exams between the campuses.

XIV. Affiliation Agreements:

1. The following applies to the teaching hospitals where the institution's medical school students receive their clinical training. Describe how affiliation agreements between a hospital and the institution meet the standard set forth by California's Business and Professions Code Section 2089.5:
 - A) formal affiliation documented by a written contract detailing the relationship between the institution and hospital and the responsibilities of each
 - B) institution and hospital provide to the division a description of the clinical program sufficient to evaluate the adequacy of the medical education
 - C) is accredited in accordance with the law of resident country
 - D) clinical instruction is supervised by a full-time director of medical education, and the head of the department for each core clinical course shall hold a full-time faculty appointment of the institution or institution of osteopathic medicine and shall be board certified or eligible, or have an equivalent credential in that specialty area appropriate to the country in which the hospital is located
 - E) clinical instruction is conducted pursuant to a written program of instruction provided by the institution
 - F) institution supervises the implementation of the program on a regular basis, documenting the level and extent of its supervision
 - G) the hospital based faculty evaluates each student on a regular basis and documents the completion of each aspect of the program for each student
 - H) the hospital ensures a minimum daily census adequate to meet the instructional needs of the number of students enrolled in each course area of clinical instruction, but no less than 15 patients in each course area of clinical instruction
2. Attach a brief explanation of any areas of noncompliance with the above affiliation requirements.
3. Provide proof that the affiliation agreements are up to date and explicit on the role of and expectations for medical students.
4. Provide the standardized course and clerkship evaluation forms.
5. Describe the internal structure of the clerkship, including the amount of time spent in various rotations, and the consistency of instruction across sites.
6. Provide evidence that there is an appropriate balance among the methods of instruction used, between inpatient and outpatient clinical experiences, and between clinical experiences in primary care and specialties.

7. Describe how the chief academic officer and directors of all courses and clerkships have designed and implemented a system of evaluation of the sites and course work of each student.
8. List the major hospitals and ambulatory-care facilities utilized for medical student education
9. Are students permitted to obtain clinical instruction at sites that are not included on the above list? If so, describe the process of permitting students to obtain clinical instruction at alternate sites.
10. Describe the financial arrangements that have been made between the institution and teaching hospitals.
11. Are clinical faculty compensated by the institution? If yes, how?
12. What percent of clinical instructors are working full-time and what percent are working part-time?
13. What percent of clinical instructors are hospital based and what percent are private practice based?

XV. Summary:

1. What are the areas of strength of the institution or educational program?
2. What are the areas of partial or substantial noncompliance of the institution or educational program?
3. What are the areas in transition of the institution or educational program?

NOTE: An area of strength is an aspect of the institution or its educational program that is clearly valuable for the successful achievement of one or more of the institution's principle missions or goals. It is a truly distinctive activity or characteristic worthy of emulation or adoption by other institutions or educational programs. Areas of partial or substantial noncompliance are those that do not fully comply with the requirements set forth in this self-assessment tool. Provide specific information as to the areas of noncompliance and potential reasons for deficiency. The process of listing areas in transition is intended to identify significant events or activities taking place which, depending on their final outcome, could result in noncompliance with one or more standards. Transition issues require specific information regarding the time of completion, as well as, construction or operational plans.

AGENDA ITEM 29
CONSIDERATION OF REQUEST
FOR RECOGNITION OF
ROSS UNIVERSITY
will be sent under separate cover

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 27, 2010
ATTENTION: Medical Board of California
SUBJECT: Recognition of International Medical School
Ross University – Freeport, Grand Bahama Campus
Request to Approve Bahamas Campus for Medical
Education for Semesters Three and Four Only
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Approve Ross University's Freeport, Grand Bahama campus to provide medical school education for semesters three and four only at this time. In addition, recommend site visits to Ross University's main campus, the Bahamas campus and several representative teaching hospitals in the United States where students receive clinical training, as part of Ross University's reevaluation by the Board.

BACKGROUND AND ANALYSIS:

The Board recognizes Ross University's main campus located in Dominica, West Indies. In January 2009, Ross opened a branch campus in the Bahamas to provide medical education for the third and fourth semesters of medical school. As a medical school whose primary purpose is to educate non-citizens to practice medicine outside of Dominica and the Bahamas, Ross meets the criteria for the Board's review pursuant to Section 1314.1 (a)(2) of Title 16, California Code of Regulations.

In November 2009, Ross University officials submitted a Self Assessment Report to commence the Board's review process of their Bahamas campus. Medical Consultant Mark Servis, M.D., has been reviewing the school's application. Staff and Dr. Servis requested additional information on two different occasions and the medical school officials provided the requested information.

Staff requests that Board members review Dr. Servis' report and determine whether to recognize the medical education provide to students for the third and fourth semesters at the Bahamas campus.

Alternatively, if the Board requires further information regarding the school's educational resources before you reach a decision, staff will request Ross officials to submit the information for your review during a future meeting. If the Board determines site inspections are necessary prior to making a determination, staff will prepare the necessary documents.

FISCAL CONSIDERATIONS:

In accordance with Business and Professions Code Section 2089.5, the costs of conducting a site inspection are borne by the medical school applying for the Board's recognition. These costs include all team members' air and ground travel costs within the guidelines allowed by the State, the consultant's daily per diem expense, and the consultant's travel expenses to and from any Board meetings where the team presents its report. Subsection (e) of Section 1314.1 of the regulations requires the medical school to reimburse the Board for the team's estimated travel expenses in advance of the site visit.

The Board has been informed that representatives from Ross University will be available during the meeting to answer any questions you may have concerning the school's medical education program.

If you have any questions concerning this memorandum, please telephone me at (916) 263-2382.

October 26, 2010

Agenda Item 29

To: Linda Whitney
Executive Director
Medical Board of California

From: Mark Servis, MD 
Professor and Associate Dean of Curriculum and Competency Development
UC Davis School of Medicine
2230 Stockton Blvd.
Sacramento, CA 95817

Re: Evaluation of the Ross University School of Medicine Branch Campus in
Freeport, Grand Bahama Self-Assessment Report; Application for Recognition in
California.

BACKGROUND

The Medical Board of California (Board) requested a review of materials provided by the Ross University School of Medicine for their branch campus in Freeport, Grand Bahama. These were submitted in a request for recognition for the Freeport branch campus from the Board. Ross University provided an initial Self Assessment Report in January 2009 and several clarifications and additional materials in response to subsequent questions.

Ross University's main campus is in Dominica, West Indies and was founded in 1978. The new branch campus in Freeport opened in January 2009. Ross University's main administrative offices are in North Brunswick, New Jersey. Freeport is 1,356 miles northwest of Dominica. The Dominica campus and the Freeport campus are located 1,902 miles and 989 miles, respectively, from Ross University's administrative offices in New Jersey.

The Dominica campus has been recognized by the Board, but is in the process of being scheduled to be reviewed as part of the regular re-evaluation process for previously recognized medical schools. The Freeport branch campus offers only the 3rd and 4th semesters of a 10 semester Ross University curriculum, or approximately one fifth of the Ross University educational program for medical students. The stated reason for the creation of the Freeport branch campus is its proximity to the mainland United States compared to the Dominica campus and the opportunity for greater clinical exposure during the 2nd year curriculum at the affiliated Grand Bahamas Health Services (GBHS) hospital facility.

This report is based on my review of the documents submitted by Ross University, as well as unsolicited documents and materials submitted by a student at Ross University. The goal of the review was to determine if the medical education received at the Freeport

branch campus meets the requirements of current California statutes and regulations for recognition by the Board.

RECOMMENDATIONS

The Ross University branch campus in Freeport, Grand Bahama has provided sufficient documentation to satisfy the criteria in Sections 2089 and 2089.5 of the Business and Professions Code and Section 1314.1 of Title 16, California Code of Regulations. The provided documentation also satisfies the stated criteria of Section 2036 of the Business and Professions Code. Specifically, the Freeport branch campus curriculum provides faculty guided and monitored self-study with temporal and spatial distance learning that does meet the Section 2036 criteria for: "classroom, laboratory, practical and clinical instruction, received and given the person physically present..."

REVIEW

This was a unique review in two respects:

1. As a branch campus the review examined only the 2 semesters or 30 weeks that are taught at the Freeport Branch campus of a four year curriculum based out of the Dominica campus. Therefore in considering whether the program met the California requirements and statutes, it was assumed that these 2 semesters needed to be equivalent to the already recognized curriculum provided at the Dominica campus. These 2 semesters, the 3rd and 4th semesters in the Ross University Curriculum, consist of 30 weeks of Microbiology, 30 weeks of Pathology, 30 weeks of Pharmacology, 15 weeks of Behavioral Science, and 15 weeks of Introduction to Clinical Medicine. Ross University did provide evidence of measures taken to ensure equivalent experiences between these two sites, for example the regular exchange of faculty between sites and the sharing of content through distance learning. Indeed, the course syllabi provided for the Freeport Branch campus courses is identical to the Dominica campus. The primary method used for delivering content at the Freeport campus, the Progressive Academic Education Program (PACE), is used by a small proportion of students at the Dominica campus. Ross University was able to demonstrate that they have adequate monitoring and documentation of student learning in the PACE program, particularly the 20 hours of weekly self-study that students are typically expected to engage in as part of the PACE curriculum, to assure that the students at the Dominica and Freeport campuses are having equivalent learning experiences.
2. Distance learning, both spatial and temporal, is an integral part of the PACE curriculum and is the primary method of learning used in the student self-study process. The PACE program typically includes 2 hours of Problem-Based Learning (PBL) small groups, 3 hours of simulation, and 2 hours of Team-Based Learning (TBL) small groups each week, in addition to the 20 hours of student self-directed learning. Ross University's description of TBL and PBL teaching, and associated faculty development, is consistent with US LCME accredited medical school standards. Similarly, Ross University's use of distance learning meets the LCME accreditation standards applied to US medical schools.

The following is a detailed assessment of the School's Freeport campus for the third and fourth semesters based on the relevant California statutes and regulations and on the School's responses to the Self-Assessment Report.

Business and Professions Code Section 2089

Section 2089 requires the medical curriculum to extend over four years or 32 months of actual instruction. The Freeport campus offers the same courses that are part of the already approved Dominica campus curriculum. Therefore the Freeport campus appears to meet this requirement. Section 2089 also requires a minimum of 4,000 hours of course instruction with 80% actual attendance. The Freeport campus curriculum constitutes a total of 810 possible hours out of a probable total of 4,050 in the Ross University 4 year curriculum (assuming the same weekly hours of course instruction over the 10 semesters). The 600 hours of independent self-study of the 810 total hours of instruction at the Freeport campus are necessary to achieve the 4,000 hour minimum standard. Ross University has an evaluation mechanism for tracking "attendance" in this portion of the curriculum. Consequently it appears that the Freeport campus meets the 4,000 hour minimum requirement for course instruction, and for the PBL and TBL portions of the curriculum there is a mechanism for assuring that the 80% attendance requirement is being met.

Business and Professions Code Section 2089.5

The documents provided by Ross University for the Freeport campus do not address instruction in any clinical courses, which are the focus of Section 2089.5. It should be noted that there are clinical experiences at the affiliated Grand Bahamas Health Services (GBHS) hospital during the third and fourth semester curriculum at the Freeport campus. Elements of this instruction are referenced in the affiliation agreement with GBHS and are consistent with the provision of relevant and appropriate clinical instruction and experience provided to second year medical students. Supervision and curriculum oversight of these clinical experiences are discussed in the GBHS affiliation which has been provided. Assuming that the approved Ross University four year curriculum meets or exceeds the minimum requirements in Section 2089.5, the Freeport campus is in compliance with this statute.

California Code of Regulations, Title 16, Division 13, Section 1314.1

Most of the applicable portions of Section 1314.1 are encompassed by the prior approval of the Dominica campus, as Freeport is only a branch campus for a pre-clinical portion of the curriculum. The school does have a clearly defined mission statement with educational goals and objectives.

As required in Section 1314.1, the administration and governance system allows the institution to accomplish its objectives and the faculty have a formal role in curriculum oversight and evaluation of student progress. There is an adequate number of faculty at

the Freeport campus for the size of the program. The faculty credentials indicate that they are qualified to teach their respective courses and fulfill their roles.

Admissions criteria apply only to the Dominica campus and students self select after admission for entry into the Freeport campus.

The institution's financial resources are adequate to accomplish its mission. The Freeport campus facilities are up to date with adequate technology and library resources to support distance learning and TBL and PBL teaching. There is common space provided for student wellness and student affairs activities. Faculty and administration offices are provided for advising and mentoring students and there is administrative support for student records.

Summary

In summary, I believe there is sufficient documentation to support the application for recognition of the Freeport Campus as a branch campus of Ross University's Dominica campus. Specifically, the portions of the curriculum reproduced at the Freeport campus are equivalent to the PACE program already used for a portion of the Dominica campus students. The school provides adequate measures to monitor student participation and progress. The TBL, PBL and distance learning used at the Freeport campus is in compliance with accepted LCME accreditation standards.

Unsolicited materials provided by a Ross University student, were also reviewed for this report. The student alleges that the Freeport campus, because it uses distance learning, was developed so that Ross University could enroll more students, thereby earning a greater profit. The student also alleges that the quality of medical education at Ross University has deteriorated and that the clinical education is below average because of limited clinical spots, but these allegations are relevant only to the Dominica campus. While concerning, I did not find the student's allegations and supporting documentation applicable to the Freeport Campus review. The materials provided do not indicate that the student was ever a student at the Freeport campus, and it appears the student completed five semesters at the Dominica campus.

My recommendation is based on the already established content of the PACE program at the Dominica campus, therefore I would strongly recommend that the Dominica campus be site visited in the near future and that the PACE program be carefully reviewed. The allegations from the student including the statement that there is "no one-to-one professor-student interaction at Ross University," can also be investigated. While the Dominica campus should be the focus of a site visit, it would be advantageous to also visit the Freeport campus to verify what is documented.

Thank you for the opportunity to review the materials from Ross University concerning the Branch Campus in Freeport, Grand Bahama.

CONSUMER INFORMATION UNIT FY 10/11					
	FY 09/10	Q1	Q2	Q3	Q4
Total Calls Answered	97,450	*26,974			
Calls Requesting Call Back	16,318	*3,792			
Calls Abandoned	17,248	*5,544			
Address Changes Completed	9,700	*3120			

* 1.5 days phone outage; technical issues w/dropped calls.

PHYSICIAN & SURGEON DATA FY 10/11					
	FY 09/10	Q1	Q2	Q3	Q4
Applications Received	5,822	1,568			
Initial Reviews Completed	3,530	1,208			
Total Pending		5,291			
Reviewed		4,460			
Not Reviewed		831			
(SR2s Pending)		98			
Licenses Issued	5,111	1,447			
Renewals Issued	60,814	16,168			

SPECIAL PROGRAMS FY 10/11																				
Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2111	19				18				16				13				4			
2112	0				0				0				0				0			
2113	7				5				4				20				6			
2168	0				0				0				3				1			
2072	0				0				0				0				0			
1327	1				1				0				0				1			

2111 - Visiting Fellow (doesn't satisfy postgraduate training required for licensure)

2112 - Hospital Fellowship Program Non-Citizen (does not satisfy postgraduate training required for licensure)

2113 - Medical School Faculty Member (may satisfy postgraduate training required for licensure)

2168 - Special Faculty Permit (academically eminent; unrestricted practice within sponsoring medical school - not eligible for licensure)

2072 - Special Faculty Permit - Correctional Facility

1327 - Special Faculty Permit - Hospital

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 10/11					
	<i>FY 09/10</i>	Q1	Q2	Q3	Q4
New Applications Received	3	0			
Total Pending Applications	6	6			

LICENSED MIDWIVES FY 10/11					
	<i>FY 09/10</i>	Q1	Q2	Q3	Q4
Applications Received	16	12			
Applications Pending		4			
Licenses Issued	19	9			
Licenses Renewed	74	30			

OPTICAL REGISTRATIONS FY 10/11					
	<i>FY 09/10</i>	Q1	Q2	Q3	Q4
Business Registrations Issued	142	16			
Pending Applications Business		25			
Out-of-State Business Registrations Issued	1	0			
Pending Applications Out of State Bus.	0	0			
Spectacle Lens Registrations Issued	221	42			
Pending Applications-Spectacle Lens		62			
Contact Lens Registrations Issued	98	19			
Pending Applications-Contact Lens		20			
Spectacle Lens Registrations Renewed	906	200			
Contact Lens Registrations Renewed	366	81			

RESEARCH PSYCHOANALYST (RP) FY 10/11					
	<i>FY 09/10</i>	Q1	Q2	Q3	Q4
RP Applications Received	4	3			
RP Licenses Issued	3	2			

FICTITIOUS NAME PERMITS (FNP) FY 10/11					
	<i>FY 09/10</i>	Q1	Q2	Q3	Q4
P&S - FNP Issued	1,100	310			
P&S - FNP Pending		66			
Podiatric FNP Issued	18	7			
Podiatric FNP Pending	1	1			

SPECIALTY BOARD APPLICATIONS FY 10/11					
	<i>FY 09/10</i>	Q1	Q2	Q3	Q4
Applications Received	1	0			
Applications Pending		1			

Licensing Program Weekly Application Production

Week Ending -->	24-Jul	31-Jul	7-Aug	14-Aug	21-Aug	28-Aug	4-Sep	11-Sep	18-Sep	25-Sep	2-Oct	9-Oct	16-Oct
Number of Workdays -->	5	5	5	5	4	4	5	3	4	4	5	4	4
Applications Received													
US/CAN	61	80	53	67	65	86	133	58	80	84	70	94	61
IMG - License	15	16	16	18	22	26	21	5	7	15	5	22	13
IMG - PTAL	28	32	30	38	29	31	39	15	41	38	30	18	31
Total	104	128	99	123	116	143	193	78	128	137	105	134	105
Applications Completed (License or PTAL Issued)													
US/CAN - Licensed	119	61	104	47	65	83	99	60	71	52	106	72	48
IMG - Licensed	23	27	38	16	17	26	33	19	30	28	36	24	15
Total - Licensed	142	88	142	63	82	109	132	79	101	80	142	96	63
Total - PTAL's Issued	22	46	43	32	16	47	54	25	33	52	34	33	27
Applications Processed (Initial Review Completed)													
Application Complete Upon Initial Review (ready for licensure)													
US/CAN	3	2	1	3	9	14	12	2	9	6	19	27	14
IMG - License	0	0	0	0	2	0	0	0	0	1	0	1	0
IMG - PTAL	0	6	1	0	1	0	2	1	1	1	0	1	0
Subtotal	3	8	2	3	12	14	14	3	10	8	19	29	14
Initial Review (Application Deficient)													
US/CAN	39	41	49	34	46	62	59	35	65	58	57	81	81
IMG - License	11	13	14	3	9	16	21	13	8	16	16	57	20
IMG - PTAL	13	23	29	6	7	21	23	29	24	27	35	74	37
Subtotal	63	77	92	43	62	99	103	77	97	101	108	212	138
Total	66	85	94	46	74	113	117	80	107	108	127	241	152
Inventory Awaiting Initial Review - Current as of -->													
NEW: 0-30 days	382	419	428	447	452	361	547	533	542	544	459	525	494
AGING: 31-60 days	149	135	143	202	227	243	217	245	249	275	311	159	190
AGING: 61-90 days	0	0	0	0	1	1	0	0	3	7	0	0	0
BACKLOG: Over 90 days	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	531	554	571	649	680	605	764	778	794	826	770	684	684
Date of Oldest US Appl Awaiting Initial Review-->													
Number of calendar days for US Initial Reviews				34	34	34	34	33	34	37	37	36	37
Date of Oldest IMG Appl Awaiting Initial Review-->													
Number of calendar days for IMG Initial Reviews				57	55	54	54	55	59	63	55	49	49
Date of Oldest US Pending Mail Awaiting Review-->													
Number of calendar days for US Pending Mail				3	3	5	5	5	4	8	7	8	7
Date of Oldest IMG Pending Mail Awaiting Review-->													
Number of calendar days for IMG Pending Mail				9	19	12	11	12	17	15	14	16	16

*Note: Live data numbers are subject to change depending on the date that they are ran. All data on the report is ran weekly reflecting a Sunday through Saturday reporting period with the exception of the *Inventory Awaiting Initial Review* section. The data in the *Inventory Awaiting Initial Review* section reflects current data when the report is ran on the following Tuesday.

**Medical Board of California
Expert Reviewer Program Report**

**CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY**

October 1, 2010

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Y-T-D 1,207↑
<i>ADDICTION</i>	5	2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	15
ALLERGY & IMMUNOLOGY (A&I)	2	2 LIST EXPERTS REVIEWED 1 CASE	10
ANESTHESIOLOGY (Anes)	8	7 LIST EXPERTS REVIEWED 1 CASE 1 OFF LIST EXPERT REVIEWED 1 CASE	98
Critical Care Medicine (CCM)			-
Hospice & Palliative Medicine (HPM)			-
Pain Medicine (PM)			16
COLON & RECTAL SURGERY (CRS)	1	1 LIST EXPERT REVIEWED 2 CASES	5↑
<i>COMPLEMENTARY/ALTERNATIVE MEDICINE</i>	5	2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	20↑
<i>CORRECTIONAL MEDICINE</i>	11	6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	33↑
DERMATOLOGY (D)	6	1 OFF LIST EXPERT REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	16↑
Clinical & Laboratory Dermatological Immunology (CLD)			-
Dermatopathology (DP)			5
Pediatric Dermatology (PedD)			-
EMERGENCY (EM)	12	7 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	62
Hospice & Palliative Medicine (HPM)			-
Medical Toxicology (MT)			2
Pediatric Emergency Medicine (PEM)			4
Sports Medicine (SM)			-
Undersea & Hyperbaric Medicine (UHM)			-
<i>ETHICS</i>	3	1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	6

**Medical Board of California
Expert Reviewer Program Report**

**CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY**

October 1, 2010

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Y-T-D 1,207↑
FAMILY (FM)	63	24 LIST EXPERTS REVIEWED 1 CASE 1 OFF LIST EXPERT REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES	100
Adolescent Medicine (AM)			-
Geriatric Medicine (Ger)			59
Hospice & Palliative Medicine (HPM)			2
Sleep Medicine (SLP)			-
Sports Medicine (SM)			44
<i>HAND SURGERY</i>			24
<i>HOSPICE & PALLIATIVE MEDICINE</i>	1	LIST EXPERT	9
INTERNAL (General Internal Med)	65	23 LIST EXPERTS REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 7 CASES	230↑
Adolescent Medicine (AM)			-
Cardiovascular Disease (Cv)	22	3 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 5 CASES	37↑
[Interventional Cardiology (Intv Cd)]	17	5 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES	24↑
[Non-Interventional Cardiology]	5	2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	23↑
Clinical Cardiac Electrophysiology (CCEP)			3
Critical Care Medicine (CCM)	1	LIST EXPERT	18
Endocrinology, Diabetes and Metabolism (EDM)	3	3 LIST EXPERTS REVIEWED 1 CASE	8↑
Gastroenterology (Ge)	6	4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	23↑

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SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts Y-T-D 1,207↑
Geriatric Medicine (Ger)	2	2 LIST EXPERTS REVIEWED 1 CASE	41
Hematology (Hem)	1	LIST EXPERT	7
Hospice & Palliative Medicine (HPM)	2	2 LIST EXPERTS REVIEWED 1 CASE	9
Infectious Disease (Inf)			12
Medical Oncology (Onc)	6	1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	15
Nephrology (Nep)			9
Pulmonary Disease (Pul)	4	4 LIST EXPERTS REVIEWED 1 CASE	22
Rheumatology (Rhu)			9
Sleep Medicine (SLP)			4
Sports Medicine (SM)			1
Transplant Hepatology (TH)			-
MIDWIFE REVIEWER	2	2 LIST EXPERTS	10
MEDICAL GENETICS (MG)			1
Clinical Biochemical Genetics (MG CBCGn)			-
Clinical Cytogenetics (MG CCytG)			-
Clinical Genetics (MD) (MG CGen)			-
Clinical Molecular Genetics (MG CMGn)			-
PhD Medical Genetics (MG PhDMG)			-
Medical Biochemical Genetics (MG MBGn)			-
Molecular Genetic Pathology (MGP)			-
NEUROLOGICAL SURGERY (NS)	6	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	15↓
NEUROLOGY (N)	7	5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	30↑

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Clinical Neurophysiology (C/NPh)	1	LIST EXPERT	7↑
Neurodevelopmental Disabilities (ND)			-
Neuromuscular Medicine (NeuroMed)			-
Pain Medicine (PM)			2
Sleep Medicine (SLP)			-
Vascular Neurology (VascN)			2
NEUROLOGY with Special Qualifications in Child			5
NUCLEAR MEDICINE (NuM)			6
OBSTETRICS & GYNECOLOGY (ObG)	57	13 LIST EXPERTS REVIEWED 1 CASE 3 OFF LIST EXPERTS REVIEWED 1 CASE 1 OFF LIST EXPERT REVIEWED 2 CASES 8 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 9 CASES	95↑
Critical Care Medicine (CCM)			-
Gynecologic Oncology (GO)	1	LIST EXPERT	6
Maternal & Fetal Medicine (MF)	8	4 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	10
Reproductive Endocrinology/ Infertility (RE)	1	OFF LIST EXPERT	9
OPHTHALMOLOGY (Oph)	24	5 LIST EXPERT REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES	41
<i>ORAL & MAXILLOFACIAL SURGERY</i>			1
ORTHOPAEDIC SURGERY (OrS)	13	8 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	46↑
Surgery of the Hand (HS)			22
Orthopaedic Sports Medicine (OSM)			22
OTOLARYNGOLOGY (Oto)	4	4 LIST EXPERTS	31
Neurotology (ON)			6

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Pediatric Otolaryngology (PO)			3
Plastic Surgery within the Head and Neck (PSHN)			2
Sleep Medicine (SLP)			-
PAIN MEDICINE (PM)	19	1 LIST EXPERT REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	28
PATHOLOGY (Path)	2	1 LIST EXPERT REVIEWED 2 CASES	12↑
Blood Banking Transfusion Medicine (BBTM)			6
Chemical Pathology (ChemP)			-
Cytopathology (CytoP)			3
Dermatopathology (DP)			1
Forensic Pathology (FPath)			1
Hematology (Hem)			2
Medical Microbiology (MMB)			-
Molecular Genetic Pathology (MGP)			-
Neuropathology (NPath)			2
Pediatric Pathology (PdP)			1
PEDIATRICS (Ped)	6	4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	61
Adolescent Medicine (AM)			-
Clinical & Laboratory Immunology (CLI)			-
Developmental-Behavioral Pediatrics (DBP)			6
Medical Toxicology (MT)			-
Neonatal-Perinatal Medicine (NP)			7
Neurodevelopmental Disabilities (ND)			1
Pediatric Cardiology (Cd)			7
<i>Pediatric Cardiothoracic Surgery</i>			2

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Pediatric Critical Care Medicine (CCM)			2
Pediatric Emergency Medicine (PEM)			2
Pediatric Endocrinology (En)			-
Pediatric Gastroenterology (Ge)			5
Pediatric Hematology-Oncology (HO)			3
Pediatric Infectious Diseases (Inf)			6
Pediatric Nephrology (Ne)			1
Pediatric Pulmonology (Pul)			-
Pediatric Rheumatology (Rhu)			-
Pediatric Transplant Hepatology (TH)			-
Sleep Medicine (SLP)			-
Sports Medicine (SM)			-
PHYSICAL MEDICINE & REHABILITATION (PMR)			9
Neuromuscular Medicine (NeuroMed)			-
Pain Medicine (PM)			1
Pediatric Rehabilitation Medicine (PedRM)			-
Spinal Cord Injury Medicine (SCIInj)			1
PLASTIC SURGERY (PIS)	34	1 OFF LIST EXPERT REVIEWED 1 CASE 13 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES	58↑
Plastic Surgery within the Head and Neck (PSHN)			2
Surgery of the Hand (HS)			9
PREVENTIVE MEDICINE (PrM)			
PUBLIC HEALTH and GENERAL PREVENTIVE MED.	2	1 LIST EXPERT REVIEWED 2 CASES	6
AEROSPACE MEDICINE			1
OCCUPATIONAL MEDICINE	2	1 LIST EXPERT REVIEWED 2 CASES	8

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Medical Toxicology (MT)			-
Undersea & Hyperbaric Medicine (UM; UHM)			-
PSYCHIATRY (Psyc)	63	22 LIST EXPERTS REVIEWED 1 CASE 1 OFF LIST EXPERT REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 7 CASES	110
Addiction Psychiatry (AdP)	6	2 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	27
Child & Adolescent Psychiatry (ChAP)			24
Clinical Neurophysiology (C/NPh)			-
Forensic Psychiatry (FPsy)			55
Geriatric Psychiatry (GPsyc)			28
Pain Medicine (PM)			13
Psychosomatic Medicine (PsychoMed)			18
Sleep Medicine (SLP)			1
RADIOLOGY (Rad)			
Diagnostic Radiology (Rad DR)	10	4 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES	38
Radiation Oncology (Rad RO)	2	2 LIST EXPERTS REVIEWED 1 CASE	5
Radiologic Physics (RP)			-
Neuroradiology (NRad)			17
Nuclear Radiology (NR)			2
Pediatric Radiology (PR)			8
Vascular/Interventional Radiology (VIR)			4
SLEEP MEDICINE (S)	1	LIST EXPERT	8
SPINE SURGERY (SS)			1
SURGERY (S)	18	7 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	60↑

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Pediatric Surgery (PdS)			5
Surgery of the Hand (HS)			-
Surgical Critical Care (SCC)			3
Vascular Surgery (VascS)	1	LIST EXPERT	16
THORACIC SURGERY (TS)	1	LIST EXPERT	19
<i>(MEDICAL) TOXICOLOGY</i>			4
UROLOGY (U)	14	4 LIST EXPERTS REVIEWED 1 CASE 1 OFF LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	16↑
<i>WORKERS= COMP/QME/IME</i>			27

/susan (10/1/10)

Medical Board of California
Investigation & Prosecution Timeframes*

	2005		2006		2007		2008		2009		Q1 2010		Q2 2010		Q3 2010	
	Prior to VE	All	VE	All	VE	All	VE	All	VE	All	VE	All	VE	All	VE	
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution																
Average	271	299	138	330	268	374	358	383	381	329	329	323	323	319	319	
Median	252	285	134	304	269	335	324	346	346	291	291	282	282	292	292	
Record Count	827	703	192	648	539	609	588	673	672	161	161	177	177	168	168	
Calendar Day Age from Request to Suspension Order Granted																
Average	51	44	4	34	38	19	19	52	39	18	18	75	75	18	18	
Median	17	3	2	22	23	10	10	23	23	23	23	27	27	4	4	
Record Count	24	21	11	17	13	21	17	17	16	3	3	3	3	7	7	
Calendar Day Age from Request to Receipt of Medical Records																
Average	58	53	37	59	57	63	58	73	73	80	80	51	51	49	49	
Median	32	31	26	31	31	28	28	32	32	31	31	34	34	23	23	
Record Count	475	376	228	264	259	256	252	243	243	50	50	38	38	52	52	
Calendar Day Age from Request to Physician Interview Completed																
Average	48	51	43	52	50	63	63	52	52	46	46	44	44	43	43	
Median	36	42	38	37	36	41	42	37	37	31	31	41	41	30	30	
Record Count	597	453	172	406	371	473	466	696	696	117	117	112	112	127	127	
Calendar Day Age from Request to Receipt of Expert Opinion																
Average	51	47	35	51	43	50	50	48	48	47	47	53	53	41	41	
Median	41	35	31	36	35	39	38	36	35	39	39	43	43	30	30	
Record Count	519	424	82	344	270	374	359	426	424	93	93	102	102	91	91	
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed																
Average	556	554	140	543	340	565	493	584	578	608	608	607	605	570	570	
Median	525	504	120	523	339	541	486	575	569	637	637	663	662	599	599	
Record Count	187	149	17	198	95	157	131	189	186	54	54	58	57	40	40	
Calendar Day Age from Accusation Filed to Disciplinary Outcome**																
Average	608	602	85	576	188	561	243	473	339	442	327	341	327	433	347	
Median	526	466	99	426	182	384	238	351	309	340	320	309	294	341	324	
Record Count	212	195	3	226	29	203	80	198	145	39	33	48	47	39	36	

*Excludes Out of State and Headquarters Cases

**Excludes Outcomes where no Accusation Filed

Relevant Statutory and Decisional Law

1. Case Law on License Discipline

“The purpose of such a [administrative disciplinary] proceeding is not to punish but to afford protection to the public upon the rationale that respect and confidence of the public is merited by eliminating from the ranks of practitioners those who are dishonest, immoral, disreputable, or incompetent.” (*Fahmy v. Medical Board of California* (1995) 45 Cal.Rptr.2d 486, citing *Borror v. Department of Investment* (1971) 15 Cal.App.3d 531, 540, 92 Cal.Rptr. 525; *Lam v. Bureau of Security & Investigative Services, supra*, 34 Cal.App.4th at p. 38, 40 Cal.Rptr.2d 137.)

2. Statutes Relating to the Medical Board

Section 2001.1 of the Business and Professions Code provides:

“Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.”

Section 2229 of the Business and Professions Code provides:

(a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

(b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.

(c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount.



STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
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MEMORANDUM

DATE: October 7, 2010

TO: Executive Officers
 Board Presidents/Chairs

FROM: *Doreatha Johnson*
 DOREATHEA JOHNSON
 Deputy Director
 Legal Affairs

SUBJECT: Board Meeting Protocols

Three Duties for Board Meetings

1. Give adequate notice of meetings that will be held and agenda items.
2. Conduct meetings in open session.
3. Provide the public an opportunity to comment.

First Duty

Adequate Notice of Meetings and Agenda Items

1. Timely – Law requires 10 days notice to those on a mailing list and posting notice and agenda on your website.
2. Specific Notice – Detailed, itemized agenda, identifying all items of business to be conducted at the meeting.
 - Items not on agenda cannot be discussed nor can they be acted on.
 - Can't discuss items under the heading of "New or Old Business" unless they are specifically identified.
 - Test for Specific Notice --Is an item specific enough for a member of the public to reasonably ascertain the nature of the business to occur at the meeting?

Second Duty Conduct Meetings

Open Session

General rule: Meetings must be conducted in Open Session and all discussion and actions must take place in the public, unless specifically authorized by law to go into closed session, with regard to that item of business.

Vote in public – Votes must be publically taken. Secret votes or votes by proxy are not permitted.

Closed Session

Business statutorily authorized to be conducted in closed session:

- Disciplinary matters;
- Preparing, approving or grading examinations;
- Pending litigation;
- Matters affecting personal privacy;
- Executive officer appointment, employment or dismissal.

Once in closed session, you can only discuss those matters that were identified as closed session on your agenda.

Third Duty Public Comment At The Meeting

General Rule

Must allow public comment on each open session agenda item.

Suggested script to be read at the beginning of the meeting:

The Board Chair will allow public comment on agenda items, as those items are taken up by the Board, during the meeting. Under the Open Meetings Act, the Board may not take any action on items raised by public comment that are not on the Agenda, other than to decide whether to schedule that item for a future meeting.

If any person desires to address the Board, it will be appreciated if he or she will stand or come forward and give his or her name, and if he or she represents an organization, the name of such organization, so that we will have a record of all those who appear. Please note that a person wishing to provide comment is not

required to identify him or herself when making public comment, but it is appreciated.

In order to allow the Board sufficient time to conduct its scheduled business, public comment will be limited to ___ minutes. Please make your comments focused and relevant to the duties of the Board. It is not necessary to repeat statements or views of a previous speaker, it is sufficient to state that you agree. Written statements should be summarized and submitted to the Board. They should not be read.

If as chairperson/president, I forget to ask for public comment on an agenda item, it is not because I intend to limit comment but just because I forgot. So in that situation, please raise your hand and I will recognize you.

Suggested script to be used for each item on the agenda:

1. Call the Agenda Item
2. Committee Presents the agenda item
3. Ask for a motion
4. Ask for a second, unless the motion is made by the committee (second is not needed)
5. Ask for board discussion.
6. Ask if there is public comment. [You may reverse the order of these 2.]
7. Ask if there is further board discussion.
8. Repeat the Motion
9. Take the vote

Suggested script for public comment on items not on the agenda:

The board values input from the public as part of its consumer protection mission. It invites and welcomes public comment during this section of the agenda. However, board members cannot engage in dialogue with those who testify during this section of the agenda due to constraints imposed on the board and its members by law. The law prohibits the board from substantively discussing or voting on any matter brought up during public comment. A member of the public who would like the board to discuss a general topic not related to a specific case involving one of its licensees can ask the board to consider placing the issue on the board's agenda for a future meeting.

If you have an application or disciplinary charges pending before the board, we ask that you not discuss the details of your case or pending complaint since the board members will be the "judges" and by law are not permitted to receive evidence or information that is not part of the administrative record in the case.

Disruptive persons:

The public has the right to express its disapproval, and may sometimes make emotional presentations. It is the board's duty and obligation to allow that public comment. Since the purpose of the meeting is for the agency to conduct its business, commenters shouldn't be permitted to thwart that purpose and may be

removed from the meeting if disruptive behavior continues after a request that it stop.

Suggested script to use when there is a disruptive person:

Under the Open Meetings Act (Government Code Section 11126.5), if you continue in this manner, I will ask you to leave the meeting and if you do not leave the meeting, you will be removed. Accordingly, I am asking you to discontinue your disruptive conduct so that all participants can be heard in an orderly fashion.

Miscellaneous

Wording of Motions

- Motions must be clearly worded.
- The test: Could a reasonable person reading the motion understand what the board meant to accomplish?
- Chair should restate the motion before the discussion and just before the vote is taken

Improper Disclosure of Information

- Improper for information received during closed session to be publicly disclosed without authorization of the body as a whole.

Role of the Attorney

The attorney's role during board meetings is to advise the agency of its obligations and authority under the law when it appears that the agency may be deviating from it, e.g. Open Meetings Act, quorum requirements, practice acts, regulations. In some cases, it may be necessary for the attorney to assist the agency in identifying an issue, framing a motion that accurately reflects the agency's deliberations and intent or seeking clarification from a speaker or board member.

When a problem is identified, the attorney is expected to assist the board in developing a lawful alternative method of accomplishing the board's goal.

It is not the attorney's responsibility or role to chair the meetings or direct the discussion. And the attorney should refrain from doing so even if requested to take on that role.