MEDICAL BOARD OF CALIFORNIA

ENFORCEMENT COMMITTEE
MEETING AGENDA

MEMBERS OF THE COMMITTEE
Reginald Low, M.D., Chair
Dev GnanaDev, M.D.
Sharon Levine, M.D.
Gerrie Schipske, R.N.P., J.D.

Courtyard by Marriott
Golden C
1782 Tribute Road
Sacramento, CA 95815
916-929-7900 (directions only)

Thursday, July 19, 2012
2:30 p.m. – 4:00 p.m.
(or until completion of business)

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

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

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

1. Call to Order / Roll Call

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

3. Approval of the Minutes from the May 3, 2012 Meeting

4. Discussion of Amended Accusations – Mr. Ramirez and Ms. Castro

5. Update on Expert Reviewer Training – Ms. Sweet

6. Presentation on CCU Process and Goals – Ms. Cady

7. Presentation on DCA – Risk Assessment Results – Mr. Hines

8. Update on Training for Administrative Law Judges – Dr. Low

9. Update on Reconciliation of MBC and HQES Data – Dr. Low

10. Discussion and Consideration of Enforcement Annual Report Format – Ms. Kirchmeyer

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.

11. Overview of Investigative Process After Vertical Enforcement – Ms. Threadgill

12. Update on SB 100 Implementation – Outpatient Surgery Center Requirements – Ms. Cady
    A. Adverse Event Report
    B. Complaint Timelines and Process

13. Agenda Items for the October 25-26, 2012 Meeting in the San Diego Area

14. Adjournment

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 Tim Einer at (916) 263-2389 or email tim.einer@mbc.ca.gov or send a written request to Tim Einer at the Medical Board of California, 2005 Evergreen Street, Ste. 1200, Sacramento, CA 95815. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meeting 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.

MEDICAL BOARD OF CALIFORNIA

ENFORCEMENT COMMITTEE

Doubletree by Hilton Hotel Torrance – South Bay
Salon A & B
21333 Hawthorne Blvd.
Torrance, CA 90503

May 3, 2012

MINUTES

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

Agenda Item 1 Call to Order / Roll Call
Dr. Low called the Enforcement Committee meeting to order on May 3, 2012, at 1:35 p.m. A quorum was present and notice had been sent to interested parties.

Members Present:
Janet Salomonson, M.D., Chair
Michael Bishop, M.D.
Jorge Carreon, M.D.
Hedy Chang
Silvia Diego, M.D.
Shelton Duruisseau, Ph.D.
Gerrie Schipske, R.N.P., J.D.

Staff Present:
Maksim Degtyar, Investigator
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Tim Einer, Administrative Assistant
Kurt Heppler, Staff Counsel
Teri Hunley, Business Services Manager
Kimberly Kirchmeyer, Deputy Director
Natalie Lowe, Licensing Manager
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Anthony Salgado, Licensing Manager
Jaime Sandoval, Investigator
Kevin Schunke, Outreach Manager
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation
Linda Whitney, Executive Director
Dan Wood, Public Information Officer

DRAFT

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Members of the Audience:

Sharon Allison, Kaiser LAMC
Teresa Anderson, California Academy of Physician Assistants
Hilma Balaian, Kaiser Permanente
Rebecca Bramble, AZCOM Midwestern
Genevieve Clavreul
Yvonne Choong, California Medical Association (CMA)
Zennie Coughlin, Kaiser Permanente
Conrad Del Rosario, San Francisco District Attorney's Office
Karen Ehrlich, L.M., Midwifery Advisory Council
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Jack French, Consumers Union CA Safe Patient Network
Joseph P. Furman, Furman Healthcare Law
Stan Furmanski, M.D.
Atoosa Hoisseni, AZCOM Midwestern
Marie Lord, AZCOM Midwestern
Ryan McAtee, AZCOM Midwestern
Michele Monserratt-Ramos, Consumers Union CA Safe Patient Network
Beshoy Nashed, AZCOM Midwestern
Carlos Ramirez, Senior Assistant AG, Office of the Attorney General
Loren Reed, Department of Consumer Affairs, Public Affairs Office
Robert Sachs, P.A., Chair, Physician Assistant Committee

Agenda Item 2 Public Comments on Items Not on the Agenda

Michele Monserratt-Ramos from the Consumers Union CA Safe Patient Network addressed the issue of the statute of limitations as it relates to the Board's website information. She stated that the information regarding the deadlines was confusing to patients and that this confusion resulted in complaints not being reviewed because they were considered untimely. She suggested the Board instruct its staff to work to develop improved ways to give patients better clarity about the statute of limitations timeframes.

Mike Grace, trial attorney with DOC Defenders and a certified professional in health care risk management, commented on disciplinary guidelines and the elimination of trial by ambush. Regarding the disciplinary guidelines, he had four specific suggestions that he thought would help bridge the divide between the Board and the risk management programs. 1) The Board should eliminate the over emphasis on probation under the model disciplinary guidelines. He stated that even though the model guidelines were recently modified, the five year probation for repeated acts of simple negligence and inadequate record keeping was problematic and not evidence based. He stated that the result of being on probation not only means risking loss of all malpractice coverage or having to pay a heightened premium, but also, possible loss of preferred provider contracts. Additionally, it may result in the inability under federal and state law to bill Medi-care or MediCal which can easily decimate a practice. 2) He mentioned that the focus and resources of the Enforcement Division and the Attorney General office be shifted away from single patient, simple negligence cases. Mr. Grace suggested that those first offences could routinely be treated as private letters of reprimand or the Board could impose an additional obligation on the physician to self report any patient care related complaints or claims to a lawyer. Let the failure to self report become the basis for further discipline so that repeat offenders could be captured. 3) Eliminate the routine use of gross negligence in accusations and institute instead, a plea of gross negligence only in cases that are an extreme departure from the standard of care. 4) Eliminate trial by ambush; institute a rule that would allow one deposition of

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a medical expert per side and adopt the federal system that would require a true report containing the opinions and the basis for those opinions from defense counsel.

Dr. Furmanski commented on the use of an exam called the Microcog as part of probation by the Board, lucrative deals with third party vendors to administer the Microcog exam and these vendors doing human subject research with the physicians taking the Microcog exam. Dr. Furmanski's concerns are that the third party vendors are not accredited, there are no medical questions on the Microcog test and that the doctors that have been sent there to test have not been given the right to quit without penalty.

Agenda Item 3 Approval of Minutes from the February 2, 2012 Meeting
Dr. GnanaDev made a motion to approve the minutes from the February 2, 2012 meeting; s/Schipske; motion carried

Agenda Item 4 Presentation on Enforcement Core Concepts
Mr. Heppler provided a presentation on Enforcement Core Concepts where he discussed concepts that included statutes and regulations, due process, and consumer protection. Mr. Heppler also reviewed the Board's primary functions which are to license qualified applicants, carry out disciplinary action and promulgate regulations. Mr. Heppler also pointed out that the Board does not determine civil liability or award monetary damages.

This presentation is available on the Board's website, Enforcement Committee Agenda Item #4.

Public comment was provided for this agenda item.

Dr. Furmanski stated there should be some mechanism in place so that whistleblowers will feel comfortable in coming forward with their information without having to face the very people they are lodging the complaint against.

Agenda Item 5 Update on Expert Reviewer Training
Laura Sweet stated tremendous progress on has been made on the expert reviewers' training and that to date 108 experts provided RSVPs. The session with the investigators and the medical consultants on April 17th, was extremely successful and well received. The group was able to work out some technical glitches and other problems, which will allow staff to refine and make the expert training much more successful. Ms. Sweet gave the Committee members a sample of the new training equipment, and an opportunity to use it. The Committee watched a portion of the training video that was a reenactment of an expert reviewer testifying in court. Ms. Sweet stated that the video was an actual case and that the reviewer fell into a lot of traps which shows the necessity for the training.

Agenda Item 6 Update on Training for Administrative Law Judges
Dr. Low stated that the Board was approached by Presiding Administrative Law Judge (ALJ) Jonathan Lew who identified some areas where the ALJs could use some additional training. The Board has drafted an agenda and the training session is to be held on June 22, 2012 via video conference.

Agenda Item 7 Discussion of the VEP Evaluation Report
Dr. Low said that on April 2, 2012 the Board's report to the Legislature on the Vertical Enforcement and Prosecution Model was emailed and hand delivered to the Legislature, distributed to the Board members and posted on the Board's website with email notification to

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the subscriber list. Dr. Low also stated that he reviewed and approved the report prior to distribution. The report is required by Government Code §12529.7; the report contains the actions by the Board to implement recommendations made by two reviewing entities to strengthen the Vertical Enforcement Prosecution Model. Some of the actions taken by the Board in conjunction with the Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) were (1) updating the vertical prosecution joint manual, (2) development of an eight hour training module for medical expert reviewers and (3) statewide training for the Board investigators and the HQES attorneys. The Board and the HQES had limited data and the Legislature approved the Board to provide only a narrative report at this time, and provide a full report with comprehensive data during the Board's sunset review process.

Agenda Item 8 Agenda Items for July 19-20, 2012 Meeting in the Sacramento Area

- Update on the expert reviewer training
- Update on the training for the Administrative Law Judges
- Update on the reconciliation of the statistics between the AG's Office and the Board

Public comment was provided for this agenda item.

Joseph Furman, defense attorney, made comments regarding what he referenced as trial by ambush, which is the frequent and sometimes belated amending of an accusation once a case is already in process.

Dr. Low recommended this item be placed on the next agenda for discussion.

Agenda Item 9 Adjournment

There being no further business, the meeting was adjourned at 2:31 p.m.

DRAFT

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Amended Accusations

Health Quality Enforcement Section
Attorney General's Office, Department of Justice

Administrative Procedures Act (APA): In brief

- The APA (Gov. Code §11370, *et seq.*) provides for the following:
  - A simpler and expeditious administrative hearing process.
  - Due process rights for Respondents (licensees) in the administrative process.
  - Regulation of the conduct of formal administrative hearings by Administrative Law Judges (ALJs) and parties to the matters.
  - Procedures by which the Board conducts its adjudicative proceedings.

APA: Respondents' Bill of Rights

The APA includes the following due process rights:

- Notice and Opportunity to be heard.
- Discovery rights to all non-privileged documents in Board's investigative files.
- Opportunity to present and rebut evidence.
- Adjudicative function shall be separated from the investigative, prosecutorial, and advocacy functions within the agency.
- Written decisions based on the administrative record at hearing, and including a statement of the factual and legal basis of the decision.

APA: Administrative Adjudication

- Government Code section 11500 et seq. sets forth provisions for the formal administrative hearing process utilized by the Board.
- Hearings to determine whether a license should be revoked, suspended, or conditioned are always initiated by the filing of an Accusation, which is subject to its own requirements.

APA: Accusation Definition

Government Code section 11503 defines Accusations as follows:

- An Accusation is a written statement of charges which set forth the acts or omissions with which the Respondent is charged, to the end that the Respondent will be able to prepare a defense.
- An Accusation shall specify the statutes and rules which the Respondent is alleged to have violated.

Government Code section 11507: Amended Accusation Elements

Timing : Amended Accusation may be filed at any time before the submission of the matter for Decision.

Notice and service of Amended Accusation is required

Trial Continuance: Where Amended Accusation presents new charges, Respondent must be afforded a reasonable opportunity to prepare a defense. Hearings may be postponed for good cause.

New Charges: Deemed to be controverted.

Objections to Amended Accusation: Included in record.

Amended Accusations: Timing

Pre-Hearing

In practice, amendments to accusations are made and served at any time during the course of the case as soon as new investigations are completed and accepted for prosecution.

Once the Pre-Hearing Conference is held 6 weeks prior to hearing, ALJs control whether and when an Accusation may be amended, filed, and served by setting deadlines.

Amended Accusations: Timing

During Hearing

Rarely, amendments to accusations regarding new charges occur during the hearing.

This is usually the result of new evidence --not disclosed in prehearing discovery due to any number of valid reasons-- being admitted at hearing.

Amended Accusations: Statistics

Fiscal Year 2009/2010

Out of 190 Accusations filed, 29 later resulted in a First Amended Accusation being filed (15.2%). To date, of those 29 cases, 6 resulted in the filing of a Second Amended Accusation, and 1 resulted in the filing of a Third Amended Accusation. 8 of the 29 amended cases are still pending.

Reasons for these amendments include:

- 10 cases were amended well in advance of hearing date to add completed vertical enforcement investigations to an existing Accusation.
- 3 cases were amended after the first day of hearing to add causes for discipline following cross-examination of a Board witness, Respondent or Respondent's witness.

Amended Accusations: Statistics

Fiscal Year 2010/2011

Out of 226 Accusations filed, 25 later resulted in a First Amended Accusation being filed (11%). To date, of those 25 cases, 2 have resulted in the filing of a Second Amended Accusation, and none have resulted in Third Amended Accusations. 11 of the 25 amended cases are still pending.

Reasons for these amendments include:

- 11 cases were amended well in advance of hearing date to add completed vertical enforcement investigations to an existing Accusation.
- 1 case was amended to address an issue required for the execution of a Stipulated Surrender.
- 1 case was amended after the first day of hearing to conform the pleading to the testimony of a Board expert witness.

Conforming to Proof: Example 1

Accusations are amended to conform to proof before the submission of the case (hearing completion) when the cumulative admitted evidence, presented by the Board and Respondent via live testimony of witnesses and/or other evidence, no longer supports a viable cause for discipline in the existing Accusation.

Accusation is amended to strike out causes for discipline that no longer meet the Board's burden to prove a disciplinable violation with "clear and convincing evidence to a reasonable certainty."

(*Ettinger v. Bd. of Medical Quality Assurance (1982) 135 Cal. App. 3d 853.)*

Conforming to Proof: Example 2

Accusations are amended to conform to proof before the submission of the case (hearing completion) when the cumulative admitted evidence, presented by the Board and Respondent via live testimony of witnesses and/or other evidence, supports an additional cause for discipline to be added to the existing Accusation. The filing of new charges support the granting of a hearing continuance.

Accusation is amended to include causes for discipline that meet the Board's burden to prove a disciplinable violation with "clear and convincing evidence to a reasonable certainty." (*Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal. App. 3d 853.)*

Effects of Additions of Causes for Discipline for New Charges

- Continuances Requested/Granted: Requests for Continuance of Hearing filed by either the Board, the Respondent or both are made and granted, thereby, bifurcating the hearing.
- Time to Defend: Continuances allow Respondents to adequately defend against the new causes for discipline.
- Settlement Options: Stipulated settlement or surrender may be obtained in the interim.
- Avoids Additional Accusations: All issues are sought to be resolved in one Accusation via amendment, rather than filing of a separate Accusation against Respondent. This prevents the delay of the resolution of the case.

Reasons Why Amendments at Hearing May Occur

- Government Code section 11507.6 sets forth the exclusive method of discovery.
  - APA does not allow for the taking of depositions or other forms of discovery, such as interrogatories.
  - As a result, some evidence might not be disclosed until the hearing.
  - In keeping with its intent for simpler and more expeditious administrative resolutions, discovery obligations are limited under the APA.

Reasons Why Amendments at Hearing May Occur

- Experts: Board produces the written expert reports obtained in every case to Respondents in discovery. Typically, Respondents do not obtain defense expert opinion reports, and they are not required to obtain them.

- Expert Designations: Board relies on Business and Professions Code section 2334 for expert designation information regarding defense experts. A brief and concise statement about defense expert testimony is required. However, hearing testimony is much more detailed, and sometimes reveals new issues in the case.

Reasons Why Amendments at Hearing May Occur

- Evidence Admission: ALJs may allow admission of newly acquired evidence at hearing on showing of good cause. New evidence may affect pending Accusation.

- Respondent Testimony: Respondent's hearing testimony, including on cross-examination, may bring new issues to light not previously known in the investigatory phase of the case.

- Expert Testimony: Testimony of Board and defense experts, including on cross-examination, may support new charges not previously known in the investigatory phase of the case.

Conclusions

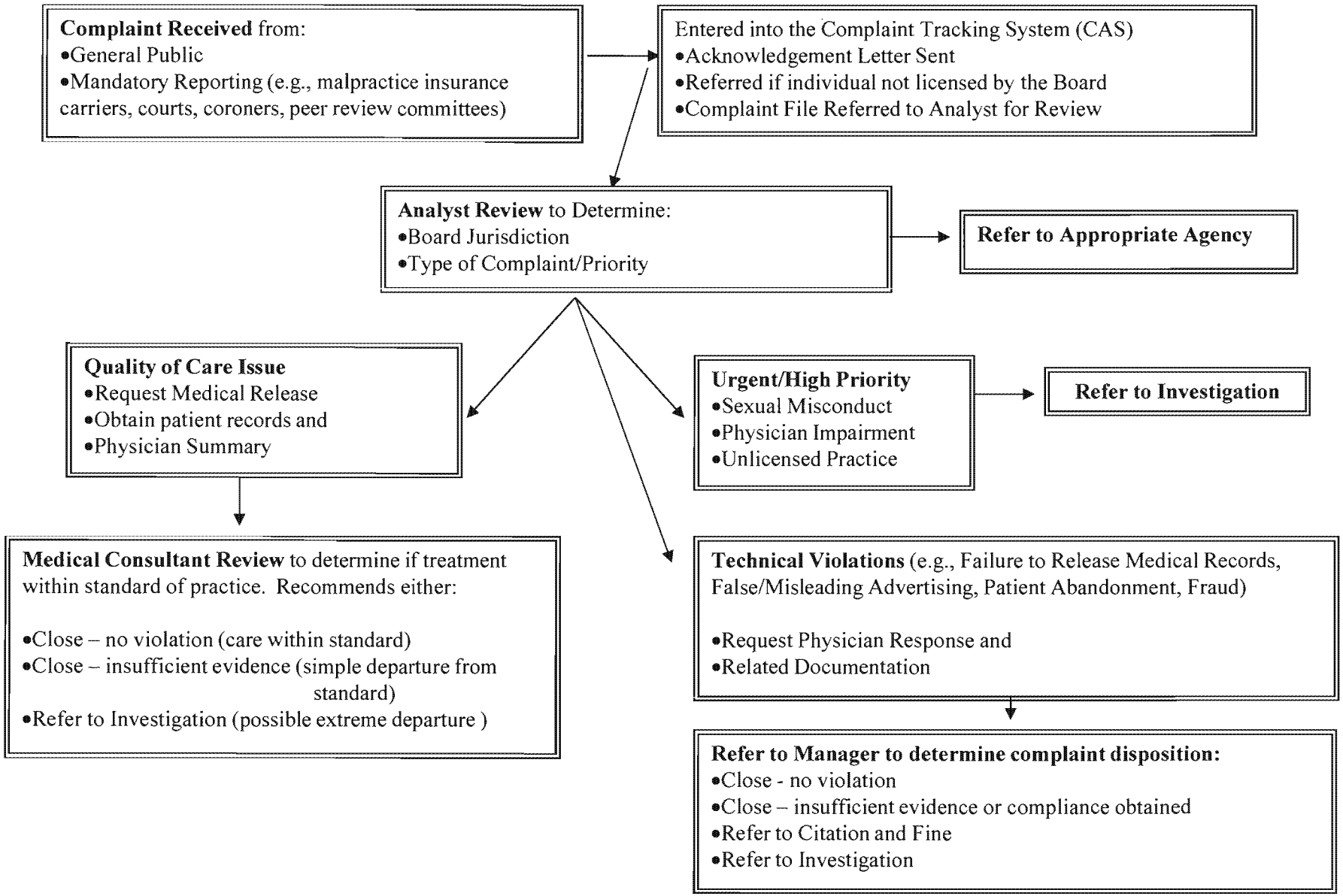
- Due process permits continuances to allow Respondents to adequately defend against new charges.
- Amendments to Accusations prevent the filing of multiple Accusations and multiple hearings against Respondent, allowing for more efficient resolution of matters.
- Amendments to Accusations pare down or add charges where justice requires it.

CENTRAL COMPLAINT UNIT

MEDICAL BOARD OF CALIFORNIA

AGENDA ITEM 6

COMPLAINT REVIEW PROCESS

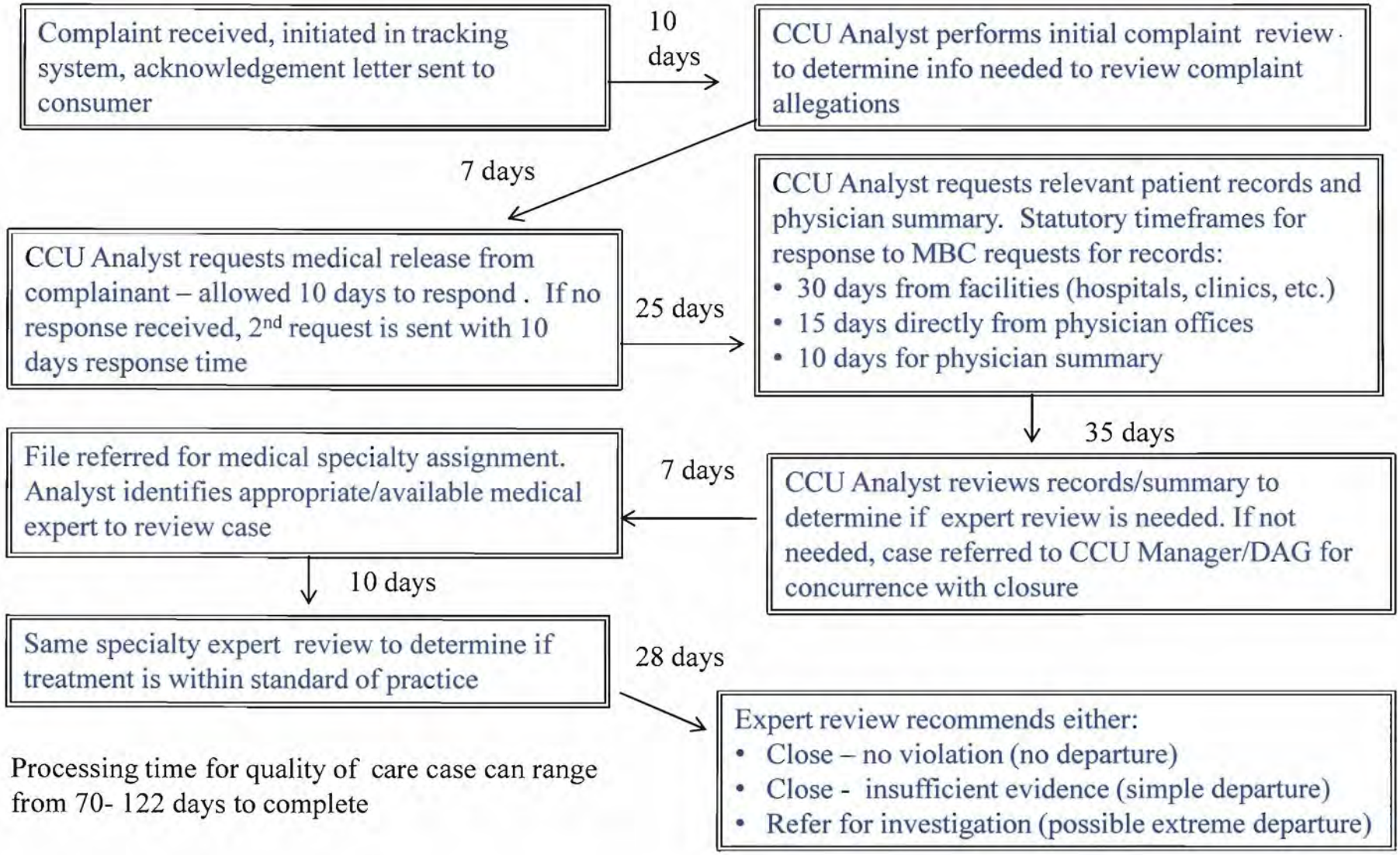


Strategic Plan Objective 5.2:	Reduce disciplinary timelines, complaint processing and investigations by 10-20%; Complaint processing averaging under 70 days with 50-60% under 50 days.

Average Days to Process a Complaint in CCU

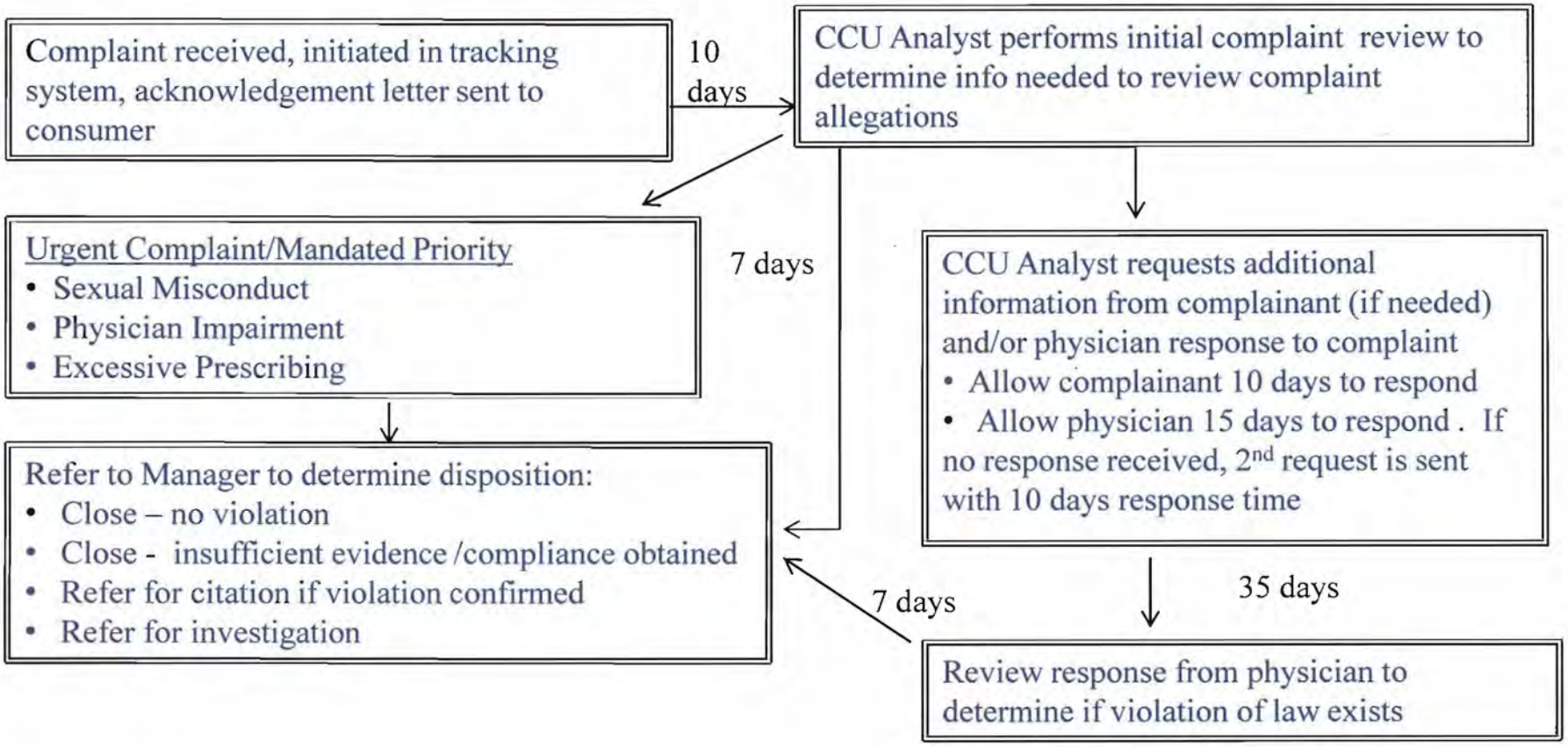
Month	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
July	57	73	79	73	71
August	54	76	78	69	77
September	54	75	76	71	79
October	54	75	76	70	79
November	55	76	75	72	82
December	55	75	76	73	83
January	57	75	76	74	83
February	58	76	76	72	84
March	59	76	76	73	85
April	60	75	76	73	84
May	62	75	75	72	84
June	61	75	75	74	83

Quality of Care Complaint Processing Time



Processing time for quality of care case can range from 70- 122 days to complete

Physician Conduct Complaint Processing Time



Processing time for a physician conduct case can range from 17 - 59 days to complete

GOALS FOR IMPROVING CASE AGING

- Reduce the time required for complaint initiation from 10 days to 5 days
- Reduce length of time required for medical consultant review on quality of care cases
- Continue specialized training for consumer services analysts to improve efficiency and effectiveness in managing complaint caseloads

A Risk Analysis:

A presentation of potential auditable risks identified in the Medical Board's Central Complaint Unit.

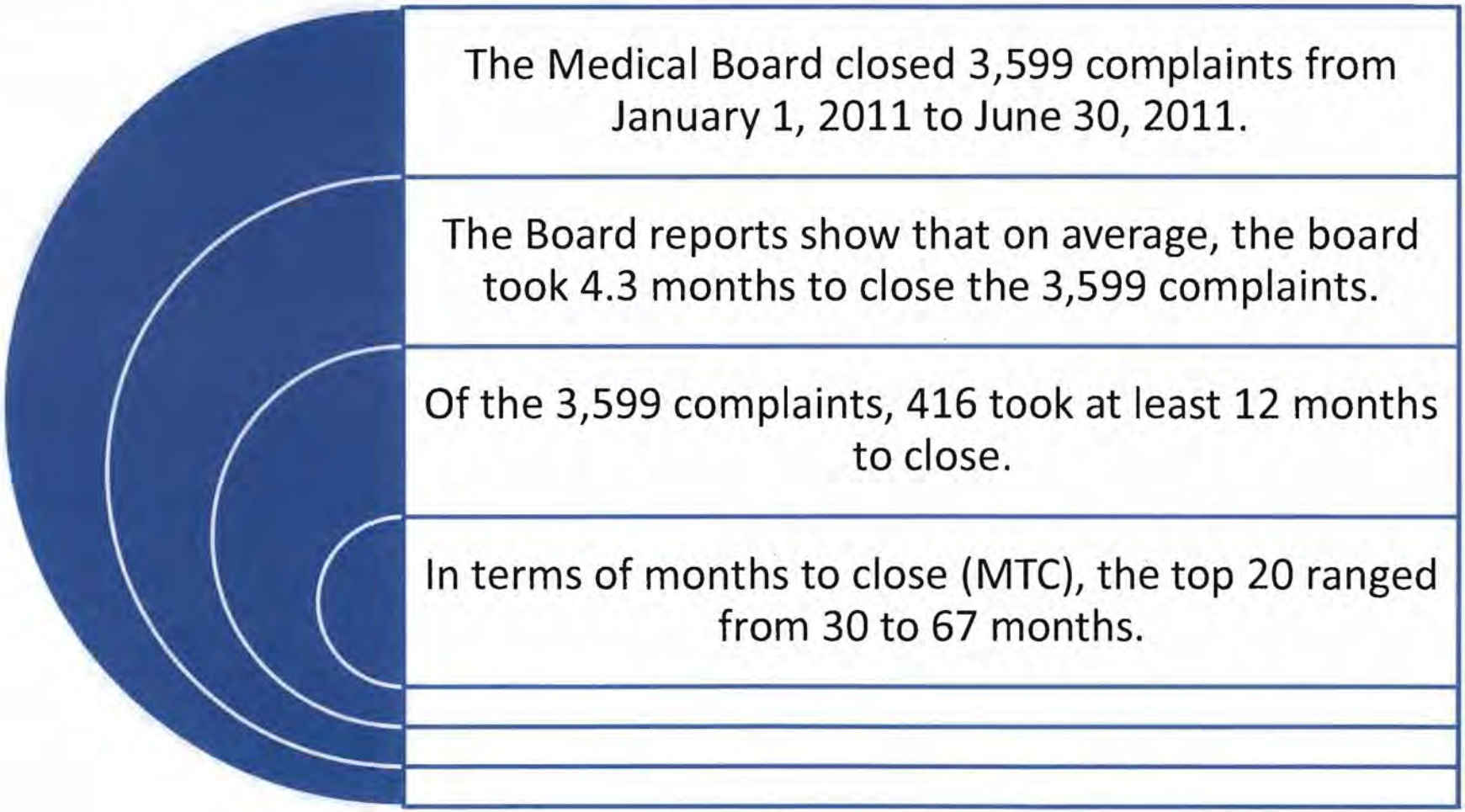
DCA Goals for High Risk Enforcement Programs:

Are the programs prioritizing and processing complaints in an efficient and effective manner?

Given existing resources, where can high risk enforcement programs improve their processes and procedures to better protect the public.

Medical Board Complaint Analysis:

(Elapsed time to conduct the entire investigation)



416 By Priority Code

(Elapsed time to conduct the entire investigation)

Priority Code	Number of Cases	Average MTC:
U3	24	24.5
H	91	19.3
U	129	19.3
U1	134	18.9
R	24	17.9
U4	14	16.3
U and U1 represent 63 percent of the 416 total.		

- **U1 – Highest Priority** (Negligence alleging death or serious bodily injury to the patient.
- U3 – Excessive prescribing or repeated acts of prescribing without a "good faith" exam.
- U4 – Sexual misconduct with one or more patients during the course of treatment or exam.
- U "Urgent" – Under-treatment of pain, allegations of physician mental or physical illness, diversion program dropouts, felony convictions and self-use of drugs/alcohol.
- H "High" – Conviction of a crime other than a felony, prescribing without a "good faith" exam, investigations/complaints not involving patient injury, etc.
- R "Routine" – False/misleading advertising, failure to release medical records, patient abandonment, fraud, etc.

Overall Medical Board Complaint Processing Results

The CCU + Field investigation average of 4.3 months compares favorably to other DCA board/bureaus we have reviewed.

However, 416/3599 (12%) took a year or longer to process.

An audit scope would include steps and procedures to ascertain the cause for the delay and provide recommendations to reduce the delay.

CCU Specialty Reviewer Process

During 2003, the CCU began implementing a new Specialty Reviewer process (SB 1950).

SB 1950 requires that before any quality of care complaint is referred for field investigation, it must be reviewed by a "medical expert".

In 2008/09, only 348/1927 (18 percent) were referred for a field investigation.

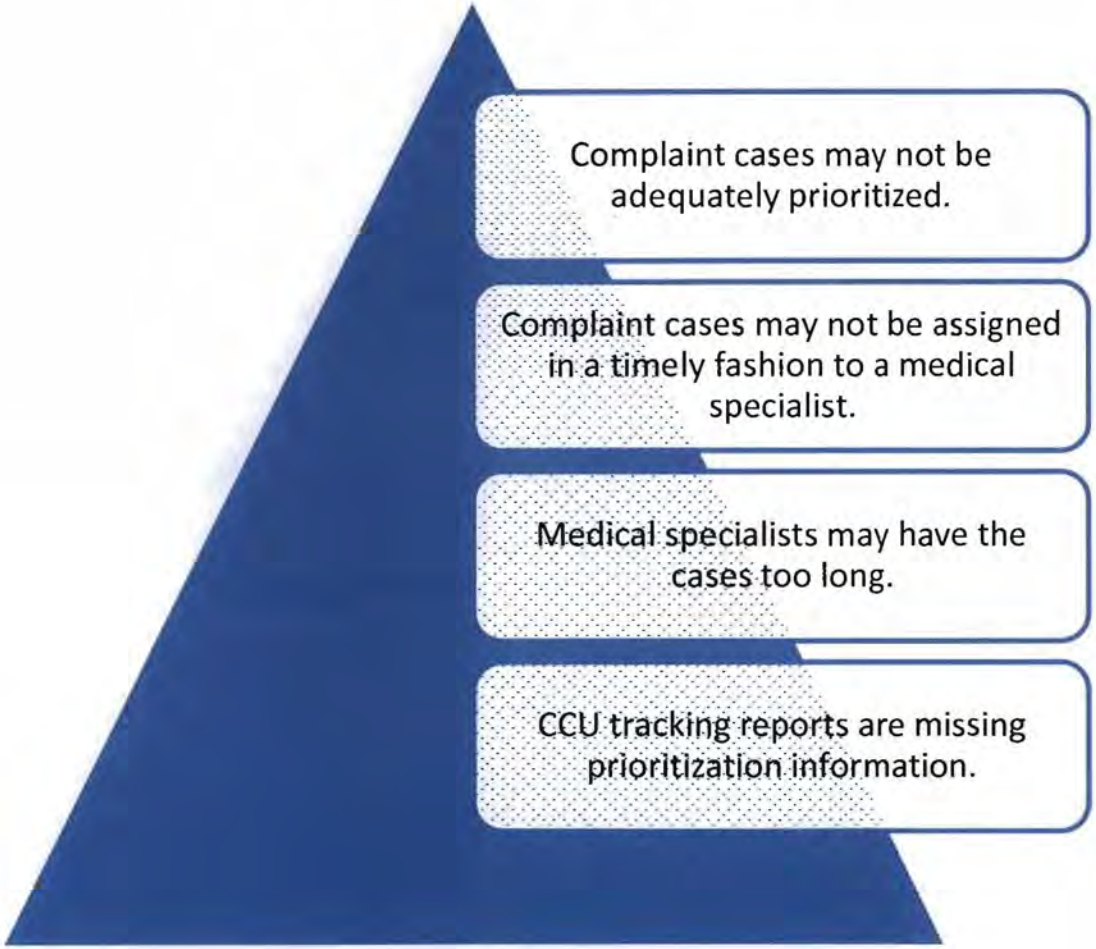
The CCU Bottleneck:

- The specialty review process requires a medical specialist to review a complaint prior to the CCU referring the case for investigation.
- During 2008/09, the CCU sent 1,927 cases to medical specialists for review.
- Of the 1,927, only 348 (18%) were referred to investigation or prosecution.
- Of the 348, 48 (14%) took longer than six months for the medical specialist review.
- Although the data used for the above analysis is a few years old, overall complaint statistics between fiscal years 2008-09 and 2010-11 compare favorably.

FY 2008/09
vs.
FY 2010/11

	Overall Average Days to Complete ALL Cases		Average Days to Complete Complaint in CCU		Average Days to Complete Case Review by MC	
	FY 08/09	**FY 10/11**	**FY 08/09**	**FY 10/11**	**FY 08/09**	**FY 10/11**
July	139	142	73	73	51	53
August	134	130	76	69	48	55
September	131	128	75	71	46	56
October	131	133	75	70	49	55
November	128	132	76	72	49	54
December	128	132	75	73	49	52
January	128	134	75	74	49	51
February	128	134	76	72	49	50
March	131	135	76	73	49	49
April	132	135	75	73	49	48
May	133	135	75	72	49	47
June	135	136	75	74	48	46
Average	**132**	**134**	**75**	**72**	**49**	**51**

The CCU Bottleneck: Areas of Risk/Concern



Complaint cases may not be adequately prioritized.

- While the CCU uses five high priority urgent codes (U1 – U5), only one type (U1) of quality of care complaint is tagged as high priority while waiting for medical specialist review assignment. Only folders with the most urgent quality of care cases waiting for a medical specialist review receive a priority red tag. (U1 only)
- According to the CCU, other high priority/urgent complaint cases (U3 for example) may not be tagged. As a result, urgent cases may be waiting with non-urgent cases for medical specialist review assignment and not receive prioritized handling.
- Examples of urgent quality of care complaints that are not U1:
  - Excessive prescribing (U3)
  - Sexual misconduct (U4)
- The CCU may want to flag all urgent cases awaiting a medical specialist assignment to ensure all urgent complaints receive prioritized handling over non-urgent cases.

Complaint cases may not be assigned in a timely fashion to a medical specialist.

- According to CCU data from 2008/09 showing the average days to assign a case to a medical specialist, some take more than 60 days.
- In many of the cases where the specialty review process takes more than 60 days to complete, the majority of the time the case sits on the CCU shelf longer than the medical specialist takes to review it. (Newer data from the current fiscal year shows cases may be spending less time waiting on the CCU shelf.)
- With a better prioritization system, the CCU may be able to get higher priority cases out to medical specialists in less time.
- The CCU should also explore whether the number of medical specialists are sufficient and recruit if necessary.

Medical specialists may have the cases too long

- CCU data reveals the process takes between 14 – 45 days.
- The CCU Overdue Cases report identifies cases that are 15 days overdue after a medical consultant had the case for the 30 days allowed by the reporting system. The CCU begins to track overdue cases after they have been with the consultant for at least 45 days. (30+15)
- The CCU may want to revise medical specialist contracts or follow-up more frequently to try and reduce the medical specialist delay.

CCU tracking reports are missing prioritization information.

- The CCU prints an overdue report to monitor all cases that are waiting a medical specialist assignment.
- The report lists all urgent/non-urgent cases in date order.
- The report does not show the urgency level of outstanding cases. As a result, non-urgent cases may be getting assigned ahead of more urgent cases.

MEDICAL BOARD OF CALIFORNIA
Executive Office

AGENDA
Office of Administrative Hearings Training
Friday, June 22, 2012
9:00 am - 5:00 pm

Time	Subject	Presenter Location
9:00 - 9:15	Welcome/ Agenda Review/Introductions Ms. Linda Cabatic, Director Office of Administrative Hearings Ms. Linda Whitney, Executive Director Medical Board Mr. Jonathan Lew, Administrative Law Judge	Sacramento
9:15 - 10:45 (60 minute talk 30 min. Q&A)	Pain Management/Appropriate Medication Standards Dr. Scott Fishman (Book ordered)	Sacramento
10:45 - 11:00	Break	All sites
11:00 – 12:30 (60 minute talk 30 min. Q&A)	Pain Management/Appropriate Medication Standards Chronic Pain Issues - diagnosis/Treatment (fibromyalgia and chronic fatigue syndrome) Dr. Eric Grigsby	Sacramento
12:30 - 1:30	Lunch	All sites
1:30 – 2:30 (30 minute talk 30 min. Q&A)	Changing Face of Medicine, New Developments in Medicine/Integrated Medicine, Managed Care versus 10 years ago. Who is the Hospitalist and how do all the Pieces fit together? Dr. Reginald Low	Sacramento
2:30 – 2:45	Break	All sites
2:45 - 3:45 (30 minute talk 30 min Q&A)	Medical Record Keeping - Electronic Medical Records what it provides, looks like, what it includes Dr. Eric Dilda	Oakland
3:45 – 4:45 (30 minute talk 30 min. Q&A)	Orthopedics - New Robotics v Old Style surgery Anatomy of the Back, when to have surgery and not Dr. Munish Gupta	Sacramento
4:45 - 5:00	Wrap up and next training opportunities	

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 9, 2012
ATTENTION:	Members, Enforcement Committee
SUBJECT:	Review Enforcement Program Annual Report Format
STAFF CONTACT:	Kimberly Kirchmeyer, Deputy Director

RECOMMENDED ACTION:

On May 2, 2012 Ms. Barbara Yaroslavsky, Board President, requested that staff provide information relative to the Enforcement Program statistical reporting format for the Annual Report.

BACKGROUND AND ANALYSIS:

Under Section 312 of the Business and Professions (B&P) Code, the Board is required to compile statistical data related to the performance of the Board's mandated functions and responsibilities. This information is reported to the Department of Consumer Affairs, the Governor's Office, the Legislature, and the general public through issuance of the Annual Report. This report is issued annually in October, following completion of the Board's fiscal year of July 1 through June 30. Additionally, Section 2313 of the B&P Code require information specific to the reporting required for the Medical Board of California. This section has been amended through the years to require additional enforcement information.

The attached excerpts from selected Annual Reports represent a sampling of twenty years of statistical data reporting regarding Enforcement. The Annual reports have improved throughout this period of time with the inclusion of new enforcement categories, new required reporting data, and a more easily readable format with clearly defined tables with brief descriptive information.

At the May meeting of the Board, staff presented the data from the 2010-2011 Enforcement Processing Time Frames (attached page vi of the 2010-2011 Annual Report) and discussed adding rows under each of the four processes to convert days to years as a secondary method of examining the time frames. This concept will be incorporated into the 2011-2012 Annual Report.

Attachments:

1. 1992-1993 Enforcement Program Annual Report
2. 1996-1997 Enforcement Program Annual Report
3. 2006-2007 Enforcement Program Annual Report
4. 2010-2011 Enforcement Program Annual Report

RECOMMENDATION:

Staff asks that the Members make suggestions to enhance or improve this report.

Attachment 1

FY 1992/1993

Enforcement Program

The Medical Board's enforcement program made tremendous strides in the '92/93 FY to increase its performance, productivity and ensure public protection.

Most notable is the exponential increase in Interim Suspension and Temporary Restraining Orders actually issued or granted by the court over the prior year. ISOs and TROs are used for the most egregious cases. The increase is due in large measure to aggressive Medical Board investigations and to the fine efforts of the Attorney General's Health Quality Enforcement Unit.

Complaints Received

		Contractual	Fraud	Health & Safety	Non-Jurisdictional	Competence/ Negligence	Other Category	Personal Conduct	Unprofessional Conduct	Unlicensed/ Unregistered	Total
Public	MD	2	270	128	504	1,499	11	43	1,915	146	4,518
	AH	0	137	3	57	177	2	13	543	114	1,046
B&P Code Section 800	MD	1	5	4	1	807	2	15	56	0	891
	AH	0	0	0	0	19	1	1	0	0	21
Other Licensee	MD	0	22	43	25	76	5	18	103	31	323
	AH	0	18	1	11	19	1	4	250	78	382
Internal (Based on Internal Information)	MD	0	24	23	0	45	0	13	33	39	177
	AH	0	3	1	0	8	0	6	67	63	148
Anonymous	MD	0	21	19	7	30	2	16	57	41	193
	AH	0	13	1	0	1	0	3	73	31	122
Law Enforcement Agency	MD	0	8	17	4	12	0	47	40	16	144
	AH	0	2	2	0	0	1	47	35	2	89
Other California State Agency	MD	0	10	9	3	16	3	15	30	21	107
	AH	0	1	2	0	5	0	19	8	13	48
Other State	MD	0	1	0	0	2	0	0	170	2	175
	AH	0	0	0	0	1	0	1	9	0	11
Society or Trade Organization	MD	0	5	4	3	6	1	1	35	11	66
	AH	0	1	0	0	3	0	0	6	4	14
Other Government Agency	MD	0	6	8	8	16	1	2	24	10	75
	AH	0	1	0	0	1	0	0	7	1	10
Other Unit of Consumer Affairs	MD	0	1	8	1	2	0	3	9	8	32
	AH	0	6	3	0	10	1	7	8	18	53
Federal Government	MD	0	3	2	1	6	0	1	2	2	17
	AH	0	0	0	0	2	0	0	0	1	3
Miscellaneous Sources	MD	0	1	0	0	7	1	1	0	2	12
	AH	0	1	0	0	2	0	2	2	2	7
Totals	MD	3	377	265	557	2,524	26	175	2,474	329	6,730
	AH	0	183	13	68	247	6	103	1,008	327	1,955
											*8,685

* These totals do not include 72 cases which resulted from background checks on applications for licenses; 19 MD, 53 AH. Those cases are included in line one of the Action Summary table on Page v.

Key: MD = Medical Doctor; AH = Allied Health Professionals

The volume of complaints received by the Board continues to increase and reached an all-time high. Despite the increase, the Board's Central Complaint Unit has processed an increasing volume of complaints, while ensuring that only those cases which truly merit more costly and intensive field investigation are assigned to field investigators.

It is important to note the '92/93 FY increase in criminal cases filed for criminal prosecution, which is significantly greater than the '91/92 FY.

There is also a difference between the '91/92 FY cases opened and closed and the '92/93 FY cases opened and closed. The current year appears less than the prior year. The accuracy of the '91/92 FY figure is questionable partially due to limitations in the Board's tracking system at the time; however, the '92/93 FY figure was accurately computer generated and is well within a reasonable range.

Medical Board of California
Officers-1993
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Bruce Hasenkamp, Vice President
Robert del Junco, M.D., Secretary

Division of Allied Health Professions
Madison Richardson, M.D., *President
Mike Mirahmadi, M.D., Vice President
Stewart Hsieh
Barbara Stemple
Jacquelin Trestrail, M.D.

Division of Licensing
Ray Mallel, M.D., President
C. Fredrick Milke, M.D., Vice President
Robert del Junco, M.D., Secretary
Bruce Hasenkamp
John C. Lungren, M.D.*
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Clarence S. Avery, M.D.
Lawrence D. Dorr, M.D.
Karen McElliott
Gayle W. Nathanson

*Term expired July 31,1993

Executive Director, Dixon Arnett

Reports Required by Law

Medical Malpractice	FY 91/92	FY 92/93
Insurers - Section 801		
Physician & Surgeon	630	634
Health Maintenance Organizations	13	6
Podiatrists	18	7
Psychologists		1
Physician Assistants		1
Subtotal	661	649
Attorneys or Self-Reported Section 802		
Physician & Surgeon	87	87
Health Maintenance Organizations	74	90
Podiatrists		1
Subtotal	161	178
Courts - Section 803		
Physician & Surgeon	9	11
Health Maintenance Organizations	2	2
Psychologists		2
Subtotal	11	15
Total Malpractice Reports	**833**	**842**
Health Facility Discipline		
Incomplete Medical Records - Section 805		
Physician & Surgeon	1,007	839
Podiatrists	1	1
Psychologists	4	4
Subtotal	1,012	844
Medical Cause or Reason - Section 805.5		
Physician & Surgeon	178	175
Podiatrists	1	1
Psychologists	4	3
Subtotal	183	179
Total Health Facility	**1,195**	**1,023**

For additional copies of this report, please fax your company name, address, telephone number and contact person to: Jennifer Bawden, Medical Board Support Services Unit, at (916) 263-2479, or mail your request to her at 1426 Howe Avenue, Suite 54, Sacramento, CA 95825.

Action Summary

	FY 91/92			FY 92/93		
	MD	AH	ALL	MD	AH	ALL
Complaints/Investigations						
Complaints Received	6,050	1,842	7,892	6,749	2,008	8,757
Complaints Closed by CCICU			4,908	3,878	1,060	4,938
Investigations						
Cases Opened	3,569	1,227	4,796	2,208	810	3,018
Cases Closed [1]	1,879	651	2,530	1,665	607	2,272
Cases to AG	347	176	523	433	221	654
Cases to DAs/CAs	60	34	94	99	25	124

[1] Investigation cases closed in '92/93 are fewer than in '91/92 due to budget induced vacancies and improved Central Complaints Unit case screening.

Administrative Filings						
Interim Suspensions	6	0	6	15	7	22
Temporary Restraining Orders [2]	25	2	27	10	1	11
Statement of issues to deny application	2	25	27	6	38	44
Petition to Compel Psychiatric Exam	8	1	9	9	4	13
Petition to Compel Competency Exam	4	0	4	17	0	17
Accusation/Petition to Revoke Probation	159	78	237	310	166	476
Total Filings	**202**	**106**	**308**	**367**	**216**	**583**

[2] '91/92 TRO figures include TROs sought; '92/93 figures show only TROs actually issued or granted by courts.

Administrative Actions						
Revocation	49	41	90	41	52	93
Voluntary Surrender (in lieu of discipline)	28	4	32	30	7	37
Probation/Suspension	24	13	37	25	6	31
Probation	41	23	64	36	34	70
Probationary License Issued	6	11	17	4	9	13
Other Actions (e.g., public reprimand)	14	2	16	13	4	17
Total Decisions	**162**	**94**	**256**	**149**	**112**	**261**
Review and Referrals						
Physicians Called in for Medical Review	269	0	269	169	10	179
Physicians Referred to Diversion Program	13	0	13	29	0	29
Total Reviews & Referrals	282			198	10	208
Total Actions	**432**	**72**	**504**	**347**	**122**	**469**
Other Administrative Outcomes						
Accusation Withdrawn	9	2	11	9	4	13
Accusation Dismissed	5	3	8	18	4	22
Petitions for Penalty Relief	18	5	23	21	10	31
SOI* Granted (Lic. Denied)				2	13	15
SOI Denied (Lic. Granted)				0	3	3
Totals				**50**	**34**	**84**

*Statement of Issues

Senate Bill 2375 Special Data Elements

Senate Bill 2375 (Presley) requires the Medical Board to report the following data in annual reports subsequent to the 1991/92 fiscal year. The following information is for fiscal year beginning 1992/93.

1. Temporary Restraining Orders Board Sought of the Attorney General: 53

Cases for which TROs were granted:	
Gross Negligence	3
Self Abuse of Drugs or Alcohol	2
Sexual Misconduct	4
Inappropriate Prescribing/ Treatment	2
Total	11

Cause for which TROs were sought, but not granted:	
Mental Illness	4
Sexual Misconduct	17
Excessive Prescribing	3
Self Abuse of Drugs or Alcohol	6
Fraud/Dishonesty	7
Gross Negligence/Incompetence	3
General Unprofessional Conduct	1
Aiding Unlicensed Practice	1
Totals	42

2. Number and type of action taken relating to prescribing narcotics or other controlled substances:

	Inappropriate Prescribing or Treatment		Self abuse of drugs or alcohol	
Penalty imposed	P/S	AHC	P/S	AHC
License revocation	6	0	3	4
Voluntary surrender	1	0	2	0
Probation w/ suspension	5	0	2	0
Probation only	5	2	4	1
Probationary new license	0	0	0	0
Other discipline	0	0	0	0
Totals	**17**	**2**	**11**	**5**

3. The number and type of action taken which resulted from cases referred* by the state Department of Health Services pursuant to Section 14124 of the Welfare and Institutions Code, relating to suspension of provider status for state medical assistance:

Physicians	48
Allied Health Professions	7
Total	55

*In all instances, the original referral came from the Board to the Department, following action by the Board. There were no referrals pursuant to Section 14124 which preceded board action against the practitioner.

4. Consumer inquiries and complaints:

Consumer inquiries	70,353
Jurisdictional inquiries	39,830
Complaint forms sent	11,426
Complaint forms returned by consumers	4,360

5. Number of reports submitted pursuant to Sections 800-805 of the Business and Professions Code: 1,023

6. Number of reports from coroners against physicians and allied health professionals:

Physicians and Surgeons	22
Allied Health licensees	0
Total	22

7. Total number of complaints referred from other agencies, by agency: 745 Total (See page iv for breakdown.)

8. Number of complaints or referrals closed, refunded or resolved without discipline prior to accusations:

	MD	AH	Total
Complaints received	6,749	2,008	8,757
Referred to other agency	782	90	872
Referred/Resolved w/out discipline	5,543	1,667	7,210
Referred to AG	433	221	654
Referred to DA	99	25	124

9. Number of accusations filed: 476

10. Number of final dispositions: 149

Physician Discipline by Category—Final Administrative Adjudication

Negligence	57
Excessive/Inappropriate drug prescribing	16
Sexual Misconduct	18
Mental Illness	2
Self-use drugs/alcohol	10
Fraud	3
Conviction of crime	4
Unprofessional conduct	7
*Other	32
Total	149

*Most of these are out-of-state discipline.

11. Number of completed investigations at the Attorney General's Office awaiting the filing of formal charges: 388
This statistic was obtained by the Office of the Attorney General, Health Quality Enforcement Division.

12. Average and median time in processing complaints, for all cases, from date of original receipt of the complaint, for each stage of discipline, through completion of judicial review:

Processing/Legal stages	Mean Average (in days)	Mean Average (in days)
Complaint receipt, preliminary assessment by Central Complaint Unit and referral for investigation.	104	76
Investigation to case closure or referral for legal action	90	72
Attorney General processing to preparation of an accusation	282	198
Other stages of the legal process	*	*

*Not available. Outside of the control of the Medical Board and the Attorney General.

13. Data on Diversion Program:

Number of participants beginning of fiscal year	259
Number of participants accepted into program	58
Successful terminations	66
Unsuccessful terminations	27
Active participants at end of year	212

14. Number of interim suspensions: 23

15. Number of probation violation reports sent to Attorney General: 23

16. Number of probation revocation filings:

Physicians and Surgeons	15
Allied Health	8
Total	23

17. Investigator caseloads as of June 30, 1992:

Active Cases	2,175
Cases per investigator	35
Probation Cases (active*)	344
Cases per investigator	57

*117 additional probation cases were inactive because licensee is out of state; Probation Unit supervisor tracks these cases.

18. Number of final dispositions of probation violation cases:

	Filed	Additional Probation	Probation Revoked	Revocation Denied
Physician	8	2	3	1
Allied Health	6	0	7	0
Total	14	2	10	1

Note: Some cases filed are not finalized within the same fiscal year.

19. Number of petitions for reinstatement of license:

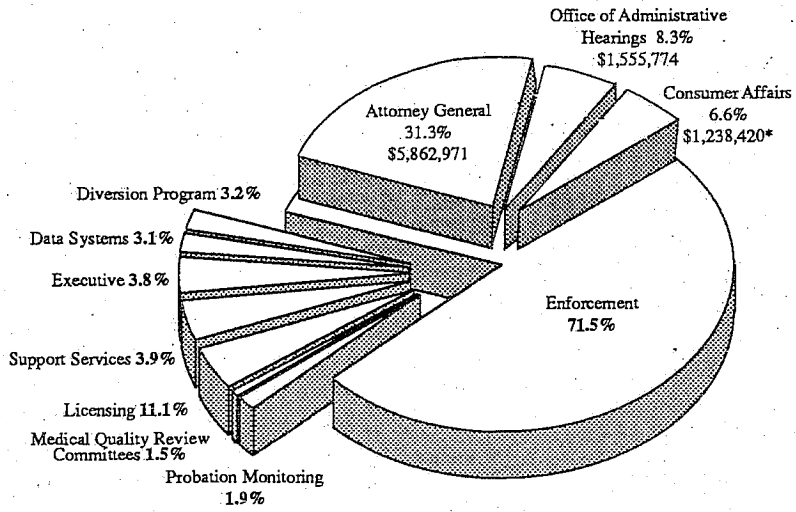
	Granted	Denied
Physician	12	9
Allied Health	2	8
Total	14	17

MEDICAL BOARD OF CALIFORNIA
1992-1993 FISCAL YEAR BUDGET

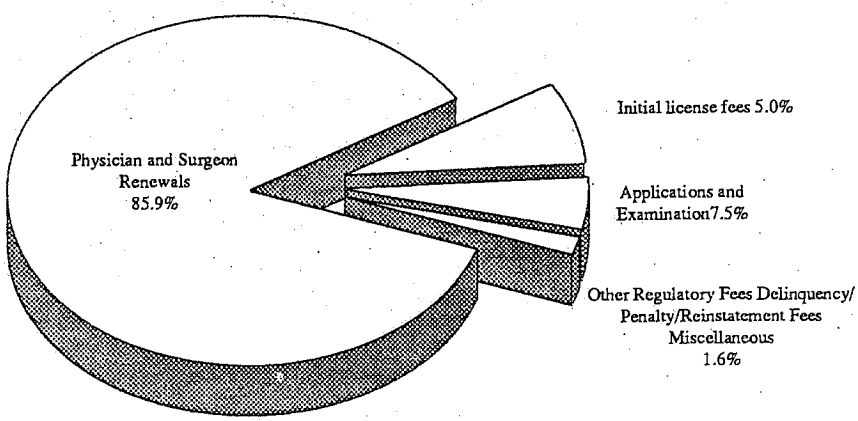
Enforcement	71.5%	$18,736,000
Licensing	11.1%	2,913,000
Support Services	3.9%	1,024,000
Executive	3.8%	981,000
Diversion Program	3.2%	842,000
Data Systems	3.1%	817,000
Probation Monitoring	1.9%	489,000
Medical Quality Review Committees	1.5%	391,000
Total Budget	**100%**	**$26,193,000**

Total amount (allocated to all programs) paid to Department of Consumer Affairs = $2,076,493

* Amount to Department of Consumer Affairs allocated to the enforcement program only.



MEDICAL BOARD OF CALIFORNIA
SOURCES OF REVENUE
1992-1993



Physician and Surgeon Renewals	85.9%	$21,532,000
Applications and Examinations	7.5%	$1,888,000
Initial License Fees	5.0%	$1,251,000
Other Regulatory Fees, Delinquency/Penalty/ Reinstatement Fees, Miscellaneous	1.6%	$410,000
Total	**100%**	**$25,081,000**

Attachment 2

Complaints Received Based Upon Reports Required by Law†

Physicians & Surgeons

	FY 95-96	FY 96-97
Medical Malpractice		
Insurers		
B&P Code §§801 & 801.1	870	1,003
Attorneys or Self-Reported or Employers		
B&P Code §§802 & 803.2	110	181
Courts		
B&P Code §803	19	23
Total Malpractice Reports	**999**	**1,207**
Coroners' Reports		
B&P Code §802.5	14	7
Criminal Charges & Convictions		
B&P Code §803.5 *(effective 1-1-96)*	16	38
Health Facility Discipline		
Medical Cause or Reason		
B&P Code §805	112	130

Affiliated Healing Arts Professionals

	FY 95-96	FY 96-97
Medical Malpractice		
Insurers		
B&P Code §§801 & 801.1	20	8
Attorneys or Self-Reported or Employers		
B&P Code §§802 & 803.2	2	3
Courts		
B&P Code §803	1	1
Total Malpractice Reports	**23**	**12**
Coroners' Reports		
B&P Code §802.5	0	0
Criminal Charges & Convictions		
B&P Code §803.5 *(effective 1-1-96)*	2	0
Health Facility Discipline		
Medical Cause or Reason		
B&P Code §805	1	7

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Division of Medical Quality Action Summary

	93-94	94-95	95-96	96-97
Complaints/Investigations[1]				
Complaints Received	7,902	11,465	11,497	10,123
Complaints Closed by CCICU†	5,614	11,058	9,751	8,161
Investigations				
Cases Opened	2,046	2,041	1,998	2,039
Cases Closed †	2,231	1,988	2,043	2,255
Cases referred to the AG	601	415	510	567
Cases referred to DAs/CAs	82	75	68	47

[1] *Some cases closed were opened in a prior fiscal year.*

Administrative Filings†				
Interim Suspensions	16	14	28	33
Temporary Restraining Orders	4	5	1	4
Automatic Suspension Orders[2]	n/a	5	8	13
Statement of Issues to deny application	3	4	2	4
Petition to Compel Psychological Exam	9	11	16	4
Petition to Compel Competency Exam	9	4	4	11
Petition to Compel Physical Exam	0	0	8	2
Accusation/Petition to Revoke Probation	407	353	262	296
Total Administrative Filings	**448**	**396**	**329**	**367**

[2] *Includes Automatic Suspension Orders per section 2236.1 B&P Code and license restrictions per section 23 Penal Code.*

Administrative Actions†				
Revocation	62	65	62	49
Surrender (in lieu of Accusation or with Accusation pending)	28	62	52	87
Suspension Only	0	2	1	0
Probation with Suspension	39	34	29	27
Probation	75	141	129	112
Probationary License Issued	2	3	1	3
Public Reprimand	9	25	67	39
Other decisions (e.g, exam required, training course)	9	21	4	23
Total Administrative Actions	**224**	**353**	**345**	**340**
Referral and Compliance Actions				
Citation and Administrative Fines Issued[3]	3	57	152	214
Physicians Called in for Medical Review	138	37	44	25
Physicians Referred to Diversion Program† [4]	31	18	19	44
Total Review & Referral Action	**172**	**112**	**215**	**283**

[3] *Citation and Fine authority effective May 1994.*

[4] *Diversion Program referrals are made pursuant to Senate Bill 779 (effective 1-1-96).*

Other Administrative Outcomes				
Accusation/Statement of Issues Withdrawn[5]	44	69	67	57
Accusation/Statement of Issues Dismissed	13	9	12	11
Statement of Issues Granted (Lic. Denied)	5	3	5	2
Statement of Issues Denied (Lic. Granted)	1	3	1	2
Petitions for Penalty Relief [6] granted	14	20	17	19
Petitions for Penalty Relief [6] denied	14	15	16	11
Petition to Compel Exams granted	20	37	16	15
Petition to Compel Exams denied	2	0	2	0

[5] *Accusations Withdrawn for the following reasons: physician passed a competency exam; physician met stipulated terms and conditions; physician was issued a citation/fine instead; physician died; or physician surrendered the license, etc.*

[6] *Penalty Relief includes Petitions for Reinstatement, Petitions for Modification of Penalty, and Petitions for Termination of Probation.*

† *Information required by Business and Professions Code section 2313.*

Division of Medical Quality

Fiscal year 1996/97 was remarkable and quantifiably the best public protection performance year the Medical Board has ever had. Provided below are a few of the most important public protection indicators which are compared to the FY 1993/94 as the baseline. All the figures are for physician cases only.

In FY 1993/94, the number of physician complaints closed by the Central Complaint Unit was 5,614. In FY 1996/97, the number of complaints closed was 8,161 (a 46% increase).

In FY 1993/94, there were 20 interim suspension orders (ISO) or temporary restraining orders (TRO) issued. In FY 1996/97, there were 37 issued (an 85% increase). The Board has never obtained more ISOs/TROs in a single year. This effort demonstrates the Division of Medical Quality's commitment to swift and direct action that ensures expeditious public protection if a physician represents a clear and immediate danger to public safety. Additionally, in FY 1996/97, pursuant to Business & Professions Code section 2236.1, which became effective January 1, 1995, the Division automatically suspended the licenses of eight physicians incarcerated for felony convictions.

In FY 1993/94, the number of license surrenders in lieu of accusation or with disciplinary action pending was 28. In FY 1996/97, the number of surrenders was 87 (a 211% increase). This reflects well on the quality of our investigations and on the expertise of the deputy attorneys general who have facilitated license surrender rather than the time consuming and expensive alternative of administrative hearing.

Prior to FY 1993/94, there was no such thing as citation & fine. However, after establishing regulations and implementing the process, the cite & fine program went on-line in May 1994. In FY 1994/95, the number of citations issued was 57. In FY 1996/97 the number was 214 (a 275% increase). The importance of the cite & fine program is that it contributed directly to fewer cases being referred to the Attorney General for administrative action regarding relatively minor violations. This has also saved the Board time and money. Likewise, in FY 1996/97 an additional 44 cases were referred directly by investigators and/or deputies to the Board's Diversion Program due to new law (SB 779). This volume exceeds original expectations (especially when one considers that the law only became effective January 1, 1996).

These improvements are the result of more efficient processes and higher quality staff work. Although the foregoing is an encouraging picture and speaks well of the Medical Board's public protection accomplishments, there are still many improvements to be made—particularly in the time it takes to complete field investigations.

Despite continuing attempts to reduce the time through improved policies, legislation, new technology, expanded training, focused managerial review and strategic planning, these efforts struggle against the increasing volume, breadth, complexities and legal issues which are often beyond the Medical Board's control, and are inherent to physician complaints/cases.

Thus, the time required to complete the investigation of certain case types remains unacceptably long even though investigators closed a record high 2,255 physician cases in FY 1996/97. Therefore, over the coming year, the Enforcement Program will search further for additional techniques and strategies which accelerate complaint processing and reduce case investigation time.

Complaints Received†

		Fraud	Health & Safety[1]	Non-Jurisdictional[2]	Competence/Negligence[3]	Other Category	Personal Conduct[4]	Unprofessional Conduct[5]	Unlicensed/Unregistered	Total
Public	MD	177	170	478	4,068	15	49	1,301	114	6,372
	AH	35	10	17	223	2	12	269	67	635
B&P Code Section 800[6]	MD	5	7	9	1,267	0	47	47	0	1,382
	AH	0	0	0	13	0	3	3	0	19
Licensee or Professional Group[7]	MD	24	28	26	49	5	12	81	28	253
	AH	6	0	2	6	8	2	37	44	105
Governmental Agency[8]	MD	45	65	17	905	80	170	560	81	1,923
	AH	17	4	1	19	5	56	61	50	213
Anonymous/ Miscellaneous	MD	17	24	9	28	0	15	63	37	193
	AH	3	0	0	1	0	0	19	13	36
Subtotals	**MD**	**268**	**294**	**539**	**6,317**	**100**	**293**	**2,052**	**260**	**10,123**
	AH	**61**	**14**	**20**	**262**	**15**	**73**	**389**	**174**	**1,008**
Grand Totals		**329**	**308**	**559**	**6,579**	**115**	**366**	**2,441**	**434**	**11,131**

MD = Medical Doctors

AH = Affiliated Healing Arts Professionals (includes: podiatrists, physician assistants, psychologists, and dispensing opticians).

1 *Health and Safety complaints, e.g. excessive prescribing, sale of dangerous drugs, etc.*

2 *Non-Jurisdictional complaints are not under the authority of the Board, and are referred to other agencies such as the Department of Health Services, Department of Insurance, etc.*

3 *Competence/Negligence complaints are related to the quality of care provided by licensees.*

4 *Personal Conduct complaints, e.g. licensee self-use of drugs/alcohol, conviction of a crime, etc.*

5 *Unprofessional Conduct complaints include sexual misconduct with patients, discipline by another state, failure to release medical records, etc.*

6 *"B&P Code §800" includes complaints initiated based upon reports submitted to the Medical Board by hospitals, insurance companies and others, as required by law, regarding instances of health facility discipline, malpractice judgments/settlements, or other reportable activities.*

7 *"Licensee or Professional Group" includes the following complaint sources: Other Licensees, Society/Trade Organizations, and Industry.*

8 *"Governmental Agency" includes the following complaint sources: Internal, Law Enforcement Agency, Other California State Agency, Other State, Other Unit of Consumer Affairs, and Federal or Other Governmental Agency.*

† *Information required by Business and Professions Code section 2313.*

Business & Professions Code §2313—Additional Data Elements

1. Additional data for Temporary Restraining Orders (TRO) and Interim Suspension Orders (ISO):

	Orders Sought: TRO/ISO	Orders Granted: TRO/ISO
Mental Illness	5	5
Drug Prescribing Violations	2	4
Sexual Misconduct	7	5
Self Abuse of Drugs or Alcohol	14	12
Fraud/Dishonesty	0	1
Gross Negligence/Incompetence	11	8
Conviction of a Crime	4	2
Total:	**43**	**37**

NOTE: Some orders granted were sought in prior fiscal year.

2. The number and type of action which resulted from cases referred by the state Department of Health Services pursuant to §14124 of the Welfare and Institutions Code, relating to suspension of provider status for state medical assistance:

All Department of Health Services (DHS) notifications of Medi-Cal provider suspensions were added to existing MBC files because the basis for the DHS action (e.g. MBC license revocation, US Dept. of Health and Human Services suspension of Medicare provider privileges, etc.) was already reported or known to MBC. Because DHS suspension of a provider's Medi-Cal privileges results from action already taken by another agency, no additional MBC actions result from these DHS notifications.

3. Consumer inquiries and complaints:

Consumer inquiries	77,056
Jurisdictional inquiries	42,380
Complaint forms sent	18,684
Complaint forms returned by consumers	6,539

4. Number of completed investigations referred to the Attorney General's Office awaiting the filing of an accusation:

Physician and Surgeon	163
Affiliated Healing Arts Professionals	32

5. Number of probation violation reports sent to the Attorney General[1]:

	MD	AH	Total
	20	6	26

6. Petitions to Revoke Probation Filed: 14 7 21

7. Dispositions of Probation Filings:

	MD	AH	Total
Additional Suspension or Probation	4	2	6
Probation Revoked or License Surrendered	14	6	20
Petition Withdrawn/Dismissed	1	0	1

8. Petitions for Reinstatement of License:

Filed	9	1	10
Granted	4	1	5
Denied	6	0	6

9. Average and median time (calendar days) in processing complaints during the fiscal year, for all cases, from date of original receipt of the complaint, for each stage of discipline, through completion of judicial review:

	FY 95-96 Avg.	FY 95-96 Median	FY 96-97 Avg.	FY 96-97 Median
(a) Complaint Unit Processing	65	7	64	15
(b) Investigation	335	250	336	230
(c) Attorney General Processing to preparation of an accusation	139	97	134	97
(d) Other stages of the legal process (e.g. after charges filed)	494	396	508	421

10. Investigator caseloads as of June 30, 1997:

Enforcement Field Operations Caseload:	Statewide	Per Investigator
Active Investigations	1,824	26
AG Assigned Cases[2]	572	8
Probation Unit Caseload:		
Monitoring Cases[3]	569	63
Active Investigations	94	10
AG Assigned Cases[2]	18	2

[1] *These are in addition to the 567 MD and 87 AH cases referred to the Attorney General reported in the Enforcement Action Summary.*

[2] *These cases are at various stages of AG processing, and may require supplemental investigative work such as subpoena service, interviewing new victims or witnesses, testifying at hearings, etc.*

[3] *189 additional monitoring cases were inactive because the probationer is out of state.*

11. Number and type of MD & AH action taken by case type in FY 96/97	Revocation	Surrender	Probation With Suspension	Probation	Probationary License Issued	Public Reprimand	Other Action	Total Actions by Case Type
Negligence	19 (17)	40 (36)	6 (5)	50 (48)	1 (0)	11 (10)	8 (7)	**135 (123)**
Inappropriate Prescribing	12 (10)	10 (10)	4 (4)	17 (15)	0	7 (7)	8 (8)	**58 (54)**
Unlicensed Activity	0	0	2 (1)	2 (2)	0	1 (1)	0	**5 (4)**
Sexual Misconduct	9 (1)	19 (11)	4 (4)	11 (8)	0	1 (1)	4 (2)	**48 (27)**
Mental Illness	5 (4)	5 (5)	1 (1)	5 (5)	0	0	2 (1)	**18 (16)**
Self-use of drugs/alcohol	5 (4)	7 (7)	4 (4)	14 (9)	0	3 (3)	0	**33 (27)**
Fraud	0	5 (4)	2 (1)	5 (2)	2 (1)	0	1 (0)	**15 (8)**
Conviction of a crime	7 (4)	3 (2)	8 (5)	14 (9)	6 (1)	3 (3)	0	**41 (24)**
Unprofessional Conduct[1]	11 (9)	14 (12)	3 (2)	14 (10)	1 (1)	14 (14)	7 (5)	**64 (53)**
Miscellaneous violations	0	0	0	4 (4)	1 (0)	0	3 (0)	**8 (4)**
Total Actions by Discipline Type (Physician only)[2]	**68 (49)**	**103 (87)**	**34 (27)**	**136 (112)**	**11 (3)**	**40 (39)**	**33 (23)**	**425 (340)**

[1] Many of the case types classified as "Unprofessional Conduct" are reciprocal action based upon discipline by another state.
[2] Figures in parentheses represent physician discipline only for each category. Figures outside parentheses represent combined MD & AH.

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Enforcement Action Summary For Affiliated Healing Arts

	FY 95-96	FY 96-97
Complaints/Investigations		
Complaints Received	948	1,008
Complaints Closed by CCICU†	703	772
Investigations		
Cases Opened	231	275
Cases Closed†	263	305
Cases referred to the AG	79	87
Cases referred to DAs/CAs	11	13
Administrative Filings†		
Interim Suspensions	2	3
Statement of Issues to deny application	4	10
Petition to Compel Psychological Exam	1	0
Accusation/Petition to Revoke Probation	47	55
Total Administrative Filings	**54**	**68**
Administrative Actions†		
Revocation	14	19
Surrender (in lieu of Accusation or with Accusation pending)	10	16
Probation with Suspension	5	7
Probation	14	24
Probationary License Issued	2	8
Public Reprimand	4	1
Other decisions (e.g., training course)	1	10
Total Administrative Actions	**50**	**85**
Referral and Compliance Actions		
Citation and Administrative Fines Issued	2	13
Office Conferences Conducted	17	9
Professionals Referred to Diversion Program†	0	0
Total Review & Referral Action	**19**	**22**
Other Administrative Outcomes		
Accusation/Statement of Issues Withdrawn	4	7
Accusation/Statement of Issues Dismissed	0	0
Statement of Issues Granted (Lic. Denied)	2	3
Statement of Issues Denied (Lic. Granted)	2	9
Petitions for Penalty Relief granted[1]	0	2
Petitions for Penalty Relief denied[1]	4	0
Petition to Compel Psychological Exam granted	1	0
Petitions to compel exams denied	0	0

[1] *Penalty Relief includes Petitions for Reinstatement, Petitions for Modificationof Penalty, and Petitions for Termination of Probation.*

† *Information required by Business and Professions Code section 2313.*

Diversion Program

The Board's Diversion Program for impaired physicians serves a dual role in the Division of Medical Quality's mission by helping to protect the public while rehabilitating physicians. The Physician Diversion Program protects the public by closely monitoring physicians who are impaired as the result of alcohol and other drug addictions or a mental disorder. Concurrently, it provides physicians who suffer from substance abuse an opportunity for rehabilitation and ongoing recovery.

The Diversion Program, created by statute in 1980 as an alternative to discipline by the Board, allows participants, when appropriate, to continue the practice of medicine. Both Board-referred and self-referred candidates can participate if deemed eligible by Diversion Evaluation Committees. These committees are composed of three physicians and two public members with expertise in alcohol and other drug addiction or mental illness. Participation by self-referred physicians, who have no Board action, is completely confidential from the disciplinary arm of the Medical Board. Currently, 68% of Diversion participants are self-referred. Being in the Diversion Program does not affect a physician's medical license, although limitations on current practice may be imposed as part of the physician's participation.

SB 779, which became effective January 1, 1996, provides for a physician's placement in the program in lieu of discipline if that physician is suffering from alcoholism or drug addition. Since January 1, 1996, Diversion Evaluation Committees have deemed 43 physicians eligible for participation in the program.

Effective January 1, 1997, Business & Professions Code section 821.5 was implemented requiring the Diversion Program to monitor the progress of peer review body formal investigations of physicians who might be disabled by mental or physical illness and pose a threat to patient care. As of June 30, 1997, 10 such investigations had been reported for monitoring by the Diversion Program.

Activity[1]	
Beginning of fiscal year	211
Accepted into program	68
Completions:	
Successful	35
Unsuccessful	21
Active at end of year	213
Applicants[2]	49
Out-of-State-monitored California MDs	12

Type of Impairment	No.	%
Alcohol	48	23
Other drugs	82	39
Alcohol & other drugs	71	33
Mental illness	5	2
Mental illness & substance abuse	7	3
Total	**213**	**100**

[1] *These statistics include doctors of podiatric medicine.*

[2] *Applicants are participants who either 1) have not been seen by a Diversion Evaluation Committee or 2) have not yet signed a Diversion Agreement.*

Medical Board of California 1996-1997

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Attachment 3

Diversion Program

The Physician Diversion Program is a statewide, highly structured, multifaceted, five year monitoring and rehabilitation program. It is administered by the Medical Board of California to support and monitor the recovery of physicians who have substance abuse or mental health disorders.

Physicians enter the Diversion Program by one of three avenues. First, physicians may self-refer. This is often the result of encouragement by concerned colleagues or family members for the physician to seek help. Second, physicians may be referred by the Enforcement Unit of the Medical Board rather than pursuing disciplinary action. Finally, physicians may be directed to participate by the Medical Board as part of a disciplinary order.

During FY 06–07, 45 physicians were accepted into the Diversion Program. Of those, 14 physicians had no open cases with the board, 23 physicians were diverted from discipline, and an additional eight physicians entered as a result of disciplinary orders. During FY 06–07, a total of 340 physicians were monitored by the Diversion Program. Of the 63 who left the program, 17 were unsuccessful, while 43 successfully completed the five years, with a minimum of three years of continuous sobriety and a change in lifestyle that would support ongoing recovery.

Activity[1]	FY 05–06	FY 06–07
Beginning of fiscal year	248	215
Accepted into program	42	45
Completions:		
Successful	54	43
Unsuccessful	18	17
Deceased[2]	3	3
Active at end of year	215	197
Other Activity		
Applicants[3]	17	30
Other Applicants[4]	26	33
Out-of-state-monitored		
California licentiates	16	13
Completions:		
Successful	4	4
Unsuccessful	1	0
Total monitored at end of FY 06–07		**273**
Total monitored during FY 06–07		**340**

Type of Impairment[1]	FY 06–07	%
Alcohol	43	22
Alcohol & mental illness	16	8
Other drugs	56	28
Other drugs & mental illness	27	14
Alcohol & other drugs	34	17
Alcohol & other drugs & mental illness	18	9
Mental illness	3	2
Total	**197**	**100%**

[1] Does not include applicant or out-of-state participant data.

[2] Deaths occurred prior to successfully completing the program.

[3] Applicants are participants who either have not been seen by a Diversion Evaluation Committee or have not yet signed a Diversion Agreement.

[4] Other Applicants are those individuals who contacted the program during the fiscal year but either declined (21) to enter the program or were ineligible (12).

Division of Medical Quality

Vertical enforcement (SB 231, Figueroa, 2005) requires the investigators of the Medical Board and the prosecutors in the Health Quality Enforcement Section (HQES) of the Attorney General's Office to work together from the beginning of an investigation of possible physician misconduct, replacing the prior, "hand-off" method where board investigators compiled the evidence and then handed it off to prosecutors for legal evaluation. This pilot project was fully implemented on all post-January 1, 2006 cases, and the board's enforcement program saw decreases in the time taken to complete an investigation. The average number of days to close cases without prosecution prior to vertical enforcement was 145; as of this report, it has been reduced to 139 days. The average number of days between the completion of an investigation and filing of an accusation has decreased from 241 to 212. Interim Suspension Orders (ISOs) saw the most dramatic impact from the implementation of vertical enforcement, with a reduction in average time of investigation to issuance of the suspension order from 91 to 30 days. This is especially impressive in that ISOs are issued when there is an imminent threat to public safety; therefore, this improvement in time has a significant impact on the board's mission of public protection.

In addition to the vertical enforcement pilot, the enforcement division implemented numerous policy changes described in the 2004–2005 Annual Report (e.g., a zero-tolerance policy regarding production of medical records; time frames by when a physician interview must occur), which also have contributed to outstanding reductions in overall investigation time. Currently, the time it takes to obtain medical records is reduced from 74 to 36 days. The average time between the initial request for a physician interview and the actual interview is reduced from 60 to 40 days. The average number of days to obtain a medical expert opinion is reduced from 69 to 36. The board only had to issue four citations and fines for failure to produce records, and two cases were referred to the Office of the Attorney General for the issuance of civil penalties.

Recruitment and retention remain a serious problem, as the board's enforcement program is remarkably complex and investigators are able to find employment with higher compensation at agencies where the work is less difficult. During this fiscal year, investigative staff operated with an average vacancy rate of 11.6 percent. Despite this, investigators remained remarkably productive.

Executive Summary *(Continued from page i)*

the development of voluntary educational programs and courses to teach foreign language competency and cultural beliefs and practices for incorporation into the diagnosis and treatment of patients.

The Midwifery Advisory Council was established to make recommendations to the Medical Board on matters that are presented to it by the Division of Licensing on issues pertaining to licensed midwives. Recently, the council developed a coding system to capture practice data related to the practice of midwifery in California, pursuant to Business and Professions Code section 2516.

The Special Faculty Permit Review Committee evaluates the credentials of all applicants under Business and Professions Code section 2168.1 (special faculty permit) and makes recommendations to the Division of Licensing relative to these applicants. After all 10 members were appointed to the committee by the Division of Licensing, the committee held its first meeting, at which officers were elected. The committee clarified the meaning of "academically eminent" as used in the statute, and provided guidance to staff as to what documentation would need to be submitted with an application for the committee to make a recommendation to the Division of Licensing. An application form and instructions were approved for individuals to use to apply for a Special Faculty Permit. This law allows more individuals to share their expertise with California physicians and their patients.

The board continues to make improvements to its Web site. The most recent includes a Subscribers' List for anyone interested in receiving e-mail alerts of board meeting agenda notices and minutes; newsletters; regulations; and timely notifications of physicians' license suspensions, restrictions, revocations, and surrenders. In addition to board agendas, the related attachments and reference materials also are now available online.

Reports Per B&P Code Section 805: FY 06—07

Total Reports Received	**127**
Peer Review Body Type	
Health Care Facility/Clinic	73
Hospital/Clinic	70
Surgical Center	3
Health Care Service Plan	10
Professional Society	0
Medical Group/Employer	44
Outcomes of Reports Received	
Accusation and Interim Suspension Order Filed	2
Accusation Filed	1
Pending Disposition	97
Cases Closed	27

Malpractice Settlement Reports Received Per B&P Code Section 801

	No. of Reports	No. of Physicians*
Anesthesiology	30	4,322
Cardiology	20	2,519
Colon and Rectal Surgery	2	143
Dermatology	16	1,534
Emergency Medicine	42	3,038
Endocrinology	1	571
Gastroenterology	5	1,211
General/Family Practice	73	7,161
General Surgery	59	3,868
Gynecology	23	4,478
Hematology	4	132
Infectitious Disease	2	572
Internal Medicine	55	19,856
Neonatal/Perinatal Medicine	4	526
Nephrology	1	840
Neurological Surgery	25	514
Neurology	13	1,235
Nuclear Medicine	1	566

	No. of Reports	No. of Physicians*
Obstetrics	65	4,478
Oncology	4	1,046
Ophthalmology	7	2,460
Orthopedic Surgery	64	2,862
Otolaryngology	15	1,340
Pain Medicine	2	291
Pathology	10	2,347
Pediatrics	14	8,530
Physical Medicine & Rehabilitation	3	757
Plastic Surgery	24	913
Psychiatry	4	4,736
Pulmonology	5	1,178
Radiology	35	4,534
Rheumatology	3	519
Thoracic Surgery	13	670
Urology	7	1,163
Vascular Surgery	7	205

* Certified in speciality

Division of Medical Quality Action Summary

Physicians & Surgeons

	FY 05-06	FY 06-07
Complaints/Investigations[1]		
Complaints received	7,663	7,259
Complaints closed by Complaint Unit	6,349	6,105
Investigations		
Cases opened	1,331	1,182
Cases closed	1,307	1,128
Cases referred to the Attorney General (AG)	458	415
Cases referred for criminal action	31	27
Number of probation violation reports referred to the AG	22	19
Consumer inquiries and complaints		
Consumer inquiries		30,678
Jurisdictional inquiries		16,873
Complaint forms sent		6,750
Complaint forms returned by consumers		2,363

Average and median time (calendar days) in processing complaints during the fiscal year, for all cases, from date of original receipt of the complaint, for each stage of discipline, through completion of judicial review:

	FY 05-06		FY 06-07	
	Avg.	Med.	Avg.	Med.
Complaint Unit processing	54	28	54	49
Investigation	277	261	307	289
AG processing to preparation of an accusation	132	78	127	76
Other stages of the legal process (e.g., after charges filed)	515	417	446	350

Enforcement Field Operations Caseload

	Statewide	Per Investigator
Active investigations	1,146	19
AG assigned cases[2]	391	6
Probation Unit Caseload		
Monitoring Cases[3]	523	37
Active Investigations	72	5
AG assigned cases[2]	46	n/a[4]

[1] Some cases closed were opened in a prior fiscal year.

[2] These cases are at various stages of AG processing and may require supplemental investigative work, such as subpoena service, interviewing new victims or witnesses, testifying at hearings, etc.

[3] 124 additional monitoring cases were inactive because the probationer was out of state as of June 30, 2007.

[4] For Probation Unit caseload, the AG Assigned Cases are included as Monitoring Cases

Complaints Received by Type & Source

	Fraud	Health & Safety[1]	Non-Jurisdictional[2]	Competence/ Negligence[3]	Other Category	Personal Conduct[4]	Unprofessional Conduct[5]	Unlicensed/ Unregistered	Total
Public	205	92	1,265	1,909	1	48	833	92	**4,445**
B&P Code[6]	1	4	0	963	1	40	52	0	**1,061**
Licensee/ Prof. Group[7]	48	16	51	84	9	19	68	32	**327**
Govt. Agency[8]	90	37	20	108	63	276	533	58	**1,185**
Misc./ Anonymous	52	9	32	42	0	23	50	33	**241**
Totals	**396**	**158**	**1,368**	**3,106**	**74**	**406**	**1,536**	**215**	**7,259**

[1] Health and Safety complaints, e.g. excessive prescribing, sale of dangerous drugs, etc.

[2] Non-jurisdictional complaints are not under the authority of the board and are referred to other agencies such as the Department of Health Care Services, Department of Managed Health Care, etc.

[3] Competence/Negligence complaints are related to the quality of care provided by licensees.

[4] Personal Conduct complaints, e.g. licensee self-use of drugs/alcohol, conviction of a crime, etc.

[5] Unprofessional Conduct complaints include sexual misconduct with patients, discipline by another state, failure to release medical records, etc.

[6] Reference is to B&P Code sections 800 and 2240(a) and includes complaints initiated based upon reports submitted to the Medical Board by hospitals, insurance companies and others, as required by law, regarding instances of health facility discipline, malpractice judgments/settlements, or other reportable activities.

[7] Licensee/Professional Group includes the following complaint sources: Other Licensee, Society/Trade Organization, and Industry.

[8] Governmental Agency includes the following complaint sources: Internal, Law Enforcement Agency, Other California State Agency, Other State, Other Unit of Consumer Affairs, and Federal or Other Governmental Agency.

Reports Received Based Upon Legal Requirements

	FY 05-06	FY 06-07
Medical Malpractice		
Insurers: B&P Code §§801 & 801.1	726	676
Attorneys or Self-Reported or Employers: B&P Code §§801(f), 802 & 803.2	185	187
Courts: B&P Code §803	6	10
Total Malpractice Reports	**917**	**873**
Coroners' Reports		
B&P Code §802.5	11	22
Criminal Charges & Convictions		
B&P Code §§802.1 & 803.5	16	29
Health Facility Discipline		
Medical Cause or Reason: B&P Code §805	138	127
Outpatient Surgery Settings Reports		
Patient Death: B&P Code §2240(a)	2	10

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Division of Medical Quality Action Summary

	FY 05-06	FY 06-07
Administrative Actions		
Accusation	226	218
Petition to Revoke Probation	26	24
Number of completed investigations referred to the Attorney General's Office awaiting the filing of an Accusation as of June 30	152	132
Number of cases over 6 months old that resulted in the filing of an Accusation	172	174
Administrative Outcomes		
Revocation	39	34
Surrender (in lieu of Accusation or with Accusation pending)	66	67
Suspension Only	0	1
Probation with Suspension	20	21
Probation	88	92
Probationary License Issued	4	6
Public Reprimand	89	59
Other actions (e.g. exam required, education course, etc.)	3	30
Accusation Withdrawn[1]	19	14
Accusation Dismissed	6	4
Dispositions of Probation Filings		
Probation Revoked or License Surrendered	15	30
Additional Suspension and Probation	0	2
Additional Suspension or Probation	5	7
Other	0	1
Public Reprimand	0	0
Petition Withdrawn/Dismissed	2	0
Referral and Compliance Actions		
Citation and Administrative Fines Issued	342	426
Physicians Referred to Diversion Program[2]	30	24

	FY 05-06	FY 06-07
Petition Activity		
Petition for Reinstatement of license filed	13	21
Petition for Reinstatement of license granted	7	5
Petition for Reinstatement of license denied	8	3
Petition for Penalty Relief[3] granted	20	19
Petition for Penalty Relief[3] denied	11	12
Petition to Compel Exam filed	9	15
Petition to Compel Exam granted	9	12
Petition to Compel Exam denied	0	0
License Restrictions/Suspensions Imposed While Administrative Action is Pending		
Interim Suspension Orders	24	18[4]
Temporary Restraining Orders	0	0
Other Suspension Orders	23	25[5]

License Restrictions/Suspensions/Temporary Restraining Orders Sought and Granted by Case Type in FY 06–07

	Orders Sought	Orders Granted
Criminal Charges/Conviction of a Crime	2	7
Drug Prescribing Violations	0	0
Fraud	4	3
Gross Negligence/Incompetence	5	4
Mental/Physical Illness	4	6
Self-Abuse of Drugs or Alcohol	8	11
Sexual Misconduct	6	10
Unlicensed Activity	0	0
Unprofessional Conduct	0	4
Total	**29**	**45**

NOTE: Some orders granted were sought in prior fiscal year.

Administrative Outcomes by Case Type in FY 06-07[6]

	Revocation	Surrender	Suspension Only	Probation with Suspension	Probation	Probationary License Issued	Public Reprimand	Other Action	Total Actions by Case Type
Negligence	7	17	1	1	49	0	39	21	135
Inappropriate Prescribing	1	5	0	1	7	0	9	3	26
Unlicensed Activity	0	1	0	2	2	0	3	1	9
Sexual Misconduct	3	8	0	4	7	0	1	0	23
Mental Illness	5	11	0	0	3	0	0	1	20
Self-Use of Drugs/Alcohol	8	12	0	4	9	3	0	1	37
Fraud	0	2	0	3	3	0	0	1	9
Conviction of a Crime	5	3	0	4	4	1	3	0	20
Unprofessional Conduct	5	7	0	2	4	2	4	2	26
Miscellaneous Violations	0	1	0	0	4	0	0	0	5
Totals by Discipline Type	**34**	**67**	**1**	**21**	**92**	**6**	**59**	**30**	**310**

[1] Accusations withdrawn for the following reasons: physician passed a competency exam; physician met stipulated terms and conditions; physician was issued a citation/fine instead; physician died; etc.

[2] Diversion Program referrals are made pursuant to B&P Code section 2350(b)

[3] Penalty Relief includes Petitions for Modification of Penalty and Petitions for Termination of Probation

[4] Pursuant to B&P Code section 2220.05(c), ISO's were granted in the following priority categories: 0–gross negligence/incompetence resulting in death or serious bodily injury, 0–drug or alcohol abuse involving death or serious bodily injury, 0–excessive prescribing, 2–sexual misconduct with a patient, and 2–practicing under the influence of drugs/alcohol.

[5] Includes 4 Automatic Suspension Orders per B&P Code section 2236, 7 license restrictions per Penal Code section 23, 8 out of state suspension orders per B&P Code section 2305, 3 stipulated agreements to suspend or restrict the practice of medicine, and 3 suspension orders issued by the Chief of Enforcement for violation of probation condition.

[6] Pursuant to B&P Code section 2220.05(c), disciplinary actions were taken in the following priority categories: 53–gross negligence/incompetence resulting in serious bodily injury or death, 0–practicing under the influence resulting in serious bodily injury or death, 9–excessive prescribing, 18–sexual misconduct with a patient, and 4–practicing under the influence of drugs/alcohol.

Enforcement Action Summary for Allied Health Care Professionals

	FY 05-06	FY 06-07
Complaints/Investigations[1]		
Complaints Received	302	313
Complaints Closed by Complaint Unit	241	259
Investigations:		
Cases Opened	167	146
Cases Closed	164	134
Cases referred to the AG	79	70
Cases referred for criminal action	5	4
Number of Probation Violation Reports referred to AG	4	3
License Restrictions/Suspensions Imposed While Administrative Action is Pending		
Interim Suspension Orders	3	3
Other Suspension Orders	1	3[2]
Administrative Actions		
Accusation	16	20
Petition to Revoke Probation	4	3
Statement of Issues to deny application	8	4
Number of completed investigations referred to AG's Office awaiting the filing of an Accusation as of June 30	12	11
Administrative Outcomes		
Revocation	8	4
Surrender (in lieu of Accusation or with Accusation pending)	6	6
Probation with Suspension	1	3
Probation	12	14
Probationary License Issued	2	3
Public Reprimand	0	0
Other Actions (e.g. exam required, education course, etc.)	0	0
Statement of Issues Granted (Lic Denied)	1	3
Statement of Issues Denied (Lic Granted)	2	2
Accusation/Statement of Issues Withdrawn	1	8
Accusation Dismissed	0	0
Dispositions of Probation Filings		
Additional Probation or Suspension	0	0
Probation Revoked or License Surrendered	3	2
Petition Withdrawn or Dismissed	0	0
Referral and Compliance Actions		
Citation and Administrative Fines Issued	10	2
Office Conferences Conducted	5	2
Petition Activity		
Petition for Reinstatement of license filed	1	5
Petition for Reinstatement of license granted	1	0
Petition for Reinstatement of license denied	0	0
Petition for Penalty Relief[3] granted	0	2
Petition for Penalty Relief[3] denied	3	0
Petition to Compel Exam granted	0	0
Petition to Compel Exam denied	0	0

Reports Received Based Upon Legal Requirements

	FY 05-06	FY 06-07
Medical Malpractice		
Insurers: B&P Code §§801 & 801.1	9	16
Attorneys or Self-Reported or Employers: B&P Code §§801(f), 802 & 803.2	1	2
Courts: B&P Code §803	0	0
Total Malpractice Reports	**10**	**18**
Coroners' Reports		
B&P Code §802.5	0	0
Criminal Charges & Convictions		
B&P Code §§802.1 & 803.5	0	0
Health Facility Discipline		
Medical Cause or Reason: B&P Code §805	2	1
Outpatient Surgery Settings Reports		
Patient Death: B&P Code §2240(a)	0	0

[1] Allied Health Care professionals include podiatrists, physician assistants, research psychoanalysts, dispensing opticians and licensed midwives, except in the categories of investigations, cases referred to the Attorney General and referred for criminal action.

[2] Includes 1 automatic suspension order, 1 license restriction per Penal Code section 23, 1 stipulated agreement to suspend or restrict practice.

[3] Penalty Relief includes Petitions for Modification of Penalty and Petitions for Termination of Probation.

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Attachment 4

2010 Licensed Midwife Annual Report Summary[1]

	2009	**2010**
Clients served as primary caregiver at the onset of care	3,023	**3,115**
Clients served with collaborative care available through or given by a licensed physician and surgeon	1,461	**1,802**
Clients served under the supervision of a licensed physician and surgeon	285	**203**
Planned out-of-hospital births at the onset of labor	1,974	**2,245**
Planned out-of-hospital births completed in an out-of-hospital setting:	1,621	**1,840**
Twin Births	8	**5**
Multiple Births (other than Twin Births)	2	**0**
Breech Births	11	**13**
VBAC (vaginal births after the performance of a Cesarean section)	90	**109**
Complications - Resulting in the mortality of the mother prior to transfer	0	0
Complications - Resulting in the mortality of the mother after transfer	1	0
Complications - Resulting in the mortality of the infant prior to transfer	2	0
Complications - Resulting in the mortality of the infant after transfer	2	2
Antepartum - Primary care transferred to another health care practitioner (elective)	209	**240**
Antepartum - Urgent or emergency transport of expectant mother	56	**49**
Intrapartum - Elective hospital transfer	282	333
Intrapartum - Urgent or emergency transfer of an infant or mother	42	53
Postpartum - Elective hospital transfer of mother	32	**28**
Postpartum - Elective hospital transfer of Infant	27	**22**
Postpartum - Urgent or emergency transfer of a mother	27	**21**
Postpartum - Urgent or emergency transfer of an infant	24	**37**

[1] Conclusions should not be drawn from this summary as data does not specify whether the death is fetal, intrapartum or neonatal; whether the affected perinate had congenital anomalies incompatible with life; or whether the perinate was born in or out of a hospital. Births are attended by the licensed midwife as the primary caregiver.

Enforcement Program

During the fiscal year, the Enforcement Program focused on identifying areas of concern and best practices to improve case timelines and was successful in the implementation of several process improvements, including: updating manuals; reviewing policies and recommending changes to the Board; and, reconciling data and statistics on a monthly basis to track timelines and trends.

Although the Enforcement Program was again faced with operational challenges including staffing shortages, the average Complaint Unit time frame was reduced despite receiving 583 more complaints than last year. The Notice to Consumer Regulation, requiring physicians in California to inform their patients that they are licensed by the Medical Board of California and provide the Board's contact information, was a large factor in the nearly 10 percent increase in complaints and is anticipated to continue to increase the amount of complaints received in the future. Faced with a substantial increase in consumer complaints, the reduction of the investigative time frame remained a high priority throughout the year. The Enforcement Program was successfully able to reduce the overall time frame to complete an investigation by 5 percent. This decrease is, in part, due to the extensive training provided to Enforcement Program investigators including training for time management, multi-tasking skills, and utilizing technological tools to improve individual tracking methods.

SB700 (Negrete McLeod, Chapter 505, Statutes of 2010), became effective this year, requiring the Board to create a new reporting form pursuant to 805.01 of the California Business and Professions Code and to post an 805 (Peer Review Process) Fact sheet on the Board's website. The law requires hospitals to inform the Board of a formal investigation within 15 days and allows the Board access to relevant documents upon the notification versus having to wait until the hospital disciplinary hearing has been held. SB700 will enable the Enforcement Program to process 805 cases in a more expedited manner resulting in better consumer protection.

The Board's Operation Safe Medicine (OSM) was responsible for seizing more than $100,000 of contraband contact lenses and arresting several unlicensed individuals who were illegally selling them. OSM was largely responsible for the 41 cases referred to the District Attorney or City Attorney resulting in an impressive 23 criminal complaints being filed. The volume and seriousness of the cases investigated and submitted for prosecution continues to underscore the importance of having a unit dedicated solely to the issue of unlicensed practice and demonstrates the Enforcement Program's goal of protecting the consumers of California.

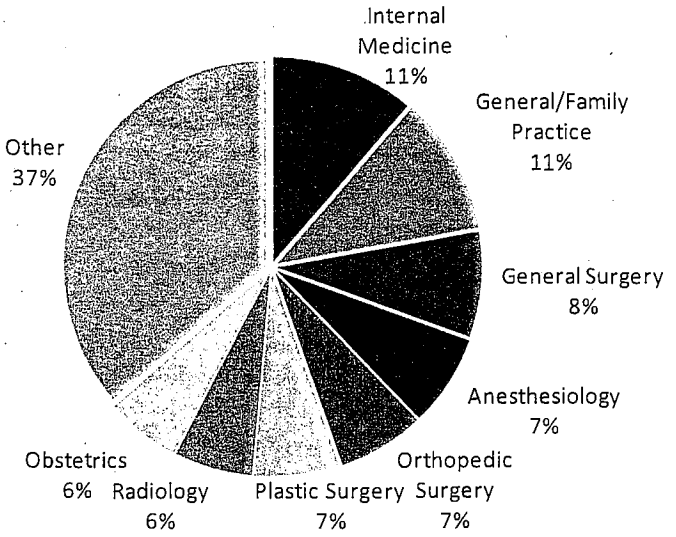
Malpractice Settlement Reports

Received per Business and Professions Code section 801.01 by Specialty Practice

Specialty/Subspecialty	No. of Reports[1]	No. of Physicians[2]
Allergy and Immunology	2	665
Anesthesiology	34	5,093
Cardiology	19	3,064
Colon and Rectal Surgery	4	161
Critical Care	1	1,123
Dermatology	4	1,908
Emergency Medicine	13	3,753
Gastroenterology	11	1,541
General/Family Practice	51	8,376
General Surgery	39	4,311
Geriatric Medicine	1	741
Gynecology	16	5,337
Infectious Disease	1	777
Internal Medicine	53	24,684
Neonatal/Perinatal Medicine	7	599
Neurological Surgery	11	550
Neurology	7	1,882
Obstetrics	28	5,337
Oncology	3	1,589
Ophthalmology	9	2,699
Orthopedic Surgery	32	3,200
Otolaryngology	8	1,472
Pain Medicine	2	530
Pathology	7	3,501
Pediatrics	9	9,818
Physical Medicine & Rehabilitation	2	923
Plastic Surgery	31	927
Psychiatry	6	6,450
Pulmonology	4	1,402
Radiation Oncology	1	537
Radiology	29	5,322
Rheumatology	1	626
Sleep Medicine	1	196
Thoracic Surgery	1	670
Urology	13	1,260
Vascular Surgery	6	253

[1] The procedure was performed in the practice specialty/subspecialty; however, the physician may or may not have been certified in the specialty/subspecialty area

[2] California physicians certified in specialty according to the American Board of Medical Specialties 2010 Certificate Statistics report



Reports per Business and Professions Code section 805

Total Reports Received	93
Peer Review Body Type	
Health Care Facility/Clinic	58
Hospital/Clinic	0
Surgical Center	0
Health Care Service Plan	19
Professional Society	0
Medical Group/Employer	16
Outcomes of Reports Received	
Accusation Filed	1
Pending Disposition	61
Cases Closed	31

Enforcement Program Action Summary
Physicians & Surgeons

	FY 09-10	FY 10-11
Complaints/Investigations[1]		
Complaints received	6,539	**7,122**
Complaints closed by Complaint Unit	5,251	**5,670**
Investigations		
Cases opened	1,312	**1,338**
Cases closed	1,290	**1,411**
Cases referred to the Attorney General (AG)	569	**594**
Cases referred for criminal action	35	**41**
Number of probation violation reports referred to the AG	32	**35**
Consumer Inquiries		
Consumer inquiries	20,447	**19,355**
Jurisdictional inquiries	11,246	**10,645**

Enforcement Processing Time Frames

Average and median time (calendar days) in processing complaints during the fiscal year, for all cases, from date of original receipt of the complaint, for each stage of discipline, through completion of judicial review:

	FY 09-10		FY 10-11	
Complaint Unit processing	76	63	**74**	**77**
Investigation	328	292	**312**	**283**
AG Processing to preparation of an accusation	106	66	**107**	**72**
Other stages of the legal process (e.g., after charges filed)	368	312	**417**	**324**

Enforcement Field Operations Caseload[2]

FY 10-11[6]	Statewide	Per Investigator
Active investigations	1,205	16
AG assigned cases[3]	660	9
Probation Unit Caseload[4]	**Statewide**	**Per Inspector**
Monitoring Cases[5]	402	25

1 Some cases closed were opened in a prior fiscal year
2 Includes physicians and surgeons, licensed midwives, research psychoanalysts, dispensing opticians, podiatrists, physician assistants, psychologists, and osteopathic physicians and surgeons
3 These cases are at various stages of AG processing and may require supplemental investigative work, such as subpoena services, interviewing new victims or witnesses, testifying at hearings, etc.
4 Includes physicians and surgeons, licensed midwives, research psychoanalysts, and dispensing opticians
5 103 additional monitoring cases were inactive because the probationer was out of state as of June 30, 2011
6 Average is determined by using the total number of authorized positions, including vacant positions.

Complaints Received by Type & Source

	Fraud	Health & Safety[1]	Non-Jurisdictional[2]	Gross Negligence/ Incompetence[3]	Other Category	Personal Conduct[4]	Unprofessional Conduct[5]	Unlicensed/ Unregistered	Total
Public	42	68	1,047	2,427	0	55	1,041	138	4,818
B&P Code[6]	0	1	0	787	0	86	25	0	899
Licensee/ Prof. Group[7]	11	13	20	50	0	42	137	32	305
Government Agency[8]	8	20	7	84	64	247	401	96	927
Misc./ Anonymous	20	15	11	29	0	13	45	40	173
Totals	81	117	1,085	3,377	64	443	1,649	306	7,122

1 Health and Safety complaints, e.g., excessive prescribing, sale of dangerous drugs, etc.
2 Non-jurisdictional complaints are not under the authority of the Board and are referred to other agencies such as the Department of Health Care Services, Department of Managed Health Care, etc.
3 Gross Negligence/Incompetence complaints are related to the quality of care provided by licensees
4 Personal Conduct complaints, e.g., licensee self-abuse of drugs/alcohol, conviction of a crime, etc.
5 Unprofessional Conduct complaints include sexual misconduct with patients, discipline by another state, failure to release medical records, etc.
6 Reference is to B&P Code §§800 and 2240(a) and includes complaints initiated based upon reports submitted to the Medical Board by hospitals, insurance companies and others, as required by law, regarding instances of health facility discipline, malpractice judgments/ settlements, or other reportable activities
7 Licensee/Professional Group includes the following complaint sources: other Licensee, Society/Trade Organization, and Industry
8 Governmental Agency includes the following complaint sources: Internal, Law Enforcement Agency, other California State Agency, other State, other Unit of Consumer Affairs, and Federal or other Governmental Agency

Reports Received Based Upon Legal Requirements

	FY 09-10	FY 10-11
Medical Malpractice		
Insurers: B&P Code §801.01	556	**482**
Attorneys or Self-Reported or Employers: B&P Code §801.01	253	**224**
Courts: B&P Code §803	8	**4**
Total Malpractice Reports	817	**710**
Coroners' Reports: B&P Code §802.5	18	**15**
Criminal Charges & Convictions: B&P Code §§802.1 & 803.5	122	**74**
Health Facility Discipline Reports Medical Cause or Reason: B&P Code §805	99	**93**
Outpatient Surgery Settings Reports Patient Death: B&P Code §2240(a)	6	**5**

Enforcement Program Action Summary

	FY 09-10	FY 10-11
Administrative Actions		
Accusation	276	**265**
Petition to Revoke Probation	24	**35**
Amended Accusation/Petition to Revoke Probation	62	**78**
Number of completed investigations referred to the AG awaiting the filing of an Accusation as of June 30, 2011	156	**173**
Number of cases over 6 months old that resulted in the filing of an Accusation	224	**213**
Administrative Outcomes		
Revocation	34	**38**
Surrender (in lieu of Accusation or with Accusation pending)	71	**46**
Suspension Only	0	**0**
Probation with Suspension	13	**15**
Probation	93	**82**
Probationary License Issued	19	**23**
Public Reprimand	116	**108**
Other Actions (e.g., exam required, educational course, etc.)	3	**5**
Accusation Withdrawn[1]	11	**14**
Accusation Dismissed	8	**7**
Dispositions of Probation Filings		
Probation Revoked or License Surrendered	14	**11**
Additional Suspension and Probation	2	**1**
Additional Suspension or Probation	9	**3**
Public Reprimand	0	**1**
Other	1	**1**
Petition Withdrawn/Dismissed	1	**1**
Referral and Compliance Actions		
Citation and Administrative Fines Issued	111	**65**

	FY 09-10	FY 10-11
Petition Activity		
Petition for Reinstatement of License Filed	16	**20**
Petition for Reinstatement of Licensed Granted	5	**5**
Petition for Reinstatement of License Denied	6	**7**
Petition for Penalty Relief[2] Granted	26	**26**
Petition for Penalty Relief[2] Denied	9	**8**
Petition to Compel Exam Filed	20	**19**
Petition to Compel Exam Granted	20	**11**
Petition to Compel Exam Denied	0	**0**
License Restrictions/Suspensions Imposed While Administrative Action Pending		
Interim Suspension Orders	19	**21[3]**
Temporary Restraining Orders	0	**1**
Other Suspension Orders	31	**38[4]**
License Restrictions/Suspensions/Temporary Restraining Orders Sought and Granted by Case Type		
Note: *Some orders granted were sought in prior fiscal year.*	**Sought**	**Granted**
Gross Negligence/Incompetence	12	**13**
Inappropriate Prescribing	6	**6**
Unlicensed Activity	1	**2**
Sexual Misconduct	6	**7**
Mental/Physical Illness	3	**11**
Self-Abuse of Drugs or Alcohol	6	**6**
Fraud	4	**4**
Criminal Charges/Conviction of a Crime	2	**7**
Unprofessional Conduct	5	**4**
Total	45	**60**

Administrative Outcomes by Case Type[5]

	Revocation	Surrender	Suspension Only	Probation with Suspension	Probation	Probationary License Issued	Public Reprimand	Other Action	**Total Actions**
Gross Negligence/Incompetence	4	13	0	1	35	0	70	2	**125**
Inappropriate Prescribing	6	5	0	4	8	0	7	0	**30**
Unlicensed Activity	0	0	0	0	1	0	1	0	**2**
Sexual Misconduct	7	6	0	2	3	0	2	0	**20**
Mental/Physical Illness	6	2	0	0	1	0	1	0	**10**
Self-Abuse of Drugs/Alcohol	0	4	0	2	12	0	1	0	**19**
Fraud	0	1	0	0	0	0	11	0	**12**
Conviction of a Crime	10	8	0	6	9	0	2	0	**35**
Unprofessional Conduct	5	7	0	0	9	23	13	1	**58**
Miscellaneous Violations	0	0	0	0	4	0	0	2	**6**
Totals by Discipline Type	**38**	**46**	**0**	**15**	**82**	**23**	**108**	**5**	**317**

[1] Accusations withdrawn for the following reasons: physician passed a competency exam; physician met stipulated terms and conditions; physician was issued a citation/fine instead; physician died, etc.

[2] Penalty Relief includes Petitions for Modification of Penalty and Petitions for Termination of Probation

[3] Pursuant to B&P Code §2220.05(c), ISOs and TROs were granted in the following priority categories: 2-gross negligence/incompetence resulting in death or serious bodily injury, 0-drug or alcohol abuse involving death or serious bodily injury, 2-excessive prescribing, 2-sexual misconduct with a patient, and 0-practicing under the influence of drugs/alcohol

[4] Includes 4–Automatic Suspension Orders per B&P Code §2236, 10-license restrictions per Penal Code §23, 20-out-of-state suspension orders per B&P Code §2310, 1–stipulated agreement to suspend or restrict the practice of medicine, and 3–suspension orders issued by the Chief of Enforcement for violation of probation condition

[5] Pursuant to B&P Code §2220.05(c), disciplinary actions were taken in the following priority categories: 38-gross negligence/incompetence resulting in death or serious bodily injury, 0-practicing under the influence resulting in death or serious bodily injury, 13-excessive prescribing, 16-sexual misconduct with a patient, and 1-practicing under the influence of drugs/alcohol

Enforcement Action Summary
Allied Health Care Professionals[1]

	FY 09-10	FY 10-11
Complaints/Investigations		
Complaints received	378	**488**
Complaints closed by Complaint Unit	309	**379**
Investigations		
Cases opened	210	**196**
Cases closed	201	**229**
Cases referred to the AG	102	**108**
Cases referred for criminal action	6	**18**
Number of Probation Violation Reports referred to AG	2	**3**
License Restrictions/Suspensions Imposed While Administrative Action is Pending		
Interim Suspension Orders	2	**7**
Other Suspension Orders	2	**3**[2]
Administrative Actions		
Accusation	22	**31**
Petition to Revoke Probation	2	**2**
Amended Accusation/Petition to Revoke Probation	6	**3**
Statement of Issues to deny application	5	**2**
Number of completed investigations referred to AG's Office awaiting the filing of an Accusation as of June 30, 2011	29	**15**
Administrative Outcomes		
Revocation	1	**13**
Surrender (in lieu of Accusation or with Accusation pending)	6	**6**
Probation with Suspension	2	**0**
Probation	17	**11**
Probationary License Issued	1	**5**
Public Reprimand	0	**1**
Other Actions (e.g., exam required, educational course, etc.)	0	**0**
Statement of Issues Granted (License Denied)	1	**2**
Statement of Issues Denied (License Granted)	5	**0**
Accusation/Statement of Issues Withdrawn	4	**4**
Accusation Dismissed	0	**1**
Dispositions of Probation Filings		
Additional Probation or Suspension	0	**1**
Probation Revoked or License Surrendered	1	**3**
Petition Withdrawn or Dismissed	0	**1**
Referral and Compliance Actions		
Citation and Administrative Fines Issued	11	**6**
Office Conferences Conducted	1	**0**
Petition Activity		
Petition for Reinstatement of license filed	0	**0**
Petition for Reinstatement of license granted	3	**0**
Petition for Reinstatement of license denied	0	**0**
Petition for Penalty Relief[3] granted	3	**1**
Petition for Penalty Relief[3] denied	2	**0**
Petition to Compel Exam granted	0	**0**
Petition to Compel Exam denied	0	**0**

Reports Received Based Upon Legal Requirements

	FY 09-10	FY 10-11
Medical Malpractice		
Insurers: B&P Code §§801 and 801.01	10	**14**
Attorneys or Self-Reported or Employers: B&P Code §§801 and 801.01	2	**3**
Courts: B&P Code §803	0	**1**
Total Malpractice Reports	12	**18**
Coroners' Reports: B&P Code §802.5	0	**1**
Criminal Charges & Convictions: B&P Code §§802.1 & 803.5	7	**2**
Health Facility Discipline Reports Medical Cause or Reason: B&P Code §805	0	**1**
Outpatient Surgery Settings Reports Patient Death: B&P Code §2240(a)	0	**1**

[1] Allied Health Care Professionals includes licensed midwives, research psychoanalysts, dispensing opticians, podiatrists, physician assistants, except in the categories of Investigations and License Restrictions/Suspensions Imposed While Administrative Action is Pending, which also includes psychologists and osteopathic physicians and surgeons

[2] Includes 2-license restrictions per Penal Code §23, and 1-stipulated agreement to suspend or restrict the licensee's practice

[3] Penalty Relief includes Petitions for Modification of Penalty and Petitions for Termination of Probation

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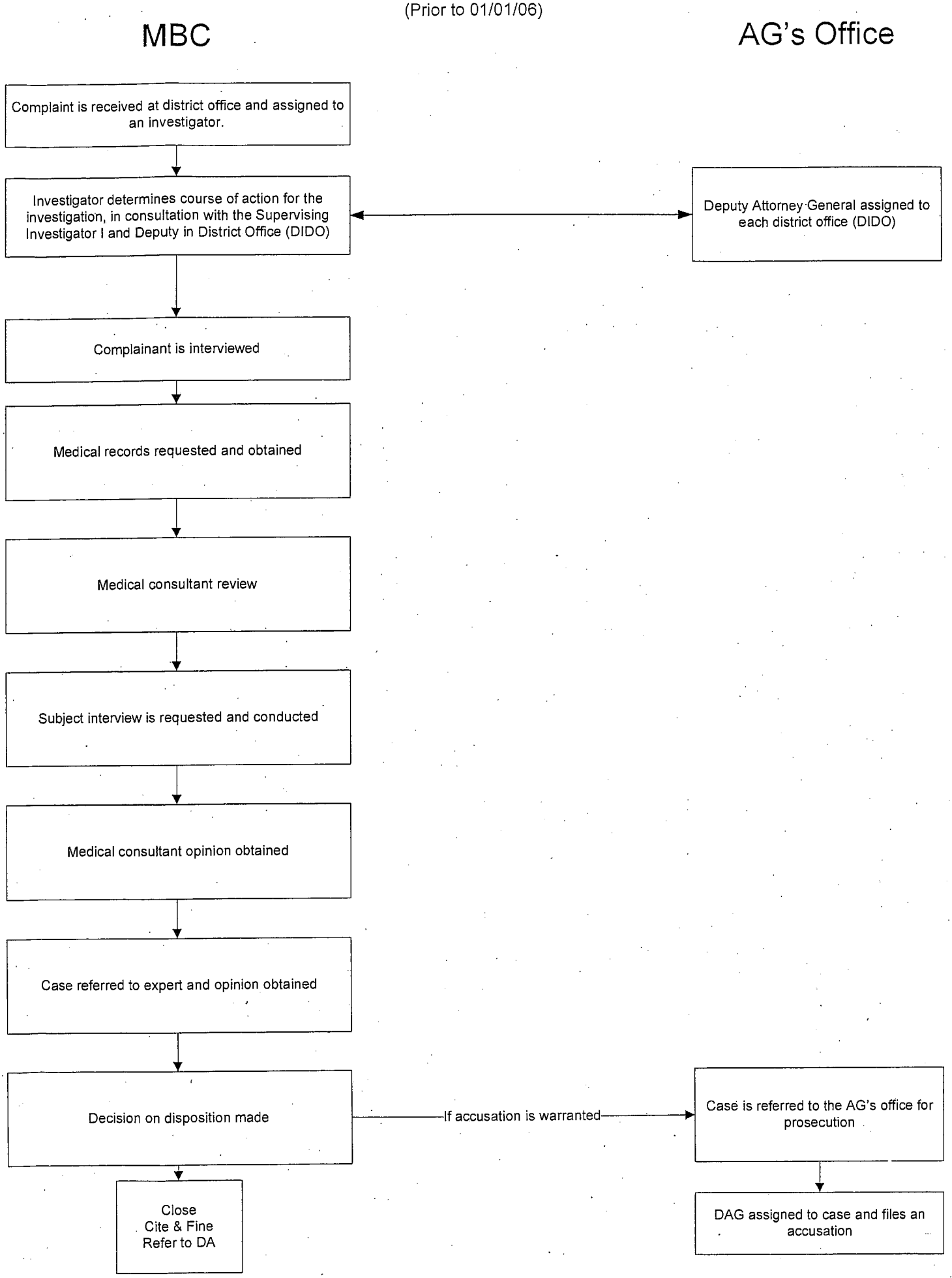
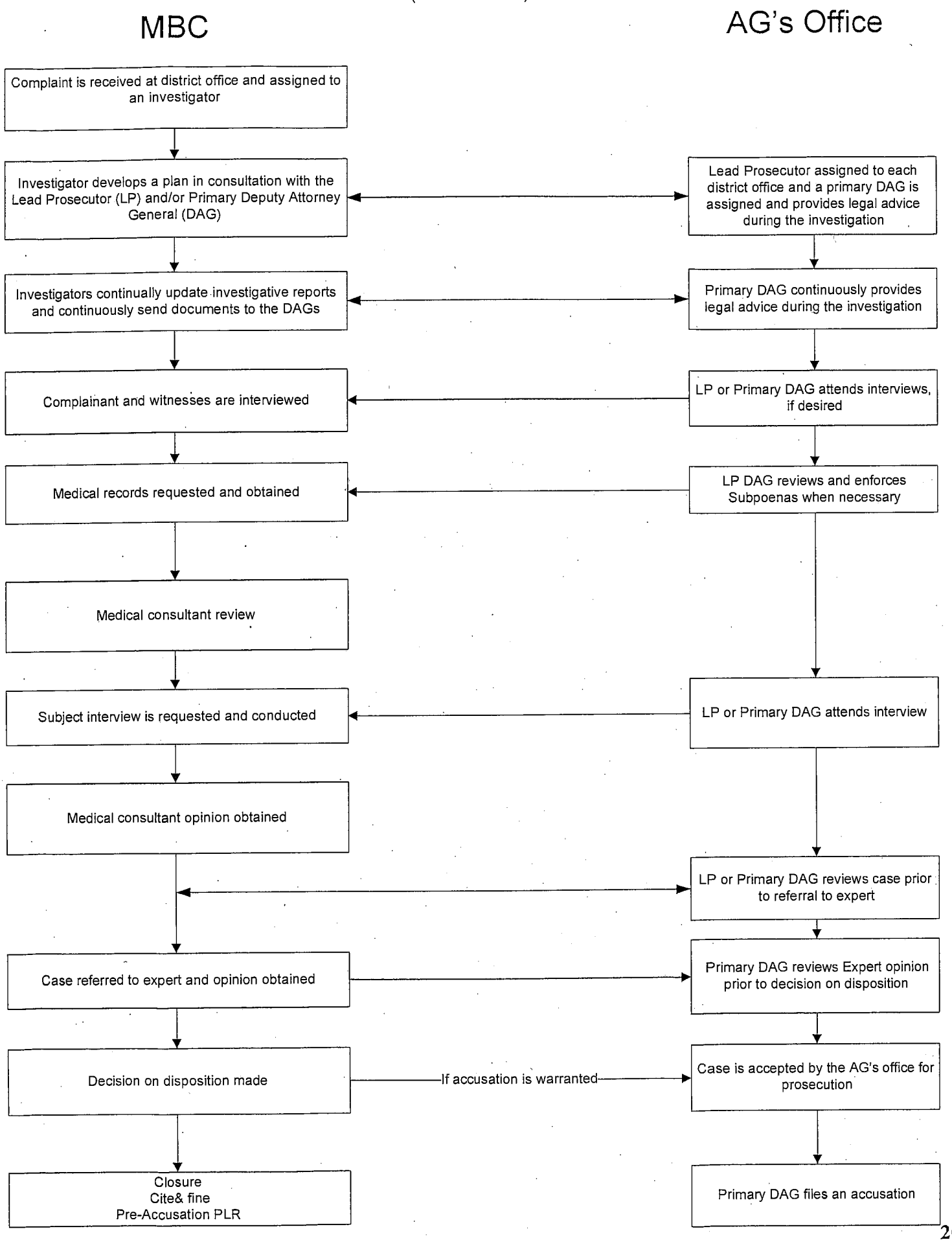
Investigative Process Before Vertical Enforcement and Prosecution (Prior to 01/01/06)



Investigative Process After Vertical Enforcement and Prosecution (After 01/01/06)



VERTICAL ENFORCEMENT PROGRAM

Process Overview

Government Code section 12529.6

The three principle elements of the "vertical enforcement and prosecution model" established by Government Code section 12529.6 can be briefly summarized as follows:

- Each physician and surgeon complaint referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an Investigator and to a Deputy Attorney General (DAG) in HQE. The DAG is responsible for prosecuting the case if the investigation results in the filing of an accusation.
- The joint assignment of the Investigator and Deputy Attorney General shall exist for the duration of the disciplinary matter.
- During the assignment, the Investigator so assigned shall, under the direction but not the supervision of the Deputy Attorney General, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action. (Gov.Code, section 12529.6, subd. (b).)

The Vertical Enforcement Team

- The "vertical enforcement model" is based on the team concept with each member working together with other members to achieve the common goal of greater public protection for the people of California.
- The development of a cohesive and positive team based on respect for the vital roles played by each team member is critical to the success of this program.
- Primary/Trial Deputy Attorneys General work closely with the Investigator and Medical Consultant team members during the investigation. They provide legal advice and direction to investigators as the case progresses.

The Vertical Enforcement Team (cont'd.)

- Lead Prosecutors are assigned to specific Board district offices, act as the principal liaison to that office, are jointly assigned with the Primary Deputy on each case and act as the Primary Deputy Attorney General when so assigned. Lead Prosecutors provide assistance onsite with investigative tools such as subpoena enforcement.

- Supervising Deputy Attorneys General oversee and monitor investigations within their respective geographical areas, and supervise the prosecution of cases when disciplinary charges are filed.

Improved Policies and Procedures

- Vertical Enforcement and Prosecution Manual, published in July 2011 imposes strict deadlines on investigators and deputies for completing important tasks.
- Joint training of investigator and deputies has enhanced the cohesiveness of the Vertical Enforcement Team.
- Expedited review of subpoenas for medical record procurement.
- No continuance of administrative hearings policy expedites resolution of administrative cases.
- On going medical expert reviewer training will improve the quality of medical expert opinions and enhance the resolution of cases.

Improved Public Protection

- Decreased the number of days required to obtain Interim Suspension Orders (ISO) from an average of 51 one days in 2005 to an average of 30 days in the current year.

- Increased the number of Penal Code Section 23 Orders obtained to an average of 36 in each of the last three years.

Improved MBC efficiency

- Decreased average number of days to complete complainant interview. Previously more than 100 days. Currently, 89 days.
- Decreased average number of days to complete Subject physician interview. Previously, 66 days. Currently, 51 days.
- Decreased average number of days to acquire medical records with release. Previously, 95 days. Currently, 64 days.
- Decreased average number of days to acquire medical records via Subpoena. Previously, 124 days. Currently, 82 days.

Improved HQE Efficiency

- Decreased the number of Accusations withdrawn. Previously, Average of 34 withdrawals per year. Currently, Average of 17 withdrawals per year.

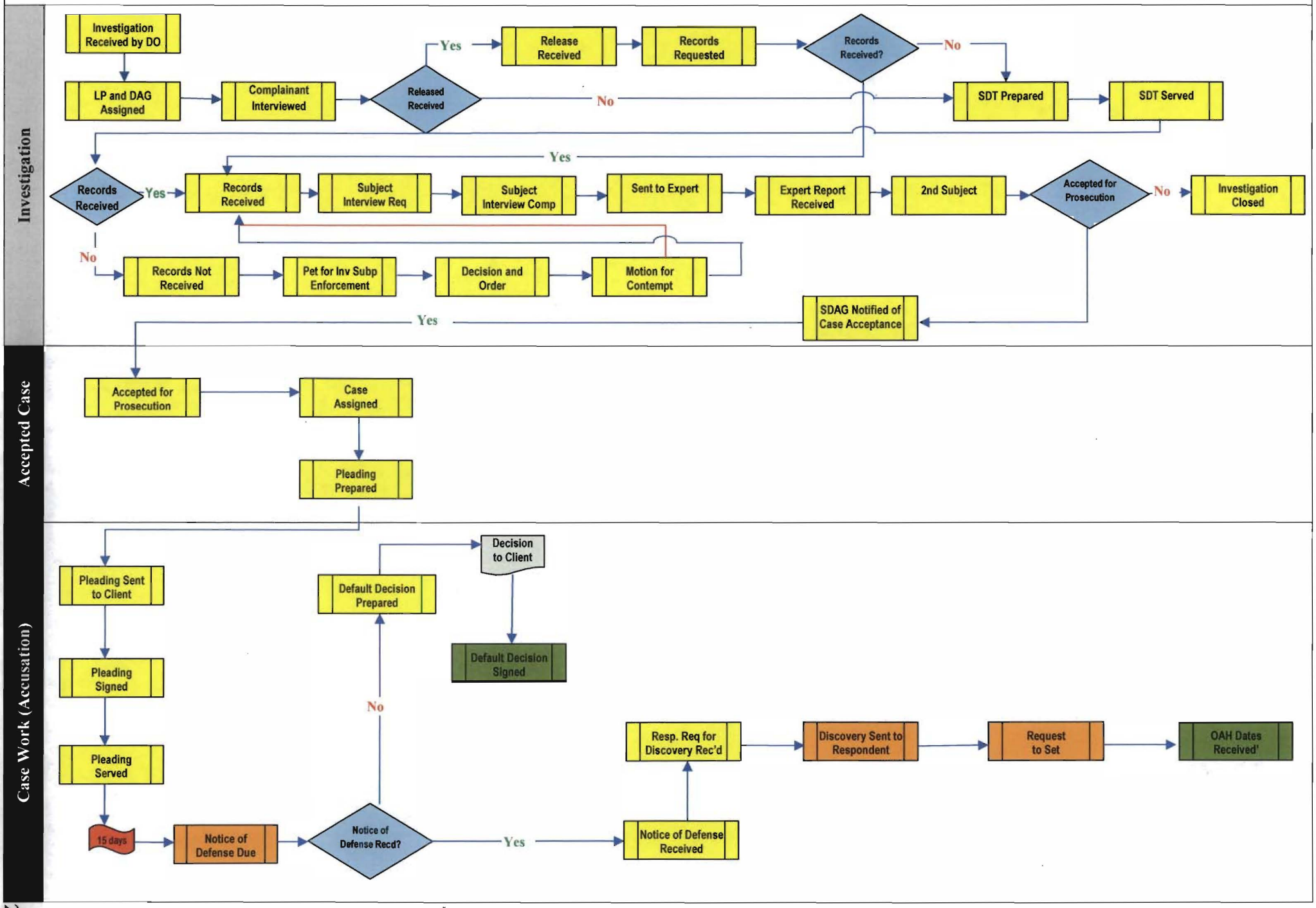
- Decreased number of Accusations Dismissed. Previously, Average of 11 dismissals per year. Currently, Average of 8 dismissals per year.

- Increased percentage of cases settled without hearing. 65% in 2005 versus 77% in 2011.

Conclusion

- Improved Public Protection.
- Improvements in the investigation and prosecution stages.
- Investigation and prosecution process continues to be impacted by external forces.

Vertical Enforcement: Investigation an Accusation Flow Chart



SB 100 – Outpatient Surgery Settings

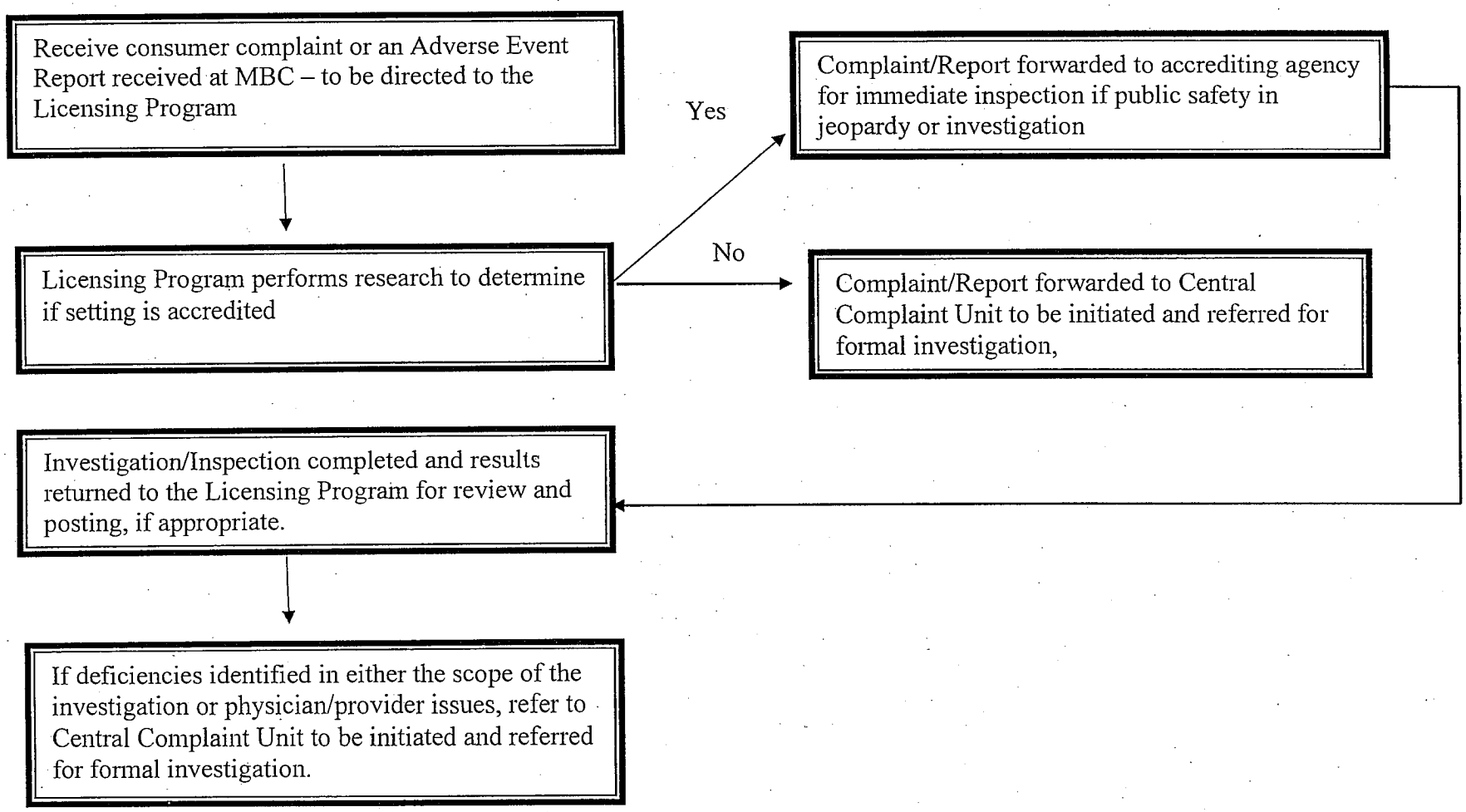
The bill requires MBC to maintain and publish a list of all accredited outpatient settings and provide information regarding the status of their accreditation. This portion of the statutory requirements is assigned to the Licensing Program and the status of implementation was reported directly to the Licensing Committee.

SB 100 also required the Medical Board to investigate complaints related to a violation of Health and Safety Code Section 1248 and, upon discovery that an outpatient setting is not in compliance with a specific provision, bring an action through or in conjunction with a district attorney to enjoin the outpatient setting's operation. In addition, SB 100 made outpatient settings subject to the adverse event reporting requirements currently required for licensing health facilities. Adverse events are reported to the Department of Public Health and the setting can be subject to penalties by Public Health for failing to report adverse events.

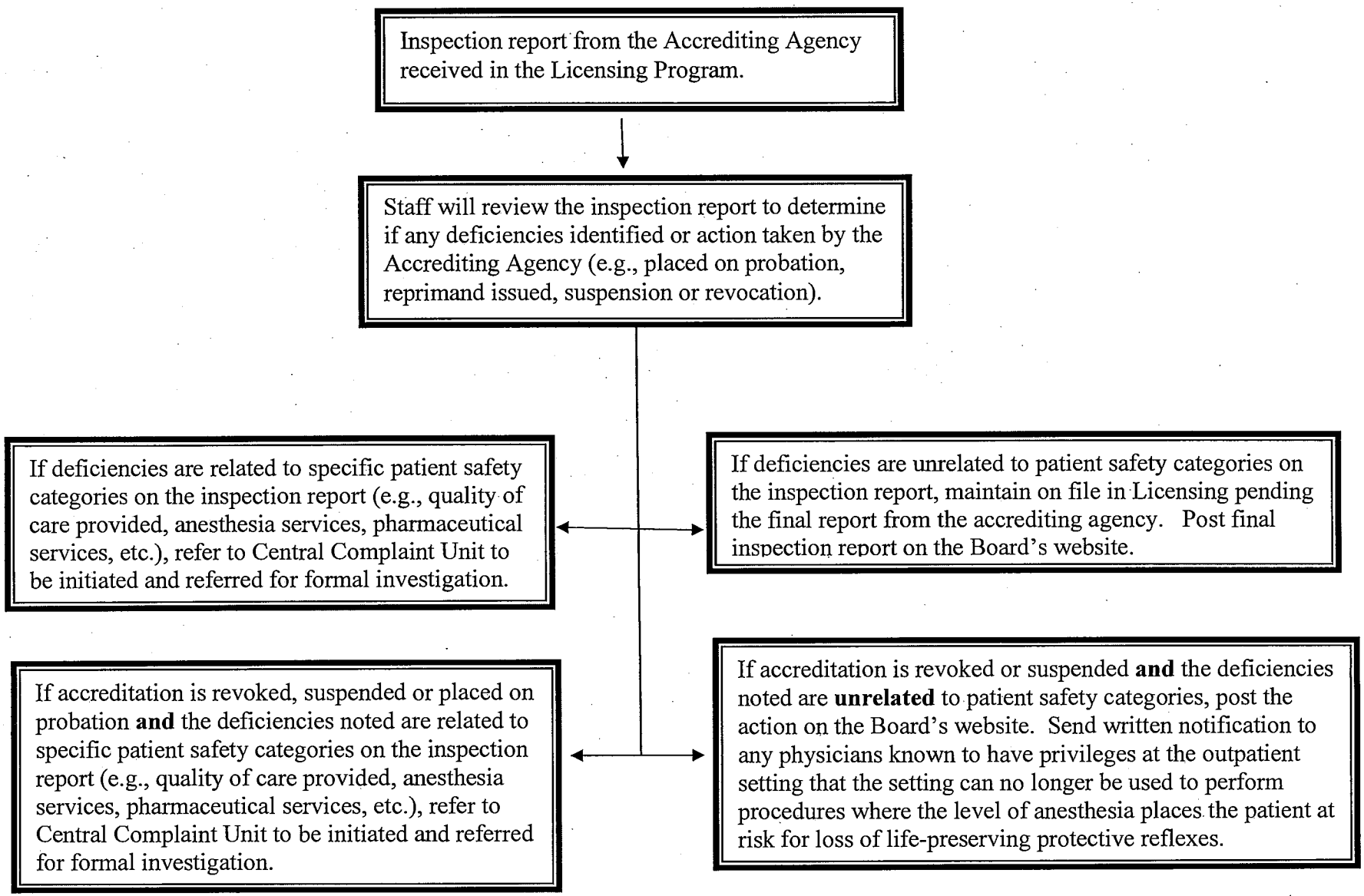
The following identifies the responsibilities assigned in statute to pertinent entities as it relates to oversight and response to patient care concerns:

H & S Section	Accrediting Agency	Medical Board
1248.35	Every outpatient setting shall be inspected no less often than 3 years.	May inspect the setting as often as necessary and shall ensure the accrediting agency conducts the required inspection
	If the results of the inspection conclude that the setting is out of compliance, they must issue a deficiency report and may 1) require correction, 2) issue a reprimand; 3) place the setting on probation; or 4) suspend or revoke the accreditation.	The accrediting agency must report within 24 hours if the setting has been issued a reprimand, been placed on probation or had the accreditation suspended or revoked.
	Shall inspect the setting within 24 hours upon receipt of a complaint from the Board that the setting poses an immediate risk to the public	Shall receive the findings of the inspection within five business days
	Shall investigate any complaint received from the Board within 30 days	Shall receive the findings of the investigation within 30 days
		Reports on the results of any inspection shall be maintained on file and final inspection reports shall be public record open to public inspection.
1248.7		Shall investigate all complaints concerning a violation of this chapter and, where appropriate, through or in conjunction with a DA may bring action to enjoin the setting's operation.

Complaint Process



Enforcement Response to Action taken by an Accrediting Agency



ADVERSE EVENT REPORT
OUTPATIENT SURGERY CENTERS

Health and Safety Code Section 1248.15 makes outpatient settings subject to the adverse events reporting requirements mandated in Health and Safety Code Section 1279.1 as follows; Facilities shall report an adverse event no later than **five days** after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or **safety** of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. The outpatient setting must also report the incident to the affected patient or the patient's representative by the time of notification to the department.

Facility Information					
Facility Name					
Facility Address					
Contact Person Preparing Report:					
Contact Phone Number:					
Practitioner Information					
Name of Practitioner Performing Procedure:					
License No/License Type					
Patient Information					
Patient Name	**Last Name**		**First Name**		
Patient Address Information					
Patient Identifier (enter one of the following)					
Medical Record No.		Social Security No		Patient ID No.	
Adverse Event Information					
Date and Time Event Occurred			**Date of Report**		
Date and Time Event Detected			**Date Patient/Pt. Rep. Notified**		
Adverse Event Category	o Surgical Event o Product/Device Event o Patient Protection Event		o Care Management Event o Environmental Event o Criminal Event		
Description of Event:					

Signature of Person Preparing Report **Date**

If a licensee fails to report an adverse event pursuant to Section 1279.1, the department may assess a civil penalty in the amount not to exceed $100 for each day that the adverse event is not reported pursuant to Health and Safety Code Section 1280.4

Surgical Event, including but not limited to:

- Surgery performed on a wrong body part inconsistent with the documented informed consent
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Retention of foreign object in a patient after surgery or other procedure
- Death during or up to 24 hours after induction of anesthesia in a normal, healthy patient

- Other _____

_____

_____

Product or device events, including but not limited to:

- A patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the facility
- A patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this section, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
- A patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism

- Other _____

_____

_____

Patient protection events, including but not limited to:

- A patient death or serious disability associated with patient disappearance for more than four hours
- A patient suicide or attempted suicide resulting in serious disability while being cared for in a facility

- Other _____

_____

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Care management events, including but not limited to

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- A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration
- A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
- A patient death or serious disability due to spinal manipulative therapy performed at the facility

- Other _____.

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Environmental events, including but not limited to

- A patient death or serious disability associated with an electric shock while being cared for in a facility
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
- A patient death or serious disability associated with a burn incurred from any source while being cared for in a facility.
- A patient death associated with a fall while being cared for in a facility.
- A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a facility

- Other _____

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Criminal events, including but not limited to

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
- Sexual assault on a patient within or on the grounds of a facility.
- The death or significant injury of a patient or staff member resulting from a physical assault that occurred within or on the grounds of the facility.

- Other_____

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