MEDICAL BOARD OF CALIFORNIA
Executive Office

MEMBERS OF THE COMMITTEE
Reginald Low, M.D., Chair
John Chin, M.D.
Sharon Levine, M.D.
Mary Lynn Moran, M.D.
Gerrie Schipske, R.N.P., J.D.
Frank Zerunyan, J.D.

Enforcement Committee

May 6, 2011

Sheraton Gateway
6101 West Century Blvd.
Los Angeles, CA 94010
310-642-1111

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

AGENDA

8:30 a.m. to 9:15 a.m.
(or until the conclusion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE
If a quorum of the Board is present, members of the Board who are not members of the Committee may attend only as observers.

1. Call to Order / Roll Call

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

3. Approval of Minutes from the January 27, 2011 Meeting

4. Update on Probation Practice Monitors
   A. Follow-up on Immunity/Waiver – Mr. Heppler
   B. Practice Monitor Improvements – Ms. Cady and Ms. Hayes

5. Expert Reviewer Utilization
   A. Central Complaint Unit – Ms. Cady
   B. District Offices – Ms. Sweet

6. Enforcement Process Data Markers/Timeline – Ms. Cady and Ms. Sweet

7. Agenda Items for July 28-29, 2011 Meeting in Sacramento, CA

8. Adjournment

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

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815 (916) 263-2389 Fax: (916) 263-2387 www.mbc.ca.gov

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

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For additional information call (916) 263-2389.

NOTICE: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Cheryl Thompson at (916) 263-2389 or 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.

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MEDICAL BOARD OF CALIFORNIA
Executive Office

ENFORCEMENT COMMITTEE
Medical Board of California
Embassy Suites Hotel – San Francisco Airport
Mendocino/Burlingame Room
150 Anza Boulevard
Burlingame, CA 94010
January 27, 2011

MINUTES

Agenda Item 1 Call to Order/Roll Call
The Enforcement Committee of the Medical Board of California was called to order by Reginald Low, M.D. With due notice having been mailed to all interested parties, the meeting was called to order at 9:05 a.m.

Members Present:
Reginald Low, M.D., Chair
Sharon Levine, M.D.
Gerrie Schipske, R.N.P., J.D.
Frank Zerunyan, J.D.

Members Absent:
John Chin, M.D.
Mary Lynn Moran, M.D.

Staff Present:
Susan Cady, Enforcement Manager
Jorge Carreon, M.D., Board Member
Hedy Chang, Board Member
Silvia Diego, M.D., Board Member
Eric Esrailian, M.D., Board Member
Catherine Hayes, Probation Manager
Kurt Heppler, Legal Counsel
Breanne Humphreys, Licensing Manager
Teri Hunley, Business Services Manager
Diane Ingram, Information Systems Branch Manager
Rachel LaSota, Supervising Inspector
Craig Leader, Enforcement Investigator
Sheronnia Little, Information Systems Branch
Ross Locke, Business Services Office
Natalie Lowe, Enforcement Analyst
Armando Melendez, Business Services Office
Regina Rao, Business Services Office
Letitia Robinson, Licensing Manager
Janet Salomonson, M.D., Board Member

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Victor Sandoval, Enforcement Investigator
Kevin Schunke, Regulations Manager
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing
Barbara Yaroslavsky, Board Member

Members of the Audience:
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Stan Furmanski, Member of the Public
Dean Grafilo, California Medical Association
Rehan Sheikh, Member of the Public

Agenda Item 2 Approval of Minutes

A. Dr. Levine moved to approve the minutes from the July 29, 2010 meeting; seconded; motion carried.
B. Dr. Levine moved to approve the minutes from the November 04, 2010 meeting; seconded; motion carried.

Agenda Item 3 Public Comment on Items not on the Agenda
There were no public comments.

Agenda Item 4 Review of Probation Practice Monitor Requirement
Dr. Low requested that Ms. Hayes and Ms. LaSota of the Probation Unit update the presentation that was provided at the November 2010 meeting; including updates based on feedback provided by committee members at that meeting.

Ms. Hayes provided a brief overview of the Probation Unit and the practice monitor requirement, including a Power Point presentation.

Currently there are 186 probationers who are required to have a practice monitor. This condition requires that the probationer identify and propose a practice monitor within 30 calendar days from the effective date of their Decision. The practice monitor must be someone who has no prior or current, business or personal relationship with the probationer. This requirement was designed to ensure that the monitor could provide fair and unbiased reports to the Board. The practice monitors are "reimbursed" by the probationer for any costs associated with acting as a monitor and typically range from $100 to $600 per hour.

Once the probationer has identified a potential practice monitor, the Probation Unit Inspector reviews the physician's background, including any complaint or disciplinary history with the Board and his/her qualifications. If approved, the Inspector will provide the monitor with copies of the accusation and decision, a brief overview of the Board's expectations and a monitoring plan.

The monitor is expected to visit the probationer's practice location at least once a month. During the visit, the monitor randomly selects 10% of the probationer's charts to review. The objective of the chart review is to

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allow the monitor to make an assessment as to whether the probationer is practicing "within the standard of care." A quarterly report is prepared by the monitor to confirm that the reviews have taken place and identify any deficiencies noted during the chart review. The practice monitor does not provide any on-site or direct supervision of the probationer.

A concern identified with the current system is that it is often difficult to find a practice monitor with no prior relationship with the probationer.

At the November 2010 meeting, concern raised by practice monitors regarding the liability they might be assuming by agreeing to serve as a practice monitor, was discussed. The committee members felt that additional options should be explored to provide immunity to the practice monitors. Staff discussed the possibility of pursuing legislation to establish in statute immunity or protection similar to what is currently provided to the Board's medical experts. However, after discussion with staff counsel, the Probation Unit is looking into developing a "waiver" which would be an agreement between the parties and would be signed by the probationer and considered to be a part of the monitoring plan. Staff have reviewed materials from the UC San Diego Physician Enhancement Program (PEP) and found that it utilized a Consent and Release of Information form that contains the following language "By my signature, I agree to hold harmless the Regents of the University of California, its officers, agents and employees from any liability resulting from or arising in connection with this agreement." This same type of language could be executed into a monitoring agreement and plan.

Another concern staff is reviewing is whether a random review of approximately 10% of a probationer's charts is sufficient to determine if the probationer is providing appropriate care.

A practice monitor performing chart review may not be appropriate in cases involving substance abuse or sexual misconduct. Staff is considering whether the use of a "worksite monitor" would be more appropriate than a practice monitor. The "worksite monitor" is a concept that was used by the Diversion Program and is another physician or health care professional would have face-to-face contact with the probationer in the work environment. The Department of Consumer Affairs has developed criteria for the monitoring, reporting, and the qualifications needed for a worksite monitor in its Senate Bill 1441 uniform standards. Should this be considered a viable option, minor changes would need to be made to the Board's Disciplinary Guidelines.

Staff reviewed background information on the Petitions to Revoke Probation filed over the past two years and found that 43 actions had been filed. Ten accusations and/or petitions to revoke probation were filed charging gross negligence; in 7 of the 10 cases, the probationer was required to have a practice monitor. In reviewing the reports from the practice monitors, all indicated that the care being provided by the probationer was "within the standard" based on their chart review. Staff is concerned that consumers may not be adequately protected by this condition in its current form.

Ms. LaSota presented the modifications being considered by the Probation Unit to enhance and improve the practice monitor condition.

Currently, the only approved option is the Physician Enhancement Program also known as PEP through UC San Diego. The program focuses on developing a mentoring relationship with the probationer by using faculty members as practice monitors. PEP staff chooses the monitor from a pool of university faculty. The PEP monitor is provided with formal training, an extensive training manual, and a structured checklist of items to review during the site visit with the probationer. The reports are returned to staff at PEP for review prior to

being forwarded to the Board. If any deficiencies are noted in the probationer's practice, improvement plans are formulated and provided to the probationer and the Board.

Several options were presented at the November 2010 meeting that staff believed might strengthen the performance of the practice monitors. These options were to exclusively use the Physician Enhancement Program (PEP), which omits the allowance of a physician selecting their monitor; have the Board develop a pool of practice monitors, who have been approved and trained by the Board; use the current system, but require mandatory training; or use the current system and develop more structured requirements. At that meeting, staff was asked to outline staff resources and cost projections which may be needed to implement the options that were proposed.

The PEP program is currently approved by the Board as an alternative to identifying and nominating a practice monitor. This alternative can be expensive for the probationer; however, the program is well developed and provides the best example of a mentoring program.

Other options were provided for Committee review:

Rather than relying on the probationer to find a physician willing to act as a practice monitor, staff has considered the option of developing and maintaining a pool of physicians to provide this service, which the probationer would select from. Staff envisions developing a training program and material similar to the program that is currently in place with the Expert Reviewer Program. While this option incorporates the best practices from the available options, this model will also be the most labor intensive to develop and implement, as it will require a large investment of staff resources and time.

Resources will be needed to develop training material and determine the method of training (such as: classroom instruction; web-based training; and, self-paced review of materials); develop selection criteria for practice monitors and develop recruitment strategies to attract physicians willing to serve in this capacity; advertise and attempt to identify physicians in a variety of practice specialties located throughout the state; provide training and make trained physician listings available to probationers with a practice monitor requirement; and, to assess practice monitor's performance and provide feedback.

Another option is to retain the Board's current system, but add a requirement that practice monitors are trained before they can be used. This would require the use of current staff resources to develop a training program for the practice monitors and determine the method of training. Training material would need to be produced and distributed to approximately 186 existing practice monitors. Staff would need to track the proposed practice monitors to ensure they complete the training. A system would need to be developed to follow-up on those who have not completed the training and possibly terminating the monitor for failing to complete the training. Lastly, an assessment of the practice monitor's performance following the training along with feedback would need to be provided to staff.

Since the November 2010 meeting, the Probation Unit staff identified several areas within the current process that could be strengthened and improved internally. Staff will be augmenting the instructional material and the orientation given to the practice monitors to provide a better explanation of their role and the Board's expectation of the type of reviews to be performed. Instead of allowing the practice monitor to submit a report that is free-form text, a standardized report format will be given to the practice monitor to use when preparing their quarterly report, to ensure a more thorough review with the probationer.

Staff will augment the orientation with the practice monitor, where the inspector prepares a monitoring plan that is specific for each probationer, and will take into account the areas of concern identified in the disciplinary action. In addition, staff is developing a checklist of items for the practice monitor that must be reviewed with the probationer during each quarterly visit. Staff is anticipating that these changes will provide more structure and better direction for practice monitors.

A letter received from a physician who had recently completed probation was shared with the Committee. The letter was addressed to an Inspector in the Probation Unit and stated:

> "I thought I might share with you my feelings about the process over the past few years. All of the Medical Board's mandated requirements were certainly beneficial to me. And the sessions with "Dr. X" (name removed for confidentiality purposes) in particular were most enlightening, clearly necessary and insightful.
>
> In addition I'd like to add that the practice monitor sessions with "Dr. X" were especially helpful and beneficial. For the past 40 years I have been in solo practice in the inner-city with a large case load of severely mentally ill patients. The practice monitor sessions with "Dr. X" brought my long time isolation to light, and provided for a much needed exchange of ideas in the real-time, day-to-day treatment of severely ill patients. "Dr. X's" insight and recommendations for individual patient care, updated theoretical developments and treatment goals proved extremely helpful.
>
> I can't speak for other practitioners in other medical disciplines who are in solo practice. But if my experience is any example, being isolated and overwhelmed has to be a universal experience. Having the opportunity and benefit of "Dr. X's" expertise and guidance certainly helped relieve the pressure and offered a new and much needed perspective on patient care.
>
> And in that respect, "Dr. X" has kindly consented to be available in the future should I have a further need for the benefit of his advice."

Staff felt that the letter reinforced the necessity of a strong practice monitoring relationship to ensure successful rehabilitation.

Dr. Levine thanked staff for their thorough and organized presentation and asked if the move to electronic health records has created complications, in terms of chart review, for practice monitors. Ms. Hayes and Ms. LaSota responded that this issue has not been communicated by practice monitors. Dr. Levine also inquired how a practitioner can indemnify a practice monitor from liability, based on something the probationer does to a patient. Mr. Heppler responded that the liability was based on the practice monitor reporting information to the Board, not the practice monitor's review of the probationers' charts. Dr. Levine also inquired how often a probationer elects to use the Physician Enhancement Program through UC San Diego. Ms. LaSota responded that approximately one out five probationers will opt to use this program and that the cost is approximately $5,000 to $6,000 per quarter.

Mr. Zerunyan inquired to the extension of liability coverage when a practice monitor fails to recognize an obvious mistake in a probationer's chart during review. Mr. Heppler responded that the core issue currently being addressed was the practice monitors failure to report general concerns to the Board, not the practice monitors review of the probationers' charts.

Dr. Low inquired as to the "shield" that is available for Expert Reviewers. Mr. Heppler responded that expert reviewers have a Civil Liability shielding that is in statute. Ms. Scuri stated that the difference between the expert reviewers and the practice monitors is that the expert reviewers are directly providing services related to the Board's core function of enforcement, and benefit the state; whereas the practice monitor is in a private relationship with the probationer. There are different liability types that would need to be reviewed as there could be issues with extending liability to individuals whom the Board is not selecting.

Ms. Schipske stated that the difference between an expert reviewer and a practice monitor is that expert reviewers are contracted by the Board, where as the practice monitor is in contract with the probationer. Ms. Schipske suggested the Board craft a statute acknowledging the role of the practice monitor which indicates that the practice monitor is not employed by the Board. Ms. Schipske also stated that there could be a conflict of interest as the practice monitor is paid for by the probationer. Ms. Schipske requested that past and present practice monitors be surveyed to obtain information on their concerns with the current system. Ms. Hayes responded that an extensive survey was previously performed and that staff is looking into doing this again.

Dr. Low stated that there is no question that the practice monitor is a very important function for consumer protection, but that there is an inherent possibility for conflicts of interest. Dr. Low felt that the idea of creating a pool of available monitors is the best option as the Board would then be able to have set standards and guidelines. Dr. Low also suggested looking into obtaining a malpractice liability coverage that would protect the monitors, possibly being funded by the probationers. Dr. Low indicated that at the next meeting staff should provide available options and the liabilities of each.

Mr. Zerunyan agreed that the idea of creating a pool of available physicians to act as practice monitors would be an acceptable option; however, as this would create another level of internal administrative service, it could be problematic and expensive.

Ms. Whitney stated that there are many aspects of contracting law, and by directing staff to present additional information at the next meeting, they will be able to provide the pros and cons; the different aspects that would affect state service; the codes that would be necessary; as well as other options that have not been pursued.

Dr. Levine stated that the creating of a pool could be done in one of two ways: the first in which the relationship remains with the probationer; and the second where the relationship remains with the Board. Ms. Whitney responded that staff will be prepared to address these issues at the next meeting.

Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL), stated that she applauds the Board for reviewing this process, as the Board has not had strict enough standards for patient protection, when it comes to the practice monitoring requirement. Ms. Fellmeth mentioned that the difference between a practice monitor and a worksite monitor (which was used in the diversion program) was that there were no set standards or criteria in place for the worksite monitor, and that diversion participants could designate whomever they chose. Ms. Fellmeth stated that the Department of Consumer Affairs, through its work to implement Senate Bill 1441, has created stringent standards for worksite monitors, and suggested the Board review these standards and bring back to future meetings for discussion. Ms. Fellmeth opined that the practice monitor is suitable for certain kinds of violations such as billing and record keeping issues; however, other types, such as substance abuse and sexual misconduct would not benefit from the practice monitor requirement. Ms. Fellmeth suggested separating the types of violations and insuring that the practice monitor has adequate training in order to evaluate the specific types of violations.

Ms. Schipske inquired as to what type of background investigation is performed when a physician applies to be a practice monitor. Ms. Hayes responded that when a physician submits an application to act as a practice monitor, a review is performed at the Board, including a review of any disciplinary or adverse actions on the physician's record, and an interview with the applicant. A brief synopsis is then provided to the Supervising Inspector to determine if the applicant meets the Board's criteria. Ms. Hayes advised there may be flaws within the system, such as when a relationship is not disclosed.

Agenda Item 5 Update on Expert Reviewer Training Progress

Ms. Sweet provided an update of the Expert Reviewer Training stating that the program was progressing well. Ms. Sweet indicated that one of the major challenges has been to find a sample case that would be suitable for training and was pleased to report that a case had been selected. All training material has been completed is awaiting conversion to an electronic format. Future tasks include setting the training date, and notifying attendees. The training is anticipated to take place in the fall of 2011.

Dr. Low inquired if there will be a requirement for the current expert reviewers to participate in the training. Ms. Sweet indicated that current and future expert reviewers will be required to participate.

Dr. Low provided a brief overview stating that this training program was being created to provide standardized training for all experts throughout the state.

Mr. Zerunyan suggested that the training sessions be recorded and be made available online to allow experts throughout the state to review the training electronically.

There were no public comments.

Agenda Item 6 Review of Training Modules

Ms. Threadgill referenced the "Ideas for Enforcement Program Training Modules in Priority Order" chart that had been created when the Enforcement Committee began, asking committee members if the Enforcement Program was moving in the right direction in presenting the committee with training information during the meetings. Ms. Threadgill asked committee members to review the chart provided which outlined the planned training sessions and to advise if it was still acceptable; if a different approach should be taken; or if they would like the sessions presented in a different order.

Mr. Zerunyan felt that the chart was great and recommended pursuing future training. Mr. Zerunyan would like to see additional enforcement statistics which provide an A-Z type review of the current internal enforcement processes; including timeframes and procedures for each step. Regarding Vertical Enforcement, while some progress has been noted, as a whole there has not been much. Providing additional statistics of the internal processes will allow a more thorough review of the process and identify any outliers. Ms. Threadgill stated that the data can be made available and further discussion will need to take place to determine what information shall be provided.

Regarding the review of training modules, Dr. Low felt that Board members would benefit from a brief executive summary of the Board's enforcement program, verses the breakdown of each module, as this would be too time consuming.

There were no public comments.

Agenda Item 7 Agenda Items for May 5-6, 2011 Meeting in Los Angeles, CA

Dr. Low requested that the following items be included on the May 2011 agenda:

- Presentation of an Overview of Enforcement Programs, Components and Processes
- Progress Report of Expert Reviewer Training

There were no public comments

Agenda Item 8 Adjournment

There being no further business, the meeting was adjourned at 10:01 a.m.

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STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	April 12, 2011
TO	Members, Enforcement Committee Medical Board of California
FROM	Kurt Heppler Senior Staff Counsel
SUBJECT	**Practice Monitors**

This memorandum provides you with an update regarding the issue of practice monitors and the difficulties that disciplined licensees may be having in obtaining such monitors.

At the recent meeting of the Enforcement Committee (Committee), it was suggested that licensed physicians may be reluctant to serve as practice monitors because they fear a possible defamation lawsuit or other tort action (possibly interference with an employment relationship or interference with a prospective economic advantage) filed by the probationer. By way of example, it was suggested that if practice monitor B submitted a report regarding the substandard performance of disciplined physician A, A may sue B in retaliation for the report. This fear of litigation may chill the interest in participating as a monitor. It was suggested at the meeting that providing civil immunity to the monitors would ameliorate this problem.

Some background information may be helpful. Practice monitoring (and hence the need for a practice monitor) is a condition of probation, as established in the Medical Board of California's Disciplinary Guidelines. (See Cal. Code Regs., tit. 16, § 1361.) A practice monitor is not a 'stand over the shoulder' type of arrangement, as a practice monitor reviews charts, evaluates performance and prepares reports for submission to the Board. It is important to note that the Board must approve the monitor as well as the monitoring plan. Approximately 200 physicians currently require practice monitors.

The Committee instructed staff to review the issue. An analysis of data supplied by the Board's Probation Program does not readily support the contention that fear of legal exposure is a significant reason for non-participation. Reasons given for difficulty obtaining a monitor include costs (the probationer is obligated to pay for all monitoring costs), possible Health Insurance Portability and Accountability Act (HIPAA) violations, and problems finding a physician in the proper specialty. Avoidance of litigation was mentioned only sparingly as a reason not to participate.

Nonetheless, out of an abundance of caution, the Probation Program is revising its monitoring forms to recommend that a practice monitor seek and execute a 'hold harmless' agreement with the disciplined physician regarding the preparation and submission of the necessary reports.

This issue will be periodically reviewed and emerging concerns will be reported to the Committee. However, at this time, legal staff believes no further action is warranted on the issue of civil immunity and practice monitors.

PRACTICE MONITOR NOMINATION

Monitor Selection

Nominate at least three licensed physician and surgeons to be your Practice Monitor (Monitor) who have no open complaints or past or pending disciplinary action with the Medical Board. The Monitor cannot have any prior or current business, personal or other relationship with you. You are responsible for any costs associated with monitoring your practice.

Monitor Resignation

If the Monitor is no longer able to monitor your practice you are required to notify your assigned inspector and re-submit this form to the Board within **5 calendar days** of the resignation or unavailability. Submit the name and qualifications of a replacement Monitor who will assume the responsibilities within **15 calendar days**. If you fail to obtain approval of a replacement Monitor within **60 days** of the resignation or unavailability of a Monitor, *you will be suspended from the practice of medicine until a replacement is approved and prepared to assume the immediate role as your Monitor.*

Probation Case #

Name:	Phone Number:
Address:	
Physician and Surgeon's License Number:	Practice Specialty or Subspecialty:
Name: :	Phone Number:
Address:	
Physician and Surgeon's License Number:	Practice Specialty or Subspecialty:
Name: :	Phone Number:
Address:	
Physician and Surgeon's License Number:	Practice Specialty or Subspecialty:

By my signature below, I acknowledge that I understand the selection and replacement criteria for the practice monitor. I understand that information about my participation with the practice monitor will be available for inspection and review by the Medical Board of California and/or its designees at any time. I agree to hold harmless the Practice Monitor; the State of California, Medical Board of California, its officers, agents and employees from any liability resulting from or arising in connection with this requirement.

I understand that this is a nomination form and does not guarantee approval of the nominee(s).

Executed on _____, 20____.

_____ _____

Probationer (Print Name) Signature

Practice Monitor
Pre-Visit Information
(To be completed by Probationer)

Instructions: Complete all sections below. Any items that do not apply enter N/A. If you change employers or place of practice you must submit a new Pre-Visit form. Please type or print clearly.

Practice Criteria

Practice address:

Business phone:	Business fax:	Practice/Clinic hours of operation:

Average number of patients seen ***per day***:
Practice/Clinic_____ Hospital _____

Average number of patients seen ***per week***:
Practice/Clinic _____ Hospital _____

Average number of patients seen ***per month***:
Practice/Clinic_____ Hospital _____

Years of practice in present discipline at current level:

Briefly describe the nature of your practice:

Discipline: _____

Select the structural setting of your practice:

- ☐ Rural
- ☐ Community Clinic
- ☐ Urgent care center/ER
- ☐ Private hospital
- ☐ Industrial
- ☐ Solo practice
- ☐ Family practice
- ☐ Public hospital
- ☐ Military/government
- ☐ Multispecialty group practice
- ☐ University or teaching program
- ☐ Other Explain:

Indicate which language(s) is spoken at your practice by the staff or physicians. For each selection, identify in the space provided if it is their first or second language:

- ☐ English _____
- ☐ Spanish_____
- ☐ French _____
- ☐ Italian _____
- ☐ German _____
- ☐ Portuguese _____
- ☐ Japanese _____
- ☐ Mandarin _____
- ☐ Cantonese _____
- ☐ Vietnamese _____
- ☐ Korean _____
- ☐ Tagalog _____
- ☐ Farsi _____
- ☐ Russian _____
- ☐ Other _____

Do you currently deliver babies? ☐ Yes ☐ No Do you have hospital privileges? ☐ Yes ☐ No

For a typical full week's worth of practice estimate the average number of patients you personally handled for: (circle the amount)

Inpatient/Outpatient visits:	0	1-50	51-100	101-150	151-200	>200
Hospital inpatients:	0	1-7	8-14	15-21	22-28	>28

Estimate the percentage of patient population by ethnic background:

African-American _____%
Asian/Pacific Islander _____%
American Indian _____%
Hispanic _____%
White (non-Hispanic) _____%
Other ethnicity, specify _____ _____%

List the types of surgical procedures performed in your office/clinic/outpatient facility:

Office Staff

Number of physicians you work with in the practice _____

Enter the number for each that assists you in your practice:

RNs _____ LVNs_____ MAs _____ PAs _____ administrators _____

receptionists _____ secretarial personnel _____

Do you instruct office personnel on:

Communicating with patients? ☐ Yes ☐ No

Cleaning and sterilization? ☐ Yes ☐ No

Measuring blood pressure? ☐ Yes ☐ No

Performing other clinical tasks, if yes, please list: ☐ Yes ☐ No

Practice Policies

Average length of time for patients in your waiting room?

Are all tests reviewed by the physician who requested each test? ☐ Yes ☐ No

Are patients notified of all abnormal results? ☐ Yes ☐ No

What procedure is employed in your practice to ensure review of all test/consultation/investigation results before they are filed in the patient's record?

When performing sensitive examinations (e.g., breast, genital) is a third person present? ☐ Yes ☐ No

How are the patients' records stored?

A Site Visit will be conducted by the Practice Monitor. The Monitor will be in your office for approximately four hours. Please indicate three options for your preferred time(s) for the Site Visit.

MON	TUES	WED	THURS	FRI	SAT	SUN

Preferred a.m. times:
8:00 a.m. - 12:00 p.m.
9:00 a.m. - 1:00 p.m.

Perferred p.m. times:
12:00 p.m. - 4:00 p.m.
1:00 p.m. - 5:00 p.m.

(Est. 3/2011)

PRACTICE MONITOR
ROLES AND RESPONSIBILITIES

Roles

The role of the Practice Monitor (Monitor) is to ensure, to the extent possible, that the physician on probation will conduct his/her practice with safety to the public and in a competent manner. The Monitor is responsible for reporting to the Board any identified problems or deficiencies in the quality of the physician's patient care, billing practices, medical record keeping, and/or professional conduct. The Monitor also fulfills the role of an educator and advisor to the physician, with the goal of assisting the physician to improve clinical skills and gain insight into practices that led to disciplinary action, so that learning and rehabilitation will occur.

Monitors are expected to render fair, objective, reliable, and unbiased reports to the Medical Board (Board) Probation Unit. In order to do this, the Monitor cannot have any *prior or current* business, personal, or other relationship with the physician on probation.

The Monitor conducts an *initial* site audit with subsequent audits annually; chart files are reviewed on a monthly basis at the physician's place of practice(s). A summary report is prepared quarterly and sent to the assigned Inspector within the Board's Probation Unit.

The Monitor will be required to: 1) complete an Agreement with the Board; 2) review the Pre-visit Information Sheet; 3) conduct an initial Site Audit with annual audits thereafter; 4) conduct once a month chart reviews; and 5) prepare quarterly reports.

Responsibilities

The Monitor's responsibilities include:

1. Reviewing all background information including the Accusation and Decision pertaining to the physician on probation.
2. Monitoring the physician for his/her entire probation period (unless otherwise stated in the Order) according to the Board's requirements.
3. Adhering to all HIPAA regulations and guidelines with respect to patient privacy.
4. Making all site visits to the physician's practice(s) following the Board's program guidelines and instruments for: timeliness, completion of questionnaires, chart reviews, and submission of reports.
5. Working together with the physician to ensure the Monitoring Plan is being followed as outlined.
6. Telephoning the physician as needed to discuss results or concerns from the monthly chart reviews.
7. Completing and providing written quarterly reports to the assigned Inspector within the Board's Probation Unit in accordance with the Monitoring Plan.

MONITORING PLAN

This Monitoring Plan (Plan) outlines the written protocols for monitoring the physician's practice. The Plan details the expectations for visiting the physician's practice; randomly selecting and reviewing charts; and reporting findings to the Probation Unit.

Initial and Subsequent Site Visits:

Prior to the *initial site visit*, the Monitor should review the physician's Curriculum Vitae and the Board's administrative Accusation and Decision. In addition, the Monitor should review the "Practice Monitor Pre-Visit Information" form that was completed by the physician.

The Monitor will make an *initial site audit* at the beginning of the monitoring program and on an annual basis thereafter during normal business hours. The *initial site audit* involves a detailed inspection of the physician's place of practice. A list of items to observe at the practice will be provided to the Monitor. After the *initial site audit* has been concluded, the Monitor will prepare a summary report of their findings and submit it to the assigned Inspector.

Subsequent visits to the physician's practice location will be made ***once each month*** for the purpose of randomly selecting and reviewing charts, inspecting the sanitation and orderliness of the office, and meeting with the physician to discuss cases or other practice related issues, such as the proper storage of controlled substances and required record keeping.

If the physician has more than one practice location, the Monitor will make an initial site audit at each practice and make subsequent monthly visits to each location on a rotating basis.

Chart Review

The *total number* of randomly selected patient charts to be reviewed by the Monitor on a ***quarterly basis*** is dependent on the size of the physician's practice and should be as follows:

Average Number of Patients Seen per Month	Percentage of Chart Review
1-20	50%
21-40	40%
40 and higher	30%

The Monitor will determine the method of random chart selection. This responsibility shall not be delegated to either the physician or the physician's staff. The random selection of charts should include charts that correlate to the patient care issues identified in the Board's accusation and decision which resulted in the physician being

placed on probation. The physician is required to make all charts available for immediate inspection and copying by the Monitor at all times during business hours. The Monitor will immediately notify the assigned Inspector if the physician fails or refuses to make the charts available for inspection and/or copying.

If the physician is required to keep a log of all medications prescribed, dispensed or administered to patients, the Monitor will periodically compare the entries in the log with the corresponding patient records, to ensure that all controlled substances are documented in the log; the physician conducted a good faith examination prior to prescribing, dispensing or administering the medication; and the medication was medically indicated.

The charts reviewed at inpatient facilities should include any cases with complications or other quality of care issues identified by the quality assurance department or through the peer review process.

Please note: Under the federal Health Insurance Portability and Accountability Act (HIPAA) the Medical Board of California (Board) is deemed a "health oversight agency" (see 45 CFR section 164.501). With regards to patient information that is being requested by and provided to the Board, 45 CFR 164.512(d) provides that a covered entity may disclose protected health information without the written authorization of the individual to a health oversight agency for oversight activities authorized by law, which are deemed to include licensure over disciplinary activities.

Since the role of the Monitor is to oversee the practice of the physician and to report the findings to the Board, the Monitor is therefore exempt from HIPAA mandates.

Monitor Reports

The Monitor will submit a written report ***once each quarter*** to the assigned Inspector summarizing the monthly site visits and review of the physician's patient records. The Monitor will be provided with a chart audit form to be used for individual chart audits or another form to be used when there are multiple charts to be reviewed. The reports shall be written on the Monitor's letterhead, will bear the original signature of the Monitor, and will have as a cover sheet "Practice Monitor Report Checklist."

The Monitor reports are due at the assigned Inspector's office ***within 10 calendar days after the end of the preceding quarter.*** The quarterly reporting periods and due dates are as follows:

Reporting Time Period	Due No Later Than
January 1 to March 31 (Quarter I)	April 10th
April 1 to June 30 (Quarter II)	July 10th
July 1 to September 30 (Quarter III)	October 10th
October 1 to December 31 (Quarter IV)	January 10th

The reports from the Monitor must contain *at a minimum*, the dates and location(s) of site visits; the chart number or patient name of the charts reviewed per visit; and whether the physician is practicing medicine safely and within the standard of care. In addition, the reports shall describe any identified problems or deficiencies in the quality of patient care, medical record keeping, billing practices, or other practice related issues (refer to sample report attached).

Medical Marijuana Practices

As the Monitor for a physician that makes recommendations for medical marijuana to their patients, the accepted standards are the same as those for any reasonable and prudent physician when recommending or approving any other medication. In reviewing the patient charts they must include the following:

- History and appropriate examination of the patient.
- Development of a treatment plan with objectives.
- Provision of informed consent including discussion of side effects.
- Periodic review of the treatment's efficacy.
- Consultant, as necessary.
- Proper record keeping that supports the decision to recommend the use of medical marijuana.

Attachments to this Plan

1. Practice Monitor Pre-Visit Information.
2. Practice Monitor Site Visit Evaluation Sheet.
3. Individual Chart Audit form.
4. Multiple Chart Audits form.
5. Practice Monitor Report Checklist.
6. Sample Practice Monitor Report.

(Est. 3/2011)

PRACTICE MONITOR AGREEMENT

I, _____ M.D., agree to serve as a practice monitor for **(insert name)**, M.D.

_____ 1. I have received, reviewed, and understand the materials provided to me describing the practice monitor roles and responsibilities. Any questions regarding my obligations as a practice monitor have been discussed with and fully addressed by the Board's Probation Inspector. I clearly understand the role of a Monitor and what is expected of me.

_____ 2. I have received and have read a copy of the Medical Board's Accusation and Decision filed against Dr. _____. The Board charged Dr. _____ with (insert violation cited such as gross negligence or repeated negligent acts or incompetence, etc.) because he/she failed to (insert explanation from the summary paragraphs which describe the omission or departure

OR (To be used with Proposed Decisions)

_____ 2. I have received and have read a copy of the Medical Board's Accusation and Decision filed against Dr. _____. The Board found Dr. _____ was (insert violation(s) the ALJ identified as ones confirmed or proven (i.e., gross negligence or repeated negligent acts or incompetence, etc.) because he/she failed to (insert explanation/findings that were proven or confirmed during the hearing – DO NOT INCLUDE THOSE FINDINGS OR VIOLATIONS THAT WERE NOT PROVEN).

_____3. I understand that, as the approved practice monitor, I am required to randomly select patient charts on a monthly basis for review. Based on the information provided by Dr. _____, an average of ___ patients per month are seen, therefore, I understand that I must review (insert percentage) or approximately (number of charts to be reviewed) each quarter.

_____ 4. Should Dr. _____'s medical practice change in either the medical setting, discipline or specialty being practiced, an increase/decrease in office location(s) being covered or in the volume of patients being seen, this monitoring agreement may be amended. If I believe an amendment is indicated, I can submit a proposed revision to the assigned Inspector for approval. I do understand that any changes to the Monitoring Plan must be approved by the Board.

_____ 5. I agree to conduct an initial site audit at Dr. _____'s place of practice and subsequent site audits annually. I understand that if Dr. _____ has multiple locations I am to conduct a site audit at each location. I will prepare a written report to the Board's Probation Unit of my findings.

_____ 6. I agree to submit written reports quarterly to the assigned Inspector regarding my review of Dr. _____'s practice. I understand that the failure to submit quarterly reports in a timely manner may result in Dr. _____ being charged with a violation of probation.

_____ 7. I have no prior or current business, personal or other relationship with Dr. _____that could reasonably be expected to compromise my ability to render fair and unbiased reports to the Board.

_____ 8. I understand that Dr. _____ is responsible for all costs associated with the monitoring of his/her practice, and that these costs are not set by the Board. I am not being compensated for my services by any form of bartering arrangement.

_____ 9. If I am no longer able or willing to continue to monitor Dr. _____'s practice, I agree to immediately notify both Dr. _____ and (insert assigned Inspector's name and contact info).

_____ 10. If I am unable contact or meet with Dr. _____ in order to fulfill my obligations as a practice monitor, I will notify (insert assigned Inspector's name and contact info) within two weeks of my failed attempts to contact Dr. _____.

_____ 11. I have reviewed the Monitoring Plan and agree to monitor Dr. _____ as specified.

I understand that my reports will be available for inspection and review by Medical Board staff or the Attorney General's Office at any time. I agree that my report and findings shall not be privileged in any way to these agencies and/or their designees.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on_____, 20_____, at

_____ _____,
California (City) (County)

_____ _____
Monitor (Print Name) Signature

Witnessed by: _____
Probation Inspector

PRACTICE MONITOR SITE VISIT EVALUATION SHEET

Date: _____

Probationer: _____

Practice Site Location: _____

Date Monitor made Site Visit to Probationer's practice: _____

Length of Time Spent on Site Visit: _____

Practice Assessment and Evaluation

Observe the following areas and provide an assessment on:

- General practice/office hygiene and organization
- Waiting room/area
- Exam rooms
- Business office area
- Bathrooms, including ease of access
- Handling and storage of drugs, including samples
- Lab and handling of specimens (if applicable)
- Management of patients with disabilities
- Office/clinic safety
- Patient education materials
- Scheduling/appointments
- Handling of hazardous wastes
- Are there *sharps* containers
- Office policies
- How sterility of instruments are insured if procedures are performed

Appointments

- Method used for scheduled patient appointments
- Average time allowed in schedule for (a) new patients, (b) return/follow-up visits, and, (c) complete examination
- Standard wait time for appointments
- Average wait time in waiting room per patient

Practice Structure

Assess the following areas of the practice and provide a summary on how each are handled:

- Telephone, fax, or e-mail (if applicable) messages

- Maintaining security/confidentiality of clinical data
- Emergency and urgent messages
- On-site clinic emergencies (e.g., oxygen, suction, airway management, other emergency equipment)
- Estimated time for emergency personnel to reach the clinic in the event of a 911 emergency
- Physician access issues including on-call, after hours, weekend, and vacation coverage
- Insuring that messages routed to the physician are timely
- Receipt of lab, x-ray, and other studies
- Timely response to lab data, consultations, and imaging studies
- Management of inpatient care/hospitalization
- Communication from other physicians
- Communication on clinical data relayed to the appropriate physician in a confidential and reliable method
- Abnormal findings/reports/lab data communicated to the patient in a timely manner

Drug Assessment

- Onsite controlled substances, how is the use monitored (if applicable)
- All drugs, including samples, are they kept in a secure area
- Controlled substances, are they locked in a secure area
- Controlled substances, is an inventory kept
- Is an inventory kept for all drugs
- Method for insuring that all drugs in the practice have not expired
- Temperature-sensitive drugs (e.g. vaccines) are they kept onsite
- Temperature-sensitive drugs are they stored in a refrigerator onsite
- Cleanliness, safety, functionality of refrigerator
- Monitoring of the temperature in the refrigerator? If yes, how is it monitored
- Requests from patients for prescription refills
- Request from pharmacists for prescription refills

Maintenance of Medical Records

- Describe method used for charting/medical record keeping
- Storage of data electronically or through the use of an electronic health record
- Describe the system on how records are stored or filed
- How long are medical records stored
- Criteria used to determine when medical records are to be destroyed or stored off-site
- Identification of records to insure attention to drug allergies or other major clinical concerns
- What system is used (tickler file, flow sheets, reminder system) to insure preventive health care, appropriate management of patients with diabetes, etc.

MEDICAL BOARD OF CALIFORNIA
PROBATION UNIT
INDIVIDUAL CHART AUDIT
(*To be used for 1-20 patients*)

Date: _____ Location: _____

Probationer: _____ Patient/Chart #: _____ Monitor: _____

CHART REVIEW	Yes	No	Comments
Patient name and medical number on each page			
Legible (1=illegible, 8=highly legible)			
Progress notes organized			
Lab work documented			
Problem list present			
Problem list up-to-date			
Medication list present and updated			
Medication allergies indicated			
Medication record completed			
SOAP format utilized			

PATIENT CARE	Yes	No	Comments
Adult or Pediatric Health Questionnaire present and complete (or, is the same information – PMH, FHx, ROS, PSH, etc. recorded in another format)			
Inquiry re: use of alcohol, tobacco, substance abuse			
Physical exam documented for breast			
Physical exam documented for genital			
Physical exam documented for rectal			
Physical exam performed within recommended time frame for age group			
Evidence lab tests/imaging studies/pap smears, etc. have been noted by the provider (e.g. initialed)			
Immunizations up-to-date and noted in chart			
Preventive services offered and/or obtained in accordance with a reasonable set of preventive practice guidelines			

Choose a single problem or recent clinic note:	Yes	No	Comments
Does the history provide sufficient pertinent information to elucidate the presenting complaint?			
Is the physical examination sufficient and appropriate for the problem?			
If diagnostic studies were ordered, are they appropriate given the data in the clinic note?			
Is the differential diagnosis clearly stated, and is it appropriate given the data in the clinic note?			
Is there evidence of underutilization or overutilization of diagnostics, consultants, etc.?			

Provide suggestions for improving the quality of the chart that was reviewed:

Provide suggestions for improving the quality of this Probationer's clinical practice:

Chart score (circle the appropriate letter):

(A) Excellent – no significant deficiencies found

(B) Acceptable – the following deficiencies were noted:

(C) Unacceptable – the following deficiencies made these charts fall below the standards for acceptable charting:

MEDICAL BOARD OF CALIFORNIA

AN OVERVIEW OF THE EXPERT REVIEWER UTILIZATION IN THE CENTRAL COMPLAINT UNIT

Business and Professions Code Section 2220.08.

….. “any complaint determined to involve quality of care, before referral to a field office for further investigation, shall meet the following criteria:

(1) It shall be reviewed by one or more medical experts with the 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.”

CCU Medical Experts

- **Possess a current California medical license in good standing**
  - no prior discipline
  - no Accusation pending
  - no complaint history within the last three years
- **Board certification in one of the 24 ABMS specialties**
- **Have an active practice or retired within the last 2-3 years**
- **Peer review or comparable experience is desirable**

MEDICAL BOARD OF CALIFORNIA
CENTRAL COMPLAINT UNIT

MEDICAL CONSULTANT
PROCEDURE MANUAL

What precedes the CCU Expert Review?

- Acquisition of all relevant medical records
- Subject is asked to provide a written summary describing the care provided to the patient

Composition of CCU Expert Pool

Medical Specialty	No. of consultants
Anesthesiology	14
Cardiology	13
Dermatology	4
ENT/Otolaryngology	3
Gastroenterology	4
Family Practice	16
Hematology/Oncology	7
Internal Medicine	31
Midwife	1
Obstetrics/Gynecology	12
Ophthalmology	7
Orthopedics	6
Neurology	5
Neurological Surgery	4
Pathology	2
Pediatrics	11
Plastic Surgery	2
Psychiatry	12
Radiology (interventional)	4
Radiology (diagnostic)	5
Surgery	15
Urology	6
Total No. of Consultants	184

Consultant Findings

- **No violation/departure** - no departure from the standard of practice or any other misconduct by the physician. The complaint is closed by CCU without further investigation.
- **Simple departure** - physician's conduct deviated from the standard of practice but does not warrant further investigation. The complaint is closed by CCU and retained for 5 years.
- **Refer for further investigation** - care found to potentially represent an extreme departure from the standard of practice. The complaint is referred for further investigation.

How Long Does it Take?

- Average No. of Days to Complete Review: 50 days
- Total No. of cases reviewed by CCU experts in 2009/2010: 2248

MEDICAL BOARD OF CALIFORNIA

AN OVERVIEW OF THE EXPERT REVIEW IN THE FIELD

EXPERT QUALIFICATIONS

- **Possess a current California medical license in good standing**
  - no prior discipline
  - no Accusation pending
  - no complaint history within the last three years
- **Board certification in one of the 24 ABMS specialties**
- **Have an active practice**
  - 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

EXPERT TRAINING

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM

EXPERT REVIEWER GUIDELINES

(revised September, 2009)

District Offices contact information

Cerritos 12750 Center Court Drive South, Suite 750 Cerritos CA 90703 Tel.: (562) 402-4668; Fax (562) 865-5247	**Fresno** 1277 E. Alluvial Avenue, Suite 110 Fresno, CA 93720 Tel.: (559) 447-3050; Fax (559) 447-3054
Glendale 320 Arden Avenue, Suite 250 Glendale, CA 91203 Tel: (818) 551-2117; Fax (818) 551-2131	**Pleasant Hill** 3478 Buskirk, Suite 217 Pleasant Hill, CA 94523 Tel: (925) 937-1900; Fax (925) 937-1964
Rancho Cucamonga 9166 Anaheim Place, Suite 110 Rancho Cucamonga, CA 91730 Tel: (909) 476-7146; Fax (909) 476-7213	**Sacramento** 2535 Capitol Oaks Drive, Suite 220 Sacramento, CA 95833 Tel: (916) 263-2585; Fax (916) 263-2591
San Bernardino 464 West 4th Street, Suite 429 San Bernardino, CA 92401 Tel: (909) 383-4755; Fax (909) 383-4172	**San Diego** 4995 Murphy Canyon Road, Suite 203 San Diego, CA 92123 Tel. (858) 467-6830; Fax (858) 467-6836
San Dimas 160 E. Via Verde, Suite 230 San Dimas, CA 91773 Tel. (909) 421-5800; Fax (909) 599-2756	**San Jose** 1735 Technology Drive, Suite 800 San Jose, CA 95110 Tel: (408) 437-3680; Fax (408) 437-3693
Tustin 15641 Redhill Avenue, Suite 215 Tustin, CA 92780 Tel: (714) 247-2126; Fax (714) 247-2137	**Valencia** 27202 Turnberry Lane, Suite 280 Valencia, CA 91355 Tel: (661) 295-3397; Fax (661) 295-3030
Office of Standards & Training/MBC HQ 2005 Evergreen St., Suite 1200 Sacramento, CA 95815 (916) 263-2517; Fax (916) 263-2530	**Operation Safe Medicine** 160 E. Via Verde, Suite 245 San Dimas, CA 91773 (909) 421-5830; Fax (909) 599-4609

www.mbc.ca.gov

Expert Reviewer Program

320 Arden Avenue, Suite 250, Glendale, CA 91203 Tel. (818) 551-2129; Fax (818)551-2131

http://www.mbc.ca.gov/licensee/expert_reviewer.html

WHAT PRECEDES AN EXPERT REVIEW

- ACQUISITION OF ALL RELEVANT RECORDS
- INTERVIEWS OF ALL SALIENT WITNESSES
- INTERVIEW OF SUBJECT

CHOOSING AN EXPERT

Expert Reviewer Master Page - Windows Internet Explorer

http://165.235.24.248/ExpertReviewerProgram/

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

Medical Board of California
Expert Reviewer Program

Search By Last Name

Primary Specialties

- ADDICTION MEDICINE - ASAM CERTIFIED
- ADMINISTRATIVE MEDICINE
- AEROSPACE MEDICINE
- AIDS/HIV
- ALLERGY & IMMUNOLOGY
- ANESTHESIOLOGY
- BIOETHICS
- CARDIOLOGY
- COLON & RECTAL SURGERY
- COMPLEMENTARY/ ALTERNATIVE/ INTEGRATIVE MEDICINE
- CORRECTIONAL MEDICINE
- DERMATOLOGY
- ECHOCARDIOGRAPHY - NBE CERTIFIED
- EMERGENCY MEDICINE
- ENDOCRINOLOGY & METABOLISM
- ETHICS

Expert Reviewer Master Page - Windows Internet Explorer

http://165.235.24.248/ExpertReviewerProgram/ExpertFind.aspx

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Expert Reviewer Master Page

STATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAIRS

Medical Board of California
Expert Reviewer Program

Search By Last Name | Clear Results

Primary Specialties

- ADDICTION MEDICINE - ASAM CERTIFIED
- ADMINISTRATIVE MEDICINE
- AEROSPACE MEDICINE
- AIDS/HIV
- ALLERGY & IMMUNOLOGY
- ANESTHESIOLOGY
  - ADDICTION MEDICINE -NOT CERTIFIED, PRACTICING
  - BOARD CERTIFIED-PEDIATRICS
  - CARDIAC ANESTHESIA
  - CRITICAL CARE MED- BOARD CERTIFIED
  - EPIDURAL STEROIDS
  - GENERAL ANESTHESIA
  - ICU CARE
  - ICU CARE-PEDIATRIC
  - IMPLANTATION OF SPINAL CORD STIMULATORS
  - INTERNAL MED-BOARD CERTIFIED

Profile Info	County	Last Name	First Name	In Use	Flagged	Rating AVG	Cases	License	License Status	Zip
Click Here	Alameda	Jaffe	Rory	Available	OK TO USE	5	3	G48138	License Renewed & Current	946
Click Here	Alameda	O'Young	Judy	Available	OK TO USE	5	10	G49793	License Renewed & Current	946
Click Here	Alameda	Jenkins	William	Available	OK TO USE	4	3	G52263	License Renewed & Current	945
Click Here	Alameda	Clauson	William	Available	OK TO USE	1	5	G 27171	License Renewed & Current	945
Click Here	Alameda	Schuchard	Marilee	Available	OK TO USE	3	2	G 28782	License Renewed & Current	945
Click Here	BINGHAM	Porot	Marc	Available	OK TO USE	2	2	A42809	License Renewed & Current	832
Click Here	Contra Costa	Baumgartl	William	Available	OK TO USE	3	2	G 67802	License Renewed & Current	945
Click Here	Contra Costa	Hershey	Brian	Available	OK TO USE		1	G52478	License Renewed & Current	945

Local intranet 100%

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INTERVIEWING THE EXPERT

MEDICAL BOARD OF CALIFORNIA
EXPERT REVIEWER PROGRAM

CASE REVIEW CHECKLIST

EXPERT REVIEWER NAME:	CASE NUMBER:
MBC EMPLOYEE:	DATE OF INTERVIEW:

BACKGROUND CHECKS:

	Review CAS Licensing and Enforcement to ensure no prior or pending discipline, or any disqualifying complaints or investigations pending or closed due to insufficient evidence.
	Review Civil Index

ONCE THE EXPERT REVIEWER IS CLEARED THROUGH ABOVE ITEMS, CONTACT THE SELECTED EXPERT AND CONDUCT A BREIF PHONE INTERVIEW TO ENSURE THE EXPERT UNDERSTANDS:

	The specialty or subspecialty of the subject, and has a minimum of three years in practice in the specialty/subspecialty, currently practices in the same specialty/subspecialty and has expertise regarding the issue/treatment in question (performed the same procedure) during the time period in question.
	Name of the subject and there are no personal or financial conflicts of interest.
	Ask if there are any pending legal or administrative matters that could, in anyway, be used to challenge the physician's credentials or expertise (e.g., pending hospital charges or discipline; pending criminal/civil litigation, pending criminal violations).
	The amount of material to be reviewed. Determine if there is anything that would preclude the expert from providing the opinion/report within 30 days.
	They are to complete the review in less than 10 hours, unless preapproved for more hours.
	The reimbursement rate for case review and report preparation is set at $150.00 per hour (unless the Deputy Chief has preapproved a higher rate).
	To contact MBC **immediately** if they discover the opinion cannot be furnished in 30 days or in less than 10 hours.
	That confidentiality is a **legal requirement.**
	To contact MBC immediately if they are contacted by outside sources, e.g., the media, defense counsel, etc.
	The need to define medical terminology so a lay person understands their opinion. The best mechanism found is to parenthetically explain any medical term.
	They are not to conduct their own investigation or contact any witnesses. They are welcome, however, to contact the Investigator or Medical Consultant to acquire additional information if it is necessary to develop/complete their opinion.
	They are welcome to consult medical literature, if appropriate.
	They are to render their own opinion as to the standard of practice at the time of the event(s) in question. The expert must have been in practice at the time of the event(s) in question, and have direct experience with the medical issue(s) under review.
	The format for the report as follows: • Describe/List **all** the Records/Materials reviewed. • Summarize the Case (they are to identify and ask for any missing records and to contact the investigator if there are missing records to be requested). • List the Medical Issue and for each issue, state the Standard of Care at the time of the event(s) in question. • Provide an Analysis and determine if the care in question was or was not a deviation from the standard of practice. • Under Conclusion, define the deviation from the standard in terms of **No Departure**, **Simple Departure**, or **Extreme Departure;** and/or **Lack of Knowledge** and state why and be specific. ***Before preparing an opinion, experts shall review the instructions provided with the Expert Package.**
	Remind experts to listen to the recording of the physician interview or to listen to any recordings provided before preparing their report and to contact the investigator with any problems about the recordings.
	Draft reports (via fax, email, mail) are not accepted. Experts must proofread their reports thoroughly. Expert reports are read by many (supervisors, attorneys, and administrative law judges).
	The request for this review does not imply there is a deviation from the standard of care.
	All records provided to them must be returned to the Investigator.
	To contact the Investigator or Medical Consultant if they are unclear about how to complete this process.

RETAIN THIS DOCUMENT IN THE INVESTIGATION CASE FOLDER

ER-4 (Rev. 08/10)

PREPARING THE EXPERT PACKAGE

- ASSEMBLING ALL RELEVANT INFORMATION
- REVIEW BY SUPERVISOR
- REVIEW BY DEPUTY ATTORNEY GENERAL
- PERSONAL DELIVERY (IDEAL) TO EXPERT

FOLLOWING UP

Investigators follow up with experts three weeks after package delivery.

HOW LONG DOES IT TAKE?

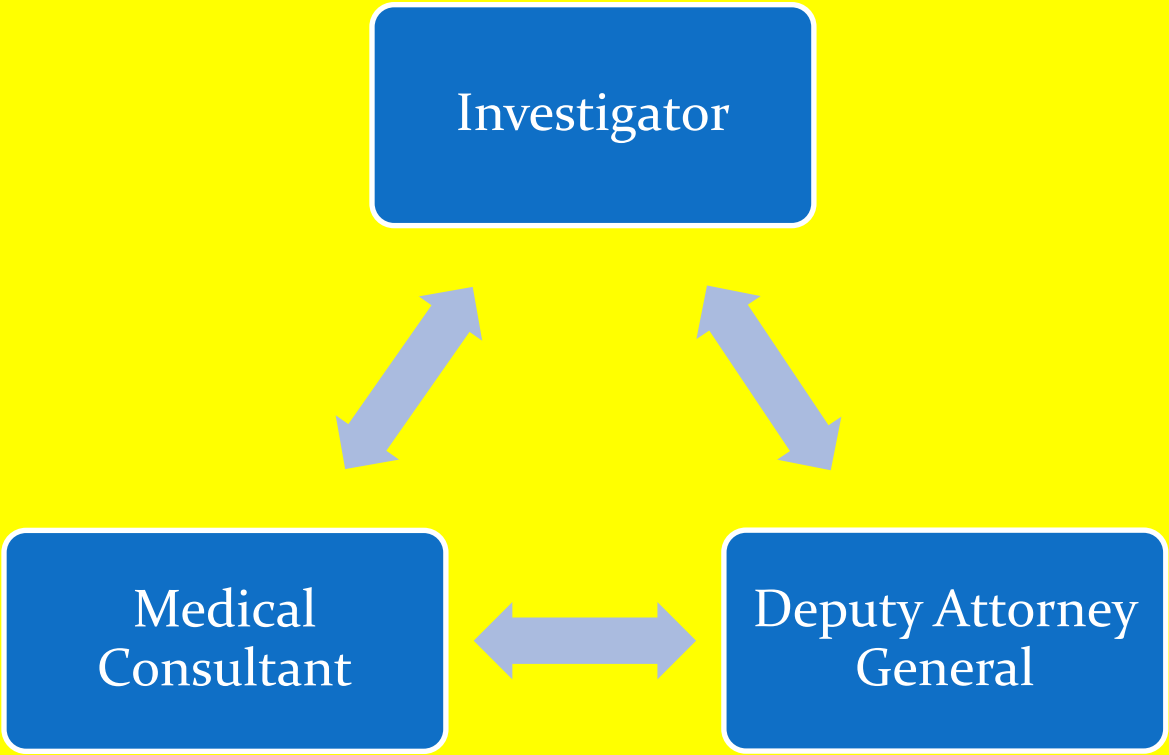
Since July 01, 2010, out of 299 records:

- the average day between delivery of package to receipt of opinion is 47 days
- the median is 36 days

OTHER WAYS EXPERTS ARE UTILIZED

- ORAL COMPETENCY EXAM
  - 3 examiners
- MENTAL EXAM
- PHYSICAL EXAM
  - Either voluntary or can be compelled by the Board.

RECEIVING THE OPINION



OPINION REVIEWED

Common problems:

- Incorrect terminology
- Arriving at a conclusion without analysis
- Failing to review all documents
- Failing to listen to recording

EXPERT FINDINGS

- **No violation/departure** - no departure from the standard of practice or any other misconduct by the physician. The complaint is closed.
- **Simple departure** - physician's conduct deviated from the standard of practice but does not warrant further investigation. The complaint is closed and retained for 5 years.
- **Extreme departure** - Referred to the Office of the Attorney General.

RATINGS

- Upon receipt of the opinion, the expert is evaluated.
- Feedback from the investigator, medical consultant and attorney are key in rating the experts for future use.

MEDICAL BOARD OF CALIFORNIA
EXPERT REVIEWER PROGRAM

MBC EVALUATION OF EXPERT PERFORMANCE

Expert Reviewer:	**Investigator:**
Subject Name:	**Medical Consultant:**
MBC Case Number:	**Type of Case (violation):**

Rate the expert reviewer in each of the following areas. **"No"** rating must be explained in the "Comments" Column. If additional space is needed, use the "Comments" section on the reverse side of this form.

TASK			COMMENTS [Identify corresponding section letter]
The Investigator should complete Sections I and II			
I. Productivity:			
A. Date sent to Expert Reviewer:			
B. Date Returned:			
C. Complied with guidelines for expert reviewers (Explain any departures from guidelines)	☐ Yes	☐ No	
D. Records returned with report?			
E. Completed billing statement submitted?	☐ Yes	☐ No	
F. Time billed was appropriate?			
II. Relations With People:			
A. Was effective in dealing with Board and Attorney General's staff (if appropriate).	☐ Yes	☐ No	
B. Was accessible and cooperative	☐ Yes	☐ No	
C. Exhibited appropriate professional demeanor during preparation meeting and hearing.	☐ Yes	☐ No	
The Medical Consultant should complete Sections III-V			
III. Quality of Work Product:			
A. Complied with guidelines for expert reviewers (Explain any departures from guidelines)	☐ Yes	☐ No	
B. Report was clear, understandable, used lay terminology or explained technical terms.	☐ Yes	☐ No	
C. Report was complete and factual.	☐ Yes	☐ No	
D. Overall quality of report was acceptable, professional.	☐ Yes	☐ No	
IV. Medical Case Analysis:			
A. Complied with guidelines for expert reviewers. (Explain any departures from guidelines)	☐ Yes	☐ No	
B. Stated the standard of practice for each treatment reviewed .	☐ Yes	☐ No	
C. Specifically described any reported departure from the standard of practice (as described in the guidelines)	☐ Yes	☐ No	
D. Summarized each patient case reviewed.	☐ Yes	☐ No	
V. Decision Making:			
A. Complied with guidelines for expert reviewers (Explain any departures from guidelines)	☐ Yes	☐ No	
B. Listed all documents and records reviewed in forming conclusion(s).	☐ Yes	☐ No	
C. Conclusion(s) reached were supported by analysis.	☐ Yes	☐ No	
D. Opinion(s) on standard of care were within the reviewer's area of specialty.	☐ Yes	☐ No	
E. Avoided offering legal opinions in report.	☐ Yes	☐ No	
F. Avoided recommending penalty or punishment.	☐ Yes	☐ No	

TYPE OR PRINT IN INK

MEDICAL BOARD OF CALIFORNIA
EXPERT REVIEWER PROGRAM

DAG EVALUATION OF EXPERT PERFORMANCE

Expert Reviewer:	**Deputy Attorney General:**
Subject Name:	**MBC Case Number:**
Type of Case (violation):	

Provide a brief evaluation of the Expert Reviewer in each of the following areas. Any rating of 1 or 2 must be explained in the "Comments" Column. Use the following ratings:

(5) Excellent (4) Above Average (3) Average (2) Below Average (1) Poor

TASK	RATING	COMMENTS
Written Report: (Factors to consider: clarity; completeness; technical terms defined; factual accuracy; objectivity; professional "tone" and style; departures from standard of care were clearly identified, and report specifies how/why they were departures, and whether they were simple or extreme departures.)		
Knowledge of Case: (Factors to consider: demonstrated reasonable familiarity with case during pre-hearing interviews with DAG, investigator or medical consultant; during testimony did not need excessive prompting; did not make major errors regarding facts or circumstances.)		
Preparation For Hearing: (Factors to consider: was reasonably available to meet or confer with DAG; kept appointments or gave reasonable notice if unavailable; returned phone calls within reasonable time; cooperative; amendable to suggestions on procedure; did not contribute to excessive delays or continuances in scheduling of hearing; professional demeanor at all times.)		
Testimony at Hearing: (Factors to consider: responsive to questions; replies were clear, concise, on point; professional demeanor; demonstrated expertise consistent with credentials; cooperative.)		
Other: (If other factors not addressed above contributed to your overall evaluation, please summarize. Use reverse side if necessary.)		
Overall Rating		

NOTICE - CONFIDENTIAL: This evaluation is intended only for the use of the Office of the Attorney General or the Medical Board of California. It contains information from the State of California, Office of the Attorney General, or the Medical Board of California, which is privileged, confidential and exempt from disclosure under applicable law. If the reader of this evaluation is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this evaluation is strictly prohibited.

INSTRUCTIONS FOR COMPLETING THIS FORM

QUESTIONS???

Agenda item #6

Enforcement Process Data Markers/Timelines

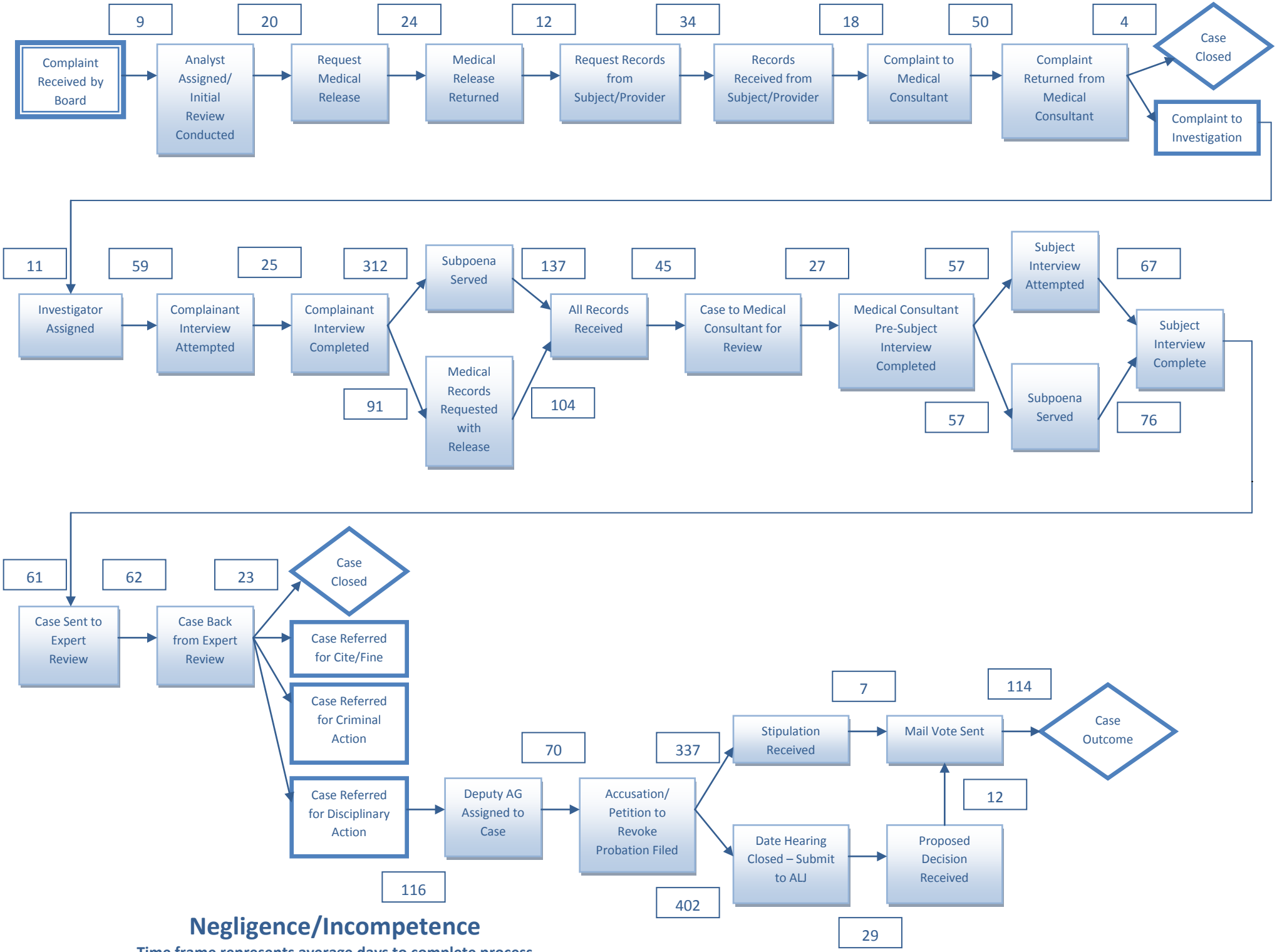
DATE REPORT ISSUED:	April 26, 2011
DEPARTMENT:	Enforcement Program
SUBJECT:	Enforcement Process Data Markers/Timelines
STAFF CONTACT:	Susan Cady and Laura Sweet

At the last Enforcement Committee meeting, staff was requested to examine all processes used by the Board to investigate complaints, with the goal of identifying opportunities for process improvement and reducing investigative timeframes. We have identified four major complaint categories as reported in the annual report, and have prepared a flow chart identifying each major step or activity, from the initial intake review through the investigation to either closure or referral for administrative action.

Data was generated from the Enforcement tracking system on CAS to identify the average number of days to complete each step in the process for each complaint type. The average number of days has been posted to the flow chart by the appropriate step in the process. The data produced reflects all cases where the activity was completed between 1/1/11-3/31/11. The average timeframes presented in this initial report contain a relatively small data set and the number of records used to calculate the "average" time is displayed on the chart.

Staff presents this material to the Committee seeking input and direction to ensure the requested information has been captured. Once final approval has been obtained, staff will return to the Committee with a report which contains a larger data set and will provide a truer reflection of the current average processing time for each step in the investigative process. Staff can also produce a report reflecting average processing times for prior years to provide data for comparison.

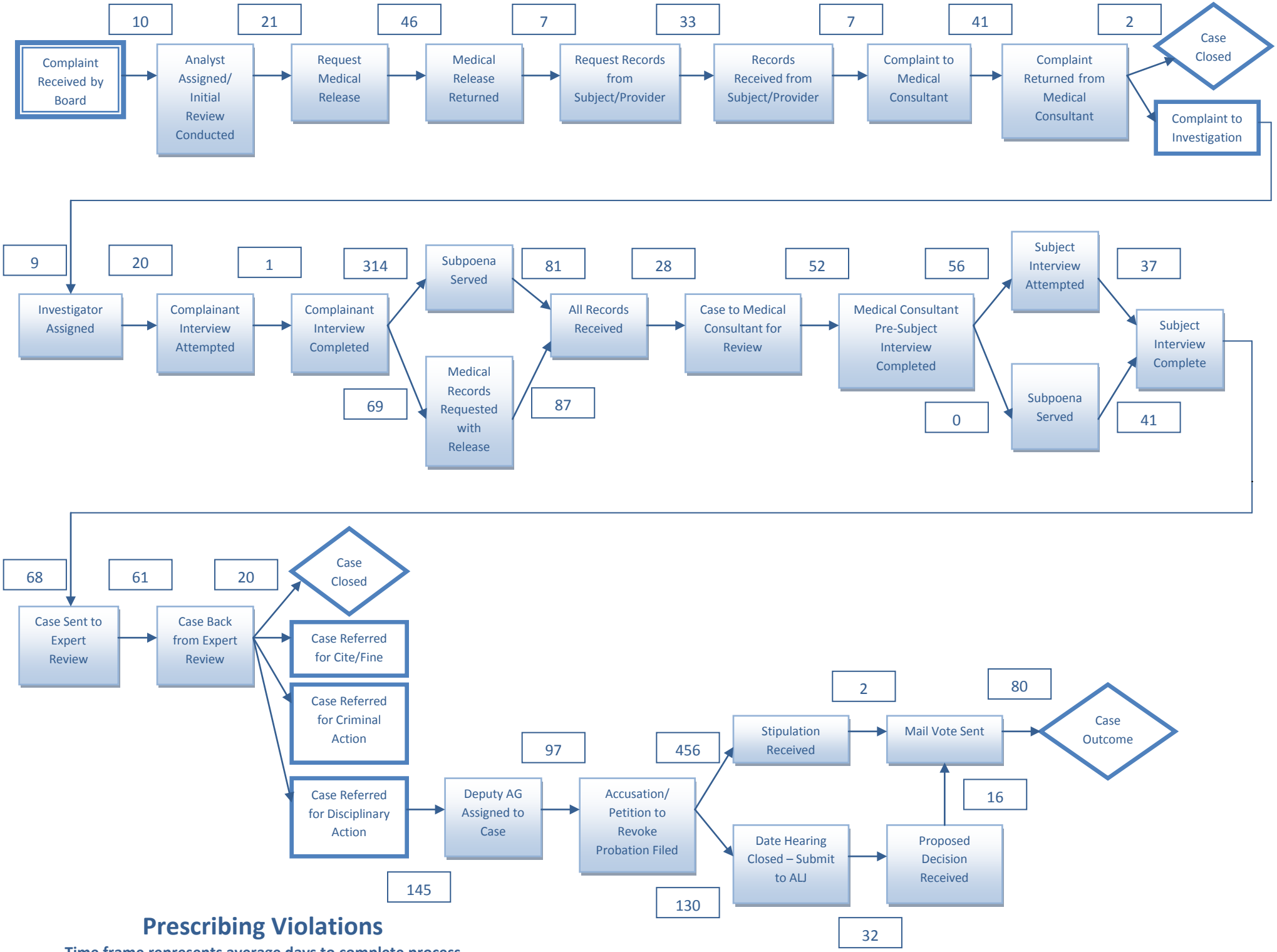
Data represents average days to complete Complaint/Investigation/Disciplinary processes based on "Action" occurring during the reported timeframe.	Q1 2011							
	Negligence/Incompetence	Number of Records	Prescribing Violations	Number of Records	Unlicensed Practice	Number of Records	Sexual Misconduct	Number of Records
Complaint Received by Board → Analyst Assigned/Initial Review Conducted	9	864	10	21	6	99	9	32
Analyst Assigned/Initial Review Conducted → Request Medical Release	20	280	21	3	19	2	30	2
Request Medical Release → Medical Release Returned	24	256	46	3	12	1	38	4
Medical Release Returned → Request Records from Subject/Provider	12	192	7	2	1	1	32	3
Request Records from Subject/Provider → Records Received from Subject/Provider	34	380	33	4	22	1	20	2
Records Received from Subject/Provider → Complaint to Medical Consultant	18	347	7	6	2	1	0	0
Complaint to Medical Consultant → Complaint Returned from Medical Consultant	50	450	41	10	25	2	51	1
Complaint Returned from Medical Consultant → Case Closed/Complaint to Investigation	4	451	2	10	27	3	1	1
Complaint to Investigation → Investigator Assigned	11	143	9	20	8	39	9	10
Investigator Assigned → Complainant Interview Attempted	59	8	20	3	46	2	145	3
Complainant Interview Attempted → Complainant Interview Completed	25	8	1	1	0	0	14	3
Complainant Interview Completed → Subpoena Served	312	1	314	2	0	0	0	0
Complainant Interview Completed → Medical Records Requested with Release	91	10	69	1	0	0	156	1
Subpoena Served → All Records Received	137	14	81	5	0	0	0	0
Medical Records Requested with Release → All Records Received	104	32	87	3	26	1	11	3
All Records Received → Case to Medical Consultant for Review	45	37	28	6	10	1	46	3
Case to Medical Consultant for Review → Medical Consultant Pre-Subject Interview Completed	27	74	52	10	1	1	8	5
Medical Consultant Pre-Subject Interview Completed → Subject Interview Attempted	57	50	56	4	6	1	0	0
Medical Consultant Pre-Subject Interview Completed → Subpoena Served	57	2	0	0	0	0	0	0
Subject Interview Attempted → Subject Interview Completed	67	103	37	4	31	5	31	6
Subpoena Served → Subject Interview Completed	76	4	41	1	0	0	159	1
Subject Interview Completed → Case Sent to Expert Review	61	106	68	7	0	0	229	1
Case Sent to Expert Review → Case Back from Expert Review	62	131	61	11	61	2	68	2
Case Back from Expert Review → Case Closed or Referred for Action	23	126	20	5	22	3	34	1
Case Referred for Action → Deputy AG Assigned to Case	116	31	145	7	0	0	4	1
Deputy AG Assigned to Case → Accusation/Petition to Revoke Probation Filed	70	27	97	1	341	1	150	3
Accusation/Petition to Revoke Probation Filed → Stipulation Received	337	13	456	1	211	2	15	1
Stipulation Received → Mail Vote Sent	7	13	2	1	9	2	0	0
Accusation/Petition to Revoke Probation Filed → Date Hearing Closed - Submit to ALJ	402	6	130	3	0	0	625	3
Date Hearing Closed - Submit to ALJ → Proposed Decision Received	29	6	32	3	0	0	117	1
Proposed Decision Received → Mail Vote Sent	12	7	16	5	0	0	17	4
Mail Vote Sent → Case Outcome	114	20	80	4	0	0	83	2
Complaint Received → Closure in Complaint Unit	99	634	54	10	81	33	66	13
Complaint Received → Closure at Field	506	114	327	5	294	22	318	12



Negligence/Incompetence

Time frame represents average days to complete process

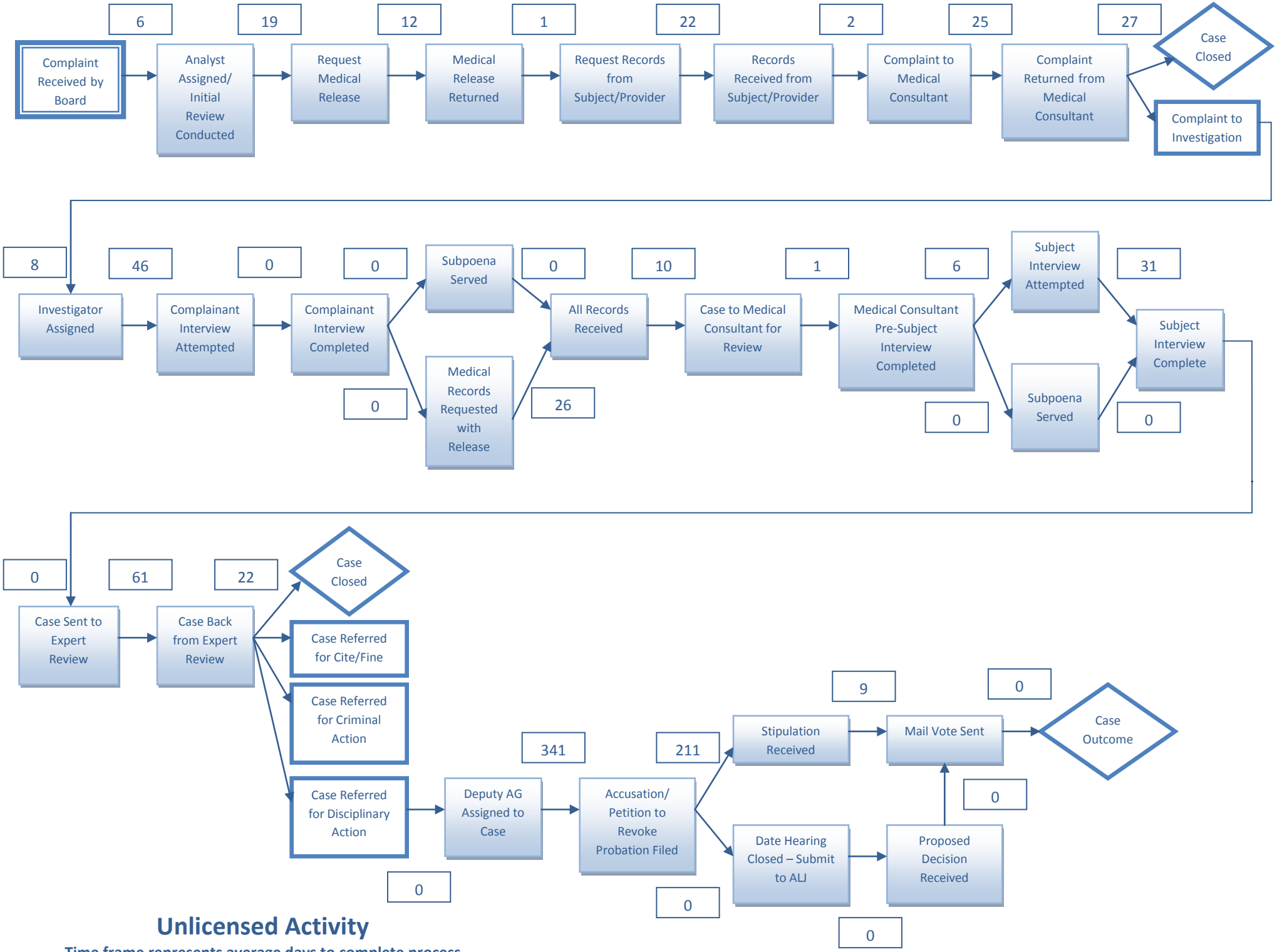
January 01, 2011 – March 31, 2011



Prescribing Violations

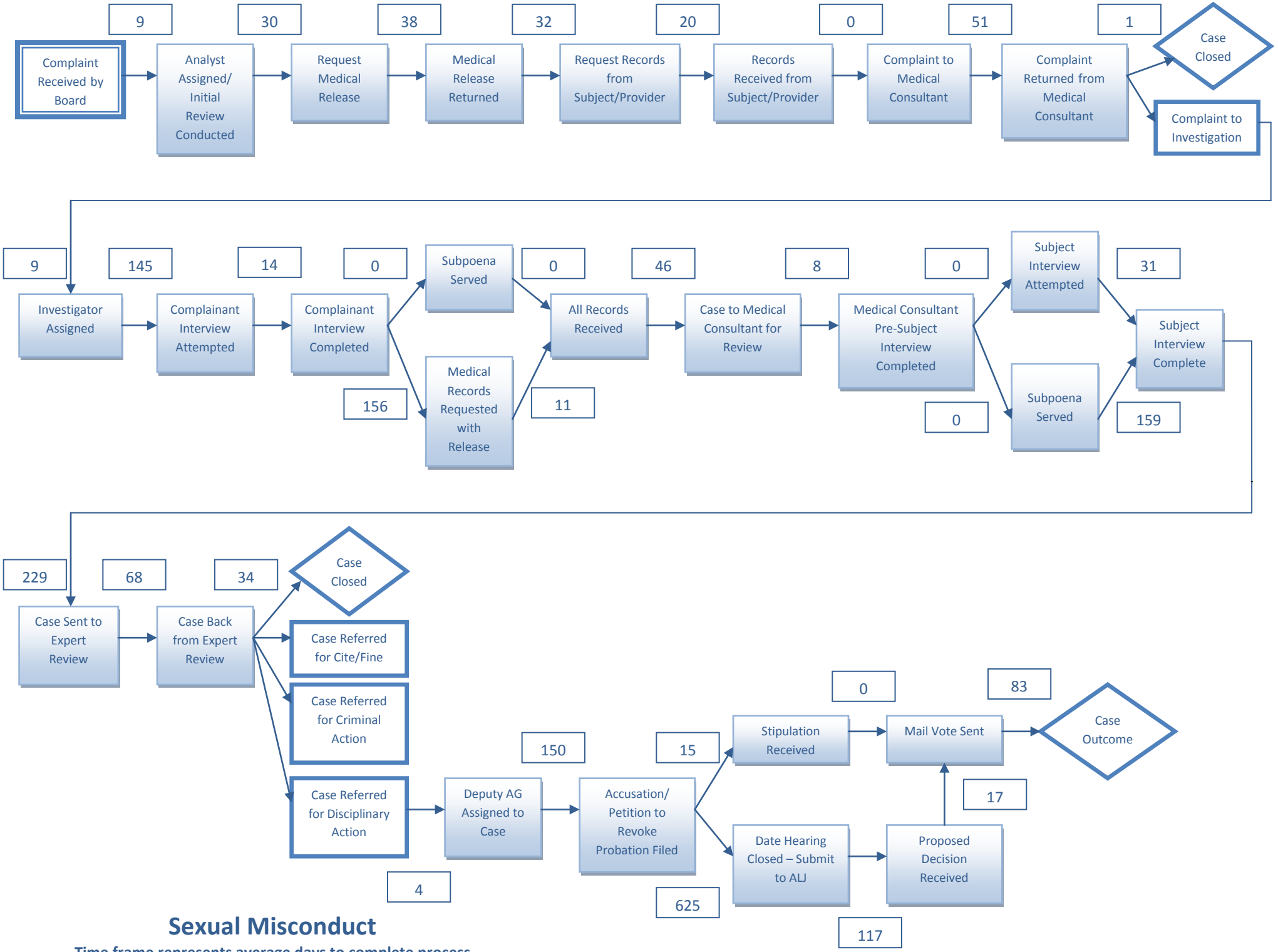
Time frame represents average days to complete process

January 01, 2011 – March 31, 2011



Unlicensed Activity

Time frame represents average days to complete process
January 01, 2011 – March 31, 2011



Sexual Misconduct

Time frame represents average days to complete process

January 01, 2011 – March 31, 2011