Medical Board of California

Program Evaluation
Volume II – Final Report

BENJAMIN FRANK LLC
MANAGEMENT CONSULTANTS

August 31, 2010

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August 31, 2010

Ms. Linda Whitney, Executive Director
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, California 95815

Program Evaluation
Volume II – Final Report

Dear Ms. Whitney,

We are pleased to present this *Final Report* which documents the major findings, conclusions, and recommendations resulting from our review of the Medical Board's programs. The report presents results of extensive analyses we performed of the Medical Board's complaint intake and screening, investigation, and prosecution processes, including numerous analyses targeted specifically on assessing fiscal and program performance impacts resulting from implementation of Vertical Enforcement (VE) during 2006. Additionally, we completed assessments of other aspects of the Board's programs as required pursuant to our contract with the Board. A condensed version of this report is provided under separate cover (*Volume I – Summary Report*).

In addition to quantitative and qualitative analyses, this report includes summaries of the results of reviews we completed of several dozen individual investigation and prosecution case histories. The individual case histories help to illustrate certain aspects of various problems currently being experienced by the Medical Board that are not as apparent from anecdotal input or statistical data. Some of these cases have already been settled or closed, while other cases are still pending final disposition. Because of the sensitive and confidential nature of these matters, considerable information was excluded from this report regarding the nature of the cases and their handling by the Medical Board and HQES.

* * * * * * * * *

We appreciate the opportunity to be of service to the Medical Board. If you have any questions or need additional information, please contact me at 916.425.1475.

Very truly yours,

BENJAMIN FRANK, LLC

Ben Frank

Benjamin Frank
Chief Executive Officer

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I. Introduction

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I. Introduction

During 2009 the Medical Board, along with all of the State's other health profession licensing programs, were the subject of a series of critical reports in the Los Angeles Times and other newspapers that highlighted the extended timeframes needed to complete investigations and initiate disciplinary actions against regulated professionals. These reports also highlighted related problems with large, and growing, workloads and backlogs at these agencies. In response to this recent publicity, a series or organizational changes were implemented at the Board of Registered Nursing, which was the primary focus of these reports. Additionally, the Governor and the newly-appointed Director of Consumer Affairs pledged to implement broad reforms to improve patient safety by reducing backlogs of work at all of the health profession licensing Boards, and initiating administrative and program oversight improvements. Concurrently, at its July Quarterly Meeting, the members of the Medical Board's Governing Board expressed concerns about the newspaper reports, and about growing backlogs of work in the Licensing and Enforcement programs, increased turnover of staff, the impacts of work furloughs, and management's plans to achieve meaningful effectiveness and efficiency improvements.

To address the above concerns, the Governing Board authorized the Executive Director to undertake a comprehensive, independent evaluation of the Medical Board. A Request for Offers (RFO) to perform the study was issued on August 25, 2009. During September 2009 the Medical Board conducted bidder interviews, completed its evaluation of proposals, and awarded the contract to Benjamin Frank, LLC. A contract to perform the assessment was issued on October 26, 2009. Performance of the contract commenced on November 4, 2009. The term of the contract extends to August 31, 2010.

This remainder of this section summarizes the purpose and scope of this study and our technical approach to performing the assessment. The section also includes a summary of significant data constraints and limitations and their potential impacts on the assessment. Subsequent sections of the report are organized as follows:

Section	Title
II.	Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program
III.	Fees, Expenditures, and Fund Condition
IV.	Profile of Complaints Opened and Dispositions
V.	Complaint Intake and Screening
VI.	Investigations
VII.	Prosecutions and Disciplinary Outcomes
VIII.	Probation Program
IX.	Integrated Assessment of Enforcement Program Performance
X.	Organizational and Management Structures
XI.	Licensing Program.

I. Introduction

A. Project Purpose and Scope

As set forth in the Medical Board's RFO, the purpose of this study was to conduct an independent and unbiased review of the Medical Board's organizational structure and core programs to identify strengths and weaknesses of current operations and develop recommendations for improvements. The scope of the review encompassed assessment of the Medical Board's governance structure including:

- Board size and composition
- Board capability to fulfill its mission, goals, and objectives
- Board meeting effectiveness in policy development
- The effectiveness of training provided to Board members.

The study scope also encompassed review of the Medical Board's internal organizational and management structures. Additionally, the study scope included assessment of:

- The sufficiency of fees to meet legislative goals and mandates
- The value of services provided by external agencies
- The value of services provided by contractors
- The uses and effectiveness of major equipment purchases
- Identification of laws, regulations, policies, and procedures that may hinder effectiveness
- The effectiveness of IT applications used for enforcement and licensing.

Finally, the study scope included development of other recommendations for improvement, including assessment of the possible elimination or transfer of non-critical functions to enable re-direction of resources to critical functions.

Initially, to refine the scope and focus of our assessment efforts, we completed a preliminary diagnostic review of the Medical Board's expenditures and Enforcement Program performance during the past five (5) years. The results of this review indicated that, subsequent to implementation of Vertical Enforcement during 2006, costs for legal services provided by the Attorney General escalated rapidly while other legal service costs declined. Concurrently, the number of cases referred for investigation, the number of completed Investigations referred for Prosecution, the number of accusations filed, the number of stipulated settlements and proposed decisions submitted, and the number of disciplinary actions all declined. Additionally, the average elapsed time to complete investigations increased while the average elapsed time to complete prosecutions declined.

I. Introduction

Given the amount of funding utilized for legal services provided by the Attorney General (currently more than $1 million per month) and these other cost and Enforcement Program performance trends, it was jointly determined, in consultation with Medical Board management, that the primary focus of this assessment should be on (1) identifying and assessing the impacts of the VE Pilot Project on the Enforcement Program, (2) identifying and assessing the benefits provided from the increased expenditures for VE-related legal services, (3) identifying and assessing other factors contributing to deteriorating Enforcement Program performance, and (4) developing an *Enforcement Program Improvement Plan*.

B. Technical Approach

Out approach to performing this assessment was initially organized into the following major components:

- Assessment of licensing fees and fund condition
- Assessment of cashiering business units and processes
- Assessment of Licensing Program business units and processes
- Assessment of complaint-handling business units and processes
- Assessment of investigation and prosecution business units and processes
- Assessment of Probation Program business units and processes
- Assessment of internal organizational structure and effectiveness
- Assessment of Governing Board size, composition, and effectiveness.

A summary of our approach to performing each of these tasks is provided below.

1. Assessment of Licensing Fees and Fund Condition

As part of this assessment we collected, compiled, and summarized data regarding historical and projected revenues and expenditures. Additionally, we reviewed and summarized the history of the Medical Board's licensing fees and statutory requirements pertaining to the Medical Board's fund reserves. We also reviewed prior reports prepared by the Bureau of State Audits concerning the Medical Board's fund condition. Finally, we conducted analyses of current and projected revenues and expenditures, the sufficiency of the Medical Board's reserve funds, and compliance with applicable statutory requirements.

2. Assessment of Cashiering Business Units and Processes

As part of this assessment we interviewed the Supervisor of the Medical Board's Cashiering Unit. We also interviewed the Supervisor of DCA's Cashiering Unit.

3. Assessment of Licensing Business Units and Processes

The assessment of Licensing Program business units and processes was limited to conducting a critical review of a recently completed detailed analysis of Licensing Program business units and processes that was recently completed by another consulting firm (Hubbert Systems Consulting). We also incorporated results of assessments we completed in other related areas.

4. Assessment of Complaint-Handling Business Units and Processes

As part of this assessment we collected, compiled, and analyzed complaint-handling workload, workflow, staffing, and performance data covering the period from 2000/01 through 2009/10. Additionally, we scheduled and conducted individual and small group interviews with Central Complaint Unit (CCU) managers, supervisors, and staff. We also researched and summarized the history and evolution of the Medical Board's complaint-handling processes. Our analyses focused on changes in performance during the past several years and on assessment of the impacts of Medical Specialist reviews on process performance.

5. Assessment of Investigation and Prosecution Business Units and Processes

As part of this assessment we collected, compiled, and analyzed investigation and prosecution workload, workflow, staffing, and performance data covering the period from 2000/01 through December 2009. Additionally, we researched and summarized the history and evolution of the Medical Board's investigation and prosecution processes. We scheduled and conducted individual interviews with Enforcement Program Managers and individual and small group interviews with Supervisors and Investigators at six (6) District offices throughout the State. We also scheduled and conducted interviews with representatives of HQES' offices in Los Angeles, Sacramento, San Diego, and San Francisco and with representatives of DCA's Division of Investigation. Finally, we collected, compiled, and analyzed HQES billings to the Medical Board and data provided by HQES regarding hours charged for investigation and prosecution services. Our analyses focused on identification and assessment of changes in performance since implementation of the VE Pilot Project during 2006. To develop a better understanding of variations and changes in Enforcement Program performance, and problems currently experienced, we researched several dozen individual case histories.

6. Assessment of Probation Program Business Units and Processes

As part of this assessment we collected, compiled, and analyzed Probationer-related workload, workflow, staffing, and performance data covering the period from 2000/01 through December 2009, including workload, workflow, and performance data related to the review and investigation of complaints involving Probationers, and petitions for modification or termination of probation. We also researched and summarized the history and evolution of the Probation Program. Additionally, we scheduled and conducted interviews with current and former Probation Program Managers and Supervisors. We also discussed the handling of probation cases with representatives of HQES' offices in Sacramento, San Francisco, Los Angeles, and San Diego. Finally, to develop a better understanding of variations and changes in Probation Program performance, and problems currently experienced, we researched several individual case histories.

7. Assessment of Internal Organizational Structure and Effectiveness

The assessment of internal organizational structure and effectiveness focused on review and analysis of the different approaches used by HQES to direct the completion of investigations in different geographic regions of the State. Additionally, we assessed the dual management structure used to direct Medical Board Investigators in conducting investigations. Finally, we identified and assess alternative approaches to organizing and management investigations and prosecutions.

8. Assessment of Governing Board Size, Composition, and Effectiveness.

As part of this assessment we researched and summarized the history and evolution of the Governing Board's structure, size, and composition. We also developed a customized survey to obtain input from all Board members regarding the Board's structure, size, composition, effectiveness, training provided to members of the Board, and suggestions for improvements. A sufficiently high response rate was not reached to enable development of any findings, conclusions, or recommendations for improvements based on the survey responses.

C. Medical Board Data Constraints and Effects

As part of this assessment Medical Board staff produced several dozen sets of data pertaining to the intake, screening, investigation, and prosecution of complaints, disciplinary outcomes, and other related activities and events. The data provided also included mandated reports submitted by licensees, insurers, and other government agencies, reports submitted by medical/osteopathic boards in other states, Medical Board-originated complaint records, petitions for modification or termination of probation, Petitions for reinstatement, and other matters that are tracked using the Medical Board's Complaint Tracking System (CAS), such as statements of issues (SOIs) and probationary license certificates issued to some new licensees in lieu of full licensure. We filtered, compiled, summarized, and analyzed the data provided as needed for purposes of this study. Where required, we requested and were provided with replacement or supplemental sets of data were requested and provided. To the extent practicable we corrected significant anomalies in the data and, where appropriate, excluded some records from our analyses.

In any database as large as that maintained and used by the Medical Board for tracking complaints, investigations, prosecutions, and disciplinary actions, there is always some incomplete or incorrect data (or "noise"). However, as best we can determine, the data used for our analyses was substantially complete and reasonably accurate. Also, isolated variances in individual records would generally tend to have offsetting impacts and, even if the variances were not offset, the isolated variances would not significantly impact aggregate annual measures of workload, output, or performance. Also, any impacts on the aggregate measures would tend to be consistent over time in both direction and magnitude.

In the past, and currently, a major area of contention between the Medical Board and HQES involves differences in how the two agencies determine the average amount of time that elapses between referral (or transmittal) of a case to HQES for prosecution and filing of an accusation. The Medical Board generally measures the total elapsed time from transmittal of the case to HQES to the filing of the accusation. HQES generally measures the elapsed time from its acceptance of a case for prosecution to completion of its preparation of a pleading. Several significant differences between the measurement approaches used by the two agencies are outlined below.

- The Medical Board's measurement approach includes the elapsed time between transmittal of the case to HQES and HQES' acceptance of the case for prosecution. Generally, the difference between these two approaches should be limited to a period of just a few days or, at most, a few weeks. However, in some cases HQES requests that the Medical Board complete a supplemental investigation and may not formally accept the case for prosecution until the supplemental investigation is completed and accepted. In some cases, multiple supplemental investigations may be requested. In these circumstances the elapsed time between transmittal of the case and filing of the accusation includes a significant amount of time related to completing one or more supplemental investigations. This additional elapsed time would be included in the Medical Board's elapsed time measures, but not in the HQES' elapsed time measures.

- The Medical Board's elapsed time measurement approach includes elapsed time from HQES' submittal of the accusation to the Medical Board to the filing of the accusation. In some cases the Medical Board may request that HQES modify the accusation which can delay the filing. This additional elapsed time is included in the Medical Board's elapsed time measures, but not in HQES' elapsed time measures.

Because of these and other differences, the average elapsed time metrics calculated by HQES are necessarily significantly shorter than the average elapsed time metrics calculated by the Medical Board.

While the data maintained in CAS appears to be reasonably complete and accurate for most data elements, it appears that some updates to CAS are not always consistently posted by District office staff for various interim investigation activities, including activities involving (1) medical records requests, (2) Complainant and Subject interviews, and (3) Medical Consultant case reviews. In some cases CAS is updated to show when the activity commenced (e.g., requested medical records, requested or scheduled a Complainant or Subject interview, or submitted records to the Medical Consultant or a Medical Expert for their review), but CAS is not updated to show when the activity was completed). In other cases CAS is updated only when the activity is completed, or not updated to show either initiation or completion of the activity. Sometimes, interim investigation activity updates are not posted until the investigation is completed. To varying degrees, District office Supervisors post updates to CAS when reviewing completed case files prior to closure or referral of the case for prosecution. Consequently, statistical data generated regarding these interim activities, although more complete with the passage of time, may still understate actual activity levels. Additionally, measures of the average elapsed time to complete these interim activities may not be representative of actual performance. The measures related to obtaining Medical Records are especially limited. Medical records are sometimes requested from multiple sources for the same case, but the Medical Board's performance measures typically only count each case once. Also, in some cases the records submitted are incomplete or overly redacted and are re-requested. The Medical Board's measures count the records as received irrespective of the completeness or quality of the records provided, and do not account for supplemental submissions. Because of these deficiencies and complexities, we did not perform any analyses of changes in (1) the number of completed medical records requests, or (2) the average elapsed time to submit responses to these requests.

In the past concerns have surfaced about the extent to which measures of Enforcement Program performance focus on outputs without consideration of the quality of the outputs (e.g., measures of the number of cases referred for prosecution, without consideration of the quality of the completed investigations). Our analysis included assessment of the following measures which potentially reflect the quality of completed investigations, but which have various inherent limitations:

Supplemental Investigations – If a completed investigation does not contain sufficient evidence to meet the burden of proof, HQES can request a supplemental investigation to address the deficiencies. However, HQES Attorneys sometimes request supplemental investigations to strengthen a case even though another HQES Attorney might consider the initial submission sufficient without further investigation.

HQES Decline to File – If a completed investigation does not contain sufficient evidence to meet the burden of proof that cannot reasonably be corrected with a supplemental investigation, HQES can decline to file the case. However, HQES Attorneys sometimes reject cases that other HQES Attorneys accept for prosecution.

Accusations Withdrawn or Dismissed – If after an accusation is filed it is determined that there is insufficient evidence to meet the burden of proof, HQES can, with the permission of the Board, withdraw the accusation or, if the case proceeds to hearing, the Hearing Officer can dismiss the case. However, accusations can be, and oftentimes are, withdrawn or dismissed for reasons completely unrelated to the quality of the completed investigation (e.g., successful completion of Diversion Program, death of the physician, settlement with a citation or public letter of reprimand, cancellation of the license, modified Expert opinion, etc.).

A final area of concern about statistical measures of Enforcement Program performance involves consideration of not just the number of disciplinary actions taken by the Medical Board, but also the level of discipline imposed. To address this concern, our assessment includes analysis, where appropriate, of the number and proportion of public reprimands compared to other types of discipline imposed (license revocation, surrender, suspension, or probation). Additionally, where appropriate, we segregated disciplinary actions taken related to complaints investigated by the Medical Board's District offices from disciplinary actions taken related to other types of cases (e.g., license surrenders resulting from disciplinary actions taken by medical/osteopathic boards in other states).

D. Health Quality Enforcement Section Data Constraints and Effects

In the past, concerns have been expressed about the failure to include HQES data in prior analyses of Enforcement Program performance. Accordingly, as part of this assessment, in mid-January 2010 we asked HQES' Senior Assistant Attorney General to provide us with detailed organization charts and staffing rosters for HQES, to disclose to us the availability of any workload, workflow, or performance data showing how VE had impacted investigation or prosecution processes, and to provide us with any general background information that would be helpful to us in performing our assessment. HQES provided us with staff rosters showing HQES positions, by office, but provided no other information to us in response to this request.

During February 2010 we met with the HQES' Supervising DAGs and selected Attorneys at HQES' offices in San Diego, Los Angeles, Sacramento, and San Francisco. At each of these meetings we requested copies of any background documents or statistical data that HQES thought might be helpful to us for purposes of our assessment of the impacts of VE on the investigation and prosecution processes. At these meetings we were told that Los Angeles-based HQES technical support staff could potentially provide us with workload, workflow, and performance data that was available from HQES' ProLaw System. With the exception of a one-page spreadsheet summarizing the number of Investigation and Administrative matters opened and closed by HQES during 2009, no other data or other background information was provided to us following these meetings.

On March 3, 2010, we submitted to HQES' Senior Assistant Attorney General a draft data request listing about 20 specific sets of data. The draft data request included requests for time series data for the past 4 to 5 years regarding:

- Numbers of hours charged to Investigation matters
- Numbers of Investigation matters opened and closed
- Numbers of Subject interviews attended
- Numbers of Expert opinions reviewed
- Numbers of Final Reports of Investigation reviewed
- Numbers of ISOs, TROs, and PC 23s
- Numbers of hours charged to Administrative matters
- Number of Administrative matters opened and closed
- Numbers of accusations and SOIs prepared
- Numbers of petitions to revoke probation prepared
- Numbers of stipulations prepared
- Number of administrative hearings attended.

We also requested extracts of data showing the migration of cases, by milestone, through the investigation and prosecution processes, and the hours charged to each completed case. We reviewed the draft data request with HQES' Senior Assistant Attorney General and HQES' technical support specialist to identify items for which sufficiently complete and reliable data were not available and to identify ways to better align the data request with the specific data elements captured within the ProLaw System. Finally, HQES agreed to provide us with the requested data on a flow basis as it was prepared, with a goal of providing all of the requested data by March 31, 2010. A

revised data request was transmitted to HQES' Senior Assistant Attorney General on March 9, 2010. The revised data request excluded nearly one-half of the items included in the draft data request because:

- The data is captured in ProLaw, but is substantially incomplete or reliable (e.g., numbers of investigation and Administrative cases closed)
- The data is only captured in ProLaw in non-standardized "case notes" (e.g., numbers of Subject interviews, Expert report reviews, and Report of Investigation reviews)
- More reliable data was believed to be available from the Medical Board (e.g., numbers of ISOs, TROs, and PC 23s).

We also consolidated data elements to make it simpler and easier for HQES to provide the requested data.

After a period of nearly a month, HQES provided a partial response to the revised data request. However, in terms of completeness and quality, there appeared to be some significant deficiencies with some of the data provided. We requested additional information from HQES regarding these deficiencies. HQES was non-responsive to this request.

On April 22, 2010, the Medical Board re-submitted the revised data request to HQES. Additionally, the Medical Board again requested an explanation of the completeness and quality deficiencies identified with some of the previously provided data. The Medical Board also requested additional data regarding hours charged for Investigation Stage-related activities that would supplement data previously provided by HQES regarding hours charged to specific Investigation matters. Finally, the Medical Board requested that HQES submit a schedule indicating when the requested data would be provided.

As of June 20, 2010, the following three (3) sets of useable statistical data had been provided by HQES:

- Numbers of Investigation matters opened, by HQES office, by year (CY2006 through CY2009)
- Numbers of hours charged to Investigation matters, by classification level, by HQES office, by year (CY2006 through CY2009)
- Numbers of hours charged to Administrative matters, by classification level, by HQES office, by year (CY2005 through CY2009).

During late-June, HQES provided data showing the number of Administrative matters opened by HQES office by year (CY2005 through CY2009). This data set also included information showing the completion of pleadings, settlement agreements, and other milestones for these matters. However, the data is incomplete because it does not include pleadings, settlement agreements, and other milestones completed during 2005, and subsequent years, related to Administrative matters opened by HQES during 2004 and prior years. Thus, the data was of limited utility for purposes of this analysis.

Finally, in mid-July HQES provided data showing Investigation matters opened by HQES office by year (CY2006 through CY2009). This data set also included information showing the assignment of an Attorney to each case and acceptance of the case for prosecution. However, because HQES only began tracking cases referred for investigation after January 1, 2006, the data provided for the first several years following implementation of Vertical Enforcement is incomplete and not representative of all completed investigations. For example, the cases shown as referred for prosecution during 2006 only includes cases referred for investigation after 2005 and, hence, only includes a small number of investigations that were completed in less than one (1) year. The data provided for cases referred for prosecution during 2009 (and possibly the latter part of 2008) is the only data that appears reasonably complete. The data provided for these cases is not completely consistent with comparable data separately provided by the Medical Board. For example, HQES' data shows somewhat fewer cases referred for prosecution, possibly due to failure to open separate Investigation matters for each complaint referred for investigation. On a statewide basis, the average elapsed timeframes to complete the investigations, as shown by HQES' data for cases referred for prosecution during 2008 and 2009, were similar to comparable data obtained from the Medical Board (e.g., an average elapsed time of about 15 to 16 months). However, because of the limitations mentioned above, the data provided by HQES for cases referred for prosecution during 2009 is not comparable to HQES' data for prior years (2006 through 2008). For 2009, HQES' data shows significantly longer average elapsed times to complete investigations of cases referred for prosecution in the Los Angeles Metro region than for other geographic regions of the State (an average of 16.8 months for the Los Angeles Metro region compared to an average of 15.3 months in the Other Southern California region and an average of 14.3 months in the Northern California region).

II. Overview of the Evolution of the Medical Board's Governance Structure, License Fees, and Enforcement Program

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II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

This section presents an overview of the history and evolution of the Medical Board's governance structure, licensing fees, and Enforcement Program. The overview of the Enforcement Program highlights a 35-year history of efforts to strengthen discipline and reduce the time required to complete complaint intake/screening, investigation, and prosecutorial processes. A more detailed chronicle of the history of the Medical Board from the mid-1970s through 2004/05 is included in the *Initial* and *Final Reports* prepared by the Medical Board Enforcement Monitor (dated November 1, 2004 and November 1, 2005, respectively). The section is organized as follows:

Subsection	Title
A.	Governing Board Structure and Composition
B.	Licensing Fees, Expenditures, and Fund Condition
C.	Complaint Intake and Screening
D.	Investigations and Prosecutions
1.	1980 to 1990
2.	1991 to 2000
3.	2001 to 2004
4.	2005 to 2009
E.	Section 805 Reports and Investigations
F.	HQES Staffing Resource Allocations
G.	Enforcement Program Attrition History
H.	Prior Analyses of the Impacts of Vertical Enforcement
1.	November 2007 Medical Board Analysis
2.	June 2009 Integrated Solutions for Business and Government, Inc. Analysis
3.	Medical Board Quarterly Reports
I.	Probation Program
J.	Diversion Program
K.	Current Enforcement Program Organization and Staffing Resource Allocations
L.	Pending 2010/11 Budget Change Proposals.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

A. Governing Board Structure and Composition

Prior to 1975, the Medical Board, known then as the Board of Medical Examiners (BME), had 11 members, of which 10 were physicians. During this period, responsibility for physician discipline was largely delegated to physician-dominated regional Medical Quality Review Committees (MQRCs). The MQRCs were five-member panels that held medical disciplinary hearings and made recommendations to the (BME). The BME rarely disciplined physicians for incompetence or gross negligence and nearly all disciplinary actions took two (2) to three (3) years to complete.

Concurrently, during the early-1970s, medical malpractice insurance premiums in the State skyrocketed due to increased costs associated with medical malpractice litigation. The insurance premium increases threatened to disrupt delivery of physician services, particularly to economically disadvantaged segments of the population. In response, the *Medical Injury Compensation Reform Act* (MICRA) was enacted (AB 1, Keene) during a 1975 Special Session of the Legislature. MICRA established a $250,000 cap on non-economic damages in medical malpractice actions, such as damages for pain and suffering, and limited the contingency fees that could be charged by the plaintiff's counsel. Additionally, MICRA abolished the Board of Medical Examiners and created a new Board of Medical Quality Assurance (BMQA) consisting of 12 physician members and seven (7) public members. BMQA was organized into three divisions:

- A 7-member Division of Licensing (DOL) responsible for administering licensing examinations, issuing licenses, and administering a new Continuing Medical Education (CME) program
- A 7-member Division of Medical Quality (DMQ) responsible for overseeing the BMQA's Enforcement Program and disciplinary actions
- A 5-member Division of Allied Health Professions (DAHP) responsible for overseeing non-physician Allied Health Licensing Programs (AHLPs) that were placed under the jurisdiction of the BMQA.

MICRA also transferred responsibility for investigating complaints against physicians from the Department of Consumer Affairs (DCA) to the BMQA, and added public members to the MQRCs which continued to be responsible for conducting disciplinary hearings. Finally, MICRA added several mandatory reporting requirements, including requirements that:

- Insurers and insureds report to the BMQA the payment of judgments, settlements, and arbitration awards in medical malpractice actions (Sections 801 and 802 of the Business and Professions Code)
- Court clerks report to the BMQA criminal charges and convictions against physicians (Section 803 of the Business and Professions Code)

- Hospitals and health care institutions report to the BMQA adverse peer review actions taken against physicians (Section 805 of the Business and Professions Code).

During 1990 the BMQA was renamed the Medical Board of California (AB 184, Speier) and, in 1993, the DAHP was abolished and its members were combined with the DMQ (SB 916, Presley). SB 916 also abolished the MQRCs and assigned responsibility for conducting medical disciplinary hearings to the Office of Administrative Hearings (OAH). SB 916 preserved the DMQ's authority to review disciplinary actions, but divided the DMQ into two panels for purposes of reviewing (1) stipulated settlement agreements (STIPs) that are oftentimes entered into in lieu of proceeding to an Administrative Hearing, and (2) proposed decisions (PDs) prepared by Administrative Law Judges (ALJs) for cases where a hearing is held.

Effective January 1, 2003, two (2) additional public members were added to the DMQ (SB 1950, Figueroa), thereby increasing the size of the Medical Board to 21 total members, including 12 physicians and nine (9) public members. With these additions, the DOL had seven (7) members (4 physicians and 3 public members) and the DMQ had 14 members (8 physicians and 6 public members). For purposes of reviewing STIPs and PDs, each DMQ panel was allocated seven (7) members (4 physicians and 3 public members).

Effective January 1, 2008, the DOL and DMQ were consolidated into a single 15-member governing Board, including eight (8) physicians and seven (7) public members (AB 253, Eng). This is the fewest physician members that the Medical Board has ever had. Additionally, AB 253 mandated that the Medical Board delegate to the Executive Director authority to adopt Default Decisions and specified types of STIPs.

To carry out its responsibilities, the Medical Board subsequently established the following 15 Standing Committees:

- Executive Committee
- Access to Care Committee
- Cultural & Linguistic Competency Work Group
- Public Education Committee
- Midwifery Advisory Council
- Physician Recognition Committee
- Special Faculty Permit Review Committee
- Special Programs Committee
- Physician Wellness Committee
- Malpractice Task Force
- Enforcement Committee
- Licensing Committee (including Application Review Subcommittee)
- Physician Supervision Advisory Committee (supervision of allied health professionals)
- Physician Discipline – Panel A
- Physician Discipline – Panel B.

B. Licensing Fees, Expenditures, and Fund Condition

During 1992, initial and biennial renewal fees for physicians and surgeons were increased to $480 ($240 per year) from $400 previously ($200 per year). Subsequently, during November 1993 the Medical Board adopted Emergency Regulations increasing initial and biennial renewal fees to $600 ($300 per year). The primary purpose of the higher fees was to fund a 100 percent increase in staffing for the Health Quality Enforcement Section (HQES) within the Office of the Attorney General (from 22 Attorney positions, to 44 Attorney positions). At the time, HQES Attorneys were carrying an average of 30 cases per position and taking an average of 16 months to file accusations. Initial and biennial renewal fees remained at the $600 level until 2003 when they were increased marginally to $610 ($305 per year).

Effective January 1, 2006, initial and biennial fees were statutorily increased to a maximum of $790 ($395 per year). This increase was needed to replenish the Medical Board's depleted reserves and to fund general cost increases and additional Investigator and HQES Attorney positions in support of implementation of the VE Pilot Project (see Section D). By May 1 of each year, the Medical Board is required to set the fee for the next subsequent fiscal year, subject to the ceiling set in statute. The fee is required to be sufficient to recover actual costs of operating the Medical Board's Licensing Program as projected for the fiscal year commencing on the date that the fees become effective. Initially, provisions were include in the statutes stating that it was the intent of the Legislature that the Medical Board also maintain a reserve fund equal to two months' operating expenditures.

In conjunction with the 2006 fee increase, the statutory provisions governing the reimbursement of investigative and enforcement costs, by licensees subject to disciplinary action by the Medical Board (cost recovery), were repealed. Subject to several limiting provisions set forth in statute, the maximum initial and biennial licensee fees may be increased above the current $790 ceiling to recover the difference, if any, between (1) the average amount of reimbursements (cost recovery) paid for investigation and enforcement costs during the three fiscal years preceding July 1, 2006, and (2) any increase in investigation and enforcement costs incurred following July 1, 2006, as compared to average costs during the three fiscal years preceding July 1, 2006. The purpose for incorporating these provisions was to enable the Medical Board to potentially recover some of the increased costs of investigation and enforcement that would otherwise have been paid by licensees subject to disciplinary action if the provisions governing cost recovery had not been repealed.

During 2007, initial and biennial renewal fees were increased by $15 to $805. Then, following termination of the Diversion Program, these fees were reduced by $22 to $783. Additionally, during 2010/11, some licensees will receive a $22 renewal credit reflecting their prior over-payment of Diversion Program costs when they renewed their license during 2008/09.

Exhibit II-1, on the next page, delineates actual personal services and operating expenditures by year for the past five (5) years, and projected expenditures for 2009/10. As shown by Exhibit II-1, total expenditures peaked at a level of about $49.5 million during 2007/08, and then declined by $1.75 million (4 percent) during 2008/09. The recent decrease in expenditures was due to (1) a decrease in salaries and benefits paid to Medical Board staff, (2) reductions in major and minor equipment purchases, and (3) decreases in general

Historical and Budgeted Medical Board Expenditures

Personal Service and Operating Expenditures		Actual					2009/10 Budget[3]
		2004/05	2005/06	2006/07[1]	2007/08	2008/09[2]	
Personal Services	Salaries/Wages, Including Fitness Incentive Pay	$12,688	$12,647	$13,253	$13,527	$13,425	$13,336
	Staff Benefits	5,620	4,719	5,067	5,340	5,327	6,005
	Temporary Help (Medical Consultants, Retired Annuitants, and Student Assistants)	1,154	1,143	1,270	1,742	1,321	1,144
	Board Members	33	32	34	24	24	31
	Overtime (Primarily for the Licensing Program)	21	31	77	86	196	12
	DEC	21	32	27	22	0	0
	Salary Savings	0	0	0	0	0	(836)
	Total Personal Services Expenses	$19,537	$18,604	$19,728	$20,741	$20,293	$19,692
General Expenses	Printing, Communications, and Postage	$1,413	$1,050	$1,121	$1,350	$1,475	$1,603
	General Expense, Minor Equipment, and Insurance	535	626	716	928	721	472
	Travel	291	314	380	403	379	397
	Vehicle Operation/Other Items	273	269	350	446	300	262
	Training	57	45	79	74	89	66
	Total General Expenses	$2,569	$2,304	$2,646	$3,201	$2,964	$2,800
Facilities Operation (Rent)		$1,851	$1,963	$2,814	$2,235	$2,173	$2,702
Professional Services		$605	$788	$1,397	$1,386	$870	$983
Fingerprint Reports		$358	$382	$380	$334	$332	$492
Major Equipment (Items greater than $5,000)		$295	$370	$375	$192	($9)	$333
Legal Services	Attorney General Services	$8,292	$8,596	$11,247	$12,316	$11,881	$13,347
	Evidence/Witness Fees	1,563	1,367	1,215	1,391	1,519	1,893
	Office of Administrative Hearings	1,248	915	1,200	1,344	1,099	1,863
	Court Reporter Services	69	113	143	158	128	175
	Total Legal Services	$11,172	$10,991	$13,805	$15,209	$14,627	$17,278
Allocated Administrative & Data Processing	Department Prorata	$3,296	$3,395	$3,670	$3,906	$3,671	$3,882
	Statewide Prorata	1,185	1,315	1,376	1,794	2,323	1,699
	Consolidated Data Center (Teale)	304	293	238	259	300	647
	Data Processing	289	321	128	232	224	125
	Total Administrative and Data Processing Services	$5,074	$5,324	$5,412	$6,191	$6,518	$6,353
Other Expenses	DOI Investigations	$0	$0	$0	$2	$0	$0
	State Controller's Office (Including 21st Century Project)	0	0	0	38	2	0
	Special Adjustment	(24)	0	0	(1)	10	0
	Court-Ordered and Tort Payments	7	2	13	3	0	0
	Total Miscellaneous Expenses	($17)	$2	$13	$42	$12	$0
Total Operating Expenses		$21,907	$22,124	$26,842	$28,790	$27,487	$30,941
Total Personal Services and Operating Expenses		$41,444	$40,728	$46,570	$49,531	$47,780	$50,633

[1] In 2006/07, authorized staffing levels increased by 12.50 positions (2.0 Diversion Program, 4.0 Investigators, 4.0 Investigative Assistants, 2.0 Information System Analysts, and 0.5 Staff Services Analyst).

[2] In 2008/09, authorized staffing levels decreased by 12.40 positions due to termination of the Diversion Program.

[3] The 2009/10 budget incorporates cost-savings related to the Furlough Friday Program and includes unfunded allocations for six (6) new Operation Safe Medicine positions **($500,000)**, four (4) new Probation Program positions **($300,000)**, and contracts for Telemedicine ($399,734 for the first year), an evaluation of Medical Board programs ($159,300), and an analysis of Licensing Program business processes ($40,350).

administrative and operating expenses, including reduced expenditures for professional services and lower costs for support services provided by the Department of Consumer Affairs (DCA). These expenditure reductions resulted primarily from spending controls implemented during 2008/09 in response to the State's General Fund fiscal crisis. Additionally, charges during 2008/09 for legal services provided by the Attorney General and OAH were more than $600,000 lower than the amounts charged during the prior fiscal year.

Over the 5-year period from 2004/05 through 2008/09, total expenditures increased by about $6.3 million (15 percent). **Table II-1**, below, shows the primary categories of expense that contributed to these increased costs. As shown by Table II-1, costs for legal services provided by the Attorney General increased significantly on both an absolute and percentage basis, and accounted for more than one-half of the total increase in expenditures during this period. In contrast, costs for services provided by OAH fluctuated between $0.9 million and $1.4 million during this same period, and the most recent year's costs for OAH services were about average for the period ($1.1 million). The increased costs for Attorney General services reflect the combined impacts of rate increases during this period and the authorization of 10 additional Attorney positions to support implementation of Vertical Enforcement.

Table II-1. Expenditure Increases - 2004/05 through 2008/09

Category	Amount	Percent Increase
Attorney General Services	$3.6 million	43%
State Prorata	$1.1 million	96%
Personal Services	$0.8 million	4%
Department Prorata	$0.4 million	11%
Facilities (Rent)	$0.3 million	17%
Total	$6.2 million	18%

During 2007, the Bureau of State Audits (BSA) completed a statutorily mandated review of the Medical Board's fund condition. The BSA determined that the Medical Board consistently exceeded the two-month reserve ceiling set forth in statute, and recommended that the Medical Board reduce its fees. No changes were made to these fees in the following years. However, during 2009 the provisions governing the fund reserve were modified, effective January 1, 2010, to enable the Medical Board to maintain a level of reserves equal to between two (2) and four (4) months operating expenditures (AB 501, Emmerson). Additionally, AB 501 requires the Office of State Audits, within the Department of Finance, to complete another review of the Medical Board's revenues, expenses, and reserves (by June 1, 2012). Costs of this review are required to be funded from existing resources.

C. Complaint Intake and Screening

During the 1980s complaint intake and screening were handled by a handful of Customer Service Representatives (CSRs) dispersed across regional offices in Sacramento, San Francisco, Los Angeles, and San Bernardino/San Diego. Each regional office also had 1 to 2 full-time Medical Consultants who assisted the CSRs in determining which complaints should be referred for field investigation. During this period the Medical Board received fewer than 5,000 complaints per year, of which about one-half involved negligence/competency (quality of care) issues. About one-half of complaints received were referred to the District offices for investigation. Complaints that were not referred for investigation were referred to other agencies, mediated and closed, or closed based on a determination that no violation of governing statutes or regulations was involved (e.g., billing disputes).

During the early-1990s the Medical Board consolidated responsibility for complaint intake and screening in the Sacramento Headquarters Central Complaint Unit (CCU). Since that time the number of positions authorized for the CCU has grown. The CCU is currently authorized 24 positions, including two (2) supervisors and 22 subordinate Associate Government Program Analysts (AGPAs), Staff Services Analysts (SSAs), Management Services Technicians (MSTs), and Office Technicians (OTs). About two-thirds of CCU staff are classified at the SSA or AGPA levels, which are higher classification levels than their predecessor CSR positions (i.e., the top step salary of an SSA is 7 percent above the top step of a CSR, and the top step of an AGPA is 29 percent above the top step of a CSR).

In the early-2000s CCU was reorganized into two specialized sections based on the type of complaint handled. CCU staffing levels changed little in subsequent years. Currently, each section is supervised by a Staff Services Manager I (SSM I) and subordinate staff are allocated about equally between the two sections.

Quality of Care Section (10 AGPA/SSA/MST positions) – The Quality of Care Section handles all quality of care (QC) complaints. Most staff are assigned to specific geographic regions of the State. One AGPA position has lead responsibility for identifying and selecting outside Medical Specialists to review complaints, where needed, and performs related case file transfer and tracking functions.

Physician Conduct Section (9 AGPA/SSA/MST positions) – The Physician Conduct (PC) Section handles all other categories of complaints involving physicians and surgeons, plus all AHLP complaints. Most staff are assigned specific categories or types of complaints (e.g., Section 805 reports, criminal arrest and conviction reports, complaints involving certain types of offenses, such as fraud, sexual misconduct, corporate practice, and advertising violations, and AHLP complaints). Staff are cross-trained to fill in for other staff when absences, vacation, or turnover occur.

Clerical support services for the CCU are provided by one (1) full-time and two (2) part-time OTs. Additionally, within the CCU, one (1) AGPA position is assigned responsibility for the Cite and Fine Program.

In the early 1990s, Attorneys were assigned to work at the CCU on a part-time basis to assist in evaluating and screening complaints. During October 2003 the assignment of this position was formalized in response to legislative requirements enacted twelve (12) years earlier during 1991 (SB 2375, Presley).

Also during 2003, CCU began implementing a new Specialty Reviewer process pursuant to requirements set forth in SB 1950 (Figueroa). The Specialty Reviewer requirement was enacted to help reduce the number of complaints referred for Investigation, and related needs to conduct field investigations in cases where it might not be warranted. Prior to implementation of the Specialty Reviewer process, a physician not specializing in the Subject physician's case may have reviewed the complaint and, in some cases, were unable to make a preliminary determination regarding the merits of the complaint because they lacked knowledge of, and experience with, the medical specialty involved. In these circumstances the cases were referred for investigation where a more specialized medical professional would make a determination on the merits of the case as a part of the field investigation process. Pursuant to requirements established by SB 1950 (Section 2220.08 of the Business and Professions Code), before any quality of care complaint is referred for field investigation, it must be reviewed by "one or more medical experts with pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." The evaluation must include a review of relevant patient records, a statement or explanation of the care and treatment provided by the physician, expert testimony or literature provided by the subject physician, and any additional information requested by the reviewer that may assist is determining whether the care provided constitutes a departure from the standard of care. However, if this information is not provided to the Medical Board within ten (10) working days after its request, the complaint may be reviewed by the Expert Reviewer and referred to a District office for investigation without the information.

Including all complaints that are determined to be outside of the Medical Board's jurisdiction, CCU currently handles about 7,200 complaints per year involving physicians and surgeons, or about 50 percent more complaints than were handled during the 1980s. These complaints include about 1,000 mandated reports that are submitted to the Medical Board pursuant to statutory requirements that were not in effect prior to 1990. The number of complaints received by the Medical Board has grown modestly over time, but more slowly than the growth rate of the industry during this period (e.g., the number of licensed physicians and surgeons practicing in California grew by about 100 percent over the past 25 years). CCU now performs a much more rigorous review of complaints than was previously performed and, except for disputes involving the release of the patients records, does not attempt to mediate complaints. CCU currently refers fewer than 20 percent of complaints for investigation, including some high-priority complaints that are automatically referred for investigation with only limited screening (e.g., Section 805 reports), and either closes or refers complaints received within an average of 60 to 75 days, with some cases taking longer than six (6) months to close or refer for investigation.

For some types of cases CCU works collaboratively with the Discipline Coordination Unit (DCU). For example, CCU receives a significant number of reports of physician discipline from licensing boards in other states. Following intake by CCU, these cases are forwarded directly to DCU which reviews each case and, if needed, requests additional records. DCU may then close the case, prepare a

proposed settlement agreement with the licensee (referred to as a pre-filing stipulation), or refer the case to HQES' San Francisco office for prosecution. District offices are rarely involved with these cases, unless the licensee is practicing in California.

Exhibit II-2, on the next page, provides a statistical overview of complaints opened and dispositions from 2000/01 through 2008/09. Over the past eight (8) years, the numbers of complaints opened and referred for investigation or Prosecution have decreased, even after accounting for reductions due to changes in the reporting of (1) change of address citations, and (2) non-jurisdictional complaints identified during CCU's initial intake process. The reduction in number of complaints opened is attributable primarily to reductions in the number of:

- Medical malpractice reports received from insurers and licensed physicians
- Disciplinary action reports received from other states
- Complaints submitted by patients and others
- Complaints opened by Medical Board staff.

The reduction in number of complaints referred for investigation or prosecution is attributable primarily to:

- Reductions in the number of complaints received from external sources (e.g., fewer medical malpractice reports and disciplinary action reports from other states)
- Reductions in the number of Medical Board-originated complaints
- Improved screening of complaints following the 2003 implementation of the Specialty Reviewer requirement for quality of care complaints
- The accumulation of additional backlogs of pending complaints (e.g., from about 1,000 cases in June 2005 to more than 1,300 cases in June 2009).

The decrease in number of complaints opened has been only partially offset by recent increases in the number of criminal charge and conviction self-reports received by the Medical Board. The recent increase in this category of mandated reports is due to new requirements (SB 231, Figueroa) that licensees self-report misdemeanor convictions. This requirement became effective in January 2006. During 2008/09, 91 reports were received compared to only 16 reports received during 2005/06.

As shown by Exhibit II-2, during the early part of the decade the Medical Board closed or referred for investigation or prosecution significantly more complaints than were opened, and reduced the backlog of open complaints by 50 percent (from 2,000 open complaints to 1,000 open complaints). However, in recent years fewer complaints have been closed or referred for investigation or prosecution than

Overview of Complaints Opened and Dispositions - 2000/01 through 2008/09

	Category of Complaints	2000/01 through 2002/03 (3-Year Avg.)	2003/04	2004/05[1]	2005/06	2006/07	2007/08	2008/09[2]
Mandated Reports	Malpractice Reports from Insurers (Section 801 & 801.1)	888	787	722	726	676	597	605
	Malpractice Self-Reports (Section 801(c), 802, and 803.2)	328	228	212	185	187	150	204
	Malpractice Reports from Others (Section 803)	24	3	9	6	10	6	2
	Coroner Reports (Section 802.5)	32	18	23	11	22	16	16
	Health Care Facility Reports (Section 805)	146	157	110	138	127	138	122
	Surgical Death/Complication Self-Reports (Section 2240(a))	8	14	11	2	10	7	6
	Criminal Charge and Conviction Self-Reports (Section 802.1 and 803.5)	33	33	20	16	29	76	91
	Total Mandated Reports	1,459	1,240	1,107	1,084	1,061	990	1,046
Disciplinary Action Reports Submitted by Other States (IDENT 16)		323	371	448	385	279	288	258
Medical Board Originated Complaints with District Office Identifiers		286	212	202	216	216	161	113
Medical Board Originated Complaints with Headquarters Identifier[1 3] (IDENT 20, Excluding Petitions)		375	377	281	133	31	65	102
Medical Board Originated Complaints with CME Audit Failure Identifier (IDENT 21)		66	0	0	1	140	75	0
Medical Board Originated Complaints with Probationer Identifiers (IDENT 19)		6	13	22	23	9	11	34
Medical Board Originated Complaints with Other Identifiers[4] (IDENTs 22, 23, and 25)		32	12	7	9	10	6	10
Petitions for Modification or Termination of Probation (IDENT 26)		29	37	42	50	47	37	40
Petitions for Reinstatement (IDENT 27)		14	25	19	13	21	9	18
Other Complaints and Reports[1 2] **Includes NPDB (26 in 2008/09)**		5,968	5,953	5,375	5,749	5,445	5,197	4,821
Total Complaints and Other Matters Opened[1 2]		8,558	8,240	7,503	7,663	7,259	6,839	6,442
Complaints and Other Matters Closed		5,967	6,837	6,603	6,349	6,105	5,608	5,303
Complaints and Other Matters Referred for Investigation or Prosecution[1 3] **Incl. PLRs (31 in 2008/09**		2,355	1,887	1,443	1,331	1,182	1,133	1,123
Total Complaints and Other Matters Closed or Referred for Investigation or Prosecution[1 2 3]		8,322	8,724	8,046	7,680	7,287	6,741	6,426
Percent of Cases Referred for Investigation or Prosecution[1 3]		28%	22%	18%	17%	16%	17%	17%
Reported Average Days to Close or Refer Cases for Investigation or Prosecution[1 2 3]		55 Days	76 Days	66 Days	54 Days	54 Days	61 Days	75 Days
Reported Open Complaints and Petitions (End of Period)		2,019	1,566	1,011	1,086	1,133	1,283	1,323

[1] Effective in January 2005, change of address citations were no longer counted as complaints or investigations.

[2] Effective in 2008/09, some complaints received and determined by CCU to be outside of the Medical Board's jurisdiction were no longer counted as received or closed, thereby increasing the CCU's reported average elapsed time to process complaints.

[3] Includes probationary license certificates, SOIs, and criminal conviction notification, advertising violation, and cite and fine non-compliance cases. Also includes change of address citation cases (through December 2004),

[4] Includes Operation Safe Medicine, Internet Crimes Unit, and probation violation citation cases.

have been opened. This has resulted in continuous increases in the number of pending complaints. At the end of 2008/09 there were 1,323 pending complaints. This is 300 (30 percent) more pending complaints than existed at the end of 2004/05. Inevitably, the growing number of open complaints will soon translate into longer average processing times, particularly given the continuation of the Furlough Friday Program through June 2010. Ultimately, over a period of several years, these complaint-handling delays will adversely impact aggregate Enforcement Program performance measures (e.g., total elapsed time from receipt of complaint to disciplinary outcome).

Since 2004/05, the number of complaints closed, adjusted for recent changes in the reporting of change of address citations and non-jurisdictional complaints, decreased by about 10 percent. Concurrently, the number of complaints referred for investigation or prosecution decreased by about 15 percent, after adjustment for changes in the reporting of change of address citation cases. During the past two (2) years an average of 1,128 complaints was referred for investigation or prosecution – about 200 fewer complaints than were referred during 2004/05, after adjustment for changes in the reporting of change of address citations. Over the past five (5) years, the Medical Board has consistently closed about 83 to 84 percent of all complaints, and referred the remaining 16 to 17 percent for investigation or prosecution.

From 2004/05 through 2007/08, the Medical Board maintained an average processing timeframe for all complaints of about two (2) months (60 days). The recent increase in the average complaint processing time to 75 days in 2008/09 is partially attributable to elimination of about 800 non-jurisdictional complaints from the calculation of this performance measure.

Finally, Exhibit II-2 shows that, in recent years, fewer complaints have been closed or referred each year than have been opened. This has resulted in continuous increases in the number of pending complaints. At the end of 2008/09 there were 1,323 pending complaints. This is 300 (30 percent) more pending complaints than existed at the end of 2004/05. Recent increases in the number of pending complaints are correlated with increases in the average time to close or refer cases for Investigation or Prosecution.

Exhibit II-3, on the next page, provides an overview of 2008/09 complaints received and dispositions by referral source. As shown by Exhibit II-3, complaints received from patients, patient advocates, family members, and friends account for the largest share of complaints received (58 percent). However, fewer than 10 percent of these complaints are referred for investigation. During 2008/09, 81 cases from these sources were referred for prosecution, representing 2 percent of complaints received from these sources. Even though only a small proportion of these cases are investigated and subsequently referred for prosecution, cases from these referral sources still account for more than 30 percent all cases referred for investigation and a comparable proportion of cases referred for prosecution (excluding Out-of-State and Medical Board-originated cases).

Overview of 2008/09 Complaint Handling and Dispositions by Referral Source

Referral Source	Quality of Care Complaints and Reports										Other Types of Cases										Total						
	CCU and Other HQ Business Units					Closed by Investigation		Referred for Prosecution (HQES or DA)		Total INV Closures and Legal Referrals	CCU and Other HQ Business Units					Closed by Investigation		Referred for Prosecution (HQES or DA)		Total INV Closures and Legal Referrals	CCU and Other HQ Units				Closed by Investigations	Referred for Prosecution[6]	Legal Referrals - Percent of Complaints Received
	Received	Reviewed by Medical Consultant	Closed	Referred to Investigation							Received	Reviewed by Medical Consultant	Closed	Referred to Investigation							Received	Reviewed by Medical Consultant	Closed	Referred to INV			
				No.	%	No Cite	Cite	HQES	DA[7]					No.	%	No Cite	Cite	HQES	DA[7]								
Patient, Patient Advocate, Family Member or Friend (including 801.01(E) Reports)	2,075	1,165	1,810	247	12%	130	10	58	1	199	1,681	52	1,567	75	5%	59	3	18	4	84	3,756	1,217	3,377	322	202	81	2%
Insurance Companies and Employers (including 801.01(B&C) and NPDB Reports)	597	428	468	105	18%	92	7	27	0	126	14	1	11	3	21%	4	0	2	0	6	611	429	479	108	103	29	5%
Health Facilities (805 and Non-805 Reports)	82	0	4	80	95%	40	3	28	0	71	49	0	22	23	51%	12	2	10	0	24	131	0	26	103	57	38	29%
California Department of Health Services (or Successor State Agency)	38	17	19	14	42%	9	1	6	0	16	22	4	12	7	37%	7	1	1	0	9	60	21	31	21	18	7	12%
M.D., Pharmacist, Allied Health or Healing Arts Licensee, or Medical Society or Association	52	27	32	26	45%	14	0	6	1	21	235	10	216	31	13%	20	1	3	1	25	287	37	248	57	35	11	4%
CII - Department of Justice, Criminal Identification and Information Bureau	0	0	0	0	NMF	0	0	0	0	0	186	0	166	45	21%	19	1	25	0	45	186	0	166	45	20	25	13%
Other Governmental Agencies, Including FDA, DEA, Other DCA Boards and Bureaus, and 801 Reports	51	32	37	20	35%	10	0	2	0	12	42	0	40	9	18%	9	1	11	0	21	93	32	77	29	20	13	14%
Other[1]	71	16	46	25	35%	11	1	7	0	19	286	9	252	53	17%	29	0	11	3	43	357	25	298	78	41	21	6%
Police/Sheriff Department, Coroner's Office, District Attorney, and Courts (803 Reports, Criminal Filings, Non-Felony and Felony Conviction Reports)	32	10	23	16	41%	9	0	3	0	12	35	1	10	16	62%	7	2	6	0	15	67	11	33	32	18	9	13%
Licensee Self-Reporting (2240(A), 801.01, 802.01, 802.1, and Misdemeanor Conviction Reports)	204	149	141	35	20%	22	1	6	0	29	85	1	77	7	8%	4	1	1	0	6	289	150	218	42	28	7	2%
California Attorney General and Department of Justice, Including Medi-Cal Fraud and Narcotics Enforcement Bureaus	6	0	1	1	50%	1	0	1	0	2	24	0	27	1	4%	1	0	1	0	2	30	0	28	2	2	2	7%
Total, Excluding Out of State and Medical Board Cases	3,208	1,844	2,581	569	18%	338	23	144	2	507	2,659	78	2,400	270	10%	171	12	89	8	280	5,867	1,922	4,981	839	544	243	4%
Out of State Medical/Osteopathic Boards[2] (IDENT 16)	21	0	0	0	NMF	N/A	0	20	0	20	237	0	161	1	1%	2	0	69	0	71	258	0	161	1	2	89	34%
Medical Board Cases with District Identifiers (IDENTs 2 to 18, except 16)	47	10	19	31	62%	19	0	16	2	37	66	0	40	35	47%	31	0	12	4	47	113	10	59	66	50	34	30%
Medical Board Cases with Probationer Identifier (IDENT 19)	2	0	1	1	50%	3	0	0	0	3	32	0	1	24	96%	12	0	19	0	31	34	0	2	25	15	19	56%
Medical Board Cases with Other Identifiers[3] (IDENTs 20 to 25)	4	2	2	2	50%	1	2	0	0	3	108	0	74	6	8%	2	2	46	1	51	112	2	76	8	7	47	42%
Petitions for Reinstatement or Modification or Termination of Probation[4] (IDENTs 26 and 27)	0	0	0	0	NMF	0	0	0	0	0	58	0	0	58	100%	2	0	37	0	39	58	0	0	58	2	37	64%
Total, Including Out of State and Medical Board Cases	3,282	1,856	2,603	603	19%	361	25	180	4	570	3,160	78	2,676	394	13%	220	14	272	13	519	6,442	1,934	5,279	997	620	469	7%

[1] Includes CA Medical Review Inc., 803.6, 364.1, and NPDB Reports, Jury Verdict Weekly, HEAL, MQRC District, WE Tip, Consumer or Industry Group, Employee, Co-worker, Witness, Informant, Anonymous, and Unknown.

[2] Out-of-State cases are researched by the Discipline Coordination Unit (DCU) and, where appropriate, referred directly to HQES. Cases are only assigned to District offices when the licensee is practicing in California.

[3] Includes Probationary License Certificates, SOIs, and CME Audit Failure, Advertising Violation, Citation Non-Compliance, Operation Safe Medicine (OSM) and Internet Crimes Unit cases. These matters are nearly always directly referred for prosecution by the originating Headquarters Unit without any District office involvement.

[4] Petitions are initially handled by the Discipline Coordination Unit (DCU) which forwards the petition and supporting documentation to the District offices. The District offices complete required background research, interview the Petitioner and their references, prepare a Report of Investigation summarizing results of their review, and then forward the completed case to HQES.

[5] Includes 31 Pre-Filing Public Letter of Reprimand (PLR) cases not actually referred to HQES (Patient = 1, Insurer = 4, MD = 1, Licensee Self-Report = 1, and Out of State = 24).

[6] Excludes ten (10) dual referrals.

Exhibit II-3 also shows the flow of cases through the complaint intake/screening and investigation process for more than a dozen other major categories of complaints, including the following three (3) categories which account for nearly 40 percent of cases referred for prosecution (excluding Out-of-State and Medical Board-originated cases):

Medical Malpractice Reports – Medical malpractice reports represent nearly 10 percent of opened complaints. By definition, almost all of these cases involve quality of care issues. About 20 percent of these cases are referred for investigation and about 30 percent of the cases referred for investigation are referred for prosecution. While only about 5 percent of these cases are referred for prosecution, medical malpractice reports nonetheless account for more than 10 percent of cases referred for prosecution (excluding Out-of-State and Medical Board-originated cases).

Section 805 Reports – Section 805 Reports may, or may not, involve quality of care issues (60 percent are quality of care cases). While Section 805 cases represent only about 2 percent of opened complaints, most of the cases (including nearly all quality of care cases) are referred for investigation. More than 60 percent of the cases referred for investigation are referred for prosecution. Section 805 cases account for about 15 percent of cases referred for prosecution (excluding Out-of-State and Medical Board-originated cases).

Criminal Arrest and Conviction Reports – Complaints opened based on criminal arrest and conviction reports, submitted by the Department of Justice, represent only about 3 percent of opened complaints. By definition, none of these cases involve quality of care issues. About 20 percent of the cases are referred for Investigation. More than 50 percent of the cases referred for investigation are referred for prosecution. These cases account for about 10 percent of cases referred for prosecution (excluding Out-of-State and Medical Board-originated cases).

Disciplinary action reports from medical/osteopathic boards in other states (referred to as Out-of-State cases) also account for significant numbers of complaints opened. Additionally, these cases, which are rarely referred for investigation, represent the largest category of complaints referred for prosecution (89 of 469 total cases referred for prosecution, including 24 cases settled with a pre-filing public letter of reprimand (PLR) and, hence, not actually referred for prosecution). Even if PLRs are excluded, Out-of-State cases still account for a large number and a high percent of cases referred for prosecution (65 cases and 15 percent of total referrals, respectively).

Finally, Exhibit II-3 shows that Medical Board-originated cases account for about 29 percent of all cases referred for prosecution (137 of 469 cases referred for prosecution). Most Medical Board-originated cases do not involve quality of care issues. Most of these cases involve:

- Probationary License Certificates (issued to new licensees in lieu of full licensure)
- Statements of Issues (SOIs)
- Citation non-compliance
- Probation violations
- CME audit failures
- Petitions for Modification/Termination of Probation
- Petitions for Reinstatement
- Operation Safe Medicine cases
- Internet Crimes Unit cases.

Except to open the complaint records in CAS, these cases are not usually handled by CCU and, because of the nature of the matters, these cases are much more likely to be referred for prosecution (or hearing in the case of SOIs and petitions) than complaints received from the public and other external referral sources.

D. Investigations and Prosecutions

This section summarizes major legislative and other changes impacting the Medical Board's investigation and prosecution processes over the past 30 years. These efforts include several major comprehensive reform initiatives and numerous targeted changes and improvements. **Over the past three (3) decades the number of cases referred for investigation decreased, but the number of cases resulting in disciplinary action increased**. However, concerns have been raised nearly continuously throughout this period about the extended timeframes needed to complete investigations and prosecutions. Additionally, during the past several years the number of cases referred for investigation, the number of investigations completed, the number of cases referred for prosecution, and the number of disciplinary actions all decreased.

1. 1980 to 1990

Throughout the 1980s a series of reports by the Office of the Auditor General, the Assembly Office of Research, the Legislative Analyst's Office (LAO), the Little Hoover Commission, and the Center for Public Interest Law (CPIL) documented significant deficiencies with the BMQA's Enforcement Program. Identified deficiencies included a highly fragmented organizational structure, large case backlogs at all stages of processing, and minimal disciplinary actions. To address these deficiencies, during 1989/90 an additional 28 Investigator positions were authorized for the Enforcement Program (18 permanent positions and 10 limited-term positions).

During 1990 adverse publicity regarding the Medical Board's Enforcement program, and new reports from the LAO and the U.S. Department of Health and Human Services highlighting continuing Enforcement program deficiencies, prompted support for adoption of a new physician discipline system. The *Medical Judicial Procedures Improvement Act* (SB 2375, Presley), which was signed into law during September 1990, restructured the Medical Board's Enforcement Program by:

- ✓ Creating a new Health Quality Enforcement Section (HQES) within the Attorney General's Office, organizationally separate from the Licensing Section, with specialized responsibility for prosecuting medical disciplinary cases generated by the Medical Board and AHLPs. The statutes required the HQES Chief to:

  > ". . . assign attorneys to assist [the Division of Medical Quality] in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit . . ., to assist in evaluating and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations."

- ✓ Creating a new Medical Quality Hearing Panel (MQHP), a specialized panel of Administrative Law Judges (ALJs) within the Office of Administrative Hearings (OAH) to hear medical discipline cases

- ✓ Shifting DMQ's primary focus from rehabilitating physicians to consumer protection.
- ✓ Enabling the Division of Medical Quality (DMQ) to seek Interim Suspension Orders (ISOs) to halt the practice of dangerous physicians
- ✓ Requiring DMQ to establish a goal, by January 1, 1992, of allowing not more than six (6) months to elapse from receipt of a complaint to completion of the Investigation, or one (1) year in the case of specified complex complaints
- ✓ Providing absolute immunity from civil liability for physicians who serve as Expert Reviewers and Expert Witnesses to the Medical Board in disciplinary proceedings (Section 43.8 of the Civil Code)
- ✓ Providing fast track superior court judicial review of DMQ disciplinary decisions
- ✓ Extending the time between license revocation and filing of a petition for reinstatement from one (1) to three (3) years.

Additionally, SB 2375 introduced new mandatory reporting requirements, including requirements that (1) coroners report when they suspect a physician's gross negligence is a cause of death (Section 802.5 of the Business and Professions Code), (2) local prosecutors report the filing of felony charges against physicians (Sections 803.5 and 803.6 of the Business and Professions Code), (3) court clerks transmit conviction records and preliminary hearing transcripts, and (4) probation officers transmit certain probation reports on physicians

Initially, 22 Deputy Attorney General (DAG) positions were assigned to HQES and a goal was established to file all accusations within 60 days of receipt of a completed investigation. However, HQES determined that it was severely understaffed and, as a result, could not place Prosecutors on-site at the Medical Board's offices to assist Medical Board staff with complaint handling and investigations. Concurrently, the Director of the OAH appointed all of the OAH's ALJs to the new MQHP, thereby effectively defeating the intent of the statute to develop a specialized pool of ALJs within the OAH.

2. 1991 to 2000

During 1991 the Auditor General completed a review of the Medical Board which found that investigations were taking an average of fourteen (14) months to complete, substantially longer than the 6-month goal set forth in statute, that HQES took more than six (6) months to file an accusation in a fully investigated case, significantly exceeding its own 60-day goal, and that, for cases that proceeded to hearing, another nine (9) months elapsed from filing of the accusation to completion of the hearing. Subsequently, in an effort to address excessive caseloads at HQES (up to 30 cases per position) and extended

timeframes to file accusations, during 1992 and 1993 the Medical Board provided funding for 22 additional HQES Attorney positions (44 total Attorney positions).

During the early-1990s the Medical Board, HQES, and OAH continued to be the subject of adverse publicity and criticism by the media and outside agencies charged with reviewing its Enforcement Program. During 1993 a second major Enforcement Program reform bill was enacted (SB 916, Presley). SB 916, which was signed into law during October 1993, made the following significant changes to the Medical Board's Enforcement Program:

- Abolished the DAHP, transferred its members to the DMQ, and divided the DMQ into two panels for purposes of reviewing stipulations and proposed decisions
- Limited the number of ALJs that the Director of OAH could appoint to the MQHPs (a maximum of 25 percent of all OAH Hearing Officers)
- Abolished the MQRCs
- Eliminated Superior Court judicial review of DMQ decisions and, instead, provided for review of DMQ decisions through a Writ of Mandate to a Court of Appeal (subsequently modified prior to enactment (SB 609, Rosenthal) to preserve Superior Court review, but enable appeal of Superior Court decisions by a Petition of Extraordinary Writ)
- Authorized the DMQ to establish panels or lists of experts to assist in administering the Enforcement Program
- Enhanced Investigators' authority to obtain medical records, and enabled imposition of fines up to $1,000 per day for refusal to comply with the Medical Board's record requests
- Authorized issuance of public letters of reprimand (PLR) for minor violations in lieu of filing an Accusation
- Authorized the Director of DCA to audit and review inquires and complaints regarding Medical Board licensees at the request of a consumer or licensee
- Codified the Medical Board's public disclosure policy
- Required the State Auditor to audit the Medical Board's Enforcement Program, including services provided by the HQES and the OAH (by March 1, 1995)
- Increased initial and biennial renewal fees to $600 ($300 per year).

During 1994 the Medical Board restructured its Medical Consultant workforce by (1) replacing its full-time Chief Medical Consultant position with a position (or positions) that would report directly to the governing Board, and (2) abolishing all full-time Medical Consultant positions, most of whom were no longer actively in practice, and replacing them with a larger number of part-time positions who would continue to be active practitioners. The Medical Board also adopted (1) a set of minimum qualifications for Expert Reviewers, and (2) regulations for issuing citations and imposing fines for minor violations.

Throughout the mid- and late-1990s the Medical Board continued to experience chronic delays in completing Investigations, and also in filing accusations after the Investigations were completed. During this period the number of complaints received increased to nearly 8,000 complaints per year, of which about 25 percent were referred for investigation (2,000 per year). Investigator caseloads, which sometimes averaged as many as 25 to 30 cases per position, were considered excessive. During this period it continued to take the Medical Board longer than a full year, on average, to complete investigations. No increases in Medical Board staffing were authorized throughout this period.

During 1997 the Deputy in District Office (DIDO) Program was introduced whereby a DAG from HQES worked at each District office one to two days per week to provide prosecutorial guidance during investigations. By this time HQES had reduced the average timeframe to file accusations to about five (5) months. The DIDO Program was not always consistently implemented at all District offices.

During 1998 legislation was enacted that established a statute of limitations on the timeframe available to the Medical Board to complete Investigations (AB 2719, Gallegos). AB 2719 required that accusations be filed within three (3) years of discovery of the act, or within seven (7) years of the act, whichever occurs first. These changes resulted in legal challenges to a number of investigations that had been pending at the Medical Board for periods exceeding these limitations. As a result of these limitations, I=investigations are now always either closed or referred for prosecution within a maximum of three (3) years of receipt of the initiating complaint. This requirement also effectively caps the maximum time that an investigation can remain open, irrespective of whether the investigation is actually completed.

3. 2001 to 2005

During 2001 the Medical Board created two proactive enforcement units; the Operation Safe Medicine (OSM) and Internet Crimes Units. OSM was structured as a small team of Investigators and support staff focusing on the unlicensed practice of medicine, particularly in at-risk communities. The Internet Crimes Unit, which typically consisted of just one (1) or two (2) Investigators, targeted Internet activities, such as misleading advertising, prescribing drugs without an examination, and narcotics trafficking. Both units were expected to work collaboratively with other state, local, and federal law enforcement agencies and prosecutors.

Chronic delays in investigating complaints continued to plague the Enforcement Program after the turn of the century. These delays prompted another wave of adverse publicity during 2002 and a series of related hearings by the Joint Legislative Sunset Review Committee. Subsequently, during September 2002, SB 1950 (Figueroa) was signed into law to address the Medical Board's Enforcement Program deficiencies. Major changes made by SB 1950 involving investigations and prosecutions included:

- ✓ A delineation of five types of "priority" cases that were seen as representing the greatest threat of harm to the public and, therefore, should be investigated and prosecuted on an expedited basis by the Medical Board and HQES
- ✓ Requirements that an ALJ that finds a physician has engaged in multiple acts of sexual exploitation to include an Order of Revocation with their PD
- ✓ Definition of the basis for imposing discipline for "repeated negligent acts"
- ✓ Authorization of the appointment of an independent "Enforcement Monitor" by the Director of DCA to conduct a review of the Medical Board's Enforcement and Diversion Programs.

Pursuant to requirements of SB 1950, during August 2003 the Director of DCA appointed CPIL to serve as the Medical Board's Enforcement Monitor. In November 2004 CPIL issued an *Initial Report* that highlighted the extended timeframes and delays in the Investigation process (an average of more than 11 months from receipt of a complaint to completion of the Investigation). Factors cited by CPIL as contributing to the extended timeframes needed to complete investigations included:

- ❖ The complexity and difficulty of Medical Board cases, including changes in the composition of cases referred for Investigation due to improved screening of complaints by CCU and challenges posed in meeting the applicable burden of proof which requires "clear and convincing proof to a reasonable certainty"
- ❖ The loss of 19 Investigator positions between 2000 and 2004
- ❖ Outdated procedures manuals, insufficient Investigator training, and inadequate or inconvenient Investigator access to law enforcement databases and commercial applications
- ❖ Investigator recruitment and retention problems attributed to the lower pay and benefits of Medical Board Investigators compared to the pay and benefits available at competing agencies, such as the Department of Justice
- ❖ Chronic delays in obtaining Medical Records and in scheduling and completing Subject interviews

- A 15 percent reduction in Medical Consultant hours imposed during 2003/04, insufficient training of Medical Consultants, inadequate monitoring and management of Medical Consultant performance, and delays throughout the process associated with the limited availability of Medical Consultant resources (e.g., medical record reviews, Subject interviews, Expert Reviewer identification and selection, and Expert package preparation)
- Reductions in the availability of Medical Experts due to insufficient outreach by Medical Consultants and the increased use of Medical Experts by CCU, the limited availability of Medical Experts in highly specialized fields, insufficient training of Medical Experts, and Medical Expert Program management deficiencies
- Increased use of defense counsel by physicians
- Inadequate communication, coordination, and teamwork between the Medical Board's Investigators and HQES Prosecutors, and an inability of HQES to provide DIDO Attorneys to some District offices and assist CCU with incoming complaint reviews
- Inadequate communication and coordination with other State and local law enforcement agencies.

Notwithstanding the above problems, CPIL noted that Medical Board Investigators had closed more cases than opened during the past several years (e.g., 2,117 cases closed during 2003/04 compared to 1,887 opened), and were carrying record low caseloads (about 18 cases per position).

CPIL also highlighted the extended timeframes for HQES to file accusations (an average of 2 to 3 months, depending on whether Medical Board or HQES statistical data are used), and the extended total elapsed time to reach a disciplinary outcome (an average of 2.6 years from receipt of a complaint to final disposition for cases where a disciplinary outcome was reached). Factors cited by CPIL as contributing to the extended timeframes to complete prosecutions included:

- Insufficient HQES staffing due to the loss of six (6) Attorney positions
- Insufficient coordination and teamwork with Medical Board Investigators
- Case tracking and management information system deficiencies
- Inconsistent policies and procedures and the absence of a standard policies and procedures manual
- Statutory requirements that hearings be held in locations where the HQES and OAH did not have offices.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

To address deficiencies identified with the investigation and prosecution processes, CPIL presented an integrated set of recommendations. CPIL's recommendations included:

- ✓ Implementation of a Vertical Prosecution Model, now commonly referred to as Vertical Enforcement (VE), in which the trial Attorney and Investigator would be assigned as the team to handle a complex case upon referral for investigation
- ✓ Restoration of the 19 Investigator positions lost during the past several years, plus 10 other Enforcement Program positions, resumption of the OSM and Internet Crimes Units, and formation of two (2) regional rapid response teams to handle major cases of unusual complexity and emergency matters
- ✓ Restoration of the six (6) lost HQES Attorney positions and provision of additional assistance by HQES to the CCU
- ✓ Better and more extensive use of Interim Suspension Orders (ISOs) and Temporary Restraining Orders (TROs)
- ✓ Stricter and more consistent enforcement of a comprehensive medical records procurement policy
- ✓ Development and enforcement of a consistent policy on physician interviews
- ✓ Improved cooperation with other State and local prosecutors by both the Medical Board and HQES
- ✓ Expansion and improvement of the Medical Consultant Program, including a restoration of the 15 percent reduction to budgeted Medical Consultant hours, improved training of Medical Consultants, and greater Medical Consultant involvement in training Expert Reviewers
- ✓ Increased pay levels and improved training for Expert Reviewers
- ✓ Improved training for Investigators and improved Investigator access to law enforcement databases and commercial applications
- ✓ Development of a policy and procedures manual for HQES Attorneys
- ✓ Modification of the statutes governing the venue for Hearings to enable HQES to require that they be held at locations where HQES and OAH have offices.

Exhibit II-4, on the next page, summarizes authorized Medical Board staffing levels for the 10-year period from 2000/01 through 2009/10 for the Executive and Administration, Licensing, and Enforcement Programs, excluding the Diversion Program which was terminated in 2008/09. As shown by Exhibit II-4, in 2000/01 the Medical Board was authorized a total of 300 positions, including 90 Investigator positions. During the next several years, as a result of the State's General Fund fiscal crisis, 48 positions were abolished (16 percent), including:

- 10.5 Executive and Administration positions (20 percent)
- 3 Licensing Program positions (8 percent)
- 34 Enforcement Program positions (17 percent).

Over the 4-year period from 2000/01 to 2003/04, authorized staffing levels for the Medical Board's Regional and District offices, excluding staffing for the Probation Program, were reduced by 30 positions (from 137 positions to 107 positions). The staffing reductions imposed on the District offices included elimination of 18 Investigator positions (from 77 positions to 59 positions), representing a 23 percent reduction in authorized Investigator positions. In response to these circumstances, the Medical Board disbanded the OSM and Internet Crime Units. As shown by Exhibit II-4, authorized staffing levels for the Enforcement Program, and throughout the Medical Board, remained at historically low levels through 2005/06.

4. 2005 to 2009

During 2005, SB 231 (Figueroa) was signed into law mandating implementation of Vertical Prosecution (or Enforcement). Section 12529.6(b) of the Governmnet Code states:

> ". . . each complaint that is referred to a district office of the board for investigation, shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action".

There are several ambiguities in the construction of this statute. For example, it is somewhat ambiguous whether the Medical Board must accept the Attorney General's advice. It might be argued that the Investigator assigned to a case is prohibited from pursuing an investigation if the Attorney General directs that no further investigation occur. Alternatively, it might be argued that there is no requirement that the Medical Board follow the advice provided regarding the disposition of an investigation. There also is ambiguity regarding the expected level of involvement of the Attorney General in evidence

Authorized Medical Board Positions - 2000/01 through 2009/10

Excluding Diversion Program

Business Unit		Position Classification	2000/01	2001/02	2002/03[1]	2003/04[2]	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Total Authorized Positions			299.7	298.7	282.2	253.9	252.0	251.0	261.5	261.1	262.2	272.2
Executive, Administrative, and IT Services			53.8	52.5	44.5	44.5	44.3	43.3	45.3	44.1	40.1	40.0
Licensing Program			40.6	43.1	41.6	37.8	37.4	37.4	37.9	40.7	45.8	45.7
Enforcement Program	**Headquarters**	CEA II / Deputy Chief	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	2.0
		Supervising Investigator II									1.0	1.0
		Supervising Investigator I	2.0	2.0	2.0	1.0	1.0	1.0	1.0	1.0	2.0	2.0
		Senior Investigator / Investigator	1.0	1.0	1.0					1.0	2.0	2.0
		Investigator Assistant	2.0	1.0								
		Staff Services Manager II/I	3.0	2.0	2.0	3.0	3.0	3.0	3.0	3.0	3.0	4.0
		Analyst (AGPA/SSA/JSA)	27.0	27.0	26.0	26.0	27.0	27.0	26.0	26.0	26.0	26.0
		Technical and Clerical Support	13.0	14.0	14.0	12.5	11.5	11.5	12.5	10.6	9.6	9.6
		Total - Headquarters Enforcement	51.0	50.0	48.0	45.5	45.5	45.5	45.5	44.6	46.6	46.6
	Regional and District Offices[3]	Supervising Investigator II (Regional Managers)	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
		Supervising Investigator I	13.0	12.0	12.0	11.0	11.0	11.0	11.0	11.0	12.0	13.0
		Senior Investigator / Investigator	77.3	72.0	69.0	59.0	59.0	56.0	60.0	59.0	70.0	74.0
		Investigator Assistant	9.0	11.0	9.0	7.0	7.0	8.0	11.0	11.0		
		Technical and Clerical Support	23.4	20.5	20.5	17.5	17.1	14.1	14.1	14.0	14.0	15.0
		Temporary Help	11.0	11.0	11.0	11.0	9.6	9.6	9.6	9.6	9.6	9.2
		Total - Regional and District Offices	136.7	129.5	124.5	108.5	106.7	101.7	108.7	107.6	108.6	114.2
	Probation	Supervising Investigator II	1.0	1.0	1.0			1.0	1.0	1.0		
		Supervising Investigator I	1.0	2.0	3.0	2.0	2.0	3.0	3.0	3.0		
		Senior Investigator / Investigator	12.0	17.0	16.0	12.0	12.0	14.0	14.0	14.0		
		Investigator Assistant	2.0	1.0	2.0	2.0	2.0	2.0	3.0	3.0		
		Staff Services Manager I									1.0	1.0
		Inspector III									3.0	3.0
		Inspector II/I									13.0	16.0
		Analyst (AGPA/SSA/JSA)									1.0	1.0
		Technical and Clerical Support	1.6	2.6	1.6	1.6	2.0	3.0	3.0	3.0	3.0	4.0
		Temporary Help					0.1	0.1	0.1	0.1	0.1	0.7
		Total - Probation	17.6	23.6	23.6	17.6	18.1	23.1	24.1	24.1	21.1	25.7
	Total Enforcement Program		**205.3**	**203.1**	**196.1**	**171.6**	**170.3**	**170.3**	**178.3**	**176.3**	**176.3**	**186.5**
Total Investigators and Inspectors		Senior Investigator / Investigator	90.3	90.0	86.0	71.0	71.0	70.0	74.0	74.0	72.0	76.0
		Investigator Assistant	13.0	13.0	11.0	9.0	9.0	10.0	14.0	14.0	0.0	0.0
		Subtotal	103.3	103.0	97.0	80.0	80.0	80.0	88.0	88.0	72.0	76.0
		Inspector III/II/I									16.0	19.0
		Total	103.3	103.0	97.0	80.0	80.0	80.0	88.0	88.0	88.0	95.0

[1] Excludes 15 eliminated positions.

[2] Excludes 28 eliminated positions.

[3] Includes Operation Safe Medicine Unit positions.

gathering and other investigative activities. For example, it might be argued that the Attorney General's involvement is limited to providing direction to the Investigator and advice as to the disposition of the cases. Alternatively, it might be argued that, to accomplish these purposes, the Attorney General generally would need to perform other activities, such as reviewing key documents and interview summaries. By extension, it also might be argued that the Attorney General must be substantively involved in all major investigative activities (e.g., preparing for and conducting interviews with subjects, witnesses, and others, reviewing and analyzing medical and other records, selecting Experts and preparing Expert packages, reviewing Expert reports, etc.).

VE was implemented statewide beginning January 1, 2006, representing a third major restructuring of the Medical Board's Enforcement Program within a period of 20 years. Concurrently, SB 231 repealed the statutory provisions governing the reimbursement of investigative and enforcement costs by licensees subject to disciplinary action by the Medical Board (cost recovery). Opponents of the repeal of cost recovery argued that licensees would have less incentive to settle Disciplinary Action cases as there would no longer be any financial penalty for delaying a settlement, or for not settling and, instead, proceeding to Administrative Hearing.

To support implementation of VE, ten (10) additional Attorney positions were authorized for HQES, which fully restored the six (6) Attorney positions previously eliminated. However, the Medical Board's Investigator positions were not transferred to HQES, as recommended by CPIL. Also, the Investigators' position classifications and pay scales were not upgraded to the Special Agent level as would have occurred if the positions had been transferred.

Per the Enforcement Monitor's *Initial Report*, dated November 1, 2004 (page ES-22), VE was intended to address long-standing problems that contributed to the extended timeframes needed to complete investigations and prosecutions, and would provide significant benefits, including all of the following:

Improved Efficiency and Effectiveness – The system linking Medical Board Investigators and HQES Attorneys was characterized by its lack of coordination and teamwork. Medical Board Investigators generally functioned without close coordination with the trial Prosecutor that would ultimately handle the case, seldom worked directly with or received guidance from the Attorney who prosecuted their cases, and received limited legal support for their investigative work. With few exceptions the system permitted only inadequate communication and consultation between the primary field Investigator and the Attorney who would prepare the pleading and try the case. Multiple Attorneys could become involved in the case (the DIDO, initially, the Supervising DAG for review and assignment following investigation, and the trial DAG for pleading and prosecution). The lack of teamwork and coordination through the life of the case wasted effort and contributed to operational inefficiencies and last-minute requests for additional Investigation as the cases neared administrative hearing. It was expected that VE would enable the HQES Prosecutor and the Medical Board Investigator to communicate often and work together to coordinate their

activities. The assigned trial DAG would provide input to the Investigation Plan, guide the investigation, assist in obtaining medical records, and participate in the selection of the Expert Reviewer and in the identification of documents and records transmitted to the Expert Reviewer.

Reduced Case Cycle Times – The Medical Board's Enforcement Program was found to be plagued by excessive case cycle times and delays in the investigation and prosecution processes. It was expected that VE would shorten case timeframes as Prosecutors became more involved in obtaining medical records and other evidence gathering activities. Additionally, HQES Attorneys would assist is evaluating cases earlier during the process, and in identifying weak or problematic cases that should be subject to dismissal or early settlement, leading to earlier case dispositions. Finally, the earlier involvement of Prosecutors would lead to greater use of preliminary relief actions, such as Interim Suspension Orders (ISOs).

Improved Investigator and Prosecutor Morale, Recruitment, and Retention – These benefits were expected to accrue from greater operational efficiency and a greater sense of accomplishment that would flow from teaming Investigators with Prosecutors, and following cases through to their disciplinary conclusion. These benefits would be enhanced if the Medical Board's Investigators were transferred to the Department of Justice, and upgraded to Special Agents, which did not occur.

Improved Training for Investigators and Prosecutors – Medical Board Investigators were seldom involved in the Pre-Hearing and Hearing process to which their work was directed. Through participation in these processes, Investigators would achieve a better understanding of the significance of legal strategies, evidence issues, interview techniques, and witness selection and preparation. Investigator participation in the administrative hearing process would substantively enhance Investigator skills. Concurrently, HQES Attorneys would gain a greater appreciation for the challenges of the investigation process.

Improved Commitment to Cases – With VE, the Attorney who helped to work up the case would be more invested in the case, and more committed to achieving the ultimate disciplinary outcome of the case.

Improved Perception of the Fairness of the Process – This benefit would only accrue if Medical Board Investigators were transferred to the Department of Justice, which did not occur.

At the time that VE was implemented (2006), staffing levels at the Medical Board's District offices were 25 percent lower than existed earlier in the decade. Additionally, Investigator caseloads were growing and the average time to complete investigations had been steadily increasing for several years.

To support implementation of VE, eight (8) new positions were authorized for the Enforcement Program (4 Investigators and 4 Assistant Investigators). The additional positions were authorized beginning with the 2006/07 fiscal year (6 months

after implementation of VE commenced). The new positions only partially restored the 35 District office positions that had been eliminated since the beginning of the decade. Given the extended lead times to hire and train new staff, these additional resources were largely unavailable to support implementation of VE for the first full year following implementation of this new approach to conducting investigations. Subsequently, the Medical Board reclassified the four (4) new Assistant Investigator positions to Inspectors and assigned the positions to the Probation Units. Concurrently, a comparable number of Investigator positions assigned to the Probation Units were reassigned to the District offices. In summary, the Medical Board's District offices were not initially provided with any additional resources to assist them in responding to the additional workload demands associated with coordinating their investigation activities with HQES Attorneys and responding to the Attorneys' directions regarding the conduct of the investigations.

Shortly following initial implementation of VE, during 2007 the Department of Justice (DOJ) adopted a new Supervising Deputy Attorney General (SDAG) classification for use throughout the DOJ. Previously, selected Deputy Attorneys (DAGs) within HQES and other DOJ business units served as Acting Supervisors, and were commonly referred to as Supervising DAGs, but did not have formal supervisory authority over other Attorneys. During 2007, six (6) HQES Attorneys were appointed as SDAGs, including two (2) SDAGs for the San Diego office which previously had only one (1) Acting SDAG position. Currently, in addition to San Diego's two (2) SDAG positions, two (2) SDAGs are assigned to HQES' Los Angeles Metro office, one (1) SDAG is assigned to the HQES' San Francisco office, and one (1) SDAG is assigned to HQES' Sacramento office. Although unrelated to implementation of VE, the creation of an additional SDAG position in HQES' San Diego office, and the adoption of higher pay scales for all HQES SDAG positions, was viewed unfavorably by Medical Board Investigators and Supervising Investigators whose classifications and pay scales were not upgraded as had been expected.

To guide the implementation of VE, the Medical Board and HQES jointly developed a *Vertical Prosecution Manual* that defined the roles and responsibilities of the members of the VE Team, as follows:

Investigator – Develops and updates Investigation Plans and Progress Reports (IPPRs), conducts investigations, and participates in the administrative hearing process under (1) the supervision of their Supervising Investigator I and II, Deputy Chief, and Chief of Enforcement, and (2) the direction of the assigned Primary DAG.

Medical Consultant – Provides medical input and advice through reviews of medical records, participation in Subject interviews, selection of Expert Reviewers, and evaluation of Medical Expert opinions under (1) the supervision of the Supervising Investigator I and II, Deputy Chief, and Chief of Enforcement, and (2) the direction of the assigned Primary DAG.

Supervising Investigator I – Supervises Investigators, Medical Consultants, and other District office staff to ensure progression of the cases for which they are responsible. Also completes monthly reports, monitors case progress through case reviews, and handles personnel matters.

Supervising Investigator II – Supervises Supervising Investigator Is, develops and implements Board policy, develops and implements training, handles complex personnel matters, acts as liaison to other government agencies, and signs subpoenas.

Deputy Chief – Manages Supervising Investigator IIs and overall Enforcement Program operations, including Training, Internal affairs, Background Investigations, and Probation.

Enforcement Chief – Supervises Deputy Chiefs and manages the overall Enforcement Program.

Primary DAG (PDAG) – Works closely with other team members and, in conjunction with Supervising Investigator I, directs Investigators in obtaining evidence. Also, provides legal advice to the Medical Board and prosecutes the case.

Supervising DAG (SDAG) – Supervises and provides support for DAGs, oversees and monitors investigations, and supervises Prosecutions.

Senior Assistant Attorney General – In conjunction with the Executive Director of the Medical Board, oversees and bears responsibility for all investigations and prosecutions.

Additionally, although not proposed as part of the Vertical Prosecution Model recommended by the Enforcement Monitor, HQES created a new **Lead Prosecutor (LP)** designation for selected DAGs to support implementation of VE. HQES assigned one (1) LP to each Medical Board District office to act as HQES' principal liaison to that office. The LP is jointly assigned to each case along with a second DAG. The LP is required to review all incoming complaints and determine whether the complaints warrant an investigation or should be closed without investigation. The determination of whether to close a complaint without investigation is required to be made in consultation with the District office Supervisor. If the LP determines that an investigation is warranted, they are required to inform the assigned Investigator and then review and approve the Investigator's Investigation Plan.

The LP is also required to identify cases in which an ISO or Penal Code Section 23 (PC 23) appearance is necessary, and notify the SDAG. In such cases the SDAG is required to designate the second DAG as the Primary DAG responsible for the ISO or PC 23 appearance. The SDAG is also required to designate the second DAG as the Primary DAG for cases involving sexual abuse or misconduct, mental or physical illness, and complex criminal conviction cases. Finally, whenever the LP determines that it is likely a violation of law may be found, the second DAG is required to replace the LP as the Primary DAG

on the case for all purposes. If the second DAG is assigned as Primary DAG, then the LP is required to monitor the progress of the investigation and the appropriateness of the direction provided by the Primary DAG. If the second DAG is not assigned by the SDAG as the Primary DAG, then the LP is required to act as the Primary DAG throughout the investigation and prosecution of the case. LPs are required to be physically present at their assigned District office to the extent necessary to fully discharge their responsibilities.

Exhibit II-5, on the next page, summarizes other significant policies and guidelines set forth in the *Vertical Prosecution Manual*. Additionally, the *Vertical Prosecution Manual* identifies and defines the following "Statistical Measure Efficiency of the Vertical Prosecution Model":

> "In additional to any other statistical measure that may be later identified, one statistical measure that shall be used to assess the efficiency of the vertical prosecution model, as described in Senate Bill 231, shall be the length of time from receipt by the Board's District Office of the original complaint from the Board's Central Complaint Unit to the date that the investigation is closed or a Request to Set is submitted to the Office of Administrative Hearings."

Medical Board Investigators and HQES DAGs "are jointly responsible for this statistical measure of efficiency". The manual notes that "in its early stages, it is anticipated that use of the "vertical prosecution model" may extend the time it takes to complete some investigations."

Subsequently, in April 2008 the Medical Board and HQES issued a set of *Joint Vertical Enforcement Guidelines* which supplement the policies and guidelines initially set forth in the *Vertical Prosecution Manual*. **Exhibit II-6,** following Exhibit II-5, summarizes some of the key polices and procedures contained in the *Joint Vertical Enforcement Guidelines*.

As is evident from the policies and guidelines governing VE, authority and accountability for the conduct and completion of investigations is now significantly more fragmented than before with as many as 5 to 6 different Medical Board and HQES staff regularly involved in many cases, including the District office Supervisor, Investigator, and Medical Consultant, and as many as three (3) HQES Attorneys (SDAG, LP, and Primary DAG). The number of Medical Board and HQES staff who become involved with each case can be (and often is) even greater when (1) cases are reassigned to different Investigators or Prosecutors to balance workloads, (2) a change is made to the LP assigned to a District office, or (3) turnover occurs among either Medical Board or HQES staff. The involvement of all of these personnel has created needs for continuous documentation and distribution of communications between most (or all) of these staff throughout the course of the investigation to keep all of the members of the VE Team updated and informed regarding the status and progress of the investigation, and to coordinate a series of investigative activities that typically extend over a period of at least 1 to 2 years, including:

Summary of Other Significant Vertical Enforcement Policies and Guidelines

- "Direction" is defined as "the authority and responsibility to direct the assigned Investigator to complete investigative tasks, obtain required testimonial and documentary evidence, make periodic reports regarding the progress of the investigation, and complete additional tasks necessary to prepare and present the case for hearing."
- Supervising Investigator Is are expected to jointly assign cases to Investigators in consultation with the LP, and assist in ensuring that investigative assignments are completed, as directed by the assigned DAG, in a timely and efficient manner.
- Supervising Investigator Is are cautioned not to undermine the direction authority of the assigned DAGs, and DAGs are cautioned not to undermine the supervisory authority of the Supervising Investigator Is.
- Investigators are required, within five (5) days of assignment of a case, to prepare and submit a Plan of Investigation to the Primary DAG for their review and approval. The Primary DAG is required to review and approve the Plan of Investigation within five (5) days.
- The investigation is required to be completed pursuant to the Investigation Plan and Progress Report (IPPR). The IPPR is required to be updated as significant events occur and investigative tasks are completed and, as necessary, with any modifications submitted to, and approved by, the Primary DAG.
- The Investigator and Primary DAG are required to maintain a running e-mail thread documenting their communications and the progress of the investigation. Copies of the IPPR and subsequent IPPR emails are required to be sent to both the LP and the Supervising Investigator I.
- The Primary DAG may participate in subject or witness interviews, and is required to discuss the interview with the Investigator prior to commencement of the interview. The Medical Consultant is required to participate in the pre-interview discussion if they will be attending the interview.
- A review of the case is expected to be completed, on-site whenever possible, prior to referral of a case to an Expert Reviewer. The Medical Consultant is required to participate in the case review whenever possible. The Primary DAG is required to insure that the selected Medical Expert is appropriate for the case. The Investigator is required to promptly provide a copy of the Expert Reviewer's initial report to the Primary DAG and the Medical Consultant, and to review the Expert's report and determine whether clarification of the report or additional investigation is needed. The Primary DAG is encouraged to consult with the Medical Consultant to make these same determinations, and to inform the Investigator if additional investigation is required.
- At any point a Primary DAG may submit a recommendation to the LP to close a case. The LP is required to review and approve or disapprove the recommendation to close a case within ten (10) business days.
- The Primary DAG is required to determine whether a completed investigation will be accepted for prosecution within five (5) business days of submission. In cases where closure is recommended, the Primary DAG is required to review and approve or disapprove the recommended disposition within ten (10) business days.
- The assigned Investigator is expected to attend the administrative hearing, unless released
- If disagreements arise between the Investigator and the Primary DAG regarding an investigation that they are unable to resolve, the Investigator and Primary DAG are required to discuss the matter with the Lead Prosecutor, Supervising Investigator I, and/or Supervising Investigator II. If the disagreement remains unresolved, the matter is required to be submitted to the SDAG who, after consultation with the Chief of Enforcement, shall issue a determination. If the disagreement still remains unresolved, it is required to be submitted to the Senior Assistant Attorney General who, after consultation with the Chief of Enforcement and Executive Director of the Medical Board, shall issue a final determination.

Summary of Additional Vertical Enforcement Policies and Guidelines

Case Intake Documents – At a minimum, LPs must be provided copies, in hard copy or soft copy format, of the consumer complaint, including all attachments, all medical records sent with the case, all CCU documentation, all CCU Medical Consultant documentation, including attachments, and any statement provided by the respondent to, or from, CCU.

Complainant, Witness, and Subject Interviews – Primary DAGs are expected to participate in ALL Complainant interviews in cases involving sexual misconduct, and in ALL Subject interviews. Investigators are required to schedule these interviews on dates that the Primary DAG is available. The Primary DAG may request that the LP participate in the interview if the Primary DAG will be unavailable and the interview would be unreasonably delayed if postponed until the Primary DAG was available. Investigators are required to notify the Primary DAG of other interviews and the Primary DAG is required to notify the Investigator as to whether they want to attend the interviews within specified timeframes (e.g., 5 business days). If no response from the Primary DAG is received, the Investigator may proceed with the interview without he Primary DAG, but is required to notify the SDAG of the lack of response. All participants are required to review the case and prepare for and plan the interviews, including allocating sufficient time for meeting in person for a pre-interview meeting.

Subpoenas – Investigators and Primary DAGs are strongly encouraged to work together in preparing subpoenas. The Investigator is responsible for preparing the subpoena but, whenever requested, the Primary DAG or LP should assist the Investigator. Primary DAG or LP reviews of subpoenas are required to be completed within five (5) business days of submission. An additional five (5) business days is allowed for the DAG or LP to make changes to the subpoena. If no response is received within ten (10) business days, the Investigator may forward the subpoena to the Supervising Investigator II for approval.

Expert Package Reviews – The Investigator is required to notify the Primary DAG when an Expert Package is available for review, and to provide a copy of the notification to the Supervising Investigator I, the LP, and the SDAG. The LP should review the Expert Package if the Primary DAG is unable to do so within ten (10) days of the notification.

Case Reviews – LPs are expected to participate in all case reviews. Supervising Investigator Is are required to provide at least ten (10) days notice to the LP of all Quarterly Case Reviews and, also, any other case review, and to schedule the case reviews for the LP's normal day in the District office.

Case Closures – To ensure that no meritorious cases is closed prematurely, all cases should remain open and under active investigation until a determination is made by the Primary DAG or LP, in consultation with the Investigator and Supervising Investigator, that the case has no merit or there is insufficient evidence to establish a violation of law. If there is a disagreement over whether to close a case, the disagreement is required to be resolved in accordance with the Dispute Resolution procedures set forth in the *Vertical Prosecution Manual*. If the Dispute Resolution procedures are not invoked within five (5) business days of the disagreement, the Investigation is required to be promptly closed by both HQES and the Medical Board, with the date of closure posted as the date that the Primary DAG directed or approved closure of the case.

Referral of Cases for Prosecution – The Supervising Investigator is required to notify the Primary DAG when a completed investigation is ready for review. The Primary DAG is required to determine, within five (5) business days, whether the case will be accepted for prosecution. If accepted for prosecution, the Primary DAG should promptly sign and date the Investigation Report, without any interlineations, such as "case received", and provide the signature page to the Supervising Investigator. If the case is rejected, the Primary DAG should document via email the reasons for the rejection and, if appropriate, recommended additional investigation and submit the email to the Investigator and Supervising Investigator within the five (5) business day timeframe provided for acceptance or rejection of the case. If the Primary DAG is unavailable to review the request, the LP may review the transmittal and accept or reject the case within the allotted timeframe, if so requested by the Primary DAG.

Criminal Cases – Cases involving investigations of unlicensed persons are excluded from the Vertical Enforcement process.

- ✓ Developing the initial plan for conducting the investigation and subsequent updates to the plan
- ✓ Requesting medical records and reviewing documents received in response to the requests
- ✓ Interviewing complainants, witnesses, and subjects, including related pre-interview case file review and planning meetings and post-interview debriefings
- ✓ Selecting Expert Reviewers
- ✓ Preparing and reviewing Expert Reviewer packages
- ✓ Reviewing Expert Reviewer reports
- ✓ Reviewing completed cases not referred for prosecution
- ✓ Reviewing cases referred for prosecution.

The preceding activities tend to be completed sequentially because subsequent activities typically cannot fully commence until prior activities are substantially completed. For example, most quality of care cases, and many physician conduct cases, generally progress sequentially through the following six (6) major stages of activity during the course of completing an investigation:

Stage I – Incoming complaints are reviewed to determine whether to investigate the case. Nearly all cases are accepted for Investigation.

Stage 2 – Background research is completed, records are requested and reviewed, and interviews with the complainant and witnesses are scheduled and conducted to better define the scope of the investigation and to identify and frame possible violations.

Stage 3 – The case is submitted to the Medical Consultant for review. Then an interview with the Subject is scheduled and conducted. Quality of care cases referred for investigation are rarely closed without first interviewing the Subject. The Medical Consultant usually participates in these interviews. Criminal cases and petitions are not usually submitted to the Medical Consultant for review and the Subject is not usually interviewed. Investigations of other types of physician conduct cases oftentimes include a Medical Consultant review of the case or a Subject interview, or both.

Stage 4 – Following the Subject interview, if completed, a determination is made as to whether to have an Expert Reviewer review the case. Then an Expert Reviewer is selected. Concurrently, an Expert Package is assembled to submit to the Expert Reviewer. Most quality of care cases and many physician conduct cases, excluding criminal cases and petitions, are submitted to an Expert Reviewer who determines whether the evidence supports a finding of gross negligence, repeated acts of negligence, or other professional misconduct. The Medical Consultant is usually substantively involved in these activities, particularly if the case involves quality of care issues.

Stage 5 – The Expert Reviewer's report is reviewed to determine whether to perform additional investigative work, request additional review by the Expert Reviewer or clarification of their report, close the case, or refer the case for prosecution. The Medical Consultant is usually substantively involved in these activities, particularly if the case involves quality of care issues.

Stage 6 – For both closed cases and cases referred for prosecution, the final Report of Investigation and supporting documentation are reviewed and approved.

At any point during the process, needs for additional records or interviews may be identified resulting in a resumption of earlier-stage work. These needs may be identified during the course of the investigation by the Investigator, Medical Consultant, District office Supervisor, or Primary DAG (if assigned and substantively involved with the investigation), or during a formal periodic Quarterly Case Review meetings between the District office Supervisor and Investigator, and Lead Prosecutor, if attending.

There are some disparities between the policies and guidelines established for the VE Pilot Project and actual case investigation practices, and considerable variability in how VE has been implemented in different regions throughout the State. For example:

Lead Prosecutor Assignments – For some District offices an SDAG rather than a DAG serves as LP. At some District offices the assigned LP rarely changes while, at other District offices, the LP is changed on a rotational basis. At some District offices where Primary DAGs are assigned to most cases, the LP serves as an intermediary or liaison between the Investigator and the Primary DAG, and the Investigator and Primary DAG directly interface only on an exception basis. At other District offices where Primary DAGs are assigned to most cases, the Investigator and Primary DAG usually interface directly, and the LP only becomes involved when there are disagreements or problems between the Investigator and Primary DAG. Depending on the location of the District office and other factors, LPs usually have either one (1) or two (2) regularly scheduled days each week where they are expected to physically visit their assigned District office (not necessarily for the full day).

Case Intake and Investigator Assignments – For most District offices incoming complaints are accepted by the District office Supervisor and assigned to an Investigator without any involvement or consultation with the LP. Concurrently, the case file is transmitted to the LP. At some District offices a physical copy of the entire case file is staged for the LP's review on their next regular duty day at the District office. At other District offices a soft copy of the case file is created and emailed to the LP but, if there are a large number of supporting documents, copies of all of the documents may not always be provided. Generally, the LP's review of a new complaint and their opening of a new Investigation matter in HQES' ProLaw System occurs at some point after the opening of the investigation by the District office, after the District office Supervisor's assignment of an Investigator to the case, and, in some cases, after the initiation of investigation activities.

Primary DAG Assignments – For some District offices a Primary DAG is usually assigned by the SDAG to each new investigation following the LP's opening of the new investigation matter in HQES' ProLaw System. For District offices where the SDAG serves as the LP, the assignment of a Primary DAG can occur concurrent with the SDAG's case intake review. For some District offices a Primary DAG is only assigned to an investigation on an exception basis (e.g., cases involving sexual misconduct or if requested by the District office) or the assignment of a Primary DAG is usually deferred until much later during the investigation process (e.g., when the case is ready to be transmitted to an Expert Reviewer or following completion of the investigation when the case is ready to be referred for prosecution).

Initial Investigation Plan Preparation and Review – For most District offices the assigned Investigator prepares the initial Investigation Plan, submits it to the District office Supervisor, LP, Primary DAG (if assigned), and others, as required (which varies among the District offices), and commences the investigation. HQES Attorneys rarely suggest any changes to the initial Investigation Plan. At some District offices the Investigators do not commence their investigation until either the LP or Primary DAG approves the initial Investigation Plan (which is required to be provided within 5 business days, but can take longer due to absences, vacations, or other factors).

Medical and Other Records – For some District offices complete copies of all medical and other records collected during the investigation are forwarded to the Primary DAG as they are obtained. In other District offices copies of these records are forwarded on an as-needed basis or are always forwarded to only some of the Primary DAGs assigned to the office's cases.

Subject Interviews – At some District offices the Primary DAG is expected to attend all Subject interviews. At other District offices either the LP attends most Subject interviews on behalf of the Primary DAGs or an HQES Attorney (usually either the LP or Primary DAG) only attends Subject Interviews on an exception basis (e.g., cases involving sexual misconduct or if requested by the District office). At some District offices the LP rarely attends Subject interviews. Attorney practices regarding completion of pre-interview case file reviews, attendance at pre-interview

planning meetings, and the extent of their participation during the interview vary greatly depending on individual Attorney work style differences. Primary DAGs sometimes fail to show for Subject interviews that they were scheduled to attend.

Expert Reviewer Selection and Expert Package Review – For some District offices the Primary DAG is usually substantively involved in selecting an Expert Reviewer and reviewing Expert packages. At other District offices the Primary DAG is not usually substantively involved in the investigation until this point in the process. At other District offices the Primary DAG usually declines to review the Expert Package. In some cases the Primary DAGs are not substantively involved in reviewing the Expert package because they were previously substantively involved in the case during earlier stages of the investigation. At some District offices an HQES Attorney (Primary DAG or LP) is only involved in Expert Reviewer-related activities on an exception basis. There is considerable variability in Medical Board and HQES practices related to the preparation and review of Expert packages.

Completed Investigation Case Reviews – For some District offices most completed cases are regularly reviewed and accepted for closure or prosecution within required timeframes (5 business days for cases recommended for prosecution and 10 business days for cases recommended for closure). For other District offices the completed cases oftentimes are not reviewed and approved within the required timeframes. At some District offices there appear to be chronic problems with these processes with HQES either (1) delaying the closure or transmittal of cases by requesting completion of additional investigation activity, or (2) not informing the District office regarding its approval or disapproval of the recommended case disposition, or not doing so on a timely basis. According to Medical Board staff, there is considerable variability in HQES practices related to acceptance of cases for prosecution.

Investigator Attendance at Hearings – Investigators attend hearings to assist the DAGs prosecuting the cases, however, hearings are rarely conducted (fewer than 50 per year for cases investigated by District offices). When hearings are held, it is a major drain of resources as the hearing may extend over a period of weeks. The experience, however, is valuable and essential for the growth and development of seasoned Investigators.

Finally, ambiguities in the statutes mandating use of the VE Model appear to underlie some of variability that exists is how VE was implemented in different regions of the State. Additionally, there is great deal of variability in the relationships between Medical Board Investigators and HQES Attorneys. Generally, there is a fairly high level of friction between Investigators and Attorneys throughout the State. However, the relationships are particularly poor in the Los Angeles Metro region. One source of the friction and conflict between Medical Board and HQES staff is variability in the perceptions of different individuals regarding the Legislative intent in mandating use of the VE Model, and ambiguities in the statutes requiring its use.

Following implementation of VE, during 2007/08 and 2008/09, there were some minor shifts in authorized positions between various programs and business units within the Medical Board. Collectively these shifts increased authorized staffing for the Licensing Program by eight (8) positions (21 percent), but most of this increase is attributable to a concurrent transfer of the Cashiering Unit to the Licensing Program. Subsequently, in 2009/10, ten (10) additional positions were authorized for the Enforcement Program, the first increases since the addition of eight (8) Investigator and Assistant Investigator positions in 2006/07. Six (6) additional positions were authorized to re-establish the OSM Unit (1 Supervising Investigator, 4 Investigators, and 1 Office Technician) and four (4) additional positions were authorized for the Probation Program (3 Inspectors and 1 Office Technician). No additional positions were authorized for the District offices to support implementation of VE and investigate growing backlogs of complaints against licensed physicians.

E. Section 805 Reports and Investigations

The Medical Board relies heavily upon Section 805 reporting to identify instances of physician negligence or misconduct. Initially, legislation enacted during 1975 (AB 1, Keene) required submission of these reports and, during the early-1990s, the Medical Board received an average of 159 Section 805 Reports per year (which was considered seriously deficient). Since that time, major legislative changes have been enacted to improve Section 805 reporting, but the number of reports submitted has continued to decline.

During the early 1990s, SB 2375 (Presley) and SB 916 (Presley) were enacted to improve Section 805 reporting. SB 2375 increased the fines charged for failure to submit Section 805 Reports (to a maximum of $5,000 for failure to submit a required report, or $10,000 for willful failure to submit a required report). SB 16 enhanced Section 805 reporting (e.g., by reducing the timeframes to submit required reports). Subsequently, during 2001, SB 16 (Figueroa) was enacted to address problems with Section 805 reporting. SB 16 significantly increased the maximum fines for failure to file a Section 805 Report (to a maximum of $50,000 for failure to submit a required report, or $100,000 for willful failure to submit a required report). SB 16 also required that the Medical Board contract with the Institute for Medical Quality, a subsidiary of the California Medical Association (CMA), to conduct a comprehensive study of the peer review process to determine the continuing validity of Section 805 reporting requirements. A written report was required to be submitted to the Medical Board and the Legislature by November 1, 2002 (later extended to November 1, 2003). Due to budget constraints, this study was never completed.

In 2005 legislation was enacted (SB 231, Figueroa) which required that the Medical Board contract with an independent entity to conduct the peer review study previously required by SB 16. A written report was required to be submitted to the Medical Board and the Legislature by July 31, 2007 (later extended to July 31, 2008). In July 2008 this study was completed. The study was conducted by a non-profit healthcare consulting organization (Lumetra). Lumetra found failures throughout current peer review process, including inconsistent standards and practices, a lack of objective and confidential review, insufficient transparency, extensive delays and inefficiencies, and prohibitive costs. Lumetra also concluded that the current peer review process rarely leads to Section 805 Reports and that the high costs associated with Section 805 reporting may influence the pursuit of cases against physicians. According to Lumetra:

> "Entities can take multiple steps to follow the letter but avoid the "spirit" of the 805 law by using tactics such as pressuring an offending physician to resign for reasons other than "medical cause or reason", by having summary suspensions less than 14 days, by negotiating with an offending physician privately through attorneys to avoid an 805 report, or by offering extended educational sessions and other remedial opportunities that would not trigger an 805 report."

Lumetra recommended a re-design and restructuring of the peer review process, including establishment of a separate, independent peer review organization that would investigate cases referred to it by the peer review organizations, and then make recommendations regarding the filing of Section 805 reports or taking other corrective action. Under this proposed model, responsibility for hearings concerning a final proposed action by a peer review body, including the filing of Section 805 reports, would be transferred from health

care facilities to the Medical Board or a designated independent organization. The Medical Board would continue to investigate all Section 805 Reports and, if appropriate, initiate disciplinary actions. To date, Lumetra's recommendations have not been implemented.

Although the number of Section 805 reports submitted to the Medical Board has declined in recent years (from an average of about 150 reports per year during the early-2000s to an average of 129 reports per year during the past three (3) years), the average elapsed time to complete investigations of these reports has increased dramatically. **Exhibit II-7**, on the next page, shows average elapsed times, by year for the past four (4) years, to complete investigations of Section 805 cases that were referred to HQES for prosecution. As shown by Exhibit II-7, about 30 to 40 Section 805 case investigations were completed each year with a referral for prosecution. During 2005/06 the timeframe to complete these investigations exceeded two (2) years in only two (2) cases, and 90 percent of the investigations were completed in a period of two (2) years or less. Since 2005/06 the timeframes to complete these investigations increased significantly. For example:

- The average elapsed time to refer Section 805 quality of care cases for prosecution increased by 44 percent (from 16.7 months to 24.0 months). During 2008/09, 50 percent of these quality of care cases took longer than two (2) years to Investigate. In contrast, during 2005/06 only 10 percent of these cases took longer than two (2) years to investigate.
- The average elapsed time to refer other (non-quality of care) Section 805 cases for prosecution increased by 22 percent (from 9.4 months to 11.5 months).
- On an aggregate basis, the number of Section 805 cases that took longer than two (2) years to Investigate and refer for prosecution increased every year subsequent to 2005/06. In 2008/09, 15 of 37 Section 805 cases referred for prosecution (41 percent) took longer than two years to investigate.

Throughout this period, the average elapsed time to investigate Section 805 cases that were closed, and not referred for prosecution, was about 14 months. This average elapsed time includes cases that were closed because the investigation was not completed with statutorily-mandated timeframe limitations.

Finally, Section 805 cases referred for prosecution may be less likely than other types of cases to have a successful disciplinary outcome. For example, during 2007/08 as especially large number of accusations (36 cases) were withdrawn or dismissed, excluding Out of State and Headquarters cases. Eight (8) of these (22 percent) were Section 805 cases. Of 26 accusations that were withdrawn, six (6) were Section 805 cases (31 percent). Additionally, Section 805 cases may account for a disproportionate share of multiple complaint cases. For example, of 126 multiple complaint cases that had a disciplinary outcome during 2007/08 and 2008/09, 14 percent (18 cases) were Section 805 cases.

Summary of Section 805 Case Investigations Referred for Prosecution
2005/06 through 2008/09

Case Type	Elapsed Time to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	1 Year or Less	3	15%	6	27%	2	7%	1	4%
	1 to 2 Years	15	75%	10	45%	17	59%	13	46%
	2 to 3 Years	2	10%	6	27%	10	34%	14	50%
	Total	20	100%	22	100%	29	100%	28	100%
	Average Number of Months	16.7 Months		17.3 Months		21.3 Months		24.0 Months	
Other Cases	1 Year or Less	6	75%	8	57%	5	38%	5	56%
	1 to 2 Years	2	25%	6	43%	7	54%	3	33%
	2 to 3 Years	0	0%	0	0%	1	8%	1	11%
	Total	8	100%	14	100%	13	100%	9	100%
	Average Number of Months	9.4 Months		10.7 Months		16.4 Months		11.5 Months	
Total	1 Year or Less	9	32%	14	39%	7	17%	6	16%
	1 to 2 Years	17	61%	16	44%	24	57%	16	43%
	2 to 3 Years	2	7%	6	17%	11	26%	15	41%
	Total	28	100%	36	100%	42	100%	37	100%
	Average Number of Months	14.6 Months		14.7 Months		19.8 Months		21.0 Months	

F. HQES Staffing Resource Allocations

Table II-2, below, shows filled HQES positions by year from 2004/05 through 2008/09. Excluding temporary help (retired annuitants) and Secretaries (7 positions) assigned to HQES' Senior Assistant Attorney General and each of six (6) Supervising DAGs, 58 full-time, permanent positions were authorized for HQES, including:

- 1 Senior Assistant Attorney General
- 6 Supervising Deputy Attorneys
- 47 Deputy Attorneys (all levels)
- 3 Senior Legal Analysts
- 1 Associate Government Program Analyst.

Prior to implementation of Vertical Enforcement, HQES did not have an Associate Government Program Analyst position and had nine (9) fewer Attorney positions. The Secretary positions are not shown as budgeted to HQES in the *Wage and Salary Supplements to the Governor's Budgets*.

Table II-2. Health Quality Enforcement Section Staffing Profile
2004/05 through 2008/09

Classification	Filled Positions				
	2004/05	2005/06[1]	2006/07	2007/08	2008/09
Senior Assistant Attorney General (CEA)	1.00	1.00	1.00	1.00	1.00
Supervising Deputy Attorney General (SDAG)	Not Applicable		4.40	6.00	6.00
Deputy Attorney General IV	29.90	29.70	32.30	27.10	24.00
Deputy Attorney General III	10.40	10.30	9.80	17.80	19.00
Deputy Attorney General	1.30	3.90	3.90	2.00	2.70
Senior Legal Analyst	3.00	3.00	3.00	3.00	3.00
Associate Government Program Analyst	0.00	0.00	0.00	0.70	1.00
Total, Excluding Secretaries and Temporary Help	45.60	47.90	54.40	57.60	56.70

[1] The Vertical Enforcement Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

Table II-3, below, shows allocations of authorized SDAG, DAG, and Senior Legal Analyst positions by HQES office during 2008/09 and 2009/10 as shown on HQES' staffing rosters. Currently, nearly one-half of HQES' Attorneys are assigned to the Los Angeles Metro office, 30 percent are assigned to Northern California offices (Sacramento and San Francisco), and less than one-quarter are assigned to the San Diego office. During 2009/10, authorized Attorney staffing for HQES was reduced by four (4) positions. All of the reductions were absorbed by the Sacramento, San Francisco, and San Diego offices. None of the reductions were absorbed by the much larger Los Angeles Metro office. Additionally, one (1) vacant Attorney position was shifted to the Los Angeles Metro office to accommodate unrelated personnel placement needs at that location. To better balance workload between the various HQES offices, the geographic boundaries of the Los Angeles Metro office were recently extended, both North and South, to encompass portions of the areas served previously by HQES' Sacramento and San Diego offices.

Table II-3. Health Quality Enforcement Section Staff Allocations by Office

Fiscal Year	HQES Office Location	Postion Classification			Total[1]		Percent of DAGs
		Supervising Deputy Attorney General (SDAG)	Deputy Attorney General (DAG)	Senior Legal Analyst	Number	Percent	
2008/09	Sacramento, San Francisco, and Oakland	2	16	1	19	33%	33%
	Los Angeles Metro	2	20	1	23	40%	42%
	San Diego (Other Southern California)	2	12	1	15	26%	25%
	Total Allocated Positions[1]	6	48	3	57	100%	100%
2009/10	Sacramento and San Francisco	2	13	1	16	30%	30%
	Los Angeles Metro	2	21	1	24	45%	48%
	San Diego (Other Southern California)	2	10	1	13	25%	23%
	Total Allocated Positions[1]	6	44	3	53	100%	100%

[1] Excludes one (1) Senior Assistant Attorney General position, one (1) Associate Government Program Analyst (AGPA) position based in HQES' Los Angeles office, and seven (7) Secretary positions.

Table II-4, below, shows the significant shift that has occurred during the past several years in the number of Attorney hours charged by HQES to Medical Board investigations. As shown by Table II-4, the number of hours charged by HQES Attorneys to Medical Board investigations increased significantly during the past three (3) years, and virtually all of the additional hours were charged by Attorneys based in HQES' Los Angeles Metro office. During 2009, Los Angeles Metro office Attorneys charged more than 17,000 hours to Medical Board Investigations compared to fewer than 6,000 hours charged to investigations by Attorneys in each of the other regions of the State. The hours charged to investigations by Los Angeles Metro office Attorneys during 2009 accounted for 60 percent of all HQES Attorney hours charged to investigations.

Table II-4. Hours Charged by HQES Staff to Investigation Matters

Includes Hours Charged to Investigation Matters, Section-Specific Tracking and Client Service

Class	HQES Office(s)	2006	2007	2008	2009
Attorneys	Northern California[1]	6,610.25	6,084.50	5,007.25	5,167.75
	Los Angeles Metro	6,349.00	6,388.00	13,527.75	17,083.50
	San Diego (Other Southern California)	4,535.50	3,777.50	5,625.50	5,988.75
	Total	17,494.75	16,250.00	24,160.50	28,240.00
Paralegals and Analysts	Northern California[1]	235.25	286.25	201.75	175.00
	Los Angeles Metro	189.50	739.00	1,166.75	1,193.75
	San Diego (Other Southern California)	1,391.25	1,369.25	1,847.25	1,386.00
	Total	1,816.00	2,394.50	3,215.75	2,754.75
Total[2]	Northern California[1]	6,845.50	6,370.75	5,209.00	5,342.75
	Los Angeles Metro	6,538.50	7,127.00	14,694.50	18,277.25
	San Diego (Other Southern California)	5,926.75	5,146.75	7,472.75	7,374.75
	Total	19,310.75	18,644.50	27,376.25	30,994.75

[1] Includes San Francisco, Oakland, Sacramento, and Fresno offices.

[2] Excludes Supervising Deputy Attorneys (SDAGs) and Special Agents.

In contrast with the distribution of Attorney billings shown in Table II-4, **Table II-5**, below, shows much smaller differences between geographic regions in the number of hours charged by HQES Attorneys to prosecutions. Generally, more hours are charged for prosecutions by HQES' Northern Region offices than are charged by HQES' other two regional offices. However, HQES' San Francisco and Sacramento offices handled nearly all Out-of-State and SOI cases. In both the Northern California and Other Southern California regions, HQES Attorneys charged significantly more hours to prosecutions than charged to investigations. In contrast, in the Los Angeles Metro region, the proportions of time charged to investigations and prosecutions are reversed, with significantly fewer hours charged to prosecutions during 2009 (9,823) than charged to investigations (17,084).

Table II-5. Hours Charged by HQES Staff to Administrative Matters

Excludes Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters.

Class	HQES Office(s)	2005	2006	2007	2008	2009
Deputy Attorney General	Northern California[1]	11,333	11,718	12,960	12,231	13,026
	Los Angeles Metro	10,150	9,696	12,937	11,820	9,823
	San Diego (Other Southern California)	9,220	8,290	11,265	8,144	8,923
	Total	30,703	29,704	37,161	32,195	31,772
Paralegals and Analysts	Northern California[1]	92	15	65	317	157
	Los Angeles Metro	579	835	463	514	1,191
	San Diego (Other Southern California)	151	98	81	133	263
	Total	822	947	608	964	1,610
Supv. Deputy Attorney General	Northern California[1]	99	221	212	106	160
	Los Angeles Metro	36	7	127	0	0
	San Diego (Other Southern California)	343	207	43	113	198
	Total	477	436	382	219	358
Total	Northern California[1]	11,524	11,954	13,237	12,654	13,342
	Los Angeles Metro	10,765	10,538	13,527	12,334	11,014
	San Diego (Other Southern California)	9,713	8,595	11,388	8,391	9,384
	Total	32,002	31,086	38,151	33,378	33,740

[1] Includes San Francisco, Oakland, Sacramento, and Fresno offices.

The time charges by Los Angeles Metro Attorneys are also disproportionate to the geographic distribution of licensees. As shown by **Exhibit II-8,** on the next page, only about 30 percent of active licensees are based in counties served by HQES' Los Angeles Metro office. Counties served by HQES' Northern California offices account for 44 percent of active licensees while counties served by HQES' San Diego office account for 25 percent of active licensees.

The time charges by Los Angeles Metro Attorneys are also disproportionate to the geographic distribution of Investigations opened and cases referred for Prosecution. As shown by **Exhibit VI-3**, in Section VI (*Investigations*), the number of investigations opened and number of cases referred for prosecution by District offices in each of the three major geographic regions of the State generally parallels the geographic distribution of licensees. For example:

- The Northern California region accounts for about 38 percent of investigations opened and 36 percent of cases referred for Prosecution
- The Los Angeles Metro region accounts for about 35 percent of investigations opened and 32 percent of cases referred for Prosecution
- The Other Southern California region accounts for about 27 percent of Investigations opened and 32 percent of cases referred for Prosecution.

The data shown in Exhibit VI-3 is fully consistent with data shown in **Table II-6**, below, separately provided by HQES, showing the number of Investigation matters opened by HQES in each major region of the State during each of the past four (4) years. As shown by Table II-6, Investigation matters opened for Los Angeles Metro cases account for about one-third of all Investigation matters opened by HQES.

Table II-6. Investigation Matters Opened by HQES

HQES Office(s)	2006	2007	2008	2009	Total	
					Number	Percent
Northern California[1]	374	387	392	340	1,493	38%
Los Angeles Metro[2]	306	350	365	340	1,361	34%
San Diego[3] (Other Southern California)	339	287	232	264	1,122	28%
Total	1,019	1,024	989	944	3,976	100%

[1] Includes HQES' San Francisco, Oakland, Sacramento, and Fresno offices.

[2] Data shown for 2009 includes 47 Fresno cases.

[3] Data shown for 2006 excludes 39 pre-2006 cases.

Active, In-State Licensees, By County
June 30, 2009

Northern California Counties					
Alameda	4,449	Marin	1,534	Santa Clara	6,946
Alpine	1	Mariposa	16	Santa Cruz	710
Amador	70	Mendocino	219	Shasta	451
Butte	474	Merced	226	Sierra	0
Calaveras	51	Modoc	6	Siskiyou	88
Colusa	10	Mono	36	Solano	843
Contra Costa	3,020	Monterey	885	Sonoma	1,360
Del Norte	44	Napa	488	Stanislaus	900
El Dorado	302	Nevada	258	Sutter	202
Fresno	1,828	Placer	1,032	Tehama	51
Glenn	13	Plumas	36	Trinity	12
Humboldt	286	Sacramento	4,248	Tulare	476
Kern	1,110	San Benito	40	Tuolumne	130
Kings	136	San Francisco	5,761	Yolo	572
Lake	80	San Joaquin	1,054	Yuba	49
Lassen	39	San Luis Obispo	806	Total	44,274
Madera	177	San Mateo	2,749	Percent	44%

Los Angeles Metro Counties	
Los Angeles	27,556
Santa Barbara	1,199
Ventura	1,675
Total	30,430
Percent	30%

Other Southern California Counties	
Imperial	131
Inyo	45
Orange	9,250
Riverside	2,818
San Bernardino	3,524
San Diego	9,428
Total	25,196
Percent	25%
Statewide Total	99,900

Finally, as shown by **Table II-7**, below, the total hours charged be Attorneys assigned to HQES' offices in Northern California and San Diego (Other Southern California) offices for investigations and prosecutions have changed little during the past several years (18,000 hours and 13,000 hours per year, respectively). In contrast, the total number of hours charged Los Angeles Metro Attorneys have exploded and, in 2009, exceeded the number of hours charged in each of the other two geographic regions by 50 to 80 percent.

Table II-7. Hours Charged by HQES Attorneys to Investigations and Prosecutions

Matter	HQES Office(s)	2006	2007	2008	2009
Investigations[2]	Northern California[1]	6,610	6,085	5,007	5,168
	Los Angeles Metro	6,349	6,388	13,528	17,084
	San Diego (Other Southern California)	4,536	3,778	5,626	5,989
	Total - Investigations	17,495	16,250	24,161	28,240
Prosecutions	Northern California[1]	11,718	12,960	12,231	13,026
	Los Angeles Metro	9,696	12,937	11,820	9,823
	San Diego (Other Southern California)	8,290	11,265	8,144	8,923
	Total - Prosecutions	29,704	37,161	32,195	31,772
Total[3]	Northern California[1]	18,328	19,045	17,238	18,194
	Los Angeles Metro	16,045	19,325	25,348	26,907
	San Diego (Other Southern California)	12,826	15,042	13,770	14,912
	Total - Investigations and Prosecutions	47,198	53,411	56,356	60,012

[1] Includes San Francisco, Oakland, Sacramento, and Fresno offices.

[2] Includes Section-Specific Tracking and Client Service hours.

[3] Excludes Supervising Deputy Attorneys (SDAGs).

The differences in hours charged by HQES Attorneys in each of the three major geographic regions of the State reflects significant differences in their level of involvement in Medical Board investigations, and substantive differences in the way that VE has been implemented. Since 2006, Los Angeles Metro office Attorneys have become increasing involved in Medical Board investigations and have, for several years, been much more intensively involved in investigations than Attorneys based in HQES' other offices. As a result, during 2009 expenditures for Attorney services provided by HQES' Los Angeles Metro office were more than $1.4 million greater than expenditures for Attorney services provided by HQES' Northern California offices, and more than $2.0 million greater than expenditures for Attorney services provided by HQES' San Diego office.

G. Enforcement Program Attrition History

Exhibit II-9, on the next page, shows the number of Investigators, Senior Investigators, and Supervising Investigators that separated from the Medical Board by year from 2004 through 2009. During the two (2) years prior to implementation of VE (2004 and 2005), the Enforcement Program lost thirteen (13) Investigators, Senior Investigators, and Supervising Investigators, including nine (9) employees who retired from State service, one (1) employee who transferred to DCA's Division of Investigation, and three (3) employees who left State service. Beginning during 2006, concurrent with implementation of VE, there was a sharp acceleration in staff turnover within the Enforcement Program. Ten (10) Enforcement Program Investigators, Senior Investigators, and Supervising Investigators retired from State service during 2006 and 2007. This is about the same number of staff with these classifications as retired during the preceding two (2) years. However, in contrast with prior years, 17 other Investigators, Senior Investigators, and Supervising Investigators separated from the Medical Board, including:

- 8 employees who transferred to DCA's Division of Investigation
- 3 employees who transferred to the Department of Justice
- 5 employees who transferred to other State agencies
- 1 employee that left State service.

Similarly, during the next two (2) years (2008 and 2009), nine (9) Investigators, Senior Investigators, and Supervising Investigators retired from State service. Concurrently, 17 others in these same classifications separated from the Medical Board, including

- 7 employees who transferred to DCA's Division of Investigation
- 3 employees who transferred to the Department of Justice
- 4 employees who transferred to other State agencies
- 3 employees who left State service.

In summary, during the past four (4) years more than one-half of the Enforcement Program's Investigators, Senior Investigators, and Supervising Investigators separated from the Medical Board. Only about one-third of the separations were due to retirements (fewer than 5 positions per year). Thirty (30) Investigators, Senior Investigators, and Supervising Investigators (7.5 positions per year) transferred to other State agencies, including 14 who transferred to DCA's Division of Investigations. The staff that separated during this period were highly experienced, with an average of eight (8) years experience with the Medical Board prior to their separation. Geographically, a disproportionate share of the separations was from Northern Region District offices which concurrently experienced both a large number of retirements and a large number of other separations. In contrast, the other two geographic regions had a lower number of total separations because they either had fewer retirements (Los Angeles Metro region) or had fewer other separations (Other Southern California region).

Enforcement Program Attrition History

Business Unit	Retirements			Transfers to Other State Agencies												Other Separations			Total Separations		
				DCA Division of Investigation			Department of Justice			Other State Agencies			Total								
	2004 and 2005	2006 and 2007	2008 and 2009	2004 and 2005	2006 and 2007	2008 and 2009	2004 and 2005	2006 and 2007	2008 and 2009	2004 and 2005	2006 and 2007	2008 and 2009	2004 and 2005	2006 and 2007	2008 and 2009	2004 and 2005	2006 and 2007	2008 and 2009	2004 and 2005	2006 and 2007	2008 and 2009
Sacramento	3		1					1						1					3	1	1
San Jose			1		1							1		1	1			1	0	1	3
Fresno	2	1	1		1				1		2			3	1				2	4	2
Pleasant Hill	1	1	1															1	1	1	2
Total Northern Region	6	2	4	0	2	0	0	1	1	0	2	1	0	5	2	0	0	2	6	7	8
Diamond Bar									1						1			1	0	0	2
Torrance/Cerritos		1			1									1			1		0	3	0
Glendale		1			1	1								1	1	2			2	2	1
Valencia						3									3	1			1	0	3
Total LA Metro Region	0	2	0	0	2	4	0	0	1	0	0	0	0	2	5	3	1	1	3	5	6
Tustin	1	1	1																1	1	1
San Diego		1	1			1						1			2				0	1	3
San Bernardino	1	1	1		1									1					1	2	1
Rancho Cucamonga								1						1					0	1	0
Total Southern Region	2	3	3	0	1	1	0	1	0	0	0	1	0	2	2	0	0	0	2	5	5
Total - District Offices	8	7	7	0	5	5	0	2	2	0	2	2	0	9	9	3	1	3	11	17	19
Area Supervisors		1	1	1	1								1	1					1	2	1
Probation North	1				1			1						2	0				1	2	0
Probation LA Metro or South			1		1	1			1		3	1		4	3				0	4	4
Headquarters/Executive		2										2			2				0	2	2
Total	9	10	9	1	8	6	0	3	3	0	5	5	1	16	14	3	1	3	13	27	26

[1] Excludes 1 position that failed Academy training and 1 position that retired and then reinstated.

We met with representatives of DCA's Division of Investigation to determine how many of the Medical Board's staff received a promotion when they transferred to that agency. Of the 14 positions that transferred to DCA during the past four (4) years, 12 were lateral transfers (86 percent) and did not receive any pay increase. Additionally, we understand that, for nearly all of these staff, the primary factors contributing to their decisions to separate from the Medical Board were:

- Difficulty and frustration working with HQES Attorneys
- Dissatisfaction with Medical Board management (e.g., effectiveness in resolving issues with HQES)
- An inability to effectively utilize their investigative skills under the VE Model.

High Investigator turnover over the past four (4) years necessarily compounded the performance problems that the Medical Board was already experiencing as a result of staffing reductions imposed on the District offices earlier in the decade. Additionally, the smaller pool of remaining seasoned Investigators was increasingly used throughout this period to provide training and mentoring to newly hired and less experienced staff.

As of late-2009 the Medical Board had thirteen (13) vacant Investigator positions, representing 16 percent of total authorized Investigator series positions. Typically, California State Government agencies operate with only about 5 percent of their positions vacant. The relatively high Investigator vacancy rate is partially attributable to the recent creation of five (5) new Investigator series positions for the Rancho Cucamonga-based OSM Unit (1 Supervising Investigator and 4 Investigators). In late-2009, Los Angles Metro region offices accounted for a disproportionate share of vacant positions due, in part, to the recent transfer of four (4) Investigator series positions from Los Angeles Metro District offices to the OSM Unit. As with the lateral transfers of Medical Board staff to DCA's Division of Investigation, the Investigators that transferred to the OSM Unit did not receive a salary increase and are no longer be required to work under the direction of HQES Attorneys. As of May 2010, the Investigator vacancy rate was reduced to 5 percent (with positions in background accounted for as filled).

H. Prior Analyses of the Impacts of Vertical Enforcement

Analyses of the impacts of Vertical Enforcement were previously completed during 2007 and 2009. Additionally, a one-page summary statistical report is provided on a quarterly basis to the Medical Board's Governing Board as part of the Board's quarterly meeting package. Below we summarize the findings and conclusions presented in these reports and identified deficiencies with the information provided.

1. November 2007 Medical Board Analysis

In November 2007 the Medical Board reported to the Legislature that implementation of VE had reduced the average time to complete investigations by ten (10) days. The Medical Board also reported reductions in:

- The average time to close cases without prosecution (6 days)
- The average time to obtain medical records (28 days)
- The average time to conduct physician interviews (20 days)
- The average time to obtain Medical Expert opinions (33 days)
- The average time for HQES to file accusations (29 days).

Some of these above findings appear inconsistent. For example, unless there were offsetting increases in the time needed for other investigative activities (which were not reported), it is difficult to reconcile the significant reductions shown in the average time to obtain medical records, conduct physician interviews, and obtain Medical Expert opinions with the minimal reductions shown in the total elapsed time to complete the investigations (10 days, or 6 days excluding cases referred for prosecution). Alternatively, there may be deficiencies with some of the data used for this report.

2. June 2009 Integrated Solutions for Business and Government, Inc. Analysis

During 2009 the Medical Board commissioned a study by an independent consultant (Integrated Solutions for Business and Government, Inc.) to review Enforcement Program statistical data collected by the Medical Board from 2005 through 2008. In June 2009 the consultant reported that (1) significantly fewer investigations were completed during 2008 as compared to 2005 (1,100 during 2008 compared to 1,382 during 2005, including AHLP investigations), and (2) significantly fewer accusations were filed (205 during 2008 compared to 224 during 2005, including AHLP accusations). The consultant also reported that investigation timeframes had increased significantly. The consultant's findings included the following:

- For cases closed without a citation, public letter of reprimand, or referral for prosecution, the average elapsed time to complete investigations increased by more than three (3) months (to 12 months)
- For cases referred for prosecution, the average elapsed time to complete investigations increased by more than two (2) months (to 13 months)
- For cases referred for prosecution, the average elapsed time for HQES to file accusations decreased by a week (to about 5 months)
- For cases with an accusation filed, the average elapsed time from assigned for investigation to filing of the accusation increased by more than a month (to nearly 19 months).

3. Medical Board Quarterly Reports

Since mid-2008, a summary statistical report has been provided on a quarterly basis to the Medical Board's Governing Board as a part of its quarterly meeting packet. The current version of the Quarterly Report provides, on one page, a series of investigation and prosecution-related performance measures, by calendar year (or calendar quarter for partial years), for each period from 2005 through the most recently completed quarter. Data are presented for a subset of all cases categorized as "VE" cases, and for "All" cases combined. Data for "Non-VE" cases is not presented, but can be imputed from the other data presented. **Exhibit II-10**, on the next page, presents the same data as presented in the most recently published Quarterly Report for the five-year period from 2005 through 2009, plus imputed data for "Non-VE" cases. Below we provide an analysis of the data presented in Exhibit II-10, including analyses of identified deficiencies with the data.

Quarterly Board Report

Investigation and Prosecution Timeframes[1]

	Indicator	2005	2006			2007			2008			2009			2005 to 2009 Increase/ (Decrease)
		Prior to VE	All	Non-VE[2]	VE	All	Non-VE[2]	VE	All	Non-VE[2]	VE	All	Non-VE[2]	VE	All[2]
Shorter Cycle Interim Investigation Activities	**Calendar Day Age from Request to Suspension Order Granted**														
	Average	51	44	88	4	34	21	38	19	19	19	52	260	39	1
	Median	17	3	N/A	2	22	N/A	23	10	N/A	10	23	N/A	23	6
	Record Count	24	21	10	11	17	4	13	21	4	17	17	1	16	(7)
	Calendar Day Age from Request to Receipt of Medical Records														
	Average	58	53	78	37	59	163	57	63	378	58	73	0	73	15
	Median	32	31	N/A	26	31	N/A	31	28	N/A	28	32	N/A	32	0
	Record Count	475	376	148	228	264	5	259	256	4	252	243	0	243	(232)
	Calendar Day Age from Request to Physician Interview														
	Average	48	51	56	43	52	73	50	63	63	63	52	0	52	4
	Median	36	42	N/A	38	37	N/A	36	41	N/A	42	37	N/A	37	1
	Record Count	597	453	281	172	406	35	371	473	7	466	696	0	696	99
	Calendar Day Age from Request to Receipt of Expert Opinion														
	Average	51	47	50	35	51	80	43	50	50	50	48	48	48	(3)
	Median	41	35	N/A	31	36	N/A	35	39	N/A	38	36	N/A	35	(5)
	Record Count	519	424	342	82	344	74	270	374	15	359	426	2	424	(93)
Extended Cycle Time Processes	**Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution**														
	Average	271	299	326	138	330	637	268	374	822	358	383	1,727	381	112
	Median	252	285	N/A	134	304	N/A	269	335	N/A	324	346	N/A	346	94
	Record Count	827	703	601	102	648	109	539	609	21	588	673	1	672	(154)
	Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed														
	Average	556	554	607	140	543	730	340	565	928	493	584	956	578	28
	Median	525	504	N/A	120	523	N/A	339	541	N/A	486	575	N/A	569	50
	Record Count	187	149	132	17	198	103	95	157	26	131	189	3	186	2
	Calendar Day Age from Accusation Filed to Disciplinary Outcome[3]														
	Average	608	602	610	85	576	633	188	561	768	243	473	840	339	(135)
	Median	526	466	N/A	99	426	N/A	182	384	N/A	238	351	N/A	309	(175)
	Record Count	212	195	192	3	226	197	29	203	123	80	198	53	145	(14)

[1] Excludes Out-of-State (IDENT 16) and Headquarters (IDENT 20) cases.

[2] Supplemental data elements imputed from other data contained in the report.

[3] Excludes Outcomes with no accusation filed.

Suspension Orders – This is a measure of the number of requests for suspension orders granted and the average and median elapsed days from request to issuance of the suspension orders. The data presented includes interim suspension orders (ISOs), temporary restraining orders (TROs), and PC 23s. The data presented show that 24 suspension orders were granted during 2005, prior to implementation of VE. In all subsequent years fewer than 24 suspension orders were granted. In the most recent year (2009), 17 suspension orders were granted (32 percent fewer than granted during 2005). In 2009, the average number of elapsed days to obtain a suspension order (52 days) was nearly identical to the average number of elapsed days shown for 2005 (51 days).

Requests for Medical Records – This is a measure of the number of completed requests for medical records and the average and median elapsed days from request to receipt of the records. The data presented shows that 475 medical records requests were completed during 2005, prior to implementation of VE. In all subsequent years significantly fewer requests for medical records were completed. In the most recent year (2009), only 243 requests were completed (49 percent fewer than completed during 2005). In 2009, the average elapsed time to obtain medical records (73 days) was more than two (2) weeks longer than the average elapsed time shown for 2005 (58 days). However, much of the data shown in the Quarterly Report appears to be substantially incomplete. Complete data should probably show at least 400 to 500 requests for medical records per year. A possible source of this undercounting is a failure by District office staff to consistently post updates to CAS showing when medical records were requested and received. Additionally, medical records are sometimes requested from more than one provider for the same case and, in some cases, the records initially provided by the respondent are incomplete or are excessively redacted, prompting requests for supplemental submissions. These circumstances are not reflected in the data presented. In summary, the record counts and elapsed time data shown in the Quarterly Reports may not be representative of all completed medical record requests for some (or all) of the years shown.

Physician Interviews – This is a measure of the number of completed Subject interviews and the average and median elapsed days from request to completion of the interview. The data presented shows that 597 Subject Interviews were completed during 2005, prior to implementation of VE. In each of the next three (3) years, the Quarterly Report shows that 20 to 30 percent fewer Subject interviews were completed. Then, in the most recent year (2009), the Quarterly Report shows that 696 Subject interviews were completed (16 percent more than completed in 2005, and nearly 50 percent more than completed during the prior year). In 2009, the average elapsed time to complete Subject interviews (52 days) was marginally higher than the average elapsed time shown for 2005 (48 days). However, the data shown for most years appears to be substantially incomplete. Complete data should probably show at least 600 Subject interviews completed for all years. A possible source of this undercounting is a failure by District office staff to consistently post updates to the CAS system showing when each Subject interview was actually scheduled and completed. For example, in some years Medical Board staff may not have regularly posted CAS updates for so called

"Knock and Talk" interviews because such interviews are not scheduled and completed in the same manner as are office interviews. In summary, the record counts and elapsed time data shown in the Quarterly Reprots may not be representative of all completed Subject interviews for several of the years shown. Also, this statistic does not capture any changes in the elapsed time needed to coordinate the scheduling of Subject interviews with the HQES' Primary DAG, if assigned.

Expert Opinions – This is a measure of the number of completed Expert opinions and the average and median elapsed time from request to receipt of the Expert opinion. The data presented shows that 519 Expert opinions were completed during 2005, prior to implementation of VE. In all subsequent years, about 20 to 30 percent fewer Expert opinions were completed. The need for Expert opinions is also dependent, in part, of the availability and capabilities of the Medical Consultants assigned to each District office. Medical Consultants, if sufficiently available, can potentially review many quality of care cases and, thereby, limit the number of cases submitted to the outside Medical Experts. Conversely, if Medical Consultant capabilities are limited, either in terms of availability or areas of specialization, then more cases may be referred to the outside Medical Experts. In 2009 the average elapsed time to complete Expert opinions (48 days) was marginally shorter than the average elapsed time to complete Expert opinions shown for 2005 (51 days). However, shifts in the mix of cases referred to outside Medical Experts could impact the average elapsed time to prepare the Expert opinions. Additionally, it is unclear whether the record counts and elapsed time data shown in the Quarterly Reports are representative of all completed Expert opinions for any particular year. Finally, this statistical measure does not account for the quality of the completed reports, or related needs for revised or supplemental reports.

Investigation Closed without Referral for Prosecution – This is a measure of the number of cases closed without referral for prosecution and the average and median elapsed time from assigned for investigation to closure of the case. The data presented show that 827 cases were closed following investigation during 2005, prior to implementation of VE. In all subsequent years, about 20 to 30 percent fewer cases were closed following investigation. Due to the extended cycle times associated with completing most investigations (1 to 2 years, or longer), the comparative data presented for VE (and Non-VE) cases during 2006, 2007, and 2008 are misleading and meaningless. Initially, all extended cycle time cases are included in the Non-VE case counts and no extended cycle time cases are included in the VE case counts because only investigations initiated after December 31, 2005, are included. In subsequent years, fewer cases with the most extended cycle times are included in the Non-VE case counts resulting in progressively longer average elapsed times (i.e., 326 days in 2006, 637 days in 2007, 822 days in 2008, and 1,727 days for a single remaining Non-VE case that was closed in 2009, nearly 5 years after it was assigned for investigation). Concurrently, increasingly larger numbers of more extended cycle time cases are included in the VE case counts, also resulting in progressively longer average elapsed times (i.e., 138 days in 2006, 268 days

in 2007, 358 days in 2008, and 381 days in 2009). Eventually, as shown by the data presented for 2009, the average elapsed times shown for VE cases and for All cases combined converge (381 days and 383 days, respectively). In 2009, the average elapsed time to complete an investigation that was not referred for prosecution was 12.6 months (383 days). This was more than 3.5 months (40 percent) longer than the nine (9) month average elapsed time shown for 2005. Historically, cases closed without referral for prosecution represent about two-thirds of all completed investigations.

Accusations Filed – This is a measure of the number of accusations filed and the average and median elapsed time from assignment of the case for investigation to filing of the accusation. The data presented show that 187 accusations were filed during 2005, prior to implementation of VE. In subsequent years, the number of accusations filed fluctuated between about 150 and 200 per year. In the most recent year (2009), about the same number of accusations were filed (189) as were filed in 2005. Due to the extended cycle times associated with completing most Investigations and filing accusations (1 to 2 years, or longer), the comparative data presented for VE (and Non-VE) cases from 2006 through 2008 are misleading and meaningless. Initially, all extended cycle time cases are included in the Non-VE case counts and no extended cycle time cases are included in the VE case counts because only Investigations initiated after December 31, 2005, are included. In subsequent years, fewer cases with the most extended cycle times are included in the Non-VE case counts resulting in progressively longer average elapsed times (i.e., 607 days in 2006, 730 day in 2007, 928 days in 2008, and 956 days for three remaining Non-VE cases that were filed in 2009, more than two years after assigned for investigation). Concurrently, increasingly larger numbers of more extended cycle time cases are included in the VE case counts, also resulting in progressively longer average elapsed times (i.e., 140 days in 2006, 340 days in 2007, 493 days in 2008, and 578 days in 2009). Eventually, as shown by the data presented for 2009, the average elapsed times shown for VE cases and for All cases combined converge (578 days and 584 days, respectively). In 2009, the average elapsed time from assigned for investigation to accusation filed was more than 19 months (584 days). This was about one (1) month (5 percent) longer than the 18 month average elapsed time shown for 2005. Historically, cases referred for prosecution represent about one-third of all completed investigations.

Disciplinary Outcomes – This is a measure of the number of completed prosecutions and the average and median elapsed days from accusation filed to Board action. The data presented shows 212 disciplinary outcomes during 2005, prior to implementation of VE. In subsequent years, the number of disciplinary outcomes fluctuated between about 195 and 225 per year. In the most recent year (2009) there were fewer Disciplinary Outcomes (198) than in 2005. Due to the extended cycle times associated with prosecuting cases (typically 1 to 2 years, or longer), the comparative data presented for VE (and Non-VE) cases from 2006 through 2009 are misleading and meaningless. Initially, all extended cycle time cases are included in the Non-VE case counts and no extended cycle time cases are

included in the VE case counts because only cases involving Investigations initiated after December 31, 2005, are included. In subsequent years, fewer cases with the most extended cycle times are included in the Non-VE case counts resulting in progressively longer average times (i.e., 610 days in 2006, 633 days in 2007, 768 days in 2008, and 840 days in 2009). Concurrently, increasingly larger numbers of more extended cycle time cases are included in the VE case counts, also resulting in progressively longer average times (i.e., 85 days in 2006, 188 days in 2007, 243 days in 2008, and 339 days in 2009). Eventually, perhaps in 2010 or 2011, the average elapsed times shown for VE cases and for All cases combined will converge. In 2009, the average elapsed time to complete prosecutions was 15.6 months (473 days). This was about 4.4 months (22 percent) shorter than the 20 month average elapsed time shown for 2005. However, this statistical measure is somewhat misleading because it does not account for the additional elapsed time, or changes in the average elapsed time, to investigate these cases and file the accusation. As discussed previously, the average elapsed time from assigned for investigation to accusation filed during 2009 was more than 19 months (about 1 month longer than shown for 2005). Thus, based on the data shown in the Quarterly Reports, the combined total average elapsed time to investigate *and* prosecute cases in 2009 was about 34 to 35 months (19 months plus 15.6 months). This compares to a combined total average elapsed time of 38 months in 2005, prior to implementation of VE. This is equivalent to a 10 percent reduction in total elapsed time for these cases. Historically, about one-third of cases assigned for investigation are referred for prosecution, and about 80 percent of these cases eventually reach a disciplinary outcome (about 25 percent of all cases investigated).

In summary, the statistical data presented in the Quarterly Reports show:

- A significant (32 percent) decrease in the number of suspension orders granted, and no significant change in the elapsed time to obtain the suspension orders
- A significant (20 to 30 percent) decrease in the number of cases closed following investigation, which historically account for about two-thirds of all completed investigations, and a significant (40 percent) increase in the average elapsed time to complete these investigations (from 9 months to 12.6 months)
- No significant change in the number of cases with a disciplinary outcome, which historically account for about 25 percent of all completed investigations, and a limited (10 percent) decrease in the average elapsed time to investigate and prosecute these cases (from 38 months to 34 to 35 months).

Finally, with respect to the disciplinary outcomes, no data is presented showing whether there was any change in the level of discipline imposed.

II. Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program

I. Probation Program

Physicians placed on probation are subject to monitoring by Medical Board staff of the Probationer's compliance with the terms and conditions of their probation. These terms and conditions may include practice restrictions, requirements to complete specified educational, training, or treatment programs, or to take a professional competency or psychiatric examination.

Since the early-1990s the Medical Board has maintained a network of regional probation offices in Sacramento and the Los Angeles Metro area (e.g., Cerritos and Rancho Cucamonga). In addition to complete intake interviews of new probationers and monitoring Probationer compliance with the terms and condition of their probation, Investigators assigned to these offices also were responsible for investigating (1) complaints involving Probationers, (2) petitions of modification or termination of probation, and (3) petitions for reinstatement.

During the early-2000s, about 500 probationers were assigned to the Probation program, including about 100 cases that were inactive because the Probationer was practicing outside the State. During 2003/04 the total number of Probationers increased by about 10 percent to 547 cases. Since that time the number of Probationers has fluctuated between 510 and 550 cases. As of June 30, 2009, there were a total of 545 probation cases, including 109 inactive cases. Probation Program Investigators typically carried an average caseload of about 36 cases per position.

In recent years the Medical Board referred for investigation an average of 48 complaints involving Probationers per year. Many of these cases were actually originated by Probation Program Investigators. On average, about two-thirds of these cases were closed following investigation and about one-third were referred to HQES for prosecution. The proportion of cases referred for prosecution is comparable to that for cases involving Non-Probationers. The average elapsed time to complete these investigations recently increased from an average of less than 10 months for the 3-year period from 2005/06 through 2007/08, to nearly 11 months during 2008/09. During the past several years the average elapsed times to complete investigations of Probationers have been several months shorter than the average elapsed times to complete Investigations of Non-Probationers. This differential widened during the past several years in parallel with the deterioration in the average elapsed time required by District offices to complete investigations of Non-Probationers.

Over the past 10 years the Medical Board received an average of about 40 petitions for modification or termination of probation per year. The number of petitions for modification or termination of probation received fluctuated within a range of 30 to 50 petitions per year. Variations in the number of petitions for modification or termination of probation received appear to be correlated with the number of Probationers. During 2008/09, 40 petitions for modification or termination of probation were received. Also over the past 10 years, the Medical Board received an average of about 16 Petitions for Reinstatement per year. The number of petitions for reinstatement received fluctuated within a range of 10 and 25 petitions per year. During 2008/09, 18 petitions for reinstatement were received. Over the past six (6) years, the total number of all petitions received fluctuated within a fairly narrow range (50 to 65 per year). Investigations of petitions are generally completed more quickly than Investigations of complaints. During 2008/09 the average elapsed time to complete

investigations of petitions for modification or termination of probation was about six (6) months and the average elapsed time to complete investigations of petitions for reinstatement was about nine (9) months.

Until recently, authorized staffing for the Probation Program typically consisted of about 24 total positions, including:

- 1 Supervising Investigator II (based in Sacramento)
- 3 Supervising Investigator I (1 per office)
- 14 Senior Investigator/Investigator (4 to 5 per office)
- 3 Investigator Assistant (1 per office)
- 3 Clerical Support staff (1 per office).

However, during 2008/09 the Medical Board transferred all of its Assistant Investigator positions to the Probation Program and reclassified the positions to Inspector I/II. Concurrently, the Probation Program's Supervisory and Management positions were reclassified to non-sworn classifications (i.e., the 3 Supervising Investigator positions were reclassified to Inspector III and the Supervising Investigator II position was reclassified to Staff Services Manager I). Subsequently, during 2009/10 three (3) new Inspector positions and one (1) new support position were authorized for the Probation Program. Currently, the Probation Program is authorized a total of 26 positions, including one (1) Staff Services Manager I, three (3) 3 Inspector III, 16 Inspector I/II, and five (5) Technical/Clerical Support staff.

Concurrent with the organizational restructuring of the Probation Program, responsibility for investigation of complaints involving Probationers and petitions for reinstatement was transferred to the District offices. Also, petitions for modification or termination of probation were transferred to the District in cases, except in cases where the Petitioner has generally been complying with the terms and conditions of their probation and there are not any pending investigations involving the Petitioner. The workload restructuring will enable Probation Program staff to focus their efforts on monitoring Probationer compliance with the terms and conditions of their probation. As part of this restructuring, the scope of the VE Pilot Project was expanded to include District office investigations of complaints involving Probationers, some petitions for modification or termination of probation, and all petitions for reinstatement. Prior to 2008/09, HQES Attorneys were not usually involved with these investigations.

J. Diversion Program

The Medical Board's Diversion program was first implemented in 1981. It was one of only a few State-operated impaired physician programs. The Medical Board's Diversion Program was a monitoring program and not a treatment program. Participants attempting to recover from their addiction were required to contract with the Diversion Program for a five-year period. The contract typically required participation in a treatment program, attendance at group meetings, random bodily fluid testing, and worksite monitoring. Medical Board staff developed customized contracts for each participant and then monitored the participant's compliance with the terms and conditions of their contract. During their participation in the Diversion Program, physicians were generally permitted to continue in practice, subject to the terms and conditions of their contract. The identity of participants in the Diversion Program was kept confidential. Some Diversion Program services, including the drug testing, laboratory, and group meeting components, were contracted out. Diversion Program staff maintained responsibility for case management and overall Diversion Program management and administrative functions.

During the 1980s, a series of reviews of the Diversion Program was completed by the Auditor General. The first review was completed in 1982. This review identified deficiencies with the Division of Medical Quality's oversight of the Diversion Program and with the Diversion's Program's monitoring of participants and the termination of participants that failed to comply with program requirements. A second review was completed during 1985. This review again identified deficiencies with the monitoring of participants and with the termination of participants that failed to comply with Diversion Program requirements. Also, deficiencies were identified with the collection of urine specimens and with the Medical Board's oversight of the Diversion Program. During 1986 a third review was completed. Again the Auditor General found systemic deficiencies with participant monitoring, including completion of periodic personal visits with the assigned Case Manager and the worksite monitoring, urine collection processes, and administrative record-keeping processes.

In 1996 the scope of the Diversion Program was expanded to include treatment for mental and physical disabilities unrelated to substance abuse (AB 1974, Friedman). In 2002 the Diversion Program was further expanded to include singly-diagnosed mentally ill physicians (SB 1950, Figueroa). Throughout this period, participation in the Diversion Program increased, but staffing levels remained unchanged. At one point when caseloads increased from 50 cases per Case Manager to more than 80 cases per Case Manager, new participant entries were delayed until caseloads decreased to more manageable levels.

During 2003/04 a comprehensive evaluation of the Diversion Program was completed by CPIL as a part of CPIL's assignment as the Medical Board Enforcement Monitor. At the time of the study, there were about 250 participants in the program. Authorized Diversion Program staffing included a Program Administrator based in Sacramento, five (5) Case Managers dispersed across the State, and four (4) Sacramento-based support staff (the same as existed in the mid-1990s). CPIL found that the Diversion Program's most important monitoring mechanisms were failing, including the Program's urine collection system which was the primary means used to monitor participants' sobriety and detect relapses. CPIL also concluded that:

- Case Managers were not consistently performing required monitoring activities

- Worksite monitoring and treating psychotherapist reporting were deficient
- There was an absence of enforceable rules or standards, including rules and standards regarding the handling of potentially dangerous physicians and the consequences for relapse
- The Diversion Program was significantly understaffed and isolated from the rest of the Medical Board.

CPIL developed a comprehensive set of ten (10) major recommendations for improvement to address the identified deficiencies.

During 2006/07 two (2) additional positions were authorized for the Diversion Program. During 2007 a follow-up review was completed by the Bureau of State Audits to determine whether the deficiencies identified by CPIL had been addressed. The Bureau of State Audits identified continuing systemic deficiencies, including significant deficiencies with the biologic fluid testing component of the program. Following publication of these findings, the Medical Board voted not to support legislation to continue the Diversion Program after June 30, 2008, when existing legislation would otherwise sunset the program. In November 2007 a transition plan for program participants was developed and approved by the Medical Board, and implemented during the remainder of the 2007/08 fiscal year. On July 1, 2008, the statutes governing the Diversion Program became inoperative and, by operation of law, were repealed on January 1, 2009.

K. Current Enforcement Program Organization and Staffing Resource Allocations

The Medical Board currently has 76 authorized Investigator and Senior Investigator positions, plus 19 Supervising Investigators (I or II). As shown by **Table II-8**, below, 10 of these positions are allocated to various Headquarters Units.

Table II-8. Investigator Positions Allocated to Headquarters Units

Headquarters Unit	Supervising Investigator I/II	Investigator/ Senior Investigator
Operation Safe Medicine (OSM)	1	4
Office of Standards and Training	3	2
Total Investigator Positions	4	6

The Medical Board's District offices are organized into three (3) regional groups (Northern California, Los Angeles Metropolitan, and Other Southern California). Four (4) District offices are assigned to each region. A Supervising Investigator II oversees the operations of each region. Within each District office, a Supervising Investigator I provides first level supervision. Subordinate staffing typically consists of six (6) full-time Investigators (Investigator or Senior Investigator) and 1 to 2 full-time clerical support staff (Office Technician or Office Assistant). A few offices have only five (5) Investigators. In total, 96 permanent, full-time positions are currently authorized for the District offices, including 12 Supervising Investigators, 70 Investigators or Senior Investigators, and 14 Office Technicians or Office Assistants.

Some offices supplement their Investigator staffing capabilities with part-time, retired annuitants Investigators. About one-half of the offices supplement their clerical support staffing capabilities with part-time, retired annuitant Office Technicians or Office Assistants. Additionally, each District office is authorized 2 to 3 part-time Medical Consultants. While Investigator positions are allocated equally among District offices, Medical Consultant staffing levels vary considerably. For example, during 2008/09 the Medical Consultants at some District offices were paid a combined total of more than 1,500 hours (the equivalent of about 0.7 positions). At other District offices the Medical Consultants worked a combined total of less than 800 hours (the equivalent of less than 0.4 positions). Due to holidays, vacation, sick leave, and other paid time off, the hours actually worked by the Medical Consultants are less than the hours paid.

Including the Regional Area Supervisors, District office Supervisors, Investigators and Senior Investigators, and clerical support staff, each of the three (3) regions is allocated 30 to 35 percent of total available staffing resources, with the fewest positions allocated to the Other Southern California region. These allocations are reasonably consistent with the geographic distribution of cases referred for Investigation. As shown by **Exhibit VI-3** in Section VI (*Investigations*), about 38 percent of cases opened are assigned to District offices in the Northern California region, 35 percent of cases opened are assigned to District offices in the Los Angeles Metro region, and 27 percent of cases opened are assigned to District offices in the Other Southern California region.

L. Pending 2010/11 Budget Change Proposals

A currently pending Budget Change Proposal (BCP), if adopted, would increase authorized Enforcement Program staffing by 22.50 positions. **Table II-9,** below, shows the planned disposition of the additional positions that would be authorized by this BCP.

Table II-9. Proposed New Enforcement Program Positions

Business Unit	2010/11				2011/12		Total
	SSM I	Non-Sworn Staff	AGPA	MST/OT	Non-Sworn Staff	AGPA	
CCU, Quality of Care Section			3.0				3.0
CCU, Physician Conduct Section			1.0	0.5			1.5
CCU, Case Management/Projects	1.0		1.0	1.0			3.0
Expert Reviewer Program			2.0				2.0
Office of Standards and Training			2.0				2.0
Disciplinary Coordination Unit						1.0	1.0
Assistant to Chief of Enforcement						1.0	1.0
Enforcement Analysts	1.0	3.0	1.0	1.0	3.0		9.0
Total	2.0	3.0	10.0	2.5	3.0	2.0	22.5

The BCP would provide:

- 2 positions to strengthen and enhance management and administration of the Expert Reviewer Program (e.g., Expert recruitment and training)
- 2 positions for the Office of Standards and Training, primarily to provide training-related services for CCU staff
- 1 position for the Discipline Coordination Unit to provide closer monitoring of disciplinary action cases
- 1 position to serve as an Assistant to the Chief of Enforcement
- 2 CCU positions to be used primarily to enhance screening of AHLP cases
- 5.5 CCU positions to be used primarily to enhance intake and screening of physician and surgeon Quality of Care cases and to improve management and administration of the specialty review process
- 9 positions to perform investigations, including six (6) "non-sworn" staff, with two (2) of the positions designated for AHLP cases.

It has not yet been decided whether the new "non-sworn" investigation positions will be based at Headquarters and will be used to conduct desk investigations of Section 801 (medical malpractice) cases, plus possibly some petitions for modification or termination of probation, petitions for reinstatement, criminal conviction reports, and probation violation cases. A workload-based analysis justifying the need for the nine (9) "non-sworn" positions was not prepared, but available data show that Section 801 cases alone currently account for about 10 percent of all cases referred to the District offices for investigation.

III. License Fees, Expenditures, and Fund Condition

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III. License Fees, Expenditures, and Fund Condition

Since increasing initial and biennial renewal fees for physicians and surgeons from $600 to $790, effective January 1, 2006, there have been continuing concerns regarding whether the higher fees are justified. Section 2435(h) of Article 20 of the *Medical Practice Act,* adopted in conjunction with the January 2006 fee increase, placed a statutory cap on the amount of reserves that the Medical Board could accumulate in its Contingent Fund. Section 2435(h) stated that "It is the intent of the Legislature that, in setting fees pursuant to this section, the board shall seek to maintain a reserve in the Contingent Fund of the Medical Board of California equal to approximately two months' operating expenditures."

Following adoption of the fee increase, during 2007 the Bureau of State Audits (BSA) completed a review of the Board's financial status and revenue, expenditure, and reserve projections. BSA concluded that, ". . . the Medical Board exceeded the mandated reserve, or fund balance, level by more than 100 percent in fiscal year 2006/07 and, therefore, needs to consider reducing or refunding license fees for physicians and surgeons." However, during 2009, Section 2435(h) was modified (AB 501, Emmerson) to enable the Medical Board to maintain a higher reserve fund balance equal to two to four months operating expenditures.

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

AB 501 also modified Section 2435(i) to require that the Office of State Audits and Evaluation, within the Department of Finance, complete another review of the Medical Board's financial status, including its revenue, expense, and reserve projections. This review is required to be completed by June 1, 2012. The scope of the review also encompasses assessment of the impact of a $6 million loan from the Medical Board Contingent Fund to the General Fund made pursuant to the *Budget Act of 2008*. Funding was not provided for the review.

This section presents results of our assessment of the Medical Board's current fiscal status and compliance with Section 2435(h) of the *Medical Practice Act*. Additionally, we critically reviewed each major category of expenditures. Results of our review show that, within 2 to 3 years, the Medical Board's reserves are likely to decrease to a level equivalent to less than four (4) months' operating expenditures. Additionally, we determined that expenditures for HQES legal services have escalated rapidly in recent years, and now account for more than 25 percent of total expenditures. We also identified potential internal control issues involving HQES' billings to the Medical Board, and potential overcharges for HQES' services.

III. License Fees, Expenditures, and Fund Condition

The section is organized as follows:

Subsection	Title
A.	Fees and Other Revenues
B.	Personal Services and Operating Expenditures
C.	Reimbursements and Prior Year Adjustments
D.	Fund Condition
E.	Compliance with Section 2435(h) of the *Medical Practice Act*.

III. License Fees, Expenditures, and Fund Condition

A. Fees and Other Revenues

Table III-1, below, shows actual fees and other revenues collected for each of the past five (5) years, and budgeted fees and other revenues for 2009/10. As shown by Table III-1, total fees and revenues reached a peak level of $52.1 million during 2007/08. Total fees and other revenues subsequently declined to $51.3 million during 2008/09, and are projected to decline further to $50.3 million during 2009/10.

Table III-1. Medical Board Contingent Fund Revenues

Revenues	Actual					2009/10 Budget
	2004/05	2005/06[1]	2006/07	2007/08	2008/09	
Initial Licensing Fees (125700)	$4,368	$5,143	$5,703	$5,596	$5,557	$5,650
Renewal Fees (125800)	31,436	36,147	42,415	44,917	44,670	43,692
Other Fees, Fines, and Penalties (125600)	231	311	348	354	371	379
Delinquent Fees (125900)	79	79	94	102	101	101
Miscellaneous Revenue	61	51	40	43	42	35
Interest	369	566	1,088	1,079	572	429
Total Revenues	$36,544	$42,297	$49,688	$52,091	$51,313	$50,286

[1] Initial and biennial renewal fees increased to $790 effective January 1, 2006.

The decrease in fee and other revenue collections is due primarily to a projected decline in renewal revenue in 2009/10. Renewal fees were projected to decrease by $1 million during 2009/10. Through March 2010, actual renewal fees were $40.8 million, or 93 percent of the amount projected for the full year. While a disproportionate share of renewal fees is normally collected during the first part of the year, actual renewal fees may exceed the amount budgeted, potentially by as much as $1 million (equivalent to the amounts collected during each of the prior two (2) fiscal years).

Another factor contributing to the recent decreases in fee and revenue collections was a decrease in interest earnings. Due to declining market interest rates, interest earnings decreased by $0.5 million during 2008/09. Interest earnings are projected to decrease further during 2009/10. Due to historically low short-term market rates, actual interest earnings through March 2010 were only $90,000. Interest earnings during 2009/10 may be significantly less than the amount budgeted.

In summary, actual fees and other revenues for 2009/10 are unlikely to be less than budgeted. Due to greater than projected renewal fee collections, total fees and other revenues for 2009/10 could be significantly higher than budgeted. A portion of any surplus renewal fees collections could be offset by lower than projected interest earnings.

B. Personal Services and Operating Expenditures

Exhibit III-1, on the next page, delineates actual personal services and operating expenditures by year for the past five (5) years, and projected expenditures for 2009/10. As shown by Exhibit III-1, total expenditures peaked at a level of about $49.5 million during 2007/08, and then declined by $1.75 million (4 percent) during 2008/09. The recent decrease in expenditures was due to (1) a decrease in salaries and benefits paid to Medical Board staff, (2) 4eductions in major and minor equipment purchases, and (3) decreases in general administrative and operating expenses, including reduced expenditures for professional services and lower costs for support services provided by DCA. These expenditure reductions resulted primarily from spending controls implemented during 2008/09 in response to the State's General Fund fiscal crisis. Additionally, charges during 2008/09 for legal services provided by the Attorney General and OAH were more than $600,000 lower than the amounts charged during the prior fiscal year. Additional information regarding significant recent changes in expenditures is provided below.

1. Personal Services Expenditures

Expenditures for staff salaries and benefits were initially projected to decline by about $1 million during 2009/10. However, primarily as a result of additional temporary help and overtime expenditures to reduce Licensing Program application backlogs, actual personal services expenditures during 2009/10 are unlikely to show much, if any, decrease from 2008/09 levels. Excluding decreases attributable to elimination of the Diversion Program, over the past five (5) years, total expenditures for personal services increased very little (less than 5 percent). The increase in expenditures for personal services over this period was limited by the Furlough Friday Program which reduced budgeted 2009/10 expenditures by nearly 15 percent. Without the Furlough Friday Program, expenditures for personal services over the past five (5) years would have increased by nearly 20 percent (about 4 percent per year).

Personal services expenditures include costs for part-time (Permanent Intermittent) Medical Consultants. Generally, each District office has 2 to 3 Medical Consultants assigned, and most of the Medical Consultants usually work at their assigned office for several hours either one or two days a week. During 2008/09 the Medical Consultants were paid a total of 13,991 hours (equivalent an average of about 22 paid hours per week per District office, or less than 7 full-time positions, statewide). Due to paid holidays, vacation, sick leave, and other paid time off, the actual hours worked by Medical Consultants during 2008/09 was less than 13,991 hours, and the average number of hours worked per week per District office was less than 22 hours. Total wages paid to Medical Consultants during 2008/09 were $852,000 ($61 per hour).

Historical and Budgeted Medical Board Expenditures

Personal Service and Operating Expenditures		Actual					2009/10 Budget[3]
		2004/05	2005/06	2006/07[1]	2007/08	2008/09[2]	
Personal Services	Salaries/Wages, Including Fitness Incentive Pay	$12,688	$12,647	$13,253	$13,527	$13,425	$13,336
	Staff Benefits	5,620	4,719	5,067	5,340	5,327	6,005
	Temporary Help (Medical Consultants, Retired Annuitants, and Student Assistants)	1,154	1,143	1,270	1,742	1,321	1,144
	Board Members	33	32	34	24	24	31
	Overtime (Primarily for the Licensing Program)	21	31	77	86	196	12
	DEC	21	32	27	22	0	0
	Salary Savings	0	0	0	0	0	(836)
	Total Personal Services Expenses	$19,537	$18,604	$19,728	$20,741	$20,293	$19,692
General Expenses	Printing, Communications, and Postage	$1,413	$1,050	$1,121	$1,350	$1,475	$1,603
	General Expense, Minor Equipment, and Insurance	535	626	716	928	721	472
	Travel	291	314	380	403	379	397
	Vehicle Operation/Other Items	273	269	350	446	300	262
	Training	57	45	79	74	89	66
	Total General Expenses	$2,569	$2,304	$2,646	$3,201	$2,964	$2,800
Facilities Operation (Rent)		$1,851	$1,963	$2,814	$2,235	$2,173	$2,702
Professional Services		$605	$788	$1,397	$1,386	$870	$983
Fingerprint Reports		$358	$382	$380	$334	$332	$492
Major Equipment (Items greater than $5,000)		$295	$370	$375	$192	($9)	$333
Legal Services	Attorney General Services	$8,292	$8,596	$11,247	$12,316	$11,881	$13,347
	Evidence/Witness Fees	1,563	1,367	1,215	1,391	1,519	1,893
	Office of Administrative Hearings	1,248	915	1,200	1,344	1,099	1,863
	Court Reporter Services	69	113	143	158	128	175
	Total Legal Services	$11,172	$10,991	$13,805	$15,209	$14,627	$17,278
Allocated Administrative & Data Processing	Department Prorata	$3,296	$3,395	$3,670	$3,906	$3,671	$3,882
	Statewide Prorata	1,185	1,315	1,376	1,794	2,323	1,699
	Consolidated Data Center (Teale)	304	293	238	259	300	647
	Data Processing	289	321	128	232	224	125
	Total Administrative and Data Processing Services	$5,074	$5,324	$5,412	$6,191	$6,518	$6,353
Other Expenses	DOI Investigations	$0	$0	$0	$2	$0	$0
	State Controller's Office (Including 21st Century Project)	0	0	0	38	2	0
	Special Adjustment	(24)	0	0	(1)	10	0
	Court-Ordered and Tort Payments	7	2	13	3	0	0
	Total Miscellaneous Expenses	($17)	$2	$13	$42	$12	$0
Total Operating Expenses		$21,907	$22,124	$26,842	$28,790	$27,487	$30,941
Total Personal Services and Operating Expenses		$41,444	$40,728	$46,570	$49,531	$47,780	$50,633

[1] In 2006/07, authorized staffing levels increased by 12.50 positions (2.0 Diversion Program, 4.0 Investigators, 4.0 Investigative Assistants, 2.0 Information System Analysts, and 0.5 Staff Services Analyst).

[2] In 2008/09, authorized staffing levels decreased by 12.40 positions due to termination of the Diversion Program.

[3] The 2009/10 budget incorporates cost-savings related to the Furlough Friday Program and includes unfunded allocations for six (6) new Operation Safe Medicine positions **($500,000)**, four (4) new Probation Program positions **($300,000)**, and contracts for Telemedicine ($399,734 for the first year), an evaluation of Medical Board programs ($159,300), and an analysis of Licensing Program business processes ($40,350).

2. General Expenses

The 2009/10 budget for general expenses, including printing, communications, postage, minor equipment, insurance, travel, and vehicle operations expenditures, was projected to decrease to $2.8 million from more than $2.9 million during 2008/09. Actual expenditures through March 2010 were $1.6 million. For the full year actual expenditures are unlikely to be greater than the amount budgeted, and could be significantly less than budgeted. These cost-savings are attributable largely to implementation of expenditure control measures in response to the State's General Fund fiscal crisis. Over the past five (5) years, general expenses have increased minimally (less than 10 percent).

3. Facilities (Rent)

The 2009/10 budget for facility expenses was projected to increase to $2.7 million from $2.1 million during 2008/09. These expenditures are largely encumbered at the beginning of the year. Through March 2010, actual expenditures were $2.1 million, or $0.6 million less than budgeted. For the full year it is likely that actual expenditures will be significantly less than budgeted. Over the past five (5) years, rent costs have increased minimally (15 percent).

4. Professional and Other Services

For 2009/10, expenditures for professional services were budgeted to increase from $0.9 million to $1.0 million. However, the Medical Board's 2009/10 budget did not provide funding for several new professional services contracts, including contracts for the Telemedicine Pilot Program ($399,734), an analysis of Licensing Program business processes ($40,350), and this Medical Board Program Evaluation ($159,300). Because of these additional costs, it is anticipated that actual professional services expenditures during 2009/10 will exceed the amount budgeted by several hundred thousand dollars. For 2009/10, the largest contract for services is a $450,000 contract with First Data Merchant Services for statutorily mandated merchant credit card services. Other major recurring services contracts include:

- Department of Justice – Controlled Substance Utilization Review and Evaluation System *($150,000)*
- National Data Services – Plastic Pocket Licenses *($53,238)*
- Lexis/Nexis – Legal and Public Records *($50,400)*
- DFS Services, LLC – Credit Card Acceptance Services *($29,000)*
- Medtox Laboratories – Statewide Drug Testing *($16,050)*
- State Personnel Board – Psychological Screening for Peace Officers *($14,577)*.

5. Major Equipment Purchases

The 2009/10 budget for major equipment provided $300,000 of funding to purchase new vehicles and other major equipment, such as copy machines, costing more than $5,000. Due to expenditure controls implemented in response to the State's General Fund fiscal crisis, actual expenditures for major equipment will likely be significantly less than the amount budgeted. Historically, the Medical Board spends several hundred thousand dollars per year for major equipment purchases, principally for fleet and information technology infrastructure replacements.

6. Legal Services

During the past four (4) years expenditures for legal services increased by $3.6 million (33 percent), from $11 million during 2005/06 to $14.6 million during 2008/09. Additionally, expenditures for legal services were projected to increase an additional 18 percent ($2.7 million) during 2009/10. Expenditures for all categories of legal services were projected to increase significantly during 2009/10. Costs for services provided by the Attorney General were projected to increase by $1.4 million (12 percent) and costs for services provided by OAH were projected to increase by $0.7 million (69 percent). Significant increases were also projected for both evidence/witness fees and court reporter services. These budget projections appear to reflect an expectation that, during 2009/10, there would be a significant increase in prosecutorial activity and the number of administrative hearings. At the time these budget projections were prepared (Summer 2008), there was an expectation that implementation of the VE Pilot Project, and associated increases in HQES staffing, would result in faster referrals of cases for prosecution, reduced elapsed times from referral of cases for prosecution to settlement or hearing, and a reduction in the number of pending legal cases.

Through March 2010, actual expenditures for legal services provided by the Attorney General were $9.9 million (75 percent of the amount budgeted). In contrast, costs for OAH through March 2010 were only $0.56 million (30 percent of the amount budgeted) and expenditures for evidence/witness fees and court reporter services were only $1.2 million (58 percent of the amount budgeted). Based on actual expenditures through March 2010, it is likely that costs for services provided by the Attorney General during 2009/10 will be about the same as the level budgeted, and that costs for all other legal services will be significantly less than budgeted.

Over the past five (5) years, evidence/witness fees have fluctuated between $1.2 million and $1.5 million. Of the total $1.5 million amount spent during 2008/09, about 75 percent ($1.1 million) was for Medical Expert review services, including:

- $361,000 for Medical Specialist reviews of complaints during the initial complaint intake/screening process (an average of about 2.5 hours per case reviewed)

- $599,000 for investigation case reviews and Expert Witness testimony services (equivalent to an average of less than 15 hours per case reviewed, assuming about 400 completed case reviews).

Most of the remaining $171,000 of expenditures for Medical Expert services was for competency evaluations ($149,000).

Over the past five (5) years costs for legal services provided by the Attorney General increased by more than $5 million (60 percent). In contrast, all of the Medical Board's other costs increased by only $4.1 million (12 percent). The increase in costs for legal services provided by the Attorney General is partially attributable to a 30 percent increase in staffing (10 positions) that was authorized to support implementation of VE. Additionally, the hourly rates charged by the Attorney General increased. For example, over the past five (5) years the hourly rates charged for Attorneys increased by 22 percent, from $139 per hour during 2004/05 to $170 per hour during 2009/10. In contrast to the large increase in costs for legal services provided by the Attorney General, costs for evidence/witness fees, OAH, and court reporter services declined by 5 percent (from $2.9 million during 2004/05 to $2.75 million during 2008/09). Costs for legal services provided by the Attorney General currently account for more than 25 percent of total Medical Board expenditures.

The payment of the Attorney General's charges to the Medical Board is accomplished by the State Controller's Office (SCO). Payment by the SCO is not dependent on review or approval of the Attorney General's charges by the Medical Board. However, the Medical Board can review and analyze detailed time charge information supporting the charges that is included in a 700 to 900 page Invoice Report provided to the Medical Board each month. If errors are identified, the Medical Board can request an adjustment in subsequent billings.

The Attorney General's monthly Invoice Report details the hours charged by Attorneys and other HQES staff to each Investigation and Administrative matter opened in the agency's ProLaw System. Time charges are posted in quarter hour increments and coded and annotated to characterize the services provided. Separate pages of the report show, for each open matter, the time charged during the reporting period for each person that charged time to the matter, by date. Time that cannot be charged to individual cases, such as supervisory and management time, or general support services, is usually charged to a general client service matter. Some exceptions to this occur when staff incorrectly charge their general administrative support time to the wrong matter. Most staff charge some time to the general client service matter, but most non-Supervisory Attorneys charge nearly all of their time to individual cases. Time may also be charged to matters that are opened for Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters. The invoices can include some charges from non-HQES staff involved in Medical Board matters. However, time charges to Investigation and Administration matters, along with time charged to the general client service matter, account for most of the total hours charged.

During the course of our review we identified two (2) instances in which HQES Attorneys appear to have misreported a significant portion of their time during 2008/09. One of the Attorneys was the designated Lead Prosecutor for a Northern

California District office and the second Attorney was the designated Lead Prosecutor for a Los Angeles Metro District office. **Exhibit II-2**, on the next three pages, provides recaps of the August 2008, January 2009, and June 2009 time charges for both of these Attorneys. The billing recaps show these Attorneys charged nearly all of their available hours to the Medical Board for Lead Prosecutor activities, with very few hours (or no hours at all) charged to specific Investigation or Prosecution matters. In contrast, other Attorneys throughout the State, irrespective of whether or not they are designated as Lead Prosecutors, generally do not charge all (or nearly all) of their time to the Medical Board, unless they are working full-time (and in some cases extended hours) preparing for and attending a hearing. In most cases Lead Prosecutors carry their own Investigation and Administrative caseloads in addition to their Lead Prosecutor assignments, and charge a portion of their time to these other matters. The only HQES personnel who generally charge very little time, or no time at all, to specific cases are the Senior Assistant Attorney General, the Supervising DAGs, and support staff.

We reviewed the Northern California Lead Prosecutor's time charges for August 2008, January 2009, and June 2009 with the Medical Board's District office Supervisor and with the Lead Prosecutor's Supervising DAG. Both Supervisors told us that the time charges appeared to be significantly overstated. Neither Supervisor could provide an explanation of how the Attorney had actually spent his time during these three (3) sample months. Both Supervisors confirmed that the time was not spent performing the Lead Prosecutor activities shown in these billings to the Medical Board. At the time of our review, this Attorney had already been reassigned to other duties and was no longer serving as a Lead Prosecutor.

We also reviewed the Los Angeles Metro Lead Prosecutor's time charges for August 2008, January 2009, and June 2009 with the Medical Board's District office Supervisor and the Lead Prosecutor's Supervising DAG. The District office Supervisor told us that the time charges, as shown, appeared to be significantly over-stated, but acknowledged that she didn't have complete knowledge of other activities in which the Lead Prosecutor might have been involved during these periods. The Supervising DAG also acknowledged that the Lead Prosecutor did not spend all of her time only performing Lead Prosecutor activities as shown in the billings, but suggested that HQES could research the matter and provide additional information that would account for all of the time charged. We did not ask HQES to research this matter further because further investigation of this issue was outside of the scope of our assessment.

With respect to these billings, we again emphasize that we reviewed all of the time charges by all HQES Attorneys for three (3) different months during 2008/09. During these months few other Attorneys ever charged all (or nearly) all of their available hours to the Medical Board except if they were preparing for, or attending, a hearing. In these circumstances, the hours to prepare for and attend the hearing were charged directly to the appropriate Administrative matter. During the three (3) sample months the Northern California Lead Prosecutor charged no hours to specific Administrative matters and the Los Angeles Metro Lead Prosecutor charged only one (1) day of time (8 hours) to a specific Administrative matter during one of the three (3) months, and a couple of hours of time on two (2) different days in another month.

Sample Billings to Medical Board for Selected Lead Prosecutors

August 2008

Date	Day	Northern California Lead Prosecutor			Los Angeles Metro Lead Prosecutor		
		Hours	Task Description	Narrative	Hours	Task Description	Narrative
08/01/08	Friday				8.00	Case Management	Case management and appearance at arraignment
08/04/08	Monday	10.00	Contract/Document Preparation	Preparation of Interim Suspension Order.	8.00	Case Review	VP/LP DBDO
08/05/08	Tuesday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO
08/06/08	Wednesday	10.00	Contract/Document Preparation	Interim Suspension Order Hearing.	8.00	Case Review	VP/LP DBDO
08/07/08	Thursday				8.00	Case Review	VP/LP DBDO
08/08/08	Friday	10.00	Contract/Document Preparation	Preparation of Interim Suspension Order.	8.00	Case Review	VP/LP DBDO
08/11/08	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO
08/12/08	Tuesday	10.00	Oral/Written Advice	Advice on investigations.	8.00	Case Review	VP/LP DBDO
08/13/08	Wednesday	10.00	Oral/Written Advice	Advice on investigations.	4.00	Case Review	VP/LP DBDO
08/14/08	Thursday	10.00	Document/Contract Review	Opening cases from D.O. and IPPR review.	4.00	Case Review	VP/LP DBDO
08/15/08	Friday				8.00	Case Review	VP/LP DBDO
08/18/08	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	4.00	Case Review	VP/LP DBDO Case Review
08/19/08	Tuesday	10.00	Oral/Written Advice	Advice on investigations.	8.00	Case Review	VP/LP DBDO Case Review
08/20/08	Wednesday	10.00	Client Consultation	Advice on pending cases.	8.00	Case Review	VP/LP DBDO Case Review
08/21/08	Thursday	10.00	Investigation Office Visit	Sac D.O. visit and advice on investigations.	8.00	Case Review	VP/LP DBDO Case Review
08/22/08	Friday				8.00	Case Review	VP/LP DBDO Case Review
08/25/08	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO Case Advice and Review
08/26/08	Tuesday	10.00	Oral/Written Advice	Advice on "Named Party" investigation	8.00	Advice	VP/LP DBDO Case Advice and Review
08/27/08	Wednesday	10.00	Oral/Written Advice	Vice on investigations.	8.00	Case Review	VP/LP DBDO Case Advice and Review
08/28/08	Thursday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO Case Advice and Review
08/29/08	Friday				4.00	Advice	VP/LP DBDO Case Advice and Review
Total Hours		160.00			152.00		

Sample Billings to Medical Board for Selected Lead Prosecutors

January 2009

Date	Day	Northern California Lead Prosecutor			Los Angeles Metro Lead Prosecutor		
		Hours	Task Description	Narrative	Hours	Task Description	Narrative
01/01/09	Thursday		State Holiday			State Holiday	
01/02/09	Friday						
01/05/09	Monday	10.00	Investigation Offiice Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO Case Review
01/06/09	Tuesday	10.00	Oral/Written Advice	Advice on investigations.			
01/07/09	Wednesday	10.00	Client Consultation	Investigators case review.	8.00	Case Review	VP/LP DBDO Case Review
01/08/09	Thursday	5.00	Document/Contract Review	Ippr evaluations.	3.00	Settlement Conference	Preparation for ESC 1/9/09
					2.00	Travel	Commute to/from DBDO
					3.00	Advice	VP/LP Advice & Case Review
01/09/09	Friday				2.50	Settlement Preparation/ Negotiation	ESC - Administrative Law Judge Montoya
					5.50	Case Review	LP/VP DBDO Case Review
01/12/09	Monday	10.00	Investigation Offiice Visit	Sac D.O. visit.	8.00	Case Review	LP/VP DBDO Case Review
01/13/09	Tuesday	10.00	Document/Contract Review	Investigation subpoena reviews.	8.00	Case Review	LP/VP DBDO Case Review
01/14/09	Wednesday				8.00	Case Review	LP/VP DBDO Case Review
01/15/09	Thursday				8.00	Case Review	LP/VP DBDO Case Review
01/16/09	Friday				8.00	Case Review	LP/VP DBDO Case Review
01/19/09	Monday		State Holiday			State Holiday	
01/20/09	Tuesday				8.00	Case Review	LP/VP DBDO Case Review
01/21/09	Wednesday				8.00	Case Review	LP/VP DBDO Case Review
01/22/09	Thursday				8.00	Case Review	LP/VP DBDO Case Review
01/23/09	Friday				6.00	Case Review	LP/VP DBDO Case Review
01/26/09	Monday	10.00	Investigation Offiice Visit	Sac D.O. visit.	8.00	Advice	LP/VP DBDO Case Review
01/27/09	Tuesday	10.00	Oral/Written Advice	Advice on investigations.	8.00	Case Review	LP/VP DBDO Case Review
01/28/09	Wednesday	10.00	Document/Contract Review	Subpoena reviews.	8.00	Case Review	LP/VP DBDO Case Review
01/29/09	Thursday	10.00	Investigation Offiice Visit	Sac D.O. visit.	8.00	Case Review	LP/VP DBDO Case Review
01/30/09	Friday						
Total Hours		95.00			134.00		

Sample Billings to Medical Board for Selected Lead Prosecutors

June 2009

Date	Day	Northern California Lead Prosecutor			Los Angeles Metro Lead Prosecutor		
		Hours	Task Description	Narrative	Hours	Task Description	Narrative
06/01/09	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/02/09	Tuesday	10.00	Oral/Written Advice	Advice on investigations at Fresno and Sac D.O.'s.	5.00	Advice	LP/VP MBC DBDO Case Advice and Review
06/02/09	Tuesday				3.00	Travel	Commute to/from DBDO
06/03/09	Wednesday	10.00	Document/Contract Review	Subpoena reviews.	8.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/04/09	Thursday	6.00	Investigation Office Visit	Sac D.O. visit.	5.00	Advice	LP/VP MBC DBDO Case Advice and Review
06/04/09	Thursday				3.00	Travel	Commute to/from DBDO
06/05/09	Friday				8.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/08/09	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/09/09	Tuesday	10.00	Oral/Written Advice	Advice on investigations.	5.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/09/09	Tuesday				3.00	Travel	Commute to/from DBDO
06/10/09	Wednesday	10.00	Investigation Office Visit	Sac D.O. work with investigators.	8.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/11/09	Thursday				6.00	Advice	LP/VP MBC DBDO Case Advice and Review
06/12/09	Friday				4.00	Case Review	LP/VP MBC DBDO Case Advice and Review
06/15/09	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	8.00	Case Review	VP/LP DBDO Case Advice and Review
06/16/09	Tuesday	10.00	Oral/Written Advice	Advice on investigations.			
06/17/09	Wednesday				8.00	Case Review	VP/LP DBDO Case Advice and Review
06/18/09	Thursday	15.00	Investigation Office Visit	Fresno D.O. visit.	3.00	Travel	Commute to/from DBDO
06/18/09	Thursday				5.00	Case Review	VP/LP DBDO Case Advice and Review
06/19/09	Friday				8.00	Advice	VP/LP DBDO Case Advice and Review
06/22/09	Monday	10.00	Investigation Office Visit	Sac D.O. visit.	6.50	Advice	VP/LP DBDO Case Advice and Review
06/23/09	Tuesday	10.00	Document/Contract Review	Reviewing investigation reports.	3.00	Travel	Commute to/from DBDO
06/23/09	Wednesday				5.00	Advice	VP/LP DBDO Case Advice and Review
06/24/09	Thursday	10.00	Oral/Written Advice	Discussing cases with investigators.	8.00	Case Review	VP/LP DBDO Case Advice and Review
06/25/09	Friday	5.00	Investigation Office Visit	Sac D.O. visit.	3.00	Travel	Commute to/from DBDO
06/25/09	Friday	5.00	Client Consultation	Discussion with sup. 1 re new cases.	5.00	Advice	VP/LP DBDO Case Advice and Review
06/26/09	Saturday				8.00	Advice	VP/LP DBDO Case Advice and Review
06/28/09	Monday						
06/29/09	Tuesday	10.00	Investigation Office Visit	Sac D.O. visit.			
06/30/09	Wednesday	10.00	Oral/Written Advice	Advice on investigations to district office investigators for MBC.	3.00	Travel	Commute to/from DBDO
06/30/09	Wednesday				5.00	Advice	VP/LP MBC DBDO
Total Hours		161.00			152.50		

In summary, during 2008/09, and possibly in some prior years and subsequently, the Medical Board may have been charged for some time that was not spent on Medical Board matters. The 700 to 900 page monthly Invoice Reports submitted to the Medical Board are not reviewed by HQES' Supervising DAGs and also are not reviewed by Medical Board staff, except at an aggregate level as needed for budget tracking purposes. It is our understanding that various reports are provided to HQES managers and supervisors on a monthly basis that enable them to review the reasonableness of subordinate staff time charges, but it appears that not all Supervising DAGs are fully utilizing these reports to ensure that time charges are posted properly by all of their staff.

Recommendation No. III-1. *Closely review each of the Attorney General's monthly Invoice Reports for the past three (3) fiscal years (2007/08 through 2009/10) to identify case billing inconsistencies by regions or billing anomalies that may have occurred. If significant over-charges are identified, request an adjustment in future billing periods.*

7. Allocated Administrative and Data Processing Costs

The 2009/10 budget for allocated administrative and data processing costs was projected to decrease to about $6.35 million from about $6.5 million in 2008/09. The amount budgeted for 2009/10 was 2.6 percent greater than actual expenditures for 2007/08. Based on actual expenditures through March 2010, total expenditures for allocated administrative and data processing costs during 2009/10 are likely to be approximately the same as the amount budgeted. Over the past five (5) years allocated administrative and data processing costs have increased by 25 percent, primarily due to increased allocations of Statewide Prorata and DCA administrative costs.

8. Total Personal Services and Operating Expenses

While actual expenditures for both personal services and outside professional services during 2009/10 are likely to be significantly greater than budgeted, these excess expenditures are likely to be more than offset by significant under-expenditures in several other areas, including general expenses, rent, major equipment, and legal services, except for services provided by the Attorney General. Total expenditures are unlikely to exceed the $50.6 million amount budgeted for 2009/10, and could be significantly less than budgeted.

C. Reimbursements and Prior Year Adjustments

Exhibit III-3, on the next page, shows reimbursements and prior year adjustments to the Medical Board Contingent Fund for each of the past five (5) years, and reimbursements budgeted for 2009/10. As shown by Exhibit III-3, budgeted reimbursements decreased during 2008/09 due to reduced reimbursements for probation monitoring. Reimbursements for probation monitoring were projected to decline further during 2009/10. However, through March 2010, actual reimbursements for probation monitoring were $0.95 million, or 95 percent of the $1 million amount budgeted. Reimbursements for probation monitoring during 2009/10 will likely exceed the amount budgeted.

Each year an adjustment to prior year costs is posted to the Medical Board's Contingent Fund. In recent years the adjustments have always been credits and, in some years, the amount of the credit has been significant (e.g., more than $0.5 million). The amount of the adjustment, if any, that will be posted for 2009/10 cannot be determined.

Historical and Budgeted Medical Board Revenues, Expenditures, and Fund Reserves

Fund Condition Summary		Actual					2009/10 Budget[4]
		2004/05	2005/06[1]	2006/07[2]	2007/08	2008/09[3]	
Total Revenues		$36,544	$42,297	$49,688	$52,091	$51,313	$50,286
Personal Services Expenses		$19,537	$18,604	$19,728	$20,741	$20,293	$19,692
Operating Expenses		21,907	22,124	26,842	28,790	27,487	30,941
Total Personal Services and Operating Expenses		$41,444	$40,728	$46,570	$49,531	$47,780	$50,633
Adjustments	Reimbursements - Scheduled (Fingerprinting and Criminal Cost Recovery)	$378	$408	$393	$347	$330	$384
	Reimbursements - Unscheduled (Probation Monitoring)	2,120	1,819	1,495	1,498	1,215	1,000
	Distributed Costs (Budgeted AHLP Reimbursements)	646	791	711	691	677	677
	Internal Cost Recovery (Additional AHLP Reimbursement)	0	0	0	151	145	150
	Prior Year Reserve Adjustments	(1)	150	551	152	613	Unknown
Total Expenditures, Including Adjustments		$38,301	$37,560	$43,420	$46,692	$44,800	$48,422
Surplus/(Deficit)		($1,757)	$4,737	$6,268	$5,399	$6,513	$1,864
Physician Loan Repayment Program		($1,150)	($1,150)	$0	$0	$0	$0
Teale Data Center Adjustment		78	0	0	0	0	0
Loan to General Fund		0	0	0	0	(6,000)	0
End of Year Reserves		$8,540	$12,127	$18,395	$23,794	$24,307	$26,171
Estimated Months Reserve (based on subsequent year expenditures)		2.7	3.4	5.1	6.4	6.0	6.0
Authorized Positions, Including Diversion Program		263.1	263.1	275.6	275.6	262.2	272.2

[1] Initial and biennial renewal fees increased $790 effective January 1, 2006.

[2] In 2006/07 authorized staffing levels increased by 12.50 positions (2.0 Diversion Program, 4.0 Investigators, 4.0 Investigative Assistants, 2.0 Information System Analysts, and 0.5 Staff Services Analyst).

[3] In 2008/09 authorized staffing levels decreased by 12.40 positions due to termination of the Diversion Program.

[4] The 2009/10 budget incorporates cost-savings related to the Furlough Friday Program and includes unfunded allocations for six (6) new Operation Safe Medicine positions **($500,000)**, four (4) new Probation Program positions **($300,000)**, and contracts for the Telemedicine Pilot Program ($399,734 for the first year), an evaluation of Medical Board programs ($159,300), and an analysis of Licensing Program business processes ($40,350).

D. Fund Condition

Exhibit III-3, on the previous page, shows the amount of the surplus/(deficit) for the Medical Board Contingent Fund by year for the past five (5) years, and the projected surplus for 2009/10. Exhibit III-3 also shows end-of-year reserves for each year. As shown by Exhibit III-3, surpluses have been generated each year since implementation of the last fee increase during 2006. The amount of the surpluses ranged from $4.7 million during 2005/06 to $6.5 million during 2008/09. For 2009/10 a surplus of $1.9 million was projected. However, it is likely that the surplus for 2009/10 will be greater than $1.9 million due to:

- ✓ Higher than projected renewal fees
- ✓ Lower than projected expenditures for general expenses, rent, and major equipment
- ✓ Lower than projected expenditures for legal services, except services provided by the Attorney General
- ✓ Higher than projected probation monitoring reimbursements.

The total amount of these additional revenues and cost-savings are unlikely to be completely offset by lower than projected revenues, or greater than projected expenditures, in other areas (e.g., lower than projected interest earnings, higher than projected expenditures for temporary help and overtime for the Licensing Program, and higher than projected expenditures for professional services).

As shown by Exhibit III-3, end-of-year reserves were about $24 million for the last two (2) years, after excluding a $6 million loan to the General Fund, and reserves were projected to increase to $26.2 million at the end of 2009/10, assuming a $1.9 million surplus for that year. It is likely that reserves at the end of 2009/10 will be greater than $26.2 million because it is likely that the 2009/10 surplus will be greater than the $1.9 amount budgeted. An end-of-year reserve of $26.2 million would be equivalent to nearly six (6) months of projected 2010/11 expenditures, assuming:

- ❖ Total fee and revenue collections are the same as budgeted for 2009/10 ($50.3 million)
- ❖ $3.2 million in additional salary and benefit costs related to the expected elimination of the Furlough Friday Program (assumes 17 percent higher salary and benefit costs than budgeted for 2009/10)
- ❖ $0.9 million in additional salary and benefit costs for 17 new Enforcement Program positions included in DCA's Consumer Protection Enforcement Initiative BCP (assumes all positions start work on October 1, 2010, and an average annual cost of $70,000 per position)
- ❖ $0.5 million in additional salary and benefit costs for 7 new Licensing Program positions recently authorized by DCA (assumes all positions start work by July 1, 2010, and an average annual cost of $70,000 per position)

- $0.5 million in additional operating expenditures (e.g., major equipment replacements, service contracts, etc.)
- $1.1 million in cost-savings related to adoption of new salary and benefit cost containment programs (e.g., pay rate reductions)
- No offsetting reductions in expenditures for overtime or temporary help
- No new funding for six (6) new Operation Safe Medicine Unit positions and four (4) new Probation Program positions authorized during 2009/10.

With these assumptions total projected 2010/11 expenditures, net of reimbursement and cost recovery adjustments, would be about $52.4 million ($4.4 million per month). As has been the case for the past five (5) years, this level of reserves ($26.2 million) significantly exceeds the maximum amount current set forth in Section 2435(h) of the *Medical Practice Act*. It is likely that reserves at the end of 2009/10 will be greater than $26.2 million, and could approach a level equivalent to about 6.5 months of projected 2010/11 expenditures ($28.6 million).

E. Compliance with Section 2435(h) of the Medical Practice Act

Section 2435(h) of the *Medical Practices Act* requires that the Medical Board "maintain a reserve in the Contingent Fund of the Medical Board of California in an amount not less than two nor more than four months' operating expenditures." Current reserves significantly exceed the minimum requirement, as has occurred for the past several years. At 2009/10 budgeted expenditure levels, a two-month reserve would be about $8 million, or $18 million less than current reserves, excluding $6 million loaned to the General Fund. However, results of our review show that, within 2 to 3 years, the Medical Board's reserves are likely to decrease to a level equivalent to less than four (4) months' operating expenditures.

As shown by Table III-2, below, even if total expenditures increase by about 8 percent during 2010/11 (to $52.4 million), and increase by an additional $1.6 million per year (3 percent) for the next several years, reserves at the end of 2012/13 will still exceed the minimum set forth in statute, excluding the $6 million loan to the General Fund. The Medical Board's proposed budget for 2010/11 assumes a similar $4 million increase in total expenditures to $52.4 million.

Table III-2. Projected End-of-Year Reserves

	2009/10	2010/11	2011/12	2012/13	2013/14
Total Fees and Revenues	$50.3	$50.3	$50.3	$50.3	$50.3
Total Expenditures, Including Adjustments and Cost Recovery	48.4	52.4	54.0	55.6	57.0
Surplus/(Deficit)	**$1.9**	**($2.1)**	**($3.7)**	**($5.3)**	**($6.7)**
End-of-Year Reserves	$26.2	$24.1	$20.4	$15.1	$8.4
Estimated Months Reserve (based on subsequent year expenditures)	**6.0**	**5.4**	**4.4**	**3.2**	**1.7**

Regardless of whether expenditures increase by $4.0 million in 2010/11, or a somewhat smaller amount, projected expenditures will likely exceed revenue collections during the year, and the resultant operating deficit will begin to deplete accumulated reserves. In subsequent years accumulated reserves will decrease further, assuming costs increase by several percent per year. It is likely that, at some point within the next two (2) to three (3) years, reserves will fall below the 4-month ceiling set forth in statute. However, in the absence of significant additional cost increases, reserves are unlikely to fall below the minimum 2-month level set forth in statute for at least several years. The $6 million loan outstanding to the State's General Fund is not expected to be repaid in the near future but, even if repaid, would not significantly impact the Medical Board's fund condition because the amount is equivalent to less than 1.5 months' expenditures.

Recommendation No. III-2. *Maintain the current $783 initial and biennial fee structure. Reserves will likely fall below the 4-month ceiling set forth in statute within the next two to three years.*

IV. Overview of Complaint Workload, Workflows, and Performance

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IV. Profile of Complaints Opened and Dispositions

Complaint data reported historically by the Medical Board includes a mix of complaints and other types of matters that are captured and tracked in its Complaint Tracking System (CAS), including reports from law enforcement and criminal justice system agencies, reports from federal government agencies and physician licensing agencies in other states, probationary license certificates issued in lieu of full licensure, appeals of license application denials, referred to as statements of issues (SOIs), petitions for modification or termination of probation, petitions for reinstatement, and cases initiated based on audits of license compliance with Continuing Medical Education (CME) requirements.

In this section we identify some of the major differences in how these different types of complaints are handled by the Medical Board and related impacts on measures of Enforcement Program workload, workflow, and performance. Additionally, a summary of complaints received and dispositions by referral source is provided at the end of the section. The section is organized as follows:

Subsection	Title
A.	Overview of Complaint Workload, Workflows, and Performance
B.	Section 800 and 2240(a) Reports
C.	Disciplinary Action Reports Submitted by Other States
D.	Medical Board-Originated Complaints with District Office Identifiers
E.	Medical Board-Originated Complaints with Headquarters Unit Identifiers
F.	Medical Board-Originated Complaints with Probationer Identifiers
G.	Petitions for Modification or Termination of Probation
H.	Petitions for Reinstatement
I.	Other Complaints and Reports
J.	Complaint Workflows and Dispositions by Referral Source.

IV. Profile of Complaints Opened and Dispositions

A. Overview of Complaint Workload, Workflows, and Performance

Over the past eight (8) years, the number of complaints opened by the Medical Board declined by about 10 percent from an average of more than 8,000 complaints per year to about 7,200 complaints per year, excluding decreases attributable to changes implemented by the Medical Board to discontinue counting certain categories of complaints. Specifically, effective January 1, 2005, the Medical Board stopped counting complaints created when initiating change of address citations which, until recently, typically accounted for 250 to 350 complaints per year. Additionally, beginning in 2008/09 the Medical Board stopped opening complaints received that are determined during intake to be outside of the Board's jurisdiction. During 2008/09 about 800 non-jurisdictional complaints were not counted as received or closed. Excluding change of address citations and non-jurisdictional complaints identified during the CCU's initial intake process, 6,442 complaints were opened during 2008/09. This figure compares to an average of more than 7,400 complaints received per year during the early part of the decade, adjusted to exclude change of address citations and a comparable number of non-jurisdictional complaints.

Exhibit IV-1, on the next page, shows the number of complaints opened from 2000/01 through 2008/09 for each of the following 10 categories of matters:

- Mandated Section 800 and 2240(a) reports
- Disciplinary Action Reports Submitted by Other States
- Medical Board-Originated Complaints with District Office Identifiers
- Medical Board-Originated Complaints with Headquarters Unit Identifiers
- Medical Board-Originated Cases with CME Audit Failure Citation Identifier
- Medical Board-Originated Complaints with Probationer Identifier
- Medical Board-Originated Complaints with Other Identifiers
- Petitions for Modification or Termination of Probation
- Petitions for Reinstatement
- Other Complaints and Reports.

Exhibit IV-1 also shows, by year, the following aggregate output and performance measures:

- Number of complaints closed with no further action
- Number of complaints referred for investigation or prosecution
- Percent of cases referred for investigation or prosecution.
- Average elapsed time to close or refer cases for investigation or prosecution.

Overview of Complaints Opened and Dispositions - 2000/01 through 2008/09

	Category of Complaints	2000/01 through 2002/03 (3-Year Avg.)	2003/04	2004/05[1]	2005/06	2006/07	2007/08	2008/09[2]
Mandated Reports	Malpractice Reports from Insurers (Section 801 & 801.1)	888	787	722	726	676	597	605
	Malpractice Self-Reports (Section 801(c), 802, and 803.2)	328	228	212	185	187	150	204
	Malpractice Reports from Others (Section 803)	24	3	9	6	10	6	2
	Coroner Reports (Section 802.5)	32	18	23	11	22	16	16
	Health Care Facility Reports (Section 805)	146	157	110	138	127	138	122
	Surgical Death/Complication Self-Reports (Section 2240(a))	8	14	11	2	10	7	6
	Criminal Charge and Conviction Self-Reports (Section 802.1 and 803.5)	33	33	20	16	29	76	91
	Total Mandated Reports	1,459	1,240	1,107	1,084	1,061	990	1,046
Disciplinary Action Reports Submitted by Other States (IDENT 16)		323	371	448	385	279	288	258
Medical Board Originated Complaints with District Office Identifiers		286	212	202	216	216	161	113
Medical Board Originated Complaints with Headquarters Identifier[1 3] (IDENT 20, Excluding Petitions)		375	377	281	133	31	65	102
Medical Board Originated Complaints with CME Audit Failure Identifier (IDENT 21)		66	0	0	1	140	75	0
Medical Board Originated Complaints with Probationer Identifiers (IDENT 19)		6	13	22	23	9	11	34
Medical Board Originated Complaints with Other Identifiers[4] (IDENTs 22, 23, and 25)		32	12	7	9	10	6	10
Petitions for Modification or Termination of Probation (IDENT 26)		29	37	42	50	47	37	40
Petitions for Reinstatement (IDENT 27)		14	25	19	13	21	9	18
Other Complaints and Reports[1 2] Includes some NPDB reports (26 in 2008/09).		5,968	5,953	5,375	5,749	5,445	5,197	4,821
Total Complaints and Other Matters Opened[1 2]		8,558	8,240	7,503	7,663	7,259	6,839	6,442
Complaints and Other Matters Closed		5,967	6,837	6,603	6,349	6,105	5,608	5,303
Complaints and Other Matters Referred for Investigation or Prosecution[1 3] Includes PLRs (31 in 2008/09).		2,355	1,887	1,443	1,331	1,182	1,133	1,123
Total Complaints and Other Matters Closed or Referred for Investigation or Prosecution[1 2 3]		8,322	8,724	8,046	7,680	7,287	6,741	6,426
Percent of Cases Referred for Investigation or Prosecution[1 3]		28%	22%	18%	17%	16%	17%	17%
Reported Average Days to Close or Refer Cases for Investigation or Prosecution[1 2 3]		55 Days	76 Days	66 Days	54 Days	54 Days	61 Days	75 Days
Reported Open Complaints and Petitions (End of Period)		2,019	1,566	1,011	1,086	1,133	1,283	1,323

[1] Effective in January 2005, change of address citations were no longer counted as complaints or investigations.

[2] Effective in 2008/09, some complaints received and determined by CCU to be outside of the Medical Board's jurisdiction were no longer counted as received or closed, thereby increasing CCU's reported average elapsed time to process complaints.

[3] Includes probationary license certificates, SOIs, and criminal conviction notifications, advertising violations, and cite and fine non-compliance cases. Also includes change of address citation cases (through December 2004).

[4] Includes Operation Safe Medicine, Internet Crimes Unit, and probation violation citation cases.

IV. Profile of Complaints Opened and Dispositions

Since the early part of the decade the number of complaints opened decreased significantly in both of the following areas:

Medical Malpractice Reports – The number of Medical Malpractice Reports submitted to the Medical Board decreased by 37 percent from an average of 1,240 reports per year during the early part of the decade to an average of 782 reports per year during the past two (2) years.

Out-of-State Disciplinary Action Reports – The number of Disciplinary Action Reports submitted to the Medical Board by medical/osteopathic boards in other states decreased by 27 percent from an average of about 350 reports per year during the early part of the decade to an average of 273 reports per year during the past two (2) years.

All complaints are opened by CCU, but are assigned different identifiers to distinguish the District office to which they are assigned. Additionally, CCU opens complaints on behalf of other Medical Board business units to track various matters that are not usually assigned to the District offices for investigation, including:

- Probationary License Certificates (issued in lieu of full licensure)
- Appeals of license application denials, referred to as statements of issues (SOIs)
- Continuing Medical Education (CME) audit failure citations
- Operation Safe Medicine (OSM) investigations
- Internet Crime investigations
- Probation violation citations
- Advertising violation citations
- Cite and fine non-compliance cases
- Petitions for modification or termination of probation
- Petitions for reinstatement.

In some years there have been significant changes in the number of complaint records opened by Headquarters Units for these matters. Since the early part of the decade the total number of complaint records opened for these matters has decreased by 60 percent (from more than 500 “records” opened per year to about 200 “records” opened per year.

Since the beginning of the decade the number of complaints submitted by patients, family members, other licensees, and numerous other similar external referral sources has fluctuated within a relatively narrow range (5,200 to 5,800 per year). There has been a significant increase in the number of complaints received since the beginning of the decade in only one category of complaints (criminal charge and conviction self-reports). The number of these reports recently increased primarily as a result of new requirements that licensees self-report misdemeanor charges and convictions in addition to previously required self-reporting of felony charges and convictions. This requirement became effective in January 2006 (SB 231, Figueroa).

Various changes that have occurred in the composition of complaints received since the early part of the decade (e.g., fewer medical malpractice reports, fewer Out-of-State reports, and fewer Medical Board-originated complaints). These changes appear to have

had offsetting impacts on some aggregate complaint-handling performance measures. For example, over the past five (5) years the Medical Board consistently closed about 83 to 84 percent of all complaints, and referred the remaining 16 to 17 percent for investigation or prosecution.

Since 2004/05 the number of complaints closed, adjusted for recent changes in the handling and reporting of non-jurisdictional complaints, decreased by about 10 percent. Concurrently, the number of complaints referred for investigation or prosecution decreased by about 15 percent, after adjustment for changes in the reporting of change of address citation cases. During the past two (2) years, an average of 1,128 complaints was referred for investigation or prosecution – about 200 fewer complaints than were referred for investigation or prosecution during 2004/05, after adjustment for changes in the reporting of change of address citations.

From 2004/05 through 2007/08, the Medical Board maintained an average processing timeframe for complaints of about two (2) months (60 days). The recent increase in the average complaint processing time to 75 days in 2008/09 is partially attributable to elimination of about 800 non-jurisdictional complaints from the calculation of this performance measure.

Finally, during the early part of the decade the Medical Board closed or referred for investigation or prosecution significantly more complaints than were opened, and reduced the backlog of open complaints by 50 percent (from 2,000 open complaints to 1,000 open complaints). However, in recent years fewer complaints have been closed or referred for investigation or prosecution than have been opened, resulting in continuous increases in the number of pending complaints. At the end of 2008/09 there were 1,323 pending complaints. This is 300 (30 percent) more pending complaints than existed at the end of 2004/05. Inevitably, the growing number of open complaints will soon translate into longer average processing times, particularly given the continuation of the Furlough Friday Program through June 2010. Ultimately, over a period of several years, these complaint-handling delays will adversely impact aggregate Enforcement Program performance measures (e.g., total elapsed time from receipt of complaint to disciplinary outcome).

In the remainder of this section we present additional profile information pertaining to each of the major categories of complaints shown in Exhibit IV-1. These profiles highlight (1) significant changes in the number of cases handled by the Medical Board, (2) substantive differences in the processes used to screen and investigate the different types of cases, and related differences in the level of involvement of CCU and the District offices in these processes, and (3) related impacts on the process output and performance measures presented above. Finally, a more detailed statistical profile of complaint-handling workflows and dispositions during 2008/09, by referral source, is presented at the end of the section.

B. Section 800 and 2240(a) Reports

Since the early part of the decade, the number of Section 800 and 2240(a) reports submitted to the Medical Board has decreased by more than 400 complaints per year. The decrease is attributable primarily to a decrease in the number of medical malpractice reports submitted by insurers, licensees, and others. Since the early part of the decade the number of medical malpractice reports has decreased by 37 percent from an average of 1,240 reports per year to an average 782 reports per year during the last two (2) years. Secondarily, there has been a small decrease in the number of Section 805 reports submitted. These decreases have been partially offset by recent increases in the number of criminal charge and conviction self-reports submitted. The increase in criminal charge and conviction reports is largely attributable to recently imposed requirements that licenses self-report misdemeanor charges and convictions (SB 231, Figueroa). Prior to 2006 licensees were only required to report felony charges and convictions.

Following screening by CCU, a relatively large proportion of these cases (about 30 percent) is usually referred for investigation, and these cases account for a significant proportion of all cases referred for investigation. Aggregate measures of CCU output and performance, such as measures of the total number and proportion of cases referred for investigation, have been impacted by the significant decrease that has occurred in the number of Section 800 and 2240(a) reports received.

C. Disciplinary Action Reports Submitted by Other States

During 2008/09 the Medical Board received 258 Disciplinary Action Reports from medical/osteopathic boards in other states. The complaint records opened for these reports are assigned a unique Identifier (IDENT 16). Historically, there have been significant fluctuations in the number of Out-of-State (IDENT 16) Reports received per year. Out-of-State cases only screened by CCU staff to determine if the other state's action was based on a disciplinary action previously taken by the Medical Board, in which case the complaint is closed. Most reports are not based on prior Medical Board disciplinary actions. However, the reports are only referred to District offices for investigation in cases where the licensee is practicing in California, which rarely occurs. Instead the cases are opened by CCU and transferred directly to the Discipline Coordination Unit (DCU). Depending on the basis for the other state's disciplinary action, DCU may:

- Close the case (e.g., the grounds for the other state's disciplinary action are not grounds for discipline in California)
- Issue a public letter of reprimand (subject to mutual consent by the Medical Board and the Licensee)
- Refer the case to HQES for prosecution.

Historically, a significant portion of Out-of-State cases have been included in statistical data showing the number of complaints referred for investigation and number of completed investigations referred to HQES for prosecution. The inclusion of these records in statistical data regarding the investigation process distorts some complaint-handling and investigation-related performance measures. For example:

- Measures of the number of completed investigations are over-stated because these cases are not actually investigated (as the term is conventionally defined)
- Measures of the average time taken to complete investigations are under-stated because the dates posted for these cases usually show that the investigation was both opened and completed within just one, or a few, business days
- Measures of the proportion of completed investigations referred to HQES are over-stated because a large proportion of these cases are referred directly to HQES without investigation and, in cases where a public letter of reprimand (PLR) is issued, the cases are not actually referred to HQES for prosecution, but for tracking purposes, are shown as if they were.

D. Medical Board–Originated Complaints with District Office Identifiers

During the early part of the decade Medical Board staff typically originated nearly 300 complaints per year with District office Identifiers (IDENTs 2 to 18, excluding 16). In contrast, during 2008/09, only 113 complaints were opened by Medical Board staff with District office Identifiers. Some of these complaints are opened by CCU in response to requests from the Medical Board's Executive Office or other Headquarters Units. Additionally, District office Investigators sometimes initiate these complaints when information is obtained during an investigation regarding other patients of the Subject of the investigation or other physicians involved in treating the patient. In these circumstances a new complaint may be opened and concurrently referred for investigation to the originating District office.

Table IV-1, below, shows the dispositions of Medical Board-originated complaints with District office Identifiers by year from 2000/01 through 2007/08. As shown by Table IV-1, nearly all of the decrease in this category of complaints is accounted for by a decrease in the number of complaints closed following investigation (from 148 complaints per year during the early part of the decade to 55 complaints during 2007/08). Additionally, the number of cases referred for prosecution decreased from an average of 51 cases per year during the early part of the decade to an average of 35 cases per year during the past several years.

Table IV-1. Dispositions of Medical Board-Originated Complaints with District Identifiers

Disposition	2000/01 to 2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Closed by CCU without Citation	61	69	83	85	77	68
Closed by Investigation without Citation	148	100	73	86	79	55
Closed by CCU or Investigations with Citation	15	3	3	5	3	2
Referred to HQES for Prosecution	51	31	37	35	45	25
Referred to District Attorney for Prosecution	11	9	6	5	12	7
Not Yet Determined	0	0	0	0	0	3
Total Dispositions	286	212	202	216	216	160

As shown by Table IV-1, during the early part of the decade a small percent of these cases was closed by CCU without referral for investigation (25 percent). In contrast, CCU closed 75 to 80 percent of all other complaints without referral for investigation. Of the complaints referred for investigation, the proportion subsequently referred for prosecution has generally been comparable to the referral rates for other complaints (e.g., 25 to 35 percent referred for prosecution).

The inclusion of these records in statistical data regarding the Medical Board's complaint-handling and investigation processes distorts some related performance measures. For example, until recently:

- Measures of the number and proportion of complaints referred by CCU for investigation are over-stated because many of the cases were concurrently opened and referred to the originating District office for investigation without screening by CCU
- Measures of the average time taken to complete complaint processing are under-stated because many of these cases were concurrently opened and referred to the originating District office for investigation without screening by the CCU
- Measures of the average time taken to complete investigations are under-stated because the average time to complete these investigations, most of which were closed and not referred for prosecution, is several months less than the average elapsed time to complete investigations of other complaints (i.e., an average of about 7 months for Medical Board-originated cases compared to more than 10 months for cases originated based on information provided by external sources).

However, as the number of these complaints has decreased, the magnitude of these distortions has diminished.

The decrease in number of Medical Board-originated complaints referred for prosecution that has occurred in recent years is a potential cause of concern. However, it is not known whether Investigators are less focused on identifying other potential cases or whether the change that has occurred has contributed to reductions in (1) the number of multiple complaint cases, or (2) the total number of cases prosecuted.

E. Medical Board–Originated Complaints with Headquarters Unit Identifiers

During 2008/09 the Licensing Division and other Headquarters business units opened more than 100 complaint records with a series of unique Identifiers (IDENTS 20 to 25) for cases involving:

IDENT 20 – Headquarters, including probationary license certificates, SOIs, and cite and fine non-compliance cases

IDENT 21 – Continuing Medical Education (CME) audit failure citation cases

IDENT 22 – Operation Safe Medicine (OSM) cases

IDENT 23 – Internet crime cases

IDENT 25 – Probation violation citation cases.

Until recently some of these cases were not assigned unique Identifiers. Instead, most were assigned the same Identifier (IDENT 20). SOIs and Cite and Fine Non-Compliance cases are referred by the originating Headquarters Unit directly to HQES without involvement of either the CCU or a District office. Most of the remaining cases, including probationary license certificates, and CME and probation violation citation cases, are not referred for investigation or to HQES for prosecution, but for tracking purposes are posted in CAS as if they were. With respect to CME audit failure citation cases, since the early part of the decade the Medical Board has not regularly performed audits of compliance with CME requirements. When CME audits were last performed during 2007, more than 200 citations were issued.

Historically, IDENT 20 to 25 cases have been included in statistical data showing the number of complaints referred for investigation and in the number of completed investigations referred for prosecution. The inclusion of these records in statistical data regarding the Medical Board's investigation process distorts some related performance measures. For example:

- Measures of the number of completed investigations are over-stated because, with the exception of a small number of OSM and Internet crime cases, the cases are not actually investigated (as this term is conventionally defined)
- Measures of the average time taken to complete investigations are under-stated because the dates posted to the Complaint Tracking System for these cases usually show that the investigation was both opened and completed within just one, or a few, business days
- Measures of the proportion of completed investigations referred for prosecution are over-stated because many of the cases are not investigated prior to referral for prosecution and also because a significant portion of the cases are not actually referred for prosecution, but for tracking purposes are posted in CAS as if they were. Additionally, where a referral for prosecution actually occurs, this most commonly occurs as a part of the process of handling appeals of denied license applications (SOIs), a Licensing Program activity.

F. Medical Board–Originated Complaints with Probationer Identifier

Complaints involving Probationers may originate from either external or internal Medical Board sources but, in all cases, are assigned the same unique Identifier (IDENT 19). Historically, most Medical Board-originated complaints involving Probationers were opened by regional Probation Unit Investigators based on information obtained from their probation monitoring activities. In these circumstances a new complaint was usually opened and concurrently referred for investigation to the originating Probation Unit.

During 2008/09 the Probation Units were restructured and Probationer complaint investigations were reassigned to the District offices. Concurrently, the cases were incorporated into the VE Pilot Project. Within the District offices, the cases are generally investigated using the same approach as is used for investigations of Non-Probationers.

During 2008/09 the Medical Board initiated 34 complaints involving Probationers (IDENT 19). The inclusion of these records in statistical data regarding the Medical Board's complaint-handling and investigation process distorts some related performance measures. For example:

- Measures of the number of complaints referred by CCU for investigation are over-stated because some of these cases are concurrently opened and referred to the originating Probation Unit or, following the restructuring of the Probation Program, to the District offices, without screening by CCU
- Measures of the average time taken to complete complaint processing are under-stated because the dates posted to the Complaint Tracking System for these cases usually show that the complaint was both opened and referred for investigation within just one, or a few, business days.

G. Petitions for Modification or Termination of Probation

Petitions for modification or termination of probation (IDENT 26) are required to be submitted by Probationers directly to DCU. Typically, about 40 to 50 petitions for modification or termination of probation are received per year, of which a portion is requests for early termination of probation. In some cases Probationers submit both a petition for modification and a petition for termination of probation. In these cases the Medical Board treats and accounts for these cases as a single case. According to Medical Board staff, Probationers are increasingly submitting requests for early termination of probation at the first possible opportunity permitted under the terms and conditions of their probation.

DCU reviews submitted petitions and, if needed, obtains additional supporting documentation from the Probationer. Until recently, DCU forwarded the petition and supporting documentation directly to one of the Medical Board's regional Probation Units. Then, an assigned Probation Unit Investigator completed related background research, interviewed references, prepared a report summarizing results of their investigation, and forwarded the completed case to HQES. Recently, the Probation Units were restructured and some functions previously performed by the Probation Units were reassigned to the District offices. Now, DCU forwards the petitions for modification or termination of probation to the Probation Unit Supervisor who screens the petitions and determines whether to have the petitions reviewed by Probation Unit staff or refer the petitions to District offices for investigation. If there is a pending investigation involving the Probationer or the Petitioner has a record of compliance deficiencies, the cases are referred to a District office. Otherwise the cases are assigned to Probation Unit Inspectors for review. Cases referred to the District offices for investigation are included in the VE Pilot Project. Hearings are required for all petitions for modification or termination of probation, irrespective of the Petitioner's compliance record or the nature of the requested modifications to the terms of their probation. Consequently, all of these cases are referred to HQES to represent the Medical Board at the hearing.

Historically, IDENT 26 cases have been included in statistical data showing the number of complaints referred for investigation and the number of completed investigations referred for prosecution. The inclusion of these records in statistical data regarding the investigation process distorts some related performance measures. For example:

- Measures of the average timeframe to complete investigations are over-stated because only a limited level of investigation activity is required to be completed.
- Measures of the proportion of completed investigations referred for prosecution are over-stated because, unless the petition is withdrawn, an administrative hearing is always required to be completed as a part of the petition review process.

H. Petitions for Reinstatement

Petitions for Reinstatement (IDENT 27) are required to be submitted by the Petitioner directly to DCU. Typically, fewer than 20 Petitions for Reinstatement are received per year.

DCU reviews the petitions and, if needed, obtains additional supporting documentation from the Petitioner. Until recently, DCU forwarded the Petition directly to one of the Medical Board's regional Probation Units. Subsequently, as assigned Probation Unit Investigator completed related background research, interviewed references, prepared a report summarizing results of their investigation, and forwarded the completed case to HQES. During 2008/09 the Probation Units were restructured and the functions previously performed by the Probation Units were reassigned to the District offices. Concurrently, all of these cases were incorporated into the VE Pilot Project.

Historically, IDENT 27 cases have been included in statistical data showing the number of complaints referred for investigation and the number of completed investigations referred for prosecution to HQES. The inclusion of these records in statistical data regarding the investigation process distorts some related performance measures. For example:

- Measures of the average timeframe to complete complaint investigations are over-stated because only a limited level of investigation activity is required to be completed
- Measures of the proportion of completed investigations referred for prosecution are over-stated because, unless the petition is withdrawn, an administrative hearing is always required to be completed as a part of the petition review process.

IV. Profile of Complaints Opened and Dispositions

I. Other Complaints and Reports

This category accounts for about 75 percent of all complaint records opened. About two-thirds of these complaints are received from patients or a member of their family, a friend, or a patient advocate. Excluding mandated Section 800 and 2240(a) reports, disciplinary action reports from other states (IDENT 16), complaints originated by Headquarters Units (IDENTs 20 to 25), complaints involving Probationers (IDENT 19), petitions (IDENTs 26 and 27), and change of address citations, during the early part of the decade the Medical Board received an average of about 5,600 complaints per year. This compares to an average of about 5,400 complaints received per year during the past two (2) years – a decrease of about 200 complaints per year, adjusted for changes in the handling and reporting of non-jurisdictional complaints. During the past five (5) years, the number of "Other Complaints" fluctuated within a limited range between 5,200 and 5,600 cases per year (including all non-jurisdictional complaints).

Following screening by CCU, only a small proportion of these cases (about 10 percent) is referred to the District offices for investigation. Aggregate measures of CCU performance, such as the proportion of cases closed and referred for investigation, have not been significantly impacted by the small decrease in number of complaints received from patients and others that has occurred since the early part of the decade.

J. Complaint Workflows and Dispositions by Referral Source

Exhibit IV-2, at the end of this section, provides a more detailed statistical profile of complaints received, closed, and referred for investigation or prosecution during 2008/09. Significant characteristics of the complaints handled during 2008/09, shown by the data presented in Exhibit IV-2, include the following:

Out-of-State Disciplinary Action Reports – Reports submitted by medical/osteopathic boards in other states represented less than 5 percent of all complaints received during 2008/09, but accounted for the largest single source of referrals for prosecution (18 percent). During 2008/09, 60 Out-of-State cases were referred to HQES. Nearly all of these cases were handled by HQES' San Francisco office. Additionally, DCU issued a PLR for 24 other Out-of-State cases. Out-of-State cases are rarely referred to District offices for investigation.

Complaints Submitted by Patients and Related Parties – During 2008/09 complaints submitted by patients, patient advocates, family members, and friends represented nearly 60 percent of all complaints received and about 32 percent of all complaints referred for investigation. Only about 2 percent of cases received from these sources were subsequently referred for prosecution. During 2008/09, 81 cases from these sources were referred prosecution, accounting for 17 percent of total referrals for prosecution. Thus, while only a small percent of these cases are referred for prosecution, they still account for a significant proportion of all cases referred for prosecution.

Mandated Reports – Insurance company medical malpractice reports, Section 805 reports, and notices of arrests and convictions received from the Department of Justice together accounted for about 14 percent of complaints received, about 25 percent of all cases referred for investigation, and about 20 percent of all cases referred for prosecution. About 10 percent of the cases from these referral sources are referred for prosecution. Section 805 reports have one of the highest prosecution referral rates (29 percent).

Medical Board Originated Complaints with Headquarters Unit or Petition Identifiers – About 18 percent of the Headquarters-originated cases (84 of 464 total cases) are shown in CAS as referred for prosecution. However, a significant portion of these cases (e.g., probationary license certificates and CME audit failure citation cases) are not actually referred for prosecution and nearly all of the remaining cases are SOIs, petitions for modification or termination of probation, or petitions for reinstatement. District offices are not involved with SOIs, do not handle all petitions for modification or termination of probation, and the scope of the review completed by District offices for petitions for modification or termination of probation and for petitions for reinstatement is limited. Unless withdrawn, SOIs and petitions are always forwarded to HQES. Currently, HQES' San Francisco office handles nearly all SOIs.

Medical Board-Originated Complaints with District Office and Probationer Identifiers – These cases represent only about 2 percent of complaints opened during 2008/09, but account for about 10 percent of referrals for investigation. Most of these cases are originated when Medical Board Probation Monitors (Inspectors) or District office Investigators identify, during the course of conducting other probation monitoring of investigation activities, probable violations of the terms and conditions of probation, the *Medical Practice Act,* or other laws. Consequently, the cases tend to have relatively high prosecution referral rates.

Other Referral Sources – All of the other categories of complaint referral sources collectively represent nearly 20 percent of complaints opened, 26 percent of cases referred for investigation, and 15 percent of cases referred for prosecution. About 6 percent of complaints from all of these other sources are referred for prosecution.

Overview of 2008/09 Complaint Handling and Dispositions by Referral Source

Referral Source	Quality of Care Complaints and Reports										Other Types of Cases										Total						
	CCU and Other HQ Business Units					Closed by Investigation		Referred for Prosecution		Total INV Closures and Legal Referrals	CCU and Other HQ Business Units					Closed by Investigation		Referred for Prosecution		Total INV Closures and Legal Referrals	CCU and Other HQ Units				Closed by Investigations	Referred for Prosecution[5]	Legal Referrals - Percent of Complaints Received
	Received	Reviewed by Medical Consultant	Closed	Referred to Investigation							Received	Reviewed by Medical Consultant	Closed	Referred to Investigation							Received	Reviewed by Medical Consultant	Closed	Referred to INV			
				No.	%	No Cite	Cite	HQE	DA[6]					No.	%	No Cite	Cite	HQE	DA[6]								
Patient, Patient Advocate, Family Member or Friend (including 801.01(E) Reports)	2,075	1,165	1,810	247	12%	130	10	58	1	199	1,681	52	1,567	75	5%	59	3	18	4	84	3,756	1,217	3,377	322	202	81	2%
Insurance Companies and Employers (including 801.01(B&C) and NPDB Reports)	597	428	468	105	18%	92	7	27	0	126	14	1	11	3	21%	4	0	2	0	6	611	429	479	108	103	29	5%
Health Facilities (805 and Non-805 Reports)	82	0	4	80	95%	40	3	28	0	71	49	0	22	23	51%	12	2	10	0	24	131	0	26	103	57	38	29%
California Department of Health Services (or Successor State Agency)	38	17	19	14	42%	9	1	6	0	16	22	4	12	7	37%	7	1	1	0	9	60	21	31	21	18	7	12%
M.D., Pharmacist, Allied Health or Healing Arts Licensee, or Medical Society or Association	52	27	32	26	45%	14	0	6	1	21	235	10	216	31	13%	20	1	3	1	25	287	37	248	57	35	11	4%
CII - Department of Justice, Criminal Identification and Information Bureau	0	0	0	0	NMF	0	0	0	0	0	186	0	166	45	21%	19	1	25	0	45	186	0	166	45	20	25	13%
Other Governmental Agencies, Including FDA, DEA, Other DCA Boards and Bureaus, and 801 Reports	51	32	37	20	35%	10	0	2	0	12	42	0	40	9	18%	9	1	11	0	21	93	32	77	29	20	13	14%
Other[1]	71	16	46	25	35%	11	1	7	0	19	286	9	252	53	17%	29	0	11	3	43	357	25	298	78	41	21	6%
Police/Sheriff Department, Coroner's Office, District Attorney, and Courts (803 Reports, Criminal Filings, Non-Felony and Felony Conviction Reports)	32	10	23	16	41%	9	0	3	0	12	35	1	10	16	62%	7	2	6	0	15	67	11	33	32	18	9	13%
Licensee Self-Reporting (2240(A), 801.01, 802.01, 802.1, and Misdemeanor Conviction Reports)	204	149	141	35	20%	22	1	6	0	29	85	1	77	7	8%	4	1	1	0	6	289	150	218	42	28	7	2%
California Attorney General and Department of Justice, Including Medi-Cal Fraud and Narcotics Enforcement Bureaus	6	0	1	1	50%	1	0	1	0	2	24	0	27	1	4%	1	0	1	0	2	30	0	28	2	2	2	7%
Total, Excluding Out of State and Medical Board Cases	3,208	1,844	2,581	569	18%	338	23	144	2	507	2,659	78	2,400	270	10%	171	12	89	8	280	5,867	1,922	4,981	839	544	243	4%
Out of State Medical/Osteopathic Boards[2] (16)	21	0	0	0	NMF	N/A	0	20	0	20	237	0	161	1	1%	2	0	69	0	71	258	0	161	1	2	89	34%
Medical Board Cases with District Identifiers (2 to 18, except 16)	47	10	19	31	62%	19	0	16	2	37	66	0	40	35	47%	31	0	12	4	47	113	10	59	66	50	34	30%
Medical Board Cases with Probationer Identifier (19)	2	0	1	1	50%	3	0	0	0	3	32	0	1	24	96%	12	0	19	0	31	34	0	2	25	15	19	56%
Petitions for Modification or Termination of Probation and Petitions for Reinstatement[3] (26 or 27)	0	0	0	0	NMF	0	0	0	0	0	58	0	0	58	100%	2	0	37	0	39	58	0	0	58	2	37	64%
Medical Board Cases with Other Identifiers[4] (20 to 25)	4	2	2	2	50%	1	2	0	0	3	108	0	74	6	8%	2	2	46	1	51	112	2	76	8	7	47	42%
Total, Including Out of State and Medical Board Cases	3,282	1,856	2,603	603	19%	361	25	180	4	570	3,160	78	2,676	394	13%	220	14	272	13	519	6,442	1,934	5,279	997	620	469	7%

[1] Includes CA Medical Review Inc., 803.6, 364.1, and NPDB Reports, Jury Verdict Weekly, HEAL, MQRC District, WE Tip, Consumer or Industry Group, Employee, Co-worker, Witness, Informant, Anonymous, and Unknown.

[2] Out-of-State cases are researched by the DCU. As appropriate, cases are referred directly to HQES without involvement of the District offices. Cases are only assigned to District offices when the licensee is practicing in California.

[3] Petitions are initially handled by DCU which forwards the petition and supporting documentation to the Probation Monitoring Unit Manager who screens the petitions and either assigns to Probation Monitoring Unit staff or refers to the District offices for investigation. Completed cases are referred to HQES for hearing.

[4] Includes probationary license certifications, license application denials (SOIs), CME audit failurs, cite and fine non-compliance cases, and Operation Safe Medicine (OSM) and Internet cases. These matters are nearly always referred by the originating Headquarters Unit directly to HQES or, if applicable, a local District Attorney without any District office involvement.

[5] Includes 31 pre-filing public letter of reprimand (PLR) cases not actually referred to HQES (Patient = 1, Insurer = 4, MD = 1, Licensee Self-Report = 1, and Out-of-State = 24).

[6] Referrals to DA shown do not include ten (10) dual referrals.

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V. Complaint Intake and Screening

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V. Complaint Intake and Screening

This section presents results of our assessment of the Medical Board's complaint intake and screening processes. The section is organized as follows:

Subsection	Title
A.	Overview of Complaint Intake and Screening
B.	2008/09 Complaint Workloads and Processing Times
C.	Medical Specialist Reviews and Processing Times
D.	Disposition of Complaints Following Medical Specialist Review
E.	In-Depth Review of Complaints Taking Longer than Six Months to Refer to Investigation
F.	Pending Complaints
G.	Recommendations for Improvements.

V. Complaint Intake and Screening

A. Overview of Complaint Intake and Screening

CCU continues to do an outstanding job of administering and operating the Medical Board's complaint intake and screening processes. However, in recent years CCU has struggled to prevent growth in the number of pending complaints which is beginning to adversely impact elapsed timeframes to close or refer complaints for investigation or prosecution. During 2008/09 the CCU closed about 85 percent of all complaints, and the average elapsed time to close or refer these complaints for investigation or prosecution was 78 days (about 2.5 months), after excluding more than 800 closed non-jurisdictional complaints. If the non-jurisdictional complaints were included, CCU's average processing time would be about 67 days. During the years preceding 2008/09, the processing time for complaints averaged about 60 days (1 week less). In recent years the number of pending complaints has increased by about 30 percent (from 1,000 at the end of 2004/05 to more than 1,300 at the end of the 2008/09).

CCU's average processing time to close or refer complaints reflects the impacts of efforts to complete a substantive screening of all complaints to identify those that require a field Investigation. The processes used to screen complaints, including independent review of nearly all quality of care complaints by a Medical Specialist, increase the amount of time needed to complete screening, but reduce the number of complaints referred to the District offices for investigation. It is much more effective and efficient for CCU to screen complaints than to have District office staff investigate and close the cases, and the case dispositions are determined within an average of about 2.5 months. Nearly 95 percent of the cases handled by CCU are closed or referred for investigation within a maximum of six (6) months.

Only about 15 percent of all complaints, those considered most likely to involve a violation of the *Medical Practice Act*, are referred for investigation, and about one-third of the cases referred for investigation are subsequently referred for prosecution. Because of the filtering performed by CCU, the District offices receive few complaints that do not require a substantive investigation. District offices, in turn, are expected to perform substantive investigations of the cases, and not simply re-screen and triage the cases to limit the number of investigations performed.

The specialist reviews and CCU's post-closure review processes help to ensure that cases requiring investigation are not improperly closed. Conversely, only a small percent of cases referred by CCU to the District offices are rejected and returned. Returns are usually due to either (1) referral of a complaint that is redundant to a currently pending investigation, or (2) referral of a complaint related to a pending multi-patient case investigation where the new patient would not strengthen the case if added to it. These cases are properly referred to the District offices for these determinations and, if returned, are properly accounted for as CCU rather than District office closures.

CCU does not conduct satisfaction surveys of patients and others that submit complaints to the Medical Board. Consequently, time series historical data showing levels of customer satisfaction are not available to determine what level of satisfaction is achieved and how it compares to historical levels. The last Customer Satisfaction Surveys were completed more than 10 years ago, several years prior to implementation of Medical Specialist reviews. Results of these surveys showed generally poor, but improving, levels of satisfaction with the services provided. For agencies like the Medical Board, the timeframe needed to resolve the complaint and the quality of communications with the Complainant are oftentimes correlated with customer satisfaction levels. It is unknown how customers would assess the level of services currently provided by CCU in either of these areas.

B. 2008/09 Complaint Workloads and Processing Times

Page 1 of Exhibit V-1, on the next page, shows the total number of complaints closed and referred to investigation or prosecution during 2008/09, and the average elapsed time to close, or refer, the complaints. Additionally, statistical data is presented for complaints reviewed by a Medical Specialist and for complaints not reviewed by a Medical Specialist. During 2008/09:

- More than 6,100 complaints were either closed or referred for investigation or prosecution by CCU. About 30 percent of these complaints were reviewed by an outside Medical Specialist prior to closure or referral for investigation or prosecution. About 85 percent of the complaints handled by CCU were closed.
- The average elapsed time for CCU to close or refer complaints for investigation or prosecution was 78 days (about 2.5 months), after excluding more than 800 closed non-jurisdictional complaints. If all non-jurisdictional complaints were included, CCU's average processing time would be about 67 days. Prior to 2008/09, the average processing time for complaints, including all non-jurisdictional complaints, was about 60 days (1 week less).
- The average elapsed time to close or refer complaints not reviewed by a Medical Specialist was about two (2) months (54 days). This compares to an average time of more than four (4) months (127 days) to close or refer complaints that were reviewed by a Medical Specialist.
- The average time to refer complaints for investigation or prosecution for cases not reviewed by a Medical Specialist was about one (1) month (33 days), reflecting both the expedited referral of selected, high-priority cases to investigation and also the accelerated processing timeframes associated with DCU's handling of Out-of-State cases, most of which are referred directly to HQES for prosecution.

Page 2 of Exhibit V-1 shows the total number of quality of care complaints closed and referred for investigation or prosecution during 2008/09 and the average elapsed time to close, or refer, the complaints. **Page 3 of Exhibit V-1** shows the total number of other complaints closed and referred to investigation or prosecution during 2008/09 and the average elapsed time to close, or refer, the complaints. As shown by Exhibit V-1, quality of care complaints represented about one-half of all complaints closed or referred, and the average time to close or refer quality of care complaints was about three (3) months (96 days) compared to about 2 months (56 days) for other complaints. quality of care complaints reviewed by a Medical Specialist took an average of more than four (4) months to close or refer. Of more than 400 complaints that took longer than six (6) months to close or refer, nearly three quarters were quality of care complaints, and nearly all of these complaints were reviewed by a Medical Specialist.

Summary of 2008/09 CCU Processing Timeframes for All Complaints

Disposition	Months	Not Reviewed by Medical Specialist[1]		Reviewed by Medical Specialist		Total	
		Number	Percent	Number	Percent	Number	Percent
Closed	Less than 1 Month	1,479	41%	6	0%	1,485	29%
	1 to 2 Months	720	20%	107	7%	827	16%
	2 to 3 Months	598	17%	304	19%	902	17%
	3 to 4 Months	366	10%	415	26%	781	15%
	4 to 6 Months	315	9%	510	32%	825	16%
	Longer than 6 Months	112	3%	237	15%	349	7%
	Total	3,590	100%	1,579	100%	5,169	100%
	Average Days	58 Days		129 Days		80 Days	
Referred to Investigation or Prosecution[2]	Less than 1 Month	391	62%	8	2%	399	41%
	1 to 2 Months	139	22%	43	12%	182	19%
	2 to 3 Months	37	6%	70	20%	107	11%
	3 to 4 Months	29	5%	82	24%	111	11%
	4 to 6 Months	23	4%	97	28%	120	12%
	Longer than 6 Months	8	1%	48	14%	56	6%
	Total	627	100%	348	100%	975	100%
	Average Days	33 Days		120 Days		65 Days	
Total	Less than 1 Month	1,870	44%	14	1%	1,884	31%
	1 to 2 Months	859	20%	150	8%	1,009	16%
	2 to 3 Months	635	15%	374	19%	1,009	16%
	3 to 4 Months	395	9%	497	26%	892	15%
	4 to 6 Months	338	8%	607	31%	945	15%
	Longer than 6 Months	120	3%	285	15%	405	7%
	Total	4,217	100%	1,927	100%	6,144	100%
	Average Days	54 Days		127 Days		78 Days	

[1] Excludes 13 closed records and 145 records referred by Medical Board Headquarters or Probation Units directly to the District offices or HQES. Nearly all of the excluded records were SOIs, petitions for modification or termination of probation, petitions for reinstatement, or probation violation matters originated by Medical Board Headquarters or Probation Units.

[2] Includes all Out-of-State (IDENT 16) cases, most of which are referred directly to HQES for prosecution.

2008/09 CCU Processing Timeframes for Quality of Care Complaints

Disposition	Months	Not Reviewed by Medical Specialist[1]		Reviewed by Medical Specialist		Total	
		Number	Percent	Number	Percent	Number	Percent
Closed	Less than 1 Month	317	30%	5	0%	322	12%
	1 to 2 Months	255	24%	94	6%	349	14%
	2 to 3 Months	280	27%	297	19%	577	22%
	3 to 4 Months	123	12%	405	26%	528	20%
	4 to 6 Months	65	6%	500	33%	565	22%
	Longer than 6 Months	13	1%	229	15%	242	9%
	Total	1,053	100%	1,530	100%	2,583	100%
	Average Days	60 Days		129 Days		101 Days	
Referred to Investigation or Prosecution[2]	Less than 1 Month	209	74%	7	2%	216	36%
	1 to 2 Months	49	17%	29	9%	78	13%
	2 to 3 Months	14	5%	66	21%	80	13%
	3 to 4 Months	7	2%	79	25%	86	14%
	4 to 6 Months	2	1%	93	29%	95	16%
	Longer than 6 Months	3	1%	45	14%	48	8%
	Total	284	100%	319	100%	603	100%
	Average Days	25 Days		123 Days		77 Days	
Total	Less than 1 Month	526	39%	12	1%	538	17%
	1 to 2 Months	304	23%	123	7%	427	13%
	2 to 3 Months	294	22%	363	20%	657	21%
	3 to 4 Months	130	10%	484	26%	614	19%
	4 to 6 Months	67	5%	593	32%	660	21%
	Longer than 6 Months	16	1%	274	15%	290	9%
	Total	1,337	100%	1,849	100%	3,186	100%
	Average Days	52 Days		128 Days		96 Days	

[1] Excludes six (6) records referred by Headquarters Units directly to the District offices or HQES.

[2] Includes all Out-of-State (IDENT 16) cases, most of which are referred directly to HQES for prosecution.

2008/09 CCU Processing Timeframes for Other Complaints

Disposition	Months	Not Reviewed by Medical Specialist[1]		Reviewed by Medical Specialist		Total	
		Number	Percent	Number	Percent	Number	Percent
Closed	Less than 1 Month	1,162	46%	1	2%	1,163	45%
	1 to 2 Months	465	18%	13	27%	478	18%
	2 to 3 Months	318	13%	7	14%	325	13%
	3 to 4 Months	243	10%	10	20%	253	10%
	4 to 6 Months	250	10%	10	20%	260	10%
	Longer than 6 Months	99	4%	8	16%	107	4%
	Total	2,537	100%	49	100%	2,586	100%
	Average Days	57 Days		116 Days		58 Days	
Referred to Investigation of Prosecution[2]	Less than 1 Month	182	53%	1	3%	183	49%
	1 to 2 Months	90	26%	14	48%	104	28%
	2 to 3 Months	23	7%	4	14%	27	7%
	3 to 4 Months	22	6%	3	10%	25	7%
	4 to 6 Months	21	6%	4	14%	25	7%
	Longer than 6 Months	5	1%	3	10%	8	2%
	Total	343	100%	29	100%	372	100%
	Average Days	41 Days		89 Days		45 Days	
Total	Less than 1 Month	1,344	47%	2	3%	1,346	42%
	1 to 2 Months	555	19%	27	35%	582	18%
	2 to 3 Months	341	12%	11	14%	352	11%
	3 to 4 Months	265	9%	13	17%	278	9%
	4 to 6 Months	271	9%	14	18%	285	9%
	Longer than 6 Months	104	4%	11	14%	115	4%
	Total	2,880	100%	78	100%	2,958	93%
	Average Days	55 Days		106 Days		56 Days	

[1] Excludes 13 closed records and 139 records referred by Headquarters or Probation Units directly to the District offices or HQES. Nearly all of the excluded records were SOIs, petitions for modification or termination of probation, petitions for reinstatement, or probation violation matters originated by Headquarters or Probation Units.

[2] Includes all Out of State (IDENT 16) cases, which are nearly always referred directly to the AG rather than to the District offices for investigation.

C. Medical Specialist Review Workloads and Processing Times

Exhibit V-2, on the next two pages, shows the number of Medical Specialist reviews completed during 2008/09, by medical specialty, and the average elapsed times to assign the cases and complete the reviews. As shown by Exhibit V-2, the average elapsed times to complete Medical Specialist reviews vary by specialty. For six (6) high volume specialties, which collectively account for nearly two-thirds of all reviews, the average elapsed time to complete the reviews is about one (1) month (31 days). This compares to an average elapsed time of about two (2) months for 14 moderate volume specialties that collectively account for most of the remaining reviews.

For nearly all of the moderate volume specialties, the Medical Board has available a pool of fewer than 10 Medical Specialists to perform the reviews. For nine (9) of the 14 moderate volume specialties, a pool of five (5) or fewer Medical Specialists is available to review the complaints. The small number of Medical Specialists available to perform reviews of moderate volume specialty complaints contributes to the longer time needed to complete the reviews. However, the moderate volume specialties represent less than one-third of all reviewed complaints, and the Medical Specialist review process accounts for only about one-half of the total elapsed time to process these complaints. Therefore, significantly reducing the average elapsed time to complete the reviews (e.g., to the same one-month average timeframe achieved for high volume specialties), will only marginally improve the Medical Board's overall average complaint processing performance.

Central Complaint Unit - 2008/09 Specialty Reviews

High Volume Specialties	Number	Average Days to Assign	Average Days to Complete	Total Days
Internal/General Medicine	546	10	15	25
Obstetrics & Gynecology	149	16	26	43
Plastic/Cosmetic Surgery	126	14	18	32
Orthopedic Surgery	123	15	13	27
Surgery	115	33	19	52
Emergency Medicine	100	10	14	24
Average - High Volume Specialties (6)	1,159	14	17	31

Moderate Volume Specialties	Number	Average Days to Assign	Average Days to Complete	Total Days
Ophthalmology	78	44	24	67
Urology	54	41	19	61
Radiology	53	42	38	80
Cardiology	49	23	21	44
Psychiatry	46	32	29	60
Orthopedics	44	12	12	25
Pediatrics	38	36	40	76
Gastroenterology	31	28	20	47
Anesthesiology	30	44	22	66
Dermatology	30	21	23	45
Neurology	28	47	34	80
Neurological Surgery	25	44	32	76
ENT/Otolaryngology	26	36	17	53
Hematology/Oncology	21	39	36	75
Average - Moderate Volume Specialties (14)	553	35	26	61

Central Complaint Unit - 2008/09 Specialty Reviews

Low Volume Specialties	Number	Average Days to Assign	Average Days to Complete	Total Days
Pulmonology	12	12	14	26
Thoracic Surgery	11	29	12	40
Pain Medicine	10	45	22	67
Cardiothoracic Surgery	5	34	10	44
Physical Medicine & Rehabilitation	5	9	22	31
Colon & Rectal Surgery	4	30	33	63
Family Medicine	4	26	25	50
Perinatal/Neonatal	4	26	17	43
Nephrology	3	8	10	18
Nuclear Medicine	3	42	47	89
Endocrinology	2	56	21	77
Pathology	2	42	12	54
Rheumatology	2	29	34	63
Spine Surgery	2	2	10	12
Vascular Surgery	2	45	34	79
Allergy & Immunology	1	4	22	26
Alternative Medicine	1	64	7	71
Gynecology Oncology	1	16	26	42
Hematology/Oncology - Pediatrics	1	46	23	69
Medicine/Pulmonology	1	75	34	109
Midwifery	1	14	25	39
Pain Management	1	27	24	51
Pathology - Forensic	1	42	44	86
Pediatric Surgery	1	22	21	43
Pediatric Cardiology	1	49	28	77
Radiology Oncology	1	60	38	98
Retinal Specialty	1	9	15	24
Total Low-Volume Specialty (27)	83	29	20	49
Total	1,795	21	20	41

D. Disposition of Complaints Following Medical Specialist Review

Table V-1, below, provides a profile of the dispositions of complaints following Medical Specialist review for periods immediate prior to, and concurrent with, implementation of Medical Specialist reviews. Additionally, a profile of the dispositions of complaints following Medical Specialist review is provided for 2008/09. As shown by Table V-1, 17 percent of complaints were referred for investigation during 2008/09 compared to 20 to 21 percent referred to investigation previously. Additionally, a higher proportion of complaints are Closed-Insufficient Evidence (which usually refers to cases involving a simple or minor departure) and a lower percent of complaints are Closed-No Violation (which usually refers to cases where no departure is identified).

Table V-1. Disposition of Complaints Following Medical Specialist Review

Disposition	CY2000 to CY2002		CY2003 to CY2004		FY2008/09	
	Average Number	Percent	Average Number	Percent	Number	Percent
Closed - No Violation (i.e., No Departure)	1,852	61%	1,331	59%	1,082	54%
Closed - Insufficient Evidence (i.e., Simple/Minor Departure)	486	16%	348	16%	456	23%
Closed - Information on File	49	2%	72	3%	80	4%
Closed - Other	29	1%	22	1%	33	2%
Total	2,416	80%	1,773	79%	1,651	83%
Referred to Investigation	596	20%	468	21%	348	17%
Total	3,012	100%	2,241	100%	1,999	100%

The primary purpose of enacting the Specialist Review requirements was to reduce unnecessary referral of cases for field investigation that occurred due to competency limitations of the assigned reviewer. The data presented in Table V-1 indicate that the Medical Specialist review requirement is, as was intended, marginally reducing the number of complaints referred for investigation (i.e., by about 50 complaints per year, assuming 20 percent of 1,999 complaints would otherwise have been referred to investigation). Additionally, significantly more complaints are now being closed with an Insufficient Evidence (Simple/Minor Departure) designation. These complaints can potentially serve to support future disciplinary actions against the licensee on the basis that the licensee performed repeated negligent acts.

E. In-Depth Analysis of Complaints Taking More than Six Months to Refer to Investigation

CCU staff researched each of 59 cases that took longer than six (6) months to review and refer for investigation during 2008/09. Common factors identified as contributing to the extended processing time associated with completing the reviews of these cases included delays associated with:

- Contacting and obtaining a release from the patient for their medical records (e.g., patient unavailable or not initially responsive)
- Obtaining medical records from the treating health care facility or physician (e.g., physician non-responsive or provides incorrect or incomplete records)
- Identifying a Medical Specialist capable of reviewing the medical records (e.g., case involves a highly specialized procedure)
- Completion of the Medical Specialist review (e.g., the Specialist took a long time to review the medical records, possibly due to the number of records involved or because additional records were needed by the Medical Specialist to complete the review).

Additionally, in some cases it appears that CCU staff failed to follow-up or complete the processing of the case on a timely basis. Finally, some cases were not referred for investigation until a post-closure audit review was completed. District office staff expressed concerns about the comparatively low quality of these latter cases and CCU recently modified its post-closure audit procedures to address problems in this area.

The most common sources of delay in referring cases for investigation were related, directly or indirectly, to obtaining and reviewing medical records. The delays become extended when problems surface at different points during the screening process (e.g., delayed getting patient cooperation and release of the records, then further delayed obtaining the records, then further delayed identifying a Medical Specialist to review the records, and then further delayed getting the completed review from the Medical Specialist). Some of these delays are within the control of CCU, or CCU can more effectively manage the process to reduce the length of such delays. In other cases the cause of the delay is outside CCU's control and CCU has limited capability to reduce the delay (e.g., waiting for a patient in recovery to provide a release).

F. Pending Complaints

Table V-2, below, shows the number of pending CCU complaints as of June 30, 2009, and December 31, 2009. As shown by Table V-2, the number of pending complaints increased significantly during this six-month period, from about 1,308 open complaints at the end of June 2009, to 1,443 at the end of the year. The 10 percent increase in open complaints during this brief period is primarily attributable to staffing reductions resulting from implementation of the closure of the Medical Board's offices during the first three Fridays of each month (Furlough Fridays). During 2004/05 and 2005/06 the Medical Board had fewer than 1,100 open complaints.

Table V-2. CCU Pending Complaints

Assigned To	As of June 30, 2009			As of December 31, 2009		
	Quality of Care	Other	Total	Quality of Care	Other	Total
Analyst	555	413	968	668	393	1,061
Medical Consultant	296	8	304	335	5	340
Supervisor	18	18	36	27	15	42
Total	869	439	1,308	1,030	413	1,443

Inevitably, the growing number of open complaints will soon translate into longer average processing times, particularly given the continuation of the Furlough Friday Program through June 2010. Ultimately, over a period of several years, these complaint-handling delays will adversely impact aggregate Enforcement Program performance measures (e.g., total elapsed time from receipt of complaint to disciplinary outcome).

G. Recommendations for Improvement

Below we present several key recommendations for improving complaint intake and screening. These recommendations concern (1) the pool of Medical Specialists available to review quality of care and selected other complaints, (2) CCU staffing, and (3) measurement and monitoring levels of customer satisfaction with CCU services.

1. Medical Specialist Reviews

There are only a relatively small number of Medical Specialists available to review complaints in a number of moderate volume specialty areas, and some of the specialty areas are the same as those that have some of the longest average elapsed times to complete complaint reviews. On average, these reviews take only a few hours of labor time, but a few months of calendar time, to complete. For example, there are only four (4) Neurologists available to review more than two (2) dozen complaints per year and the average time to review these complaints is nearly three (3) months. Similar situations exist with:

- Urologists (2 Specialists, 54 complaints, 61-day average review time)
- Radiologists (5 Specialist, 53 complaints, 80-day average review time)
- Pediatrics (8 Specialists, 38 complaints, 76-day average review time)
- Anesthesiologists (9 Specialists, 30 complaints, 66-day average review time)
- Neurological Surgeons (3 Specialists, 25 complaints, 76-day average review time)
- Oncologists (5 Specialists, 21 complaints, 75-day average review time).

It would be beneficial to increase the number of Medical Specialists available to CCU in these and other moderate volume specialty areas.

Recommendation No. V-1. *Augment the Specialist Reviewer pool in targeted medical specialties and counsel or replace Medical Specialists who consistently fail to complete reviews on a timely basis, or amend the governing statute to provide flexibility to refer complaints for investigation without review by a Medical Specialist.*

2. CCU Workforce Capability and Competency

Seven and one-half (7.5) new CCU positions, including one (1) SSM I position, five (5) AGPA positions, and 1.5 MST/OT positions, are expected to be authorized in the 2010/11 Budget. These positions will be used primarily to enhance intake and screening of physician and surgeon and AHLP cases, and to enhance management and administration of the Specialty Review process. Additionally, two (2) new AGPA positions are expected to be authorized for the Office of Standards and Training (OST). These positions are expected to focus their efforts on training programs for CCU staff. These additional positions would significantly enhance CCU workforce capabilities. To ensure anticipated benefits are actually realized, CCU management should develop a specific plan detailing the program development and performance improvement goals and objectives that will be achieved as a result of these significant increases in authorized CCU and OST staffing levels. As much as possible the program development and performance improvement goals and objectives should be stated in terms that will enable assessment of the extent to which the objectives are actually achieved.

Recommendation No. V-2. *Augment CCU's workforce capabilities. When authorized, fill the new CCU and OST positions. Develop a specific plan detailing the program development and performance improvement goals and objectives that will be achieved by increasing authorized CCU and OST staffing levels. Track progress relative to the plan and provide periodic reports to the Medical Board showing progress in achieving each of the plan's goals and objectives.*

3. Customer Satisfaction Metrics

CCU has not surveyed customers regarding the level of satisfaction with CCU services since the late-1990s. Such surveys provide an important measure of the impact of changes in CCU processes and service levels, such as implementation of Medical Specialist reviews, changes in the average elapsed time to screen complaints, time spent by staff discussing with the complainant the status and disposition of their complaint, etc. CCU should continuously survey customers regarding their level of satisfaction with CCU services. Monitoring customer satisfaction levels helps to maintain and improve the level of service provided to the public by linking changes in policies and procedures with measures of the impacts of these changes on the customer community. Other DCA-affiliated regulatory programs utilize a simple postcard survey for this purpose.

Recommendation No. V-3. *Resume surveys of CCU customer satisfaction levels and compile and publish the results of the surveys.*

VI. Investigations

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VI. Investigations

Our assessment of investigation process performance focused on determination of the numbers of investigations completed by the District offices concurrent with and following implementation of the VE during 2006, the disposition of the cases, and the elapsed time to complete the investigations. The assessment also encompassed analysis of time spent by HQES Attorneys on investigations and in-depth reviews of more than two (2) dozen cases with more than 40 hours of time charged by HQES Attorneys during 2008/09. Additionally, we completed analyses of Medical Consultant and Medical Expert services and expenditures.

Results of these analyses show that fewer investigations are being completed by the District offices, the investigations are taking significantly longer to complete, and fewer cases are being referred for prosecution. Also, performance levels have declined as much, or more, in the Los Angeles Metro region than in other regions of the State even though Los Angeles Metro region Attorneys are significantly more involved with investigations. For example, during 2008/09 Los Angeles Metro region Attorneys billed the Medical Board about 50 hours of time per completed investigation, compared to about 31 hours of Attorney time billed per completed investigation in the Other Southern California region, and 15 hours of Attorney time billed per completed investigation in the Northern California region. Yet, notwithstanding this much higher level of Attorney involvement in investigations, during 2008/09, and also during 2007/08, only about 75 cases per year were referred for prosecution by Los Angeles Metro region District offices. This compares to about 72 cases per year referred for prosecution in the Other Southern California region and more than 100 cases per year referred for prosecution in the Northern California region. During the past two (2) years, 25 percent of completed Los Angeles Metro region investigations were referred for prosecution. In the Northern California region, 28 percent of completed investigations were referred for prosecution and, in the Other Southern California region, 32 percent of completed investigations were referred for prosecution.

The remainder of this section is organized as follows:

Subsection	Title
A.	Overview of "Consolidated" Investigation Workload, Outputs, and Performance
B.	Dispositions of Completed Investigations by Business Group
C.	Investigations Opened and Completed, by Identifier
D.	Average Elapsed Times to Complete Investigations
E.	Investigations Closed without Citation or Referral for Prosecution
F.	Investigations Closed with Citation Issued
G.	Investigations Referred for Prosecution
H.	HQES Declined to File Cases
I.	Pending Investigations
J.	Expenditures for HQES Investigation Services
K.	Medical Consultant and Outside Expert Services and Expenditures
L.	Recommendations for Improvement.

VI. Investigations

A. Overview of "Consolidated" Investigation Workload, Outputs, and Performance

Exhibit VI-1, on the next page, provides an overview of consolidated investigation workflows and performance since the early part of the decade. The statistical data presented in Exhibit VI-1 includes cases handled by the District offices as well as cases involving Probationers, petitions for modification or termination of probation, and petitions for reinstatement that, until recently, were exclusively handled by regional Probation Units. Additionally, the consolidated statistical data includes cases handled primarily, or exclusively, by various Headquarters Units, including:

- Out-of-State disciplinary action reports
- Probationary license certificates
- Appeals of license application denials, referred to as statements of issues (SOIs)
- Change of address citation cases (through December 2004)
- Continuing Medical Education (CME) audit failure citation cases
- Probation violation citation cases
- Cite and fine non-compliance cases
- Internet Crime and Operation Safe Medicine (OSM) cases.

As shown by Exhibit VI-1, since the early part of the decade the number of investigations opened, the number of investigations closed, and the number of cases referred for prosecution decreased significantly. For example, from 2005/06 to 2008/09:

- The number investigations opened decreased by 16 percent (from 1,354 investigations opened during 2005/06 to 1,135 investigations opened during 2008/09)
- The number of cases closed or referred for prosecution decreased by 15 percent (from 1,281 cases closed or referred during 2005/06 to 1,092 cases closed or referred during 2008/09)
- The number of pending investigations increased by 15 percent (from 1,054 at the beginning of 2005/06 to 1,211 at the end of 2008/09)
- The average elapsed time to complete investigations increased by 26 percent (from 9.1 months during 2005/06 to 11.5 months during 2008/09).

As part of the investigation process, District office Investigators may interview the Complainant and usually must collect pertinent medical or other records. Additionally, particularly with quality of care cases, but oftentimes for other cases as well, the investigation oftentimes includes (1) an interview with the Subject, (2) a review of the case by a Medical Consultant, and (3) a review of the case by an outside Medical Expert. Exhibit VI-1 shows estimated numbers of completed Complainant interviews, Subject Interviews, Medical Consultant Reviews, and Expert Reviews by year for the past 3 to 5 years. As shown by Exhibit VI-1, in recent years the number of

Overview of "Consolidated" Investigation Workload, Outputs, and Performance

	Workflow Measure	2000/01 through 2002/03[1] (3-Year Avg.)	2003/04	2004/05[2]	2005/06[3]	2006/07[4]	2007/08	2008/09
Investigations Opened (Excluding Re-Opened Cases)	Complaints Referred to, or Opened by, District Offices (Various IDENTs)				1,123	963	867	872
	Out-of-State Cases (IDENT 16)				105	50	132	93
	Complaints Involving Probationers Referred to Field Offices (IDENT 19)				39	48	50	54
	Cases Opened by Headquarters Units[5] (IDENTs 20 through 25)				87	95	59	58
	Petitions for Modification or Termination of Probation (IDENT 26)				Included in HO Cases	1	11	40
	Petitions for Reinstatement (IDENT 27)				Included in Headquarters Cases		6	18
	Total Investigations Opened[5]	2,355	1,887	1,443	1,354	1,157	1,125	1,135
Interim District Office Activities	Complainant Interviews (Estimated - Volumes Shown May Be Understated)					418	373	337
	Subject Interviews (Estimated - Volumes Shown May Be Understated)			818	705	656	711	681
	Medical Consultant Reviews (Estimated - Volumes Shown May Be Understated)					528	540	480
	Expert Reviews (Estimated - Volumes Shown May Be Understated)			565	464	393	469	340
Case Dispositions[5]	Cases Closed without Citation, PLR, or Referral for Prosecution				767	657	711	581
	Cases Closed with Citation				44	41	43	47
	Cases Closed with Public Letter of Reprimand (PLR)				46	31	11	21
	Cases Referred for Prosecution to HQES (Includes Dual Referrals)	531	580	521	456	410	438	449
	Cases Referred for Prosecution to District Attorney (Includes Dual Referrals	62	37	34	31	27	28	27
	Total Cases Referred for Prosecution	550 to 600 per Year, Including Some PLRs			424	396	441	443
	Total Cases Closed or Referred for Prosecution	2,395	2,117	1,475	1,281	1,125	1,206	1,092
Pending Cases (End of Period, Including AHLP Cases)		1,251	1,060	1,054	1,111	1,146	1,147	1,211
Reported Average Time to Close Cases or Refer for Prosecution		6.7 Months	7.2 Months	8.5 Months	9.1 Months	10.1 Months	10.7 Months	11.5 Months

[1] During 2002/03, 19 authorized Investigator positions were abolished.

[2] Effective January 1, 2005, CCU began implementing Medical Specialist reviews. Additionally, the Medical Board discontinued counting change of address citations as complaints or investigations.

[3] Effective January 1, 2006, the Medical Board and HQES began implementing the Vertical Enforcement (VE) Pilot Project.

[4] Effective July 1, 2006, eight (8) new positions were authorized for the Enforcement Program (4 Investigators and 4 Assistant Investigators). Subsequently, the Assistant Investigator positions were reclassified to Inspectors and assigned to Probation Units. Concurrently, Investigator positions assigned to the Probation Units were reassigned to the District offices.

[5] Includes probationary license certificates, SOIs, CME audit cases, cite and fine non-compliance cases, probation violation citation cases, Internet and Operation Safe Medicine (OSM) cases, petitions for modification or termination of probation, and petitions for reinstatement. Also, includes change of address citation cases (through December 2004).

completed Complainant and Subject interviews, and the number of completed Medical Consultant and Expert reviews, have declined in parallel with decreases in (1) the number of investigations opened, and (2) the number of investigations closed or referred for prosecution.

On average over the past four (4) years, about 35 percent of cases referred for Investigation were subsequently referred for prosecution. During 2008/09 the percent of cases referred for prosecution was higher than average. However, the above-average referral rate during 2008/09 is attributable to an especially large (18 percent) decline in the number of cases closed without referral for prosecution as compared to 2007/08. There was no change in the number of cases referred for prosecution during 2008/09 compared to the prior year.

Since the early part of the decade, the reported average elapsed time to complete investigations increased by more than 70 percent (from an average of 6.7 months to an average of more than 11 months). Some of this is due to the exclusion of change of address citations when calculating this performance measure. Prior to January 1, 2005, change of address citations were counted as completed investigations, which reduced average elapsed investigation time measures. While the average elapsed time data shown for 2005/06 through 2008/09 are consistently presented without change of address citations, some other types of matters continue to be captured in the Medical Board's data systems as investigations for tracking purposes, but investigations are not actually performed (e.g., probationary license certificates, SOIs, CME audit failure citations, probation violation citations, and cite and fine non-compliance cases). The reported average elapsed time data also include (1) Out-of-State cases, which rarely require investigation, (2) petitions for modification or termination of probation, and (3) and petitions for reinstatement. Out-of-State cases and petitions are subject to different review requirements and generally take much less time to complete than investigations (as that term is conventionally defined). The inclusion of these other types of cases when determining the average elapsed time to complete investigations overstates the number of completed investigations and understates average elapsed time measures. More importantly, in recent years the consolidated data obscured the deterioration in Enforcement Program performance that actually occurred in terms of (1) the decline in number of investigations completed by the District offices, and (2) the increase in the average elapsed time to complete these investigations. Excluding cases involving Probationers, over the past three (3) years:

- The number of investigations completed by the District offices decreased by 24 percent (from 1,083 during 2005/06 to 828 during 2008/09)
- The average elapsed time to complete these investigations increased by 34 percent (from 10.2 months during 2005/06 to 13.7 months during 2008/09).

VI. Investigations

In the remainder of this section we present investigation-related workload and performance data for fiscal years 2005/06 through 2008/09 that differentiate, to the extent practicable, cases consistently investigated exclusively by the District offices throughout this period from the following other types of cases which are included in the consolidated data presented previously in Exhibit VI-1 and in periodic statistical reports published by the Medical Board and Department of Consumer Affairs:

- Out-of State disciplinary action reports
- Probationary license certificates
- Statements of Issues (SOIs)
- CME audit failure citation cases
- Cite and fine non-compliance cases
- Cases involving Probationers
- Petitions for modification or termination of probation
- Petitions for reinstatement.

The above types of cases can be distinguished from cases consistently handled exclusively by the District offices based on the Identifier (IDENT) assigned to the case and, where appropriate, elapsed time data showing the duration of the investigations. With rare exceptions, cases with certain Identifiers, or with investigation durations of only one, or a few, business days, are not handled by the District offices, or were only recently transferred to the District offices in connection with the restructuring of the Probation Units.

B. Dispositions of Completed Investigations by Business Group

Exhibit VI-2, on the next page, shows dispositions of completed investigations for each of the past four (4) fiscal years, for each of the following:

Cases Handled by the District Offices – This category includes all cases assigned District office Identifiers plus a small number of Out-of-State (IDENT 16) cases that may have been handled by the District offices as determined from the duration of the investigations.

Cases Involving Probationers and Petitions – This category includes cases with Probationer Identifiers (IDENT 19), petitions for modification or termination of probation (IDENT 20 or 26), and petitions for reinstatement (IDENT 20 or 27). Until recently these cases were handled exclusively by regional Probation Units and were not included in the VE Pilot Project.

Cases Handled by Headquarters Units – This category includes nearly all cases involving Out-of-State disciplinary action reports (IDENT 16) and a mix of other cases usually handled by various Headquarters Units, including probationary license certificates, SOIs, cite and fine non-compliance cases (IDENT 20), CME audit failure citation cases (IDENT 21), and Operation Safe Medicine and Internet crime cases (IDENTs 22 and 23, respectively).

As shown by Exhibit VI-2, in recent years the number of investigations completed by the District offices declined by 24 percent (from 1,083 during 2005/06 to 828 during 2008/09, excluding cases involving Probationers or petitions which were only recently assigned to the District office). The decrease in the total number of District office investigations completed during this period was partially offset by increases in the total number of cases closed or referred for prosecution by various Headquarters Units. Additionally, there were small increases in the number of completed investigations involving Probationers, petitions for modification or termination of probation, and petitions for reinstatement. Until recently, cases involving Probationers and all petitions were handled by regional Probation Units.

In recent years the number of cases referred for prosecution by the District offices decreased by 12 percent (from about 285 cases per year to 250 cases per year). Additionally, the number of public letters of reprimand (PLRs) issued by the District offices decreased significantly (from 29 during 2005/06 to an average of five (5) per year during the past two (2) years). On average, about 28 percent of all investigations completed by the District offices were referred for prosecution. In contrast, about 73 percent of the cases handled by Headquarters Units or involving Probationers or petitions were referred for prosecution.

Disposition of Completed Investigations, by Business Group - 2005/06 through 2008/09

Case Dispositions				2005/06	2006/07	2007/08	2008/09
Cases Handled by District Offices	Closed	No Cite	Cases with District Office Identifiers	723	619	670	534
			Out of State (IDENT 16)	9	5	2	2
		Cite	Cases with District Office Identifiers	39	41	26	39
			Out-of-State (IDENT 16)	1		2	
		PLR	Cases with District Office Identifiers **(2003/04 PLR = 12, 2004/05 PLR = 19)**	29	13	3	7
	Referred for Prosecution		Cases with District Office Identifiers (excludes PLR cases)	276	281	244	245
			Out-of-State (IDENT 16)	6	7	9	1
			Total Cases Referred to the Attorney General or a District Attorney	282	288	253	246
	Total Closed or Referred to AG of DA (Cases Handled by District Offices)			1,083	966	956	828
Cases Involving Probationers and Petitions	Closed	No Cite	Probation (IDENT 19)	29	20	31	29
			Petitions for Modification or Termination of Probation (IDENT 26)				2
		Cite	Probation (IDENT 19)	2		1	
	Referred for Prosecution		Probation (IDENT 19)	17	14	17	22
			Headquarters[1] (IDENT 20)	39	45	53	14
			Petitions for Modification or Termination of Probation (IDENT 26)	Included in Headquarters Cases			29
			Petitions for Reinstatement (IDENT 27)				8
			Total Cases Referred to AG or DA	56	59	70	73
	Total Closed or Referred to AG of DA (Cases Involving Probationers and Petitions)			87	79	102	104
Cases Handled by Headquarters Units	Closed	No Citation	Out of State (IDENT 16)			1	
			Headquarters[a] (IDENT 20)	2	5	3	5
			Internet (IDENT 23)	4	8	4	9
		Cite	Out of State (IDENT 16)	2		14	8
		PLR	Out of State (IDENT 16)	17	18	8	14
	Referred for Prosecution		Out of State, Excluding PLRs (IDENT 16)	65	27	98	71
			Probation (IDENT 19)				7
			Headquarters[a] (IDENT 20)	20	21	18	32
			CME Audit (IDENT 21)				4
			Internet (IDENT 23)	1	1	2	10
			Total Cases Referred for Prosecution (HQES and DA)	86	49	118	124
	Total Closed or Referred for Prosecution (Cases Handled by Headquarters Units)			111	80	148	160
Total Cases Closed or Refered for Prosecution (HQES and DA)				1,281	1,125	1,206	1,092

[1] May include probationary license certifications, SOIs, CME audit cases, cite and fine non-compliance cases, Internet and Operation Safe Medicine (OSM) cases, petitions for modification or termination of probation, and petitions for reinstatement.

C. Investigations Opened and Completed by Identifier

Exhibit VI-3, on the next page, shows the number of investigations opened and completed by Identifier, by fiscal year. As shown by Exhibit VI-3, in recent years the number of investigations with District office Identifiers that were opened, closed, and referred for prosecution decreased significantly. During this period there was little change in the overall percentage of cases referred for prosecution, which averaged 29 percent during this period. However, there were significant differences in performance between the three (3) regions to which District offices are assigned. For example:

- The number of cases referred for prosecution decreased significantly in the Los Angeles Metro and Other Southern California regions. In contrast, there was no decrease in the number of cases referred for prosecution by the Northern California region.
- During the past several years the Northern and Other Southern California regions both closed or referred more cases than were opened. In contrast, in the Los Angeles Metro region, fewer cases were closed or referred than were opened. However, during 2008/09 none of the three (3) regions closed or referred more cases than were opened.
- In the Los Angeles Metro region, the proportion of cases referred for prosecution decreased from 33 percent during 2005/06 to 25 percent during each of the past two (2) fiscal years. In contrast, the proportion of cases referred for prosecution by the Northern California region increased from 22 percent during 2005/06 to an average of 28 percent during the past several years. For the Other Southern California region, the proportion of cases referred for prosecution averaged about 35 percent during the past several years, a higher proportion than achieved by either of the other two regions.

In contrast to the workload trends at the District offices, the number of cases with Out-of-State, Probationer, and Headquarters Unit Identifiers that were opened, closed, and referred for prosecution increased during the past several years. About 76 percent of these cases were consistently referred for prosecution. These cases consistently have a comparatively high 76 percent referral rate, and typically account for 20 to 25 percent of all case closures and referrals. Consequently, the consolidation of these cases, for performance reporting purposes, with cases handled by the District offices, obscures changes occurring in District office performance.

Summary of Investigations Opened and Completed, by Identifier

2005/06 through 2008/09[1]

	Cases with District Office Identifiers	2005/06	2006/07	2007/08	2008/09
Opened	Northern California	398	379	324	344
	Los Angeles Metro	343	338	350	306
	Other Southern California	382	246	193	222
	Total Investigations Opened	1,123	963	867	872
Closed or Referred for Prosecution	Northern California	399	389	383	330
	Los Angeles Metro	343	308	302	305
	Other Southern California	325	257	258	190
	Total Investigations Closed or Referred	1,067	954	943	825
Difference	Northern California	(1)	(10)	(59)	14
	Los Angeles Metro	0	30	48	1
	Other Southern California	57	(11)	(65)	32
	Difference: Opened Less Closed or Referred	56	9	(76)	47
Referred for Prosecution	Northern California	89	107	100	103
	Los Angeles Metro	112	86	76	75
	Other Southern California	104	101	71	74
	Total District Office Legal Closures	305	294	247	252
Percent Referred for Prosecution	Northern California	22%	28%	26%	31%
	Los Angeles Metro	**33%**	**28%**	**25%**	**25%**
	Other Southern California	32%	39%	28%	39%
	Total - District Office Identifiers	29%	31%	26%	31%

	Cases with Other Identifiers	2005/06	2006/07	2007/08	2008/09
Opened	Out of State (IDENT 16)	105	50	132	93
	Probation (IDENT 19)	39	48	50	54
	Headquarters (IDENTs 20, 21, 22, 26, and 27)	72	88	61	108
	Internet (IDENT 23)	15	8	15	8
	Total Investigations Opened	231	194	258	263
Closed or Referred for Prosecution	Out of State (IDENT 16)	18	13	13	9
	Probation (IDENT 19)	48	34	49	51
	Headquarters (IDENTs 20, 21, 26, and 27)	41	50	55	56
	Internet (IDENT 23)	5	9	6	19
	Direct Referrals and Same-Day Closures (IDENTs 16 and 19 through 27)	102	65	105	132
	Total Investigations Closed or Referred	214	171	228	267
Difference: Opened Less Closed or Referred		17	23	30	(4)
Referred for Prosecution	Out of State (IDENT 16)	6	7	9	1
	Probation (IDENT 19)	17	14	17	22
	Headquarters (IDENTs 20, 21, 26, and 27)	39	45	53	51
	Internet (IDENT 23)	1	1	2	10
	Direct Referrals to AG or DA (IDENTs 16, 19, 20, and 21)	100	65	89	122
	Total Legal Closures - Other Identifiers	163	132	170	206
Percent Referred for Prosecution - Other Identifiers		76%	77%	75%	77%

[1] Excludes re-opened cases. Statewide, an average of about 30 cases are re-opened per year.

D. Elapsed Time to Complete Investigations

Exhibit VI-4, on the next page, shows average elapsed times to investigate cases, by fiscal year, for quality of care and other cases. The data shown excludes cases closed or referred directly for prosecution by the originating Headquarters or Probation Unit without involvement of the District offices. During the past several years the average elapsed time to complete Quality of Care case Investigations increased by 35 percent (from 11.3 months during 2005/06 to 15.2 months during 2008/09). During 2008/09, it took longer than 18 months to complete 34 percent of Quality of Care case Investigations compared to only 11 percent of cases that took longer than 18 months to Investigate during 2005/06. For other cases, the average elapsed time to investigate the cases increased by 42 percent (from 7.4 months during 2005/06 to 10.5 months during 2008/09). During 2008/09 it took longer than 18 months to complete 17 percent of the other case investigations compared to only 3 percent of Other cases that took longer than 18 months to Investigate during 2005/06.

The 35 percent increase over the past several years in the average elapsed time to complete quality of care case Investigations is particularly surprising given the impacts that VE was expected to have on these types of cases. For example, HQES Attorneys were expected to provide assistance in significantly reducing the amount of time needed to obtain patient medical records needed to determine the viability of the cases. Additionally, it was anticipated that cases that were not viable would be closed more quickly, thereby enabling redeployment of Investigators to accelerate the processing of other cases.

Exhibit VI-5, following Exhibit VI-4, shows average elapsed times to investigate cases by District office Identifier, by fiscal year. The overall average elapsed time to investigate cases with District office Identifiers increased by 35 percent (from 10.2 months during 2005/06 to 13.7 months during 2008/09). Average elapsed times increased significantly in all three (3) regions. In the Other Southern California, the average elapsed time to complete investigations in this region reached nearly 16 months and the number of cases closed or referred for prosecution decreased by 42 percent (to fewer than 200 completed investigations compared to more than 300 completed investigations in both of the other regions). For cases with other Identifiers, the number of completed investigations decreased during the past several years and the average elapsed time to investigate these cases increased significantly. Some of these cases were handled by Headquarters Units, some were handled by Probation Units, and some were handled by the District offices.

Summary of Completed Investigations, By Type of Case
2005/06 through 2008/09

Case Type	Elasped Time to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	6 Months or Less	128	17%	85	14%	90	15%	78	14%
	9 to 12 Months	323	43%	227	36%	212	35%	149	27%
	12 to 18 Months	213	28%	193	31%	161	26%	140	25%
	18 to 24 Months	59	8%	86	14%	102	17%	97	18%
	More than 24 Months	25	3%	31	5%	47	8%	86	16%
	Total	748	100%	622	100%	612	100%	550	100%
	Average Number of Months	11.3	Months	12.5	Months	13.1	Months	15.2	Months
Other Cases	6 Months or Less[1]	206	48%	183	42%	162	36%	139	34%
	9 to 12 Months	145	34%	145	33%	139	31%	133	33%
	12 to 18 Months	63	15%	78	18%	74	16%	64	16%
	18 to 24 Months	13	3%	21	5%	54	12%	33	8%
	More than 24 Months	2	0%	10	2%	25	6%	35	9%
	Total	429	100%	437	100%	454	100%	404	100%
	Average Number of Months	7.4	Months	8.4	Months	10.3	Months	10.5	Months
All Cases	6 Months or Less[1]	334	28%	268	25%	252	24%	217	23%
	9 to 12 Months	468	40%	372	35%	351	33%	282	30%
	12 to 18 Months	276	23%	271	26%	235	22%	204	21%
	18 to 24 Months	72	6%	107	10%	156	15%	130	14%
	More than 24 Months	27	2%	41	4%	72	7%	121	13%
	Total	1,177	100%	1,059	100%	1,066	100%	954	100%
	Average Number of Months	9.9	Months	10.8	Months	11.9	Months	13.1	Months

[1] Data shown excludes cases closed by Headquarters and Probation Units, cases closed with a citation issued by DCU or Probation Units, and cases referred directly for prosecution without District office investigation, including nearly all Out-of-State (IDENT 16) cases, cases involving probation violations (IDENT 19), originated by the Medical Board), and SOI, CME audit failure, and citation non-compliance cases (IDENT 20 or 21, originated by the Medical Board).

Cases Closed or Referred Directly for Prosecution	Quality of Care Cases	3	3%	12	18%	47	34%	20	14%
	Other Cases	101	97%	54	82%	93	66%	118	86%
	Total	104	100%	66	100%	140	100%	138	100%

Summary of Completed Investigations, By Identifier (8.01 to 8.03)
2005/06 through 2008/09

	Business Unit	Investigations Completed				Average Elapsed Time to Complete (Months)				Comments
		2005/06	2006/07	2007/08	2008/09	2005/06	2006/07	2007/08	2008/09	
Cases with District Office Identifiers	Fresno	72	67	87	55	12.3	13.1	15.1	18.6	Includes several aged Section 805 cases.
	Pleasant Hill	120	93	99	102	10.1	10.4	13.5	13.9	
	Sacramento	117	139	116	97	12.8	13.1	10.7	9.8	
	San Jose	90	90	81	76	9.8	10.8	11.1	12.6	
	Total - Northern California	399	389	383	330	11.2	11.9	12.5	13.2	
	Cerritos	100	86	115	118	10.2	8.7	10.1	10.9	
	Diamond Bar	83	54	60	64	8.6	11.9	12.7	17.0	
	Glendale	82	67	40	72	11.0	11.6	12.2	13.5	
	Valencia	78	101	87	51	11.1	8.9	10.9	12.2	Includes several 3-week AG cases.
	Total - Los Angeles Metro Area	343	308	302	305	10.2	9.9	11.1	13.0	
	Rancho Cucamonga	N/A	N/A	N/A	6	N/A	N/A	N/A	8.6	Prior to ____, Rancho Cucamonga was a Regional Probation Unit.
	San Bernardino	119	105	87	61	9.4	11.3	15.0	16.9	
	San Diego	102	68	106	69	9.6	12.6	12.8	15.1	
	Tustin	104	84	65	54	8.3	10.4	13.6	16.6	
	Total - Other Southern California	325	257	258	190	9.1	11.3	13.8	15.9	
	Total - District Offices	**1,067**	**954**	**943**	**825**	**10.2**	**11.1**	**12.4**	**13.7**	
Cases with Other Identifiers[1]	Out of State (IDENT 16)	16	12	13	3	3.6	8.0	6.3	11.7	These cases are nearly always referred from the Disciplinary Unit directly to the AG. The are only assigned to District offices when the licensee is practicing in California.
	Probation (IDENT 19)	48	34	49	51	9.7	10.1	9.9	10.9	Prior to 2008/09, these cases were investigated by regional Probation Units. Subsequently, the investigations were performed by District offices.
	Headquarters (IDENT 20)	41	50	55	17	3.8	6.3	7.1	7.1	Includes SOIs and probationary license certifications which are not handled by the Distric offices.
	Petition for Modification/Termination of Probation (IDENT 26)	Included with Headquarters Cases			31	Included with Headquarters Cases			6.7	Prior to 2008/09 petitions were handled by regional Probation Units. Subsequently, petitions for modification/termination of probation were handled by Probation Monitoring Units and the District offices and petitions for reinstatement were handled exclusively by the District offices.
	Petition for Reinstatement (IDENT 27)				8				9.3	
	Internet (IDENT 23)	5	9	6	19	7.6	8.3	12.1	13.2	These cases are handled by a specialized Headquarters Unit. They are usually referred to DAs for prosecution without involvement of the District offices.
	Total - Other Identifiers	**110**	**105**	**123**	**129**	**6.5**	**7.9**	**8.4**	**9.6**	
Total		**1,177**	**1,059**	**1,066**	**954**	**9.9**	**10.8**	**12.0**	**13.2**	

[1] Data shown excludes closed Headquarters and Probation Unit cases, cases closed with a citation issued by DCU or Probation Units, and cases referred directly for prosecution without District office investigation, including nearly all Out-of-State (IDENT 16) cases, cases involving probation violations (IDENT 19, originated by the Medical Board), and all SOI, CME audit failure, and citation non-compliance cases (IDENT 20 or 21, originated by the Medical Board).

Cases Closed or Referred Directly for Prosecution by the Originating Headquarters or Probation Unit	104	66	140	138	Not Applicable		

E. Investigations Closed without Citation Issued

Exhibit VI-6, on the next page, shows average elapsed times to investigate cases that were closed without a citation issued, by fiscal year, for quality of care and other cases. As shown by Exhibit VI-6, during the past several years the average elapsed time to complete quality of care case investigations increased by 29 percent (from 10.4 months during 2005/06 to 13.4 months during 2008/09). During 2008/09, it took longer than 18 months to complete 25 percent of the quality of care case investigations compared to only 8 percent of cases that took longer than 18 months to complete during 2005/06. For other cases, the average elapsed time to complete the investigations increased by 60 percent (from 7.3 months during 2005/06 to 11.7 months during 2008/09). During 2008/09 it took longer than 18 months to complete 20 percent of the investigations of other cases compared to only 2 percent of other cases that took longer than 18 months to investigate during 2005/06.

Exhibit VI-7, following Exhibit VI-6, shows average elapsed times to Investigate cases that were closed without a citation issued, by Identifier, by fiscal year. As shown by Exhibit VI-7, the average elapsed time investigate cases having a District office Identifier increased by 35 percent (from 9.5 months during 2005/06 to 12.8 months during 2008/09). The average elapsed times increased significantly in all three (3) regions. The Other Southern California region experienced the largest increase in average elapsed times and, in 2008/09 the average elapsed time to close investigations in this region without any further action reached 15 months. The Other Southern California Region also experienced an especially large 50 percent decrease in the number of cases closed without a citation issued and, in 2008/09, the region closed without a citation issued fewer than one-half as many cases as the other two regions (100 case closures compared to more than 200 case closures in the other two regions).

For cases with other Identifiers, the number of cases closed without a citation issued varied minimally during the past several years. However, the average elapsed times to investigate these cases increased significantly. Some of these cases were handled by Headquarters Units, some were handled by Probation Units, and some were handled by the District offices.

Summary of Investigations Closed without Citation Issued, By Type of Case
2005/06 through 2008/09

Case Type	Elapsed Time to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	6 Months or Less	102	20%	63	16%	73	17%	63	17%
	6 to 12 Months	233	46%	143	37%	161	38%	120	33%
	12 to 18 Months	136	27%	117	30%	109	26%	88	24%
	18 to 24 Months	32	6%	46	12%	62	15%	58	16%
	More than 24 Months	9	2%	17	4%	21	5%	32	9%
	Total	512	100%	386	100%	426	100%	361	100%
	Average Number of Months	10.4 Months		11.9 Months		12.1 Months		13.4 Months	
Other Cases	6 Months or Less[1]	118	46%	106	39%	93	33%	62	28%
	6 to 12 Months	98	38%	92	34%	83	29%	76	35%
	12 to 18 Months	33	13%	58	21%	53	19%	35	16%
	18 to 24 Months	6	2%	7	3%	34	12%	18	8%
	More than 24 Months	0	0%	8	3%	20	7%	27	12%
	Total	255	100%	271	100%	283	100%	218	100%
	Average Number of Months	7.3 Months		8.7 Months		10.9 Months		11.7 Months	
All Cases	6 Months or Less[1]	220	29%	169	26%	166	23%	125	22%
	9 to 12 Months	331	43%	235	36%	244	34%	196	34%
	12 to 18 Months	169	22%	175	27%	162	23%	123	21%
	18 to 24 Months	38	5%	53	8%	96	14%	76	13%
	More than 24 Months	9	1%	25	4%	41	6%	59	10%
	Total	767	100%	657	100%	709	100%	579	100%
	Average Number of Months	9.4 Months		10.6 Months		11.6 Months		12.7 Months	

[1] Data shown excludes cases closed without a citation issued by the originating Headquarters or Probation Unit.

Closed without Investigation	Quality of Care Cases	0	0%	0	0%	0	0%	0	0%
	Other Cases	0	0%	0	0%	2	100%	2	0%
	Total	0	0%	0	0%	2	100%	2	0%

Summary of Investigations Closed without Citation Issued, By Identifier
2005/06 through 2008/09

	Business Unit	Cases Closed without Citation				Average Elapsed Time to Close (Months)				Comments
		2005/06	2006/07	2007/08	2008/09	2005/06	2006/07	2007/08	2008/09	
Cases with District Office Identifiers	Fresno	47	38	62	43	11.6	13.9	14.3	17.9	
	Pleasant Hill	94	74	71	68	9.6	10.3	12.6	12.4	
	Sacramento	92	99	96	63	12.3	14.0	10.4	9.4	
	San Jose	75	66	53	47	9.2	9.8	10.5	12.2	
	Total - Northern California	308	277	282	221	10.6	12.0	11.8	12.6	
	Cerritos	62	62	77	88	9.2	7.7	8.6	10.5	
	Diamond Bar	56	38	47	45	7.9	10.7	11.4	15.6	
	Glendale	49	35	22	41	8.1	9.6	10.6	11.6	
	Valencia	49	73	66	39	9.9	8.8	10.3	11.9	
	Total - Los Angeles Metro Area	216	208	212	213	8.8	9.0	10.0	12.0	
	Rancho Cucamonga	N/A	N/A	N/A	4	N/A	N/A	N/A	8.8	Prior to 2008/09, Rancho Cucamonga was a Regional Probation Unit.
	San Bernardino	71	60	63	39	9.0	10.7	15.2	15.9	
	San Diego	71	35	71	31	9.0	12.0	12.0	13.9	
	Tustin	57	39	42	26	8.0	10.0	14.4	15.8	
	Total - Other Southern California	199	134	176	100	8.7	10.8	13.7	15.0	
	Total - District Offices	**723**	**619**	**670**	**534**	**9.5**	**10.7**	**11.7**	**12.8**	
Cases with Other Identifiers[1]	Out of State (IDENT 16)	9	5	2	2	4.4	7.9	2.8	15.7	These cases are nearly always referred from the Disciplinary Unit directly to the AG. They are only assigned to District offices when the licensee is practicing in California.
	Probation (IDENT 19)	29	20	31	29	8.5	9.3	10.4	11.3	Prior to 2008/09, these cases were investigated by Regional Probation Units. Subsequently, the investigations were performed by District offices.
	Headquarters (IDENT 20)	2	5	2	3	1.5	7.4	8.9	12.9	Includes Statement of Issue (SOI) cases and Probation Certifications which are not handled by the District Offices.
	Petition for Modification/Termination of Probation (IDENT 26)	Included with Headquarters Cases			2	Included with Headquarters Cases			14.7	Prior to 2008/09 petitions were handled by regional Probation Units. Subsequently, petitions for modification/termination of probation were handled by Probation Monitoring Units and the District offices and petitions for reinstatement were handled exclusively by the District offices.
	Petition for Reinstatement (IDENT 27)				0				N/A	
	Internet (IDENT 23)	4	8	4	9	7.2	8.0	9.4	11.8	These cases are handled by a specialized Headquarters Unit. They are usually referred to DAs for prosecution without involvement of the District offices.
	Total - Other Identifiers	**44**	**38**	**39**	**45**	**7.2**	**8.6**	**9.8**	**11.9**	
Total, Excluding Non-Referred Cases		**767**	**657**	**709**	**579**	**9.4**	**10.6**	**11.6**	**12.7**	

[1] Data shown excludes cases Closed without Citation Issued by the originating Headquarters or Probation Unit.

Cases Closed without Citation Issued by the Originating Headquarters or Probation Unit	0	0	2	2	Not Applicable		

F. Investigations Closed with Citation Issued

Exhibit VI-8, on the next page, shows the number of citations issued, by violation, by year. As shown by Exhibit VI-8, since the early part of the decade the total number of citations issued decreased by more than 50 percent (from more than 400 per year to fewer than 200 per year). This decrease is attributable primarily to an especially large decrease in the number of citations issued for failure to report a change of address. During 2008/09, 60 change of address citations were issued compared to more than 300 change of address citations issued per year during the early part of the decade. For nearly all of the other categories of violations for which Citations are issued, there was little or no difference in the number of citations issued during the past several years compared to the number issued during the early part of the decade. Most citations are issued by Headquarters Units without any involvement of the District offices (e.g., citations for failure to report a change of address, failure to report a criminal charge or conviction, CME audit failures, and discipline by another state that supports issuance of a citation in California).

Exhibit VI-9, following Exhibit VI-8, shows average elapsed times to investigate cases closed with citation Issued, by fiscal year, for quality of care and other cases. As shown by Exhibit VI-9, during the past several years the average elapsed time to complete quality of care case Investigations increased by nearly 100 percent (from 10.0 months during 2005/06 to 19.7 months during 2008/09). For other cases, the average elapsed time to complete the investigations increased by 44 percent (from 9.5 months during 2005/06 to 13.7 months during 2008/09).

Exhibit VI-10, following Exhibit VI-9, shows average elapsed times to investigate cases closed with citation issued, by Identifier, by fiscal year. As shown by Exhibit VI-10, the average elapsed time to investigate cases with District office Identifiers increased by 70 percent (from 10.3 months during 2005/06 to 17.5 months during 2008/09). Citations were issued somewhat more frequently in the Los Angeles Metro and Other Southern California regions than in the Northern California region. Such differences may reflect regional variations in the Attorney General's acceptance of cases for prosecution. In the Los Angeles Metro region the average elapsed time to complete these investigations increased during the past several years by nearly 50 percent (from 12.9 months to 18.3 months). In the Other Southern California region the average elapsed time to complete these investigations increased by more than 100 percent (from 8.1 months to 18.6 months).

Citations Issued
2002/03 through 2008/09

Violation	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Failure to Report Address Change	336	324	248	263	214	77	60
Failure to Report Criminal Charge or Conviction[1]	13	15	10	14	5	7	52
Failure to Maintain Adequate Medical Records	32	32	18	29	19	29	24
Failure to Comply with CME Requirements	65	0	0	0	140	75	0
Discipline by Another State	0	0	1	2	0	14	8
Unlicensed Practice of Medicine, Including Internet Rx without an Examination, and Unlawful Representation as a Physician	12	12	7	6	7	5	7
False or Misleading Advertising	3	2	0	2	7	8	6
Failure to Give Records within 15 Days	0	0	0	2	4	4	3
Failure to Provide Patient with Records	13	8	0	2	6	8	3
Violation of Term or Condition of Probation	0	0	0	2	4	0	3
Violation of Professional Confidence	6	3	0	2	1	2	2
Aiding Unlicensed Practice of Medicine	10	9	3	0	3	2	1
Violation of Drug Statutes/Regulations	14	5	4	9	1	0	1
Failure to File Death Certificate	0	1	0	0	1	3	0
Improper Supervision of a Physician's Assistant	3	0	0	2	0	0	0
Failure to Provide Information to Board	4	3	0	1	2	1	0
Failure to Report Outpatient Death	1	1	2	0	0	0	0
Other Violations (Including Unknown)	20	8	15	6	13	12	15
Total	532	423	308	342	427	247	185

[1] Beginning during 2006, licensees were required to self-report misdemeanor charges and convictions in addition to felony charges and convictions, resulting in an increase in citations issued during 2008/09 for failure to report these events.

Summary of Investigations Closed with Citation Issued, By Type of Case
2005/06 through 2008/09

Case Type	Elapsed Time to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	6 Months or Less	6	19%	1	4%	0	0%	1	4%
	6 to 12 Months	18	58%	8	32%	4	25%	3	12%
	12 to 18 Months	6	19%	11	44%	8	50%	8	32%
	18 to 24 Months	0	0%	5	20%	4	25%	5	20%
	More than 24 Months	1	3%	0	0%	0	0%	8	32%
	Total	31	100%	25	100%	16	100%	25	100%
	Average Number of Months	10.0 Months		13.1 Months		14.9 Months		19.7 Months	
Other Cases	6 Months or Less[1]	4	36%	5	31%	3	23%	2	14%
	6 to 12 Months	4	36%	7	44%	2	15%	3	21%
	12 to 18 Months	1	9%	4	25%	4	31%	6	43%
	18 to 24 Months	2	18%	0	0%	3	23%	2	14%
	More than 24 Months	0	0%	0	0%	1	8%	1	7%
	Total	11	100%	16	100%	13	100%	14	100%
	Average Number of Months	9.5 Months		7.9 Months		13.7 Months		13.7 Months	
All Cases	6 Months or Less[1]	10	24%	6	15%	3	10%	3	8%
	6 to 12 Months	22	52%	15	37%	6	21%	6	15%
	12 to 18 Months	7	17%	15	37%	12	41%	14	36%
	18 to 24 Months	2	5%	5	12%	7	24%	7	18%
	More than 24 Months	1	2%	0	0%	1	3%	9	23%
	Total	42	100%	41	100%	29	100%	39	100%
	Average Number of Months	9.9 Months		11.0 Months		14.3 Months		17.5 Months	

[1] Data shown excludes cases closed with a citation issued by DCU or Probation Units.

Citation without Investigation	Quality of Care Cases	0	0%	0	0%	0	0%	0	0%
	Other Cases	2	100%	0	0%	14	100%	8	100%
	Total	2	100%	0	0%	14	100%	8	100%

Summary of Investigations Closed with Citation Issued, By Identifier (8.02)
2005/06 through 2008/09

	Business Unit	Cases Closed with Citation Issued				Average Elapsed Time to Close (Months)				Comments
		2005/06	2006/07	2007/08	2008/09	2005/06	2006/07	2007/08	2008/09	
Cases with District Office Identifiers	Fresno									
	Pleasant Hill		1	1	1		6.2	24.1	21.8	
	Sacramento	1	2			13.6	5.9			
	San Jose	1	2		5	16.1	12.4		10.4	
	Total - Northern California	2	5	1	6	14.9	8.6	24.1	12.3	
	Cerritos	3	6	5	4	8.7	9.4	14.7	14.3	
	Diamond Bar	1		3	7	6.8		15.1	22.7	
	Glendale	6	4	4	5	15.9	15.2	13.5	16.4	
	Valencia	5	4	2	1	13.0	9.5	14.6	13.8	
	Total - Los Angeles Metro Area	15	14	14	17	12.9	11.1	14.4	18.3	
	Rancho Cucamonga	N/A	N/A	N/A		N/A	N/A	N/A		Prior to 2008/09, Rancho Cucamonga was a Regional Probation Unit.
	San Bernardino	4	6	5	7	10.0	8.1	12.5	19.3	
	San Diego	6	4	1	4	8.4	14.7	15.5	12.5	
	Tustin	12	12	5	5	7.4	12.2	17.4	22.6	
	Total - Other Southern California	22	22	11	16	8.1	11.5	15.0	18.6	
	Total - District Offices	**39**	**41**	**26**	**39**	**10.3**	**11.0**	**15.0**	**17.5**	
Cases with Other Identifiers[1]	Out of State (16)	1		2		4.7		4.3		These cases are nearly always referred from the Disciplinary Unit directly to the AG. They are only assigned to District offices when the licensee is practicing in California.
	Probation (19)	2		1		6.3		14.9		Prior to2008/09, these cases were investigated by Regional Probation Units. Subsequently, the investigations were performed by District offices.
	Headquarters (20)									
	Petitions for Modification/Termination of Probation (26)									
	Petitions for Reinstatement (27)									
	Internet (23)									
	Total - Other Identifiers[1]	**3**	**0**	**3**	**0**	**5.8**		**7.8**		
Total[1]		**42**	**41**	**29**	**39**	**10.0**	**11.0**	**14.3**	**17.5**	

[1] Data shown excludes cases Closed with Citation Issued by the Disciplinary or Probation Units.

Closed with Citation Issued by Originating HQ or Probation Unit	2	0	14	8	Not Applicable		

G. Investigations Referred for Prosecution

Exhibit VI-11, on the next page, shows average elapsed times to complete investigations for cases referred for prosecution, by fiscal year, for quality of care and other cases. As shown by Exhibit VI-11, during the past several years the average elapsed time to complete Quality of Care case Investigations increased by 34 percent (from 13.7 months during 2005/06 to 18.4 months during 2008/09). During 2008/09 it took longer than 18 months to investigate nearly 50 percent of these cases compared to 20 percent of cases that took longer than 18 months to investigate during 2005/06. For other cases, the average elapsed time to complete the investigations increased by 16 percent (from 7.5 months during 2005/06 to 8.7 months during 2008/09). During 2008/09, it took longer than 18 months to investigate 12 percent of the other cases compared to 4 percent of other cases that took longer than 18 months to investigate during 2005/06. Overall, the average elapsed time to investigate cases referred for prosecution increased by 23 percent (from 10.9 months during 2005/06 to 13.4 months during 2008/09). Concurrently, the number of cases referred for prosecution decreased by 9 percent (from 368 cases during 2005/06 to 336 cases during 2008/09).

Exhibit VI-12, following Exhibit VI-11, shows average elapsed times to investigate cases referred for prosecution, by Identifier, by fiscal year. As shown by Exhibit VI-12, the average elapsed time to investigate cases with District office Identifiers increased by 27 percent (from 11.9 months during 2005/06 to 15.1 months during 2008/09). The average elapsed time to investigate these cases increased significantly in all three (3) regions. During 2008/09, the Other Southern California region experienced the largest increase and, in 2008/09, the average elapsed time to investigate cases reached 15 months for cases referred for prosecution. The Other Southern California region also experienced a relatively large 29 percent decrease in the number of cases referred for prosecution. In contrast, in the Northern California region, the number of cases referred for prosecution, and the average elapsed time to complete these investigations, increased by 10 percent. In each of the last two fiscal years the Northern California region referred at least 30 percent more cases for prosecution than either the Los Angeles Metro or Other Southern California regions (100 cases referred for prosecution by the Northern California region compared to 76 or fewer cases referred for prosecution by each of the other regions). For other cases, the number of cases referred for prosecution and the average elapsed time to complete the investigations increased during the past several years. Some of these cases were handled by Headquarters Units, some were handled by Probation Units, and some were handled by the District offices.

Summary of Investigations Referred for Prosecution, By Type of Case
2005/06 through 2008/09

Case Type	Timeframe to Complete Investigation	2005/06		2006/07		2007/08		2008/09	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quality of Care Cases	6 Months or Less[1]	20	10%	21	10%	17	10%	14	9%
	6 to 12 Months	72	35%	76	36%	47	28%	26	16%
	12 to 18 Months	71	35%	65	31%	44	26%	44	27%
	18 to 24 Months	27	13%	35	17%	36	21%	34	21%
	More than 24 Months	15	7%	14	7%	26	15%	46	28%
	Total	205	100%	211	100%	170	100%	164	100%
	Average Number of Months	13.7 Months		13.4 Months		15.6 Months		18.4 Months	
Other Cases	6 Months or Less[1]	84	52%	72	48%	66	42%	75	44%
	6 to 12 Months	43	26%	46	31%	54	34%	54	31%
	12 to 18 Months	29	18%	16	11%	17	11%	23	13%
	18 to 24 Months	5	3%	14	9%	17	11%	13	8%
	More than 24 Months	2	1%	2	1%	4	3%	7	4%
	Total	163	100%	150	100%	158	100%	172	100%
	Average Number of Months	7.5 Months		8.0 Months		9.0 Months		8.7 Months	
All Cases	6 Months or Less[1]	104	28%	93	26%	83	25%	89	26%
	6 to 12 Months	115	31%	122	34%	101	31%	80	24%
	12 to 18 Months	100	27%	81	22%	61	19%	67	20%
	18 to 24 Months	32	9%	49	14%	53	16%	47	14%
	More than 24 Months	17	5%	16	4%	30	9%	53	16%
	Total	368	100%	361	100%	328	100%	336	100%
	Average Number of Months	10.9 Months		11.1 Months		12.4 Months		13.4 Months	

[1] Data shown excludes cases referred directly to the Attorney General or a District Attorney without District office investigation, including nearly all Out of State (IDENT 16) cases, cases involving probation violations (IDENT 19, originated by the Medical Board), and SOI, CME Audit Failure, and Citation Non-Compliance cases (IDENT 20 or 21, originated by the Medical Board).

Direct Referrals for Prosection	Quality of Care Cases	3	3%	12	18%	47	38%	20	16%
	Other Cases	99	97%	54	82%	77	62%	108	84%
	Total	102	100%	66	100%	124	100%	128	100%

Summary of Investigations Referred for Prosecution, By Identifier (8.01)

2005/06 through 2008/09

	Business Unit	Cases Referred for Prosecution				Average Elapsed Time to Refer (Months)				Comments
		2005/06	2006/07	2007/08	2008/09	2005/06	2006/07	2007/08	2008/09	
Cases with District Office Identifiers	Fresno	25	29	25	12	13.5	12.0	17.2	21.3	Includes several aged Section 805 cases.
	Pleasant Hill	26	18	27	33	12.1	11.1	15.6	16.9	
	Sacramento	24	38	20	34	14.6	11.1	12.4	10.4	
	San Jose	14	22	28	24	12.6	13.7	12.2	13.8	
	Total - Northern California	89	107	100	103	13.2	11.9	14.4	14.5	
	Cerritos	35	18	33	26	12.0	11.8	13.0	11.8	
	Diamond Bar	26	16	10	12	10.2	14.6	18.1	18.7	
	Glendale	27	28	14	26	15.2	13.6	14.4	15.8	
	Valencia	24	24	19	11	13.1	8.9	12.4	12.9	Includes several 3-week HQES cases.
	Total - Los Angeles Metro Area	112	86	76	75	12.6	12.1	13.8	14.5	
	Rancho Cucamonga	N/A	N/A	N/A	2	N/A	N/A	N/A	8.1	Prior to 2008/09, Rancho Cucamonga was a Regional Probation Unit.
	San Bernardino	44	39	19	15	10.0	12.6	15.0	18.5	
	San Diego	25	29	34	34	11.4	13.0	14.5	16.5	
	Tustin	35	33	18	23	9.0	10.3	10.8	16.1	
	Total - Other Southern California	104	101	71	74	10.0	12.0	13.7	16.6	
	Total - District Offices	**305**	**294**	**247**	**252**	**11.9**	**12.0**	**14.0**	**15.1**	
Cases with Other Identifiers[1]	Out of State (16)	6	7	9	1	2.2	8.0	7.5	3.6	These cases are nearly always referred from the Disciplinary Unit directly to the AG. They are only assigned to District offices when the licensee is practicing in California.
	Probation (19)	17	14	17	22	12.1	11.2	8.7	10.3	Prior to 2008/09, these cases were investigated by Regional Probation Units. Subsequently, the investigations were performed by District offices.
	Headquarters (20)	39	45	53	14	3.9	6.2	7.0	5.9	Includes Statement of Issue (SOI) cases and Probation Certifications which are not handled by the District Offices.
	Petitions for Modification/Termination of Probation (26)	Included with Headquarters Cases			29	Included with Headquarters Cases			6.1	Prior to 2008/09 petitions were handled by regional Probation Units. Subsequently, petitions for modification/termination of probation were handled by Probation Monitoring Units and the District offices and petitions for reinstatement were handled exclusively by the District offices.
	Petitions for Reinstatement (27)				8				9.3	
	Internet (23)	1	1	2	10	9.4	10.6	17.6	14.5	These cases are handled by a specialized Headquarters Unit. They are usually referred to DAs for prosecution without involvement of the District offices.
	Total - Other Identifiers[1]	**63**	**67**	**81**	**84**	**6.0**	**7.5**	**7.7**	**8.4**	
Total, Excluding Direct Referrals[1]		**368**	**361**	**328**	**336**	**10.9**	**11.1**	**12.4**	**13.4**	

[1] Data shown excludes closed Headquarters and Probation Unit cases, cases closed with a citation issued by DCU or Probation Units, and cases referred directly for prosecution without District office investigation, including nearly all Out-of-State (IDENT 16) cases, cases involving probation violations (IDENT 19, originated by the Medical Board), and all SOI, CME audit failure, and citation non-compliance cases (IDENT 20 or 21, originated by the Medical Board).

Cases Referred Directly for Prosecution from Headquarters or Probation Units	102	66	124	128	Not Applicable		

H. HQES Declined to File Cases

With a greater level of HQES Attorney involvement in investigations, it might be expected that the number of cases that HQES declined to file would decrease. **Table VI-1**, below, shows the number of cases with District office Identifiers that HQES declined to file, by year, for the past five (5) fiscal years. During the past several years there were not any sustained changes in the number of cases that HQES declined to file. The average number of cases that HQES declined to file during the past two (2) years (20 cases per year) was about the same as the average number of cases that HQES declined to file during the preceding three (3) years (21 cases per year).

Table VI-1. HQES Declined to File Cases

Fiscal Year	Cases with District Office Identifiers			
	Northern California	Los Angeles Metro	Other Southern California	Total
2004/05	8	7	4	19
2005/06	4	13	1	18
2006/07	8	13	4	25
3-Year Average	7	11	3	21
2007/08	4	10	0	14
2008/09	10	6	9	25
2-Year Average	7	8	5	20

Implementation of VE has not reduced the number of cases that HQES declines to file, notwithstanding HQES' higher level of involvement in the investigation of the cases. During the past two (2) years there was little difference between geographic regions in the average number of cases that HQES declined to file. However, HQES' Los Angeles Metro office continues to decline to file as many, or more, cases than offices in other regions, notwithstanding the Los Angeles Metro office's much higher level of Attorney involvement in the investigation of cases in that region.

VI. Investigations

I. Pending Investigations

Exhibit VI-13, on the next page, shows the number of pending physician and surgeon Investigations, by District office and region, as of June 30, 2009, and December 31, 2009. As shown by Exhibit VI-13, the number of pending investigations was little changed during this period. Excluding petitions, and including investigations of Probationers, nearly 1,000 investigations were pending at the District offices on June 30, 2009. This compares to about 850 to 900 investigations opened and closed or referred by the District offices during 2008/09. The number of pending investigations is consistent with the 13 to 14-month average elapsed time to complete investigations experienced by the District offices during 2008/09. Over time, changes in the number of pending investigations correlate with changes in the average elapsed time to complete investigations (i.e., longer, or shorter, elapsed times to complete investigations parallel increases, or decreases, in the number of pending investigations).

Pending Investigations by Business Unit

Business Unit			June 30, 2009			December 31, 2009		
			Physician/ Surgeon Investigations	Petitions	Total	Physician Surgeon Investigations	Petitions	Total
District Offices	Northern California	Sacramento	83	6	89	86	3	89
		Fresno	63	3	66	96	2	98
		Pleasant Hill	109	2	111	95	2	97
		San Jose	94	2	96	117	1	118
		Total	349	13	362	394	8	402
	Los Angeles Metro	Cerritos	76	1	77	76	1	77
		Diamond Bar	65	2	67	36	1	37
		Glendale	106	3	109	97	2	99
		Valencia	87	2	89	59	2	61
		Total	334	8	342	268	6	274
	Other Southern California	San Diego	100	0	100	75	0	75
		Tustin	81	3	84	91	2	93
		San Bernardino	79	0	79	83	1	84
		Rancho Cucamonga	42	1	43	60	1	61
		Total	302	4	306	309	4	313
Total - District Offices			985	25	1,010	971	18	989
Headquarters Units		Operation Safe Medicine	58	1	59	59	1	60
		Office of Standards and Training	16	0	16	18	1	19
		Total - Headquarters Units	74	1	75	77	2	79
Total Pending Investigations			1,059	26	1,085	1,048	20	1,068

J. Expenditures for HQES Investigation Services

Concurrent with implementation of VE, during 2006 HQES began opening "Investigation Matters" for specific cases during the Investigation Stage, and HQES Attorneys began charging time to these matters when they worked on these cases. Additionally, many HQES Attorneys, and Lead Prosecutors in particular, began charging additional time to general "Client Service" matters reflecting time spent assisting with Investigations that was not charged to specific cases. In some cases the HQES Attorneys charged their time to "Section-Specific Tracking" matters rather than to general "Client Service" matters. Based on a review of individual Attorney time charges during 2008/09, most of the time charged by HQES Attorneys to general Client Service and Section-Specific Tracking matters, excluding time charged by Supervising DAGs, was for time worked on Investigation-related activities. Additionally, in the Northern California region, these charges include time providing assistance to CCU (i.e., several hours per week).

Exhibit VI-14, on the next page, summarizes HQES time charges to Investigation, Client Service, and Section-Specific Tracking matters by year from 2006 through 2009, excluding time charged by Supervising DAGs and HQES' Senior Assistant Attorney General. As shown by Exhibit VI-14, during the past two years the number of hours charged by HQES DAGs to these matters increased by nearly 70 percent, from an average of 16,872 hours during 2006 and 2007 to more than 28,000 hours during 2009. Exhibit VI-14 also shows that time charges by Los Angeles Metro office Attorneys accounted for nearly all of this increase. During 2009, Los Angeles Metro office Attorneys charged more than 17,000 hours to Medical Board investigations, compared to fewer than 6,400 hours charged during 2006 and 2007. Additionally, during 2009 Los Angeles Metro office Attorneys charged about 11,000 more hours to Medical Board investigations than HQES' San Diego office Attorneys, and nearly 12,000 more hours than charged by HQES' Northern California offices.

HQES' hourly billing rates for Attorney services during 2008/09 and 2009/10 were $158 and $170, respectively, or an average of $164 per hour. Assuming a $164 hourly billing rate for Attorney services, estimated billings during 2009 for investigation-related services for cases assigned to the Northern and Southern California regions were less than $1 million each during 2009, compared to more than $2.8 million for cases assigned to the Los Angeles Metro office.

As discussed previously, there are significant variations between regions in the number of investigations completed, as well as variations in other output and performance measures, such as the proportion of completed investigations referred for prosecution. **Table VI-2**, on page VI-28, shows the number of investigations completed by year, by region. Also shown are corresponding ratios of the number of HQES Attorney hours charged per completed investigation based on the Attorney hours charged during each fiscal year as shown in Exhibit VI-14.

Hours Charged by HQES Staff to Investigation Matters - 2006 through 2009
Including Hours Charged to Section-Specific Tracking and Client Service Matters

Classification	HQES Office(s)	Calendar Year (Actual)			
		2006	2007	2008	2009
Deputy Attorneys (DAGs)	Northern California[1]	6,610.25	6,084.50	5,007.25	5,167.75
	Los Angeles Metro	6,349.00	6,388.00	13,527.75	17,083.50
	San Diego (Other Southern California)	4,535.50	3,777.50	5,625.50	5,988.75
	Total	17,494.75	16,250.00	24,160.50	28,240.00
Paralegals, Analysts, and Special Agents	Northern California[1]	235.25	286.25	201.75	175.00
	Los Angeles Metro	189.50	739.00	1,166.75	1,193.75
	San Diego (Other Southern California)	1,391.25	1,369.25	1,847.25	1,386.00
	Total	1,816.00	2,394.50	3,215.75	2,754.75
Total	Northern California[1]	6,845.50	6,370.75	5,209.00	5,342.75
	Los Angeles Metro	6,538.50	7,127.00	14,694.50	18,277.25
	San Diego (Other Southern California)	5,926.75	5,146.75	7,472.75	7,374.75
	Total, Excluding Supervising DAGs	19,310.75	18,644.50	27,376.25	30,994.75

Classification	HQES Office(s)	Fiscal Year (Interpolated)		
		2006/07	2007/08	2008/09
Deputy Attorneys (DAGs)	Northern California[1]	6,347.38	5,545.88	5,087.50
	Los Angeles Metro	6,368.50	9,957.88	15,305.63
	San Diego (Other Southern California)	4,156.50	4,701.50	5,807.13
	Total	16,872.38	20,205.26	26,200.26
Paralegals, Analysts, and Special Agents	Northern California[1]	260.75	244.00	188.38
	Los Angeles Metro	464.25	952.88	1,180.25
	San Diego (Other Southern California)	1,380.25	1,608.25	1,616.63
	Total	2,105.25	2,805.13	2,985.26
Total	Northern California[1]	6,608.13	5,789.88	5,275.88
	Los Angeles Metro	6,832.75	10,910.76	16,485.88
	San Diego (Other Southern California)	5,536.75	6,309.75	7,423.76
	Total, Excluding Supervising DAGs	18,977.63	23,010.39	29,185.52

[1] Includes Fresno, Sacramento, Oakland, and San Francisco offices, including CCU support services.

Table VI-2. HQES Attorney Hours Charged to Investigations per Completed Investigation

Performance Indicator	2006/07				2007/08				2008/09			
	Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total
Estimated Hours Charged[1] (see Exhibit VI-14)	6,347	6,369	4,157	16,872	5,546	9,958	4,702	20,205	5,088	15,306	5,807	26,200
Investigations Closed without Citation	221	213	100	534	282	212	178	672	221	213	100	534
Investigations Closed with Citation Issued	5	14	22	41	1	14	11	26	6	17	16	39
Investigations Referred for Prosecution	107	86	101	294	100	76	71	247	103	75	74	252
Total Investigations Closed or Referred for Prosecution[2]	333	313	223	869	383	302	260	945	330	305	190	825
HQES Attorney Hours Charged per Completed Investigation	**19**	**20**	**19**	**19**	**14**	**33**	**18**	**21**	**15**	**50**	**31**	**32**
Hourly Billing Rate for Attorney Services	$158	$158	$158	$158	$158	$158	$158	$158	$158	$158	$158	$158
Average Attorney Cost per Case	$3,002	$3,160	$3,002	$3,002	$2,212	$5,214	$2,844	$3,318	$2,370	$7,900	$4,898	$5,056

[1] Data shown includes hours charged by Lead Prosecutors and other Deputy Attorneys to Investigation, Section-Specific Tracking, and Client Service matters.

[2] Data shown excludes cases involving licensees on probation, Petitions for Modification or Termination of Probation, and Petitions for Reinstatement. The excluded cases are assumed to be proportionately distributed throughout the State.

As shown by Table VI-2, during 2008/09 HQES Attorneys assigned to Los Angeles Metro region cases billed:

- 60 percent more hours per completed investigation as were billed by Attorneys assigned to Other Southern California region cases (50 hours per completed investigation compared to 31 hours per completed investigation)
- More than three times (3x) as many hours per completed investigation as were billed by Attorneys assigned to Northern California region cases (50 hours per completed investigation compared to 15 hours per completed investigation).

Assuming a $158 per hour billing rate for Attorney services, on a per case basis Attorneys working on Northern California region cases billed the Medical Board an average of less than $2,400 per investigation completed during 2008/09. This compares to an average of about $4,900 billed per completed investigation for Other Southern California region cases, and an average of $7,900 billed per completed investigation for Los Angeles Metro region cases.

If HQES had charged an average of $2,400 in Attorney fees per completed investigation during 2008/09 for all completed investigations, statewide, HQES' billings to the Medical Board for Attorney services would have been about $2.0 million, or about $2.2 million less than the estimated amount actually billed ($4.2 million). Conversely, if HQES had charged $7,900 in Attorney fees per completed investigation for all completed investigations, statewide, billings to the Medical Board for Attorney services would have been about $6.5 million or nearly $2.35 million more than the estimated amount actually billed.

VI. Investigations

In an effort to better understand Los Angles Metro office Attorney charges for Investigation-related services, we researched a sample of Los Angeles Metro office cases from HQES' June 2009 Invoice Report to the Medical Board. The Invoice Report shows time charges during the month for each matter that had time charged during the billing period, and also cumulative charges for the fiscal year-to-date, and cumulative charges for the matter including charges from prior fiscal years. We selected all cases that were included in the June 2009 billing with more than 40 hours billed during 2008/09, irrespective of the number of hours charged during June. Twenty-eight (28) cases were selected. Of the 28 cases, nine (9) were assigned to the Valencia office, 11 were assigned to the Cerritos office, three (3) were assigned to the Diamond Bar office, and 4 were assigned to the Glendale office. Within these offices, the cases were assigned to various Investigators. The cases involved a mix of medical malpractice reports, Section 805 reports, sexual misconduct and impaired physician complaints, prescribing violations, and other quality of care and physician conduct matters. Of the 28 cases, 7 were assigned to one HQES Attorney, 6 were assigned to another HQES Attorney, 3 were assigned to a third HQES Attorney, and the remaining 12 cases were assigned to 10 other HQES Attorneys. **Table VI-3**, below, summarizes the disposition and current status of these 28 cases, as of mid-June 2010 (1 year later).

Table VI-3. Disposition and Status of Selected Los Angeles Metro Cases with Attorney Time Charged During June 2009

Pending or Closed	Number	Referred for Prosecution	Number
Pending Investigation	2	Referred for Prosecution, Accusation Not Yet Filed	3
Closed – Without Referral or Citation	12	Referred for Prosecution, Accusation Filed (Pending Settlement or Hearing)	4
Closed – Subject Passed Competency Exam	2	Referred for Criminal Prosecution and PC 23 (License Restricted)	1
Closed – Recommended for Citation	1	Referred for Prosecution, Disciplinary Action	2
Referred to Office of Safe Medicine (Pending OSM Investigation)	1		
Total	18	Total	10

Exhibit VI-15, on the next two pages, provides summaries of twelve (12) of the 28 Los Angeles Metro office cases included in the scope of our review, including the eight (8) cases with hours charged during June 2009, that had the most hours charged during 2008/09. **Exhibit VI-16**, following Exhibit VI-15, provides a recap of the remaining sixteen (16) cases. Several of these case histories reflect the benefits of having HQES Attorneys working jointly with Medical Board Investigators during the Investigation Stage. For example, HQES Attorneys helped to issue and enforce subpoenas for records, assisted in interviewing parties involved with the matter, provided advice and direction on the course and direction of the investigations, promptly prepared and filed pleadings, and sought adoption of disciplinary actions. However, the case histories also highlight a number of significant, and troubling, problems with the services provided by HQES' Los Angeles Metro office. Some of these problems may also exist, to a lesser extent, at other HQES offices. These problems include:

Performing Detailed Document and Record Reviews and Analyses – These case histories show that some Los Angeles Metro office Attorneys are substantively involved in performing detailed document and record reviews and analyses during the Investigation Stage. These activities appear to go well beyond providing legal advice and direction to the Medical Board regarding the course and direction of the investigation as provided in Section 12529.6 of the Government Code and in the *Vertical Prosecution Manual* adopted by HQES and the Medical Board. Nothing in Section 12529.6 suggests or implies that HQES Attorneys should be as intensively involved as they are in performing these types of investigation activities. The *VE Manual* specifically defines the role of the Primary DAG as follows:

> *"Works closely with other team members and, in conjunction with Supervising Investigator I, directs Investigators in obtaining evidence. Also, provides legal advice to the Medical Board and prosecutes the case."*

Excessive Time Spent on Cases that are Closed – These case histories show that some Los Angeles Metro office Attorneys spend as much time on cases that close as on cases that are referred for prosecution. The theory that greater Attorney involvement during the Investigation Stage will enable faster identification and earlier closure of cases is not supported by actual experience.

Delayed Filing of Pleading – Even though Attorneys were substantively involved with all of these cases, accusations were not promptly prepared for 3 of 6 cases that were referred for prosecution. The three (3) cases were referred for prosecution 5 to 7 months ago and, as of late-June, 2010, the accusations were not yet prepared.

Delayed Prosecution – Rather than initiating prosecution of a single patient case involving sexual misconduct (with a patient) that was referred for prosecution, the Primary DAG directed that the Medical Board investigate a case involving a second potential victim. The Primary DAG was extensively involved with each step of this supplemental investigation, which took eight (8) additional months to complete. Another five (5) months elapsed before the accusation was filed. Several additional months elapsed before the Primary DAG requested a hearing, which was not scheduled for another six (6) months. Throughout this period the Subject continued to practice without restriction.

Summaries of Selected Cases Billed for Investigation Services

Case History VI-1 (Estimated Cumulative HQES Fees through June 2009 – $50,000) – This case had the largest number of hours charged during 2008/09 (249) of all of investigation cases billed during June 2009. In total, 332 hours were billed to this matter through June 2009, and additional hours were billed in subsequent months. During this 3-year investigation, the Subject was placed on probation following completion of another investigation involving similar treatment issues. Just before expiration of the statutes of limitations, the case was transmitted to HQES' Los Angeles Metro office for prosecution. The submittal included two (2) Expert opinions concluding that there were extreme and simple departures involving two (2) separate patients. HQES' Primary DAG declined to file and recommended closure of the case. On the following day, or possibly the day after, the case was transferred to another HQES office which, by then, had already reviewed the matter and agreed to accept it. A pleading was filed the next day. Several months later a settlement was reached that imposed additional discipline.

Case History VI-2 (Estimated Cumulative Fees through June 2009 – $20,400) – This multiple patient case involving failure to treat issues had the second largest number of hours charged during 2008/09 (122) of all investigation cases billed during June 2009. Problems were encountered obtaining records. Subpoenas for records were obtained, but not complied with, which required court-ordered enforcement. **After the records were obtained and reviewed, the case was closed.**

Case History VI-3 (Estimated Cumulative Fees through June 2009 – $17,000) – This multiple patient case involving excessive prescribing and billing had the third largest number of hours charged during 2008/09 (95.75) of all investigation cases billed during June 2009. The accusation, which encompassed a large number of violations, was not filed until more than six (6) months after the case was referred for prosecution. **The case is currently pending settlement or hearing.**

Case History VI-4 (Estimated Cumulative Fees through June 2009 – $13,500) – This case had the fifth largest number of hours charged during 2008/09 (87.00) of all investigation cases billed during June 2009. The case number shown on this matter was closed during November 2008 because it was "redundant" to another case that was previously referred for investigation. It appears that the hours charged by HQES to this investigation matter during June 2009, and possibly in some prior months during 2008/09, were actually related to the prior case. **The case is currently assigned to an outside Expert for review.**

Case Histories VI-5 through VI-11 (Estimated Cumulative Fees through June 2009 – $70,000 for 7 cases) – These seven (7) cases include a case that had the fourth largest number of hours charged during 2008/09 (88.5) and another case that had the sixth largest number of hours charged during 2008/09, for all cases billed during June 2009. These cases also include five (5) other cases that had more than 40 hours billed during 2008/09 that had the same Primary DAG assigned. The billing records for these cases describe the types of investigation-related activities performed. These activities included:

- Reviewing investigation reports
- Corresponding with the Investigator and others
- Preparing for and meeting with the Medical Consultant
- Preparing for and interviewing the Subject
- Reviewing depositions from related litigation
- Reviewing patient medical records
- Reviewing transcripts from prior cases
- Determining needs for and selecting a Medical Expert.

These billing records also suggest that, in some cases, a significant portion of this Attorney's time is spent on activities that go beyond providing general legal advice and direction to the Medical Board regarding the course and direction of the investigation. Instead, the Primary DAG is also substantively involved in completing detailed reviews and analysis of case records. **Six (6) of these cases were subsequently closed "Insufficient Evidence" or "No Violation". One (1) case was referred for prosecution and is currently pending settlement or hearing**.

Case History VI-12 (Estimated Cumulative Fees – $15,000) – This single patient case involving sexual misconduct (with a patient) had the eighth largest number of hours charged during 2008/09 (79.5) of all investigation cases with hours charged during June. The Subject was previously disciplined by the Medical Board for the same offense. Following referral of the case for prosecution, the Primary DAG directed completion of an investigation of a second patient, which took eight (8) months to complete. The accusation was not filed until five (5) months after the second investigation was completed, and more than a full year following initial transmittal of the case. Several additional months elapsed before the Primary DAG requested a hearing, which was not scheduled for another six (6) months. Throughout this period the Subject continued to practice without restriction. **The case is currently pending settlement or hearing, and the Subject is continuing to practice without restriction.**

Summary of Other Cases Billed During June 2009 with More than 40 Hours Billed During 2008/09

Disposition Category	Case Profile	Disposition	2008/09 Investigation Hours	Total Investigation Hours through June 2009[1]	Estimated Total Fees[1]
Matters Not Referred for Prosecution	Multiple patient case involving physician impairment.	Closed - No Violation	42.75	60.00	$9,300
	Section 805 case.	Closed - Insufficient Evidence	70.75	84.00	13,020
	Section 805 case involving multiple patients.	Closed - Insufficient Evidence	77.00	83.25	12,904
	Case involving Subject's failure to diagnose/treat.	Closed - Pending Criminal	44.75	44.75	6,936
	Complex case involving prescribing violations.	Closed - Pending Criminal	52.25	53.75	8,331
	DHS referred case involving patient care issues.	Closed - Recommended Citation	52.00	53.25	8,254
	Case involving aiding/abetting unlicensed practice.	Referred to Office of Safe Medicine (HQES no longer involved with matter)	41.75	41.75	6,471
	Average HQES Fees per Case - $9,317	Total Hours/Fees	381.25	420.75	$65,216
Referred for Competency Examination	Section 805 case.	Closed - Compelled to Take Competency Exam (Passed)	57.50	57.50	$8,913
	Case involving alleged self-use of prescription medications.	Closed - Compelled to Take Competency Exam (Passed)	58.25	58.25	9,029
	Average HQES Fees per Case - $8,970	Total Hours/Fees	115.75	115.75	$17,941
Matters Referred for Prosecution	Cases involving failure to provide adequate care.	Referred to HQES - Not Yet Filed **(Pending for 7 months)**	44.25	44.25	$6,859
	Section 805 case involving multiple patients.	Referred to HQES - Not Yet Filed **(Pending for 5 months)**	59.50	78.50	12,168
	Case involving Subject misrepresentation of procedure.	Referred to HQES - Not Yet Filed **(Pending for 6 months)**	63.25	63.25	9,804
	Section 805 case.	Referred and Filed (filed within 2 months of transmittal)	64.00	69.75	10,811
	Case involving alleged prescribing violations.	Closed - Subject Deceased (following Referral for PC 23)	48.50	52.75	8,176
	Multiple patient case involving sexual misconduct.	Referred for Criminal and PC 23 (License Restricted)	46.50	46.50	7,208
	Case involving Subject's arrest for spousal abuse.	Referred to HQES, Filed, Decided (Revocation Stayed, Probation - 5 Years)	56.50	56.50	8,758
	Average HQES Fees per Case - $9,112	Total Hours/Fees	382.50	411.50	$63,783
Average HQES Hours and Fees per Case - 59.25 Hours / $9,184		Total Hours/Fees	879.50	948.00	$146,940

[1] Additional hours may have been worked on some cases subsequent to June 2009. The estimated fees shown assume a weighted average billing rate of $155 per hour.

Completed Case Rejections – This investigation initially concerned more than two (2) dozen patients, but focused on six (6) selected cases. Two (2) Expert opinions found multiple extreme and simple departures involving two (2) of the patients. During this 3-year investigation, the Subject was placed on probation following investigation of another complaint involving similar treatment issues. Just before expiration of the statute of limitations, the Primary DAG issued a 6-page Decline to File Memorandum that recommended closure of the case. Following issuance of the Decline to File Memorandum:

- ✓ The District Office Supervisor conferred with their Regional Manager
- ✓ The Regional Manager conferred with the Deputy Chief of Enforcement
- ✓ The Deputy Chief of Enforcement conferred with the Chief of Enforcement
- ✓ The Chief of Enforcement conferred with the Senior Assistant Attorney General
- ✓ The Senior Assistant Attorney General met with the Supervising DAG of another office to review the matter
- ✓ The case was transferred to the second HQES office which had agreed to prosecute the case
- ✓ An Attorney from the second HQES office came into work early the next day to prepare the pleading which was filed the next day.

A period of only three (3) days elapsed from issuance of the Decline to File Memorandum by HQES' Los Angeles Metro office to filing of the pleading by the second HQES office. Several months later the Medical Board accepted a settlement agreement imposing additional discipline that was negotiated by the second HQES office.

The problems highlighted by the above case histories are not isolated cases. Additional analyses and case histories showing the prevalence of several of these problems, particularly in the Los Angeles Metro region, are presented in Section VII (*Prosecutions and Disciplinary Action*). Additionally, the case histories highlight various internal control problems with the posting of Attorney time charges (e.g., time charges are sometimes posted to Investigation matters that reference a different Medical Board complaint from the case actually being investigated).

K. Medical Consultant and Outside Expert Services and Expenditures

Generally, each District office has 2 to 3 part-time Medical Consultants assigned, and most of the Medical Consultants usually work at their assigned office for several hours either 1 or 2 days a week. Total wages paid to Medical Consultants during 2008/09 were $852,000 ($71,000 per month) for a total of 13,991 paid hours of services ($61 per hour). This is equivalent to an average of about 22 paid hours per week for each District office. However, due to paid holidays, vacation, sick leave, and other paid time off, the actual number of hours worked by the Medical Consultants was less than 13,991 hours, and the average number of hours worked per week per District office was less than 22 hours. **Table VI-4**, below, shows the actual distribution of paid Medical Consultant hours during 2008/09, by District office and region.

Table VI-4. 2008/09 Medical Consultant Expenditures

District/Region	Hours Paid				Total Hours Paid		Avg. Hours per Office per Week	Salaries Paid
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Number	Percent		
Sacramento	482.25	351.50	377.25	520.25	1,731.25	12%	33	$105,031
Fresno	144.25	525.25	570.45	434.75	1,674.70	12%	32	101,746
San Jose	77.75	104.80	169.00	153.75	505.30	4%	10	29,384
Pleasant Hill	146.50	405.00	283.00	321.75	1,156.25	8%	22	69,879
Total Northern California	850.75	1,386.55	1,399.70	1,430.50	5,067.50	36%	24	$306,041
Glendale	128.50	442.50	414.75	373.00	1,358.75	10%	26	$84,119
Cerritos	251.00	823.00	789.00	589.00	2,452.00	18%	47	158,843
Diamond Bar	39.50	185.00	273.75	299.30	797.55	6%	15	46,087
Valencia	126.00	278.50	344.25	335.50	1,084.25	8%	21	63,213
Total Los Angeles Metro	545.00	1,729.00	1,821.75	1,596.80	5,692.55	41%	27	$352,262
San Bernardino	81.00	155.00	208.00	217.00	661.00	5%	13	$40,649
Tustin	118.50	355.00	404.00	434.50	1,312.00	9%	25	77,173
San Diego	85.00	252.00	345.25	354.75	1,037.00	7%	20	61,951
Rancho Cucamonga	64.00	60.00	56.50	40.00	220.50	2%	4	13,600
Total Other Southern California	348.50	822.00	1,013.75	1,046.25	3,230.50	23%	16	$193,373
Statewide Total	1,744.25	3,937.55	4,235.20	4,073.55	13,990.55	100%	22	$851,676

Source: State Controllers Office Blanket Reports.

VI. Investigations

At the beginning of the 2008/09 the hours paid to Medical Consultants were restricted by Executive Order S-09-09 which temporarily suspended the use of all part-time staff by agencies throughout the State. Table VI-4 also shows that, during 2008/09, Medical Consultant availability varied significantly between District offices and regions. For example, during 2008/09 an average of 15 paid hours per week, or less, of Medical Consultant services was utilized by some District offices while, at other District offices, an average of 25 paid hours per week, or more, of Medical Consultant services was utilized. Only one (1) District office (Cerritos) utilized the equivalent of more than one (1) full-time Medical Consultant position.

During 2008/09 the District offices completed investigations of 550 quality of care cases and 404 other (physician conduct) cases. **Table VI-5**, below, summarizes available historical data regarding the estimated number of Subject interviews, Medical Consultant reviews, and Expert reviews completed by the District offices, by type of case. For cases involving quality of care issues, the Medical Consultants are usually substantively involved in the investigation, provided they are available. The Medical Consultants are usually much less frequently involved with other cases.

Table VI-5. Interim Investigation Activities[1]

Type of Case	Interim Activity	2004/05	2005/06	2006/07	2007/08	2008/09
Quality of Care	Subject Interviews	614	505	429	470	453
	Medical Consultant Reviews	Sufficiently Complete Data Not Available		400	439	413
	Expert Reviews	504	403	336	404	290
Other	Subject Interviews	204	200	227	241	228
	Medical Consultant Reviews	Sufficiently Complete Data Not Available		128	101	67
	Expert Reviews	61	61	57	65	50
Total	Subject Interviews	818	705	656	711	681
	Medical Consultant Reviews	Sufficiently Complete Data Not Available		528	540	480
	Expert Reviews	565	464	393	469	340

[1] The volumes shown are estimates and may be understated in one or more years.

Based on the data presented in Tables VI-4 and VI-5, the Medical Consultants spend an average of less than 25 hours working on the cases in which they are involved, assuming that (1) at least 10 percent of the hours paid to Medical Consultants are for paid time off, and (2) substantive involvement with only about 500 completed cases per year, which is possibly understated. The amount of time spent by the Medical Consultants on these cases includes performance of, or assistance with, all of the following activities:

- Ad-hoc consultations to Medical Board Investigators, HQES Attorneys, and District office Supervisors
- Preparation and attendance at Subject interviews, including pre-interview planning and post-interview debriefing meetings
- Reviews of medical records
- Identification of cases that should be closed without obtaining an Expert opinion
- Identification and selection of Medical Experts
- Preparation of Medical Expert packages
- Review of Medical Expert reports.

Depending of their availability and area(s) of specialization, Medical Consultants can potentially impact a District office's need for outside Medical Experts and the average timeframe to complete investigations. Although there are many factors that can significantly impact the timeframe needed to complete investigations, the two (2) District offices with the highest Medical Consultant expenditures during 2008/09 (Cerritos and Sacramento) also had comparatively low average elapsed times per completed investigation for that same year (an average of 11 months and 10 months, respectively, compared to a statewide average for all District offices of nearly 14 months).

As suggested by the data shown on Table VI-5, Medical Experts are involved in fewer cases than the Medical Consultants and, except for their possible involvement in hearings, provide a more limited scope of services. During 2008/09, $598,570 was billed by Medical Experts for case review services. Some Medical Experts may not all fully charge the Medical Board for all time spent on Medical Board matters. The billing rate for case review services is currently $150 per hour. During 2008/09 the Medical Experts charged the Medical Board an average of less than 12 hours of time per completed case review, or about one-half the average amount of time utilized by the Medical Consultants. While the Medical Experts charge an average of less than 12 hours of time to complete the case reviews and prepare their Expert opinion, available data suggests that the provision of these services oftentimes extends over a period of 2 to 3 months, or longer. On average, the Medical Board's cost for Expert opinions is less than $1,800 per completed review.

Table VI-6, below, shows the frequency distribution of elapsed times for Medical Experts to provide these services for reviews completed during 2008/09, by District office Identifier. As shown by Table VI-6, on a statewide basis only 38 percent of all Medical Expert reviews are completed within one (1) month, and 23 percent take longer than two (2) months. While there is some variability, the frequency distributions of elapsed times to complete these reviews at individual District offices are similar to the statewide distribution. More than 30 percent of the Medical Expert reviews took longer than two (2) months to complete at one District office in each of the three regions (Sacramento, Valencia, and San Diego). Overall, the average elapsed time to complete Medical Expert reviews was 48 days (about 7 weeks).

Table VI-6. Elapsed Time to Prepare Expert Opinions During 2008/09

Business Unit		30 Days or Less		31 to 60 Days		61 to 91 Days		More than 91 Days		Total	
		Completed Opinions	Percent	Completed Opinions	Percent	Completed Opinions	Percent	Completed Opinions	Percent	Completed Opinions	Percent
Northern California	Sacramento	10	37%	7	26%	8	30%	2	7%	27	100%
	San Jose	11	32%	17	50%	4	12%	2	6%	34	100%
	Fresno	11	46%	10	42%	2	8%	1	4%	24	100%
	Pleasant Hill	23	45%	18	35%	4	8%	6	12%	51	100%
	Total	55	40%	52	38%	18	13%	11	8%	136	100%
Los Angeles Metro	Valencia	10	42%	6	25%	5	21%	3	13%	24	100%
	Cerritos	8	24%	18	55%	2	6%	5	15%	33	100%
	Diamond Bar	4	25%	8	50%	4	25%	0	0%	16	100%
	Glendale	10	48%	7	33%	3	14%	1	5%	21	100%
	Total	32	34%	39	41%	14	15%	9	10%	94	100%
Other Southern California	Tustin	14	47%	11	37%	5	17%	0	0%	30	100%
	San Bernardino	14	33%	21	50%	2	5%	5	12%	42	100%
	San Diego	4	21%	7	37%	2	11%	6	32%	19	100%
	Rancho Cucamonga	2	100%	0	0%	0	0%	0	0%	2	100%
	Total	34	37%	39	42%	9	10%	11	12%	93	100%
Total - District Office Identifiers		121	37%	130	40%	41	13%	31	10%	323	100%
Other Identifiers (19, 20, and 23)		5	38%	3	23%	2	15%	3	23%	13	100%
Total - All Identifiers		126	38%	133	40%	43	13%	34	10%	336	100%

VI. Investigations

There are significant regional variations in the use of Medical Experts that impact the time needed to complete investigations. For example, in the Northern California and Other Southern California regions, only one (1) Medical Expert opinion with a finding that there was an "extreme departure" or "multiple simple departures" is usually required for HQES to accept the case prosecution. In contrast, HQES Attorneys in the Los Angeles Metro region generally require completion of two (2) Medical Expert opinions in all single patient cases. There are numerous adverse impacts of this requirement on Los Angeles Metro region investigations, including:

- The second opinion is only requested after the first opinion is completed as it would serve no purpose to seek a second opinion in cases where another opinion shows no violation occurred. Thus, the requirement to obtain a second opinion adds at least 1 to 2 months to the elapsed time to complete most single patient case investigations that are referred for prosecution. The timeframe to complete these investigations can become even more extended if there are inconsistencies between the two Medical Expert opinions, if the second opinion is not timely completed, or if there are deficiencies with the quality of the second Medical Expert's review or with the report documenting results of the review.
- If the second opinion does not confirm the findings of the first opinion, it effectively kills the case, resulting in fewer cases referred for prosecution.
- The number of Medical Expert opinions is doubled for cases that are referred for prosecution, thus reducing the availability of Medical Experts to perform reviews of other cases. This can make it much more difficult and increase the time needed to complete investigations of other cases, particularly cases involving more specialized medical practice areas
- Investigator and Medical Consultant workloads are increased along with costs for Medical Expert review services.

It is our understanding that, during the 1990s, the Medical Board routinely obtained two (2) Medical Expert opinions for single patient cases, but that this practice was discontinued. However, it is evident that there have been ongoing disagreements regarding needs for obtaining more than one (1) Medical Expert opinion during the Investigation stage, particularly in the Los Angeles Metro region, and that the disagreements are not limited to single patient cases. For cases referred to investigation prior to 2006, some Los Angeles Metro region Attorneys sometimes required submission of a confirming second opinion prior to accepting a case for prosecution, or would request a second opinion before beginning preparation of the pleading. Subsequent to 2006, some Los Angeles Metro region Attorneys, in their capacity as Lead Prosecutor or Primary DAG, required second opinions as part of the investigation process. In some cases significant disputes with District office Supervisors and Investigators have arisen over this issue primarily because of concerns about increased risks of harm to patients and the general public (e.g., cases involving substance abuse), but also because of adverse impacts on workflow, caseloads, costs, and the availability of Medical Experts to perform reviews of other cases.

In connection with requirements to obtain a second Medical Expert opinion, it should not be overlooked that nearly all quality of care cases, and many other cases, were previously reviewed by a Medical Specialist as part of CCU's complaint screening process, and that the Medical Specialist determined at that point that the departures warranted referral of the case for investigation. Additionally, the District office Medical Consultant completes a review of all of these same cases. Thus, the first Medical Expert's opinion is actually the second, or third, review of the case resulting in a determination that either an extreme departure or multiple simple departures, or both, occurred. The second Medical Expert's review would be the third, or fourth, medical review of the case. It is our understanding that, outside of the Los Angeles Metro region, second opinions are rarely requested unless the case involves a second medical specialty, or it is determined that a case will proceed to hearing, which isn't determined sometime after the pleading is filed and, even then, still might not be needed if the departure is obvious. The overwhelming majority of cases are settled without a hearing, thus avoiding the need to obtain a second Medical Expert opinion in most cases.

It is our understanding that Enforcement Program and HQES management recently conferenced during April 2010 and reached an agreement to require two (2) Medical Expert opinions for all single patient cases. According to Enforcement Program management, only applying this requirement in the Los Angeles Metro region, where it is strongly supported by HQES management and practiced by their staff, was "unfair" to Los Angeles Metro region Investigators because they "had to do more work in LA". In support of this policy, it was argued that problems had recently been experienced with single patient cases that had just one Medical Expert (e.g., "a lot of San Diego cases have been dismissed at hearing."). This approach also would promote statewide uniformity. While we support the effort to promote uniformity, it makes no sense, at least to us, to subject all of the Medical Board's District office Investigators, Medical Consultants, Supervisors, and clerical support staff, to an unnecessary additional workload requirement just because it is the practice in one region of the State. Additionally, we question the assumption that the dismissals of San Diego office cases occurred solely because the Medical Board had only one (1) Medical Expert. Even if this assumption is correct, we don't understand why San Diego's cases proceeded to hearing without a second Medical Expert opinion, or why requiring a second opinion for all cases during the Investigation Stage is a better approach to resolving this problem than waiting until after the accusation is filed and determining how likely it is that a the case will actually proceed to Hearing, before obtaining the second opinion. Finally, although Enforcement Program and HQES management apparently reached this agreement to universally require two (2) Medical Expert opinions for all single patient cases, the actual practice in the field has not changed. District office Supervisors and HQES Supervising DAGs outside the Los Angeles Metro region rarely second Medical Expert opinion for single patient cases, except when an opinion is needed in a second specialty area or it appears likely that the case will proceed to hearing and a second opinion is needed to strengthen presentation of the case.

VI. Investigations

L. Recommendations for Improvement

Below we discuss several key recommendations for improving investigation process performance. These recommendations concern Medical Consultant staffing, the availability of outside Medical Experts, and retention of Investigators. Additional recommendations that would impact investigations are included in Section X (*Organizational and Management Structures*), including recommendations involving:

- ✓ Restructuring the handling of Section 801 cases
- ✓ Restructuring the management of District office investigations
- ✓ Scaling back and optimizing HQES involvement in District office investigations
- ✓ Developing new organizational structures and processes for managing cases following referral for prosecution and HQES expenditures
- ✓ Improving workload and performance reporting process.

1. Medical Consultant Staffing

As noted in the Enforcement Monitor's 2004/05 reports, "the medical consultant's (MC) function is central to the speed and quality of QC cases processing at the district office level; however problems regarding medical consultant availability, training, and proper use contribute significantly to lengthy investigations and inefficient operations. . . Shortages of medical consultant time have made it continuously difficult for investigators to obtain sufficient medical consultant assistance. . ." However, the Medical Consultant's function is not limited to quality of care cases. They are also involved in many physician conduct cases. Additionally, their availability is critical not just to the process of reviewing Expert opinion reports, as emphasized by the Enforcement Monitor. Rather, the Medical Consultants are critical during earlier stages of the investigation during which, for example, medical records are initially received and reviewed, the Subject is interviewed, a decision is made as to whether to obtain an Expert opinion, potential Experts are identified and a selection decision is made, and the Expert package and instructions are prepared for the Expert's review.

Perhaps most importantly, the Medical Consultant is a key (perhaps the key) participant in the process of assessing, prior to referral of a case to an outside Expert, whether the facts and circumstances of a case, particularly for quality of care cases, indicate that an extreme departure or multiple simple departures occurred and, hence, whether to close the case or continue the investigation. In fact, the Medical Consultant's involvement in reviewing the Expert's opinion, which is the last step in the investigation process, is only one of their many important responsibilities. If the Expert has clearly presented their opinion as to whether an extreme departure or multiple simple departures has occurred, and support for the opinion is clearly organized and presented, then subsequent involvement of the Medical Consultant will probably be minimal. However, if the

Expert's opinion is not clearly stated or well-supported in their report, the Medical Consultant's role is key in assessing the Expert's report and determining whether, or how, to proceed from that point forward (e.g., collect additional evidence, obtain clarification of the opinion, close the case, refer the case for prosecution, etc.).

Additionally, the Medical Board's pool of Medical Consultants serves as a gatekeeper on the flow of cases to Experts. In many cases the Medical Consultants are sufficiently qualified in the specialties involved to determine whether a case should be closed, avoiding completely the need for review services from an outside Medical Expert. To the extent that the Medical Consultants are able to make such determinations, the flow of cases to, and the Medical Board's needs for, outside Medical Experts is reduced. This not only reduces the timeframes to complete these investigations, but enables redirection of District office resources to other cases. It also helps to preserve the availability of outside Medical Experts for use on other cases.

Since publication of the Enforcement Monitor's reports there has been very little change in the availability of Medical Consultants. Needs in this area have not been emphasized. Additional Attorney positions (10) were authorized for HQES, additional Sworn Investigator and Assistant Investigator positions (8) were authorized for the Medical Board, additional positions (6) were authorized to reestablish an OSM Unit, additional positions (4) were authorized for the Probation Program and, most recently, new Non-Sworn positions (6) and a number of other Enforcement Program positions are expected to be authorized as part of the 2010/11 Budget, but no additional funding for Medical Consultants was included in this package.

Recommendation No. VI-1. *Augment Medical Consultant staffing. Medical Consultants should be available to all District offices all of the time (e.g., the equivalent of at least one full-time position per office, although actual availability will be less than full time due to vacations, sick leave and other time off). Because the Medical Consultant positions are classified as Permanent Intermittent, work hours can be adjusted to accommodate fluctuating workload demands, assuming a sufficient pool of resources is available to provide the services and the physicians are willing to work the number of hours needed. Offset additional costs for Medical Consultant positions by reducing expenditures for HQES investigation-related services (e.g., in the Los Angeles Metro region).*

2. Medical Expert Resources

Although Medical Experts are of vital importance to the success of investigations and prosecutions, the Expert Reviewer Program has suffered from chronic weaknesses inherent in the system. A major problem, perhaps the most critical, is the limitation on utilization of the most qualified Medical Experts. While the Medical Board has attempted to remedy some of these problems by increasing the billing rate for Medical Expert review services from $100 to $150 per hour, the rate increase did not address restrictions on the Board's use of its most qualified Medical Experts.

Under current Board policy, Medical Experts may not be used more than three (3) times per year. As with medical procedures, Medical Experts tend to become more qualified as they complete more reviews. However, under current policy, at the very point when the Medical Experts may become most qualified, and also faster and more effective, they must stop work until another year. As defense counsels are under no such restrictions, under the current system the Investigators and Prosecutors are severely handicapped.

Recommendation No. VI-2. *Eliminate the limitation on reutilization of Medical Experts and augment the Medical Expert pool and enhance capabilities. In addition to strengthening Expert Reviewer oversight and overall Expert Reviewer Program management and administration, consider redirecting some funding currently used for HQES investigation-related services toward establishing a new program under which the Medical Board would contract for the services of a pool of physicians to provide Expert Review services (e.g., through an Interagency Agreement with one or more University of California Medical Centers, although this model may have its own problems relating to conflicts of interest).*

3. Investigator Retention

It is unlikely that Enforcement Program performance will improve significantly unless Investigator workforce capability levels are stabilized. Medical Board management does not control pay and benefit levels, mandated furloughs, baby boomer retirements, or recruitment efforts by other agencies, but it can impact District office work environments in significant and meaningful ways that can help to minimize Investigator attrition. A strategy to retain experienced Investigators should include efforts to create a work environment to promote communication with staff to provide assurances that work problems will be addressed. This strategy should include the following initiatives:

- ✓ Reducing and simplifying Investigator caseloads
- ✓ Increasing the availability of Medical Consultants
- ✓ Targeting HQES Attorney involvement during investigations to those cases where such involvement is needed

- ✓ Limiting HQES Attorney involvement to activities that are appropriately performed by an Attorney (e.g., providing legal advice and direction)
- ✓ Promoting uniformity in the use of requests for supplemental investigations and decline to file cases to ensure that such requests and handling are reasonable and defensible, and do not unnecessarily delay the filing of accusations or result in inappropriate case closures.

Additionally, needs exists for all appropriate members of the Medical Board's Executive Management Team, and their counterparts at the Department of Justice, to meet jointly with staff from each District office and communicate directly to them that they are important and that management is committed to addressing as many of their issues and concerns as they reasonably can. Additionally, a process should outlined for completing a structured diagnostic review of all of the factors contributing to excessive staff turnover during the past several years, and developing and implementing a plan to address related improvement needs.

Recommendation No. VI-3. *Develop and implement an Immediate Action Improvement Plan to address critical District office workload and work environment issues. Meet with staff at each District office to present the Improvement Plan and outline a process for identifying and implementing further improvements. Conduct a structured diagnostic review of factors contributing to excessive Investigator turnover during the past several years, and develop and implement a Longer-Term Improvement Plan to reduce Investigator attrition and rebuild the Enforcement Program's field investigation workforce capabilities and competencies.*

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VII. Prosecutions and Disciplinary Outcomes

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VII. Prosecutions and Disciplinary Outcomes

This section presents results of our assessment of the prosecutions and disciplinary outcomes. Following referral of cases from Medical Board Headquarters Units or the District offices, prosecutions are largely carried out by HQES which prepares the pleading, negotiates proposed settlements, and represents the Medical Board at administrative hearings. The assessment focused on determination of the numbers of prosecutions completed and related disciplinary outcomes prior to, concurrent with, and following implementation of VE during 2006, the average elapsed time to complete the prosecutions and disciplinary actions, and expenditures for related HQES services.

Results of the assessment show that the number of accusations filed, the number of proposed stipulations and proposed decisions received, and the number of disciplinary actions all declined. Several other secondary output and performance measures also have declined. Concurrently, the elapsed time to file accusations has decreased, but this decrease is largely attributable to a decrease in the Los Angeles Metro region from an abnormally high level in prior years. In the Los Angeles Metro region the average elapsed time remains higher than in other regions due, in part, to (1) mis-use of requests for supplemental investigations, and (2) extended periods of inactivity while cases are pending at HQES following referral of the cases for prosecution. The average elapsed time from filing to settlement (stipulation received) has also decreased. However, there are significant performance variations between regions. The decrease in composite elapsed times from filing to settlement during this period, to a statewide average of 11 months during the past two (2) years, is attributable to improved performance in the Los Angeles Metro and Other Southern California regions. However, even with this improvement, the average elapsed time for the Los Angeles Metro region during the past two (2) years lagged performance of the other two regions. For the Northern California region, the elapsed times from filing to stipulation received generally averaged about ten (10) months throughout the past six (6) years.

The remainder of this section is organized as follows:

Subsection	Title
A.	Overview of Prosecutions and Disciplinary Outcomes
B.	Prosecution Process Workload, Outputs, and Performance Measures
C.	Accusations Filed and Average Elapsed Times from Transmittal to HQES to Accusation Filed
D.	Stipulations Prepared and Average Elapsed Times from Accusation Filed to Stipulation Received
E.	Average Elapsed Times from Stipulation Received to Board Action
F.	Administrative Hearings and Average Elapsed Times from Accusation Filed to Decision Received
G.	Average Elapsed Times from Decision Received to Board Action
H.	Disciplinary Outcomes
I.	Expenditures for HQES Prosecution Services
J.	Recommendations for Improvement.

VII. Prosecutions and Disciplinary Outcomes

A. Overview of Prosecutions and Disciplinary Outcomes

Exhibit VII-1, on the next page, summarizes physician and surgeon prosecutions and disciplinary actions for the six-year period from 2003/04 through 2008/09. Exhibit VII-1 shows:

- Number of petitions to revoke probation filed
- Number of accusations filed
- Number of pending accusations
- Number of pending legal cases
- Number of case dispositions, by type (default, withdrawn or dismissed, stipulation, and proposed decision)
- Number of citations issued
- Number of adopted and non-adopted disciplinary decisions
- Number of disciplinary outcomes, by type (revocation, surrender, suspension, probation, post-filing public reprimand, and pre-filing public letter of reprimand)
- Percentage of total disciplinary actions requiring revocation, surrender, suspension, or probation
- Average elapsed times to file accusations and complete prosecutions.

Exhibit VII-1 also shows numbers of cases appealed to Superior Court, number of appeals upheld, and number of appeals reversed, remanded, or vacated.

As shown by Exhibit VII-1, in recent years the total number of filings declined by nearly 10 percent. During the past three (3) years total filings averaged 244 per year compared to an average of 268 filings per year during the preceding three (3) years. At the same time, the number of post-filing stipulations and the number of proposed decisions also decreased by about 10 percent. The number of post-filing stipulations decreased to an average of 183 per year for the past three (3) years, from 202 per year during the preceding three (3) years. The number of proposed decisions decreased to an average of 67 per year for the past three (3) years, from 74 per year during the preceding three (3) years. Consistent with these reduced outputs, the number of disciplinary actions also decreased. Some of these output measures show particularly large decreases during 2008/09 compared to the levels typically achieved during the preceding five (5) years. For example:

- During 2008/09, 156 stipulations were received compared to an average of about 190 or more stipulations received during each of the preceding five (5) years
- During 2008/09, 171 licenses were revoked, surrendered, or suspended, or the licensee was placed on probation, compared to 208 to 230 comparable disciplinary actions taken during the preceding five (5) years.

Physician and Surgeon Prosecutions and Disciplinary Actions

	Workflow Measure	2003/04	2004/05	2005/06[a]	2006/07	2007/08	2008/09
Filings	Petitions to Revoke Probation	26	26	27	24	13	25
	Accusations	262	235	227	218	240	213
	Total Filings	288	261	254	242	253	238
Reported Average Time to File Accusation (Months)		3.5 Months	3.8 Months	4.3 Months	4.2 Months	4.0 Months	3.4 Months
Pending Matters	Pending Accusations (End of Period)	126	133	152	132	126	149
	Pending Legal Cases (End of Period; Including AHLP; Excluding Probation)	494	503	436	391	508	508
Case Dispositions	Default Decision (failure to appear)	21	24	23	18	23	30
	Accusation Withdrawn or Dismissed	64	33	27	18	40	26
	Petition to Revoke Probation Withdrawn or Dismissed	7	1	2	0	2	2
	Post-Filing Stipulation Submitted	200	219	187	200	193	156
	Proposed Decision Submitted - In-State Practitioner	48	38	33	39	38	40
	Proposed Decision Submitted - Out-of-State Practitioner (IDENT 16)	4	12	7	8	5	10
	Proposed Decision Submitted - Petition to Revoke Probation (IDENT 'D')	5	10	5	5	3	6
	Proposed Decision Submitted - License Application Denial Appeal (SOI - IDENT 20)	25	19	17	16	19	12
	Total Disciplinary Submittals (Excludes Filings Withdrawn/Dismissed and SOI Decisions)	278	303	255	270	262	242
Medical Board Decisions	Decision Adopted (Includes SOIs)	81	77	76	78	81	60
	Decision Not Adopted	15	10	11	13	19	15
	Stipulation Approved	186	208	193	188	206	173
	Stipulation Rejected	11	12	16	8	8	4
	Total Medical Board Decisions	293	307	296	287	314	252
Disciplinary Actions	Citations and Administrative Fines Issued	423	307	342	426	248	185
	Revocation	36	42	39	34	33	45
	Surrender	65	82	66	67	70	35
	Suspension Only	2	0	0	1	0	0
	Suspension with Probation	31	17	20	21	14	13
	Probation Only	92	89	86	91	91	78
	Public Reprimands (Post-Filing)	35	71	72	50	74	66
	Public Letters of Reprimand (Pre-Filing)	29	38	37	27	35	31
	Total Disciplinary Actions (Excludes Citations)	290	339	320	291	317	268
	Percent Revocation, Surrender, Suspension, or Probation	78%	68%	66%	74%	66%	64%
Reported Average Time to Complete Prosecutions (Months)		16.9 Months	15.6 Months	16.9 Months	14.7 Months	15.5 Months	12.5 Months
Appeals	Decisions Appealed to Superior Court	25	25	28	20	26	12
	Decisions Upheld by Superior Court	15	14	13	13	13	10
	Decisions Reversed, Remanded, or Vacated by Superior Court	15	13	10	8	6	9

[a] On January 2, 2006, the Medical Board and HQES began implementing the VE Pilot Project.

Sources: Medical Board of California Annual Reports, California Department of Consumer Affairs Annual Reports, and MBC Complaint Tracking System data.

VII. Prosecutions and Disciplinary Outcomes

In recent years there was little or no change in the number of default decisions, accusations withdrawn or dismissed, or proposed decisions received for cases involving In-State practitioners. In comparison to prior years, the total number of proposed decisions and stipulations approved by the Medical Board has decreased (particularly during 2008/09).

The disciplinary action data presented in Exhibit VII-1 show a decrease in the proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation. During 2008/09 only 64 percent of disciplinary actions required license revocation, surrender, suspension, or probation. During the preceding five (5) years the percent of disciplinary actions requiring license revocation, surrender, suspension, or probation ranged from 66 percent to 78 percent. This decrease in the proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation may be attributable to a combination of factors including (1) variations in the composition of cases referred for prosecution, (2) shifts in settlement negotiation strategies, and (3) recent legislative changes enabling issuance of public reprimands, with conditions, in lieu of stronger types of discipline. Additional information regarding this variance is presented subsequently in Section VII-H (*Disciplinary Outcomes*).

In recent years, there was little change in the number of pending accusations or total pending legal cases. The number of pending accusations fluctuated between about 125 and 150 cases, and the number of pending legal cases, after declining to about 400 cases during 2006/07, from about 500 cases previously, increased again to a level of 500 cases during the next two (2) years. Recent decreases in the number of cases referred for prosecution from the District offices have not resulted in corresponding decreases in the number of pending legal action cases.

During 2008/09 there was a marginal improvement in the average elapsed time to file accusations, and a more substantive improvement in the average elapsed time to complete prosecutions. The average elapsed time to file accusations decreased by about three (3) weeks (to 3.4 months during 2008/09 from an average of about 4.0 months during the preceding four (4) years). The average elapsed time to complete prosecutions decreased by about three (3) months (to 12.5 months during 2008/09 from an average of 15.7 months during the preceding four (4) years).

Finally, Exhibit VII-1 shows a reduction in number of appeals to Superior Court during 2008/09 compared to levels experienced during prior years. It is unclear whether this one-year reduction in appeals will be sustained over time.

B. Prosecution Process Workload, Outputs, and Performance

Exhibit VII-2, on the next five (5) pages, provides time series statistical data for the past six (6) fiscal years for a broad range of prosecution process workload, output, and performance measures for (1) cases investigated and referred for prosecution by District offices in each of three (3) major geographic regions of the State, (2) cases originated and referred for prosecution by various Headquarters Units, usually without investigation by the District offices, and (3) cases involving petitions to revoke probation which, until recently, were investigated and referred for prosecution by the Probation Units, and were not included in the VE Pilot Project. Exhibit VII-2 presents data showing:

- Number of cases that HQES and the Medical Board declined to file
- Number of accusations and petitions to revoke probation filed
- Number of accusations withdrawn or dismissed
- Number of default decisions
- Number of ISOs/TROs sought and granted
- Number of PC 23 appearances and orders
- Number of automatic suspension orders and suspension orders issued by Chief of Enforcement
- Number of post-filing stipulations submitted, approved, and rejected
- Number of proposed decisions submitted, adopted, and not adopted
- Number of decisions appealed to Superior Court, appeals upheld, and appeals reversed, remanded, or vacated
- Number of Out-of-State suspension orders
- Number of pre-filing (surrender) stipulations
- Number of compelled examinations passed
- Number of practice restriction stipulations
- Number of pre-filing public letters of reprimand
- Ratio of stipulations received to proposed decisions received
- Ratio of appeals to adopted and non-adopted decisions
- Ratio of decisions upheld to total appealed dispositions.

Prosecution Process Outputs and Performance Measures[1]
2003/04 through 2008/09

Fiscal Year	HQES Declined To File								Accusation Filed								Default Decision							
	District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers				
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total
2003/04	3	8	6	1				18	63	73	72	42	3	4	5	262	2	2	2	12	2	1		21
2004/05	8	7	4	1	1	1		22	48	61	55	60	2	6	3	235	2	6	2	11	2	1		24
2005/06	4	13	1	5	1			24	52	53	63	53	2	1	3	227	1	2	3	12	4	1		23
2006/07	8	13	4	2	4			31	65	44	66	38		5		218	2		3	7	6			18
2007/08	4	10	0	5	1			20	67	69	48	52	2	2		240	5	3	2	9	3	1		23
2008/09	10	6	9	4	1		2	32	62	40	50	51	2	5	3	213	1	6	5	17	1			30

Fiscal Year	Medical Board Declined to File								Accusation Withdrawn								Accusation Dismissed							
	District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers				
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total
2003/04	1	4	1		1			7	4	16	10	6	5	3		44	6	4	6	2	2			20
2004/05	1			4	4			9	5	5	8	6	1			25	1	5	2					8
2005/06				3	2			5	6	5	5	2	2	1		21		4	2					6
2006/07	3	1	1		1			6	4	3	4	3				14	1	1	2					4
2007/08				1	1			2	9	6	11	2	2			30	2		8					10
2008/09	5	1			1		1	8	6	2	2	1	2	1	1	15	2	6	2	1				11

[1] Based upon the Identifier assigned to the case when transmitted to HQES. In some cases, subsequent actions are handled by HQES offices in other regions.

Prosecution Process Outputs and Performance Measures[1]
2003/04 through 2008/09

Fiscal Year	ISO/TRO Sought								PC 23 Appearance								Automatic Suspension Order Issued							
	District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers				
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total
2003/04	5	4	15		1	1		26	4	8	3		1			16		1	1		1			3
2004/05	6	15	15	1	1	1		39	2	5	2					9		2			2	1		5
2005/06	10	3	10					23	1	3	1					5					1			1
2006/07	11	2	9					22	1	1	4					6	1				3			4
2007/08	6	8	4		2			20		7	3					10								0
2008/09	10	4	1		3			18	4	8	2		1	1		16	2							2

Fiscal Year	ISO/TRO Granted								PC 23 Order Issued								Suspension Order Issued by Chief of Enforcement							
	District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers				
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total
2003/04	6	1	9	1	5			22	4	8	1		2			15	1	1						2
2004/05	8	5	7	1	8			29	1	4	2					7		2	1	1	1			5
2005/06	10	1	9		4			24	1	3						4		4	1					5
2006/07	10	2	4		2			18	2	2	2		1			7	1	1	1					3
2007/08	5	6	2		2			15		2	3					5	1	1						2
2008/09	9	2	1	1	3			16	2	9			1	1		13		1						1

[1] Based upon the Identifier assigned to the case when transmitted to HQES. In some cases, subsequent actions are handled by HQES offices in other regions.

Prosecution Process Outputs and Performance Measures[1]
2003/04 through 2008/09

Fiscal Year	Post-Filing Stipulation Submitted								Post-Filing Stipulation Approved								Post-Filing Stipulation Rejected							
	District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers				
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total
2003/04	53	63	37	30	17			200	36	52	40	33	16	9		186	4	4	1			2		11
2004/05	45	54	55	43	17	2	3	219	48	50	42	41	19	6	2	208	3	5	2		1	1		12
2005/06	38	61	44	21	20		3	187	45	50	47	26	16	5	4	193	4	7	4			1		16
2006/07	45	52	42	39	19		3	200	42	51	40	27	17	8	3	188	3	4	1					8
2007/08	41	46	58	31	14	2	1	193	47	41	55	36	16	9	1	205	1	5	1		1			8
2008/09	40	45	37	23	8	3		156	35	45	45	30	6	12		173		3	1					4

Fiscal Year	Proposed Decision Submitted								Proposed Decision Adopted								Proposed Decision Not Adopted							
	District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers				
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total
2003/04	12	16	19	4	5	25	1	82	12	15	16	3	5	16		67	5	4	3		1	3		16
2004/05	11	13	13	12	10	19	1	79	4	13	9	10	7	19	1	63	1	1	3		2	4		11
2005/06	4	18	11	7	5	27		72	6	17	10	6	4	20		63	2	3	1	2		3		11
2006/07	9	17	13	8	5	16		68	10	9	7	10	6	14		56	2	3	3			4		12
2007/08	9	14	15	5	3	19		65	6	10	15	3	2	17		53		5	6	1		4	1	17
2008/09	11	12	12	10	6	12	5	68	9	7	6	10	5	9	1	47	3	6	3		1	3		16

[1] Based upon the Identifier assigned to the case when transmitted to HQES. In some cases, subsequent actions are handled by HQES offices in other regions.

Prosecution Process Outputs and Performance Measures[1]
2003/04 through 2008/09

Fiscal Year	Decision Appealed to Superior Court								Decision Upheld								Decision Reversed, Remanded, or Vacated							
	District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers				
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total
2003/04	3	7	9	1	2	2	1	25	5	4	4	1		1		15	3	6	2	2	2			15
2004/05	1	7	7	1	4	4	1	25	2	2	7		1	2		14	2	7	2	2				13
2005/06	4	8	5	3	1	7		28	2	1	5		2	2	1	13		2	2	2	1	3		10
2006/07	1	4	6	5	1	3		20	1	2	3	1	2	4		13	1	1	1	5				8
2007/08	4	12	4	1		5		26		1	6	2	1	2	1	13	1	1	1	2		1		6
2008/09	3	3	3		3			12	2	3	1	1		3		10	1	4	1	2		1		9

Fiscal Year	Out of State Suspension Order								Pre-Filing (Surrender) Stipulation								Petition to Revoke Probation Filed							
	District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers				
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total
2003/04	1			16				17	2	2	4	4	1	2		15					26			26
2004/05				12	1	1		14	6	2	2	3	2			15					26			26
2005/06				14				14	3	3	5	2		1		14		1			26			27
2006/07				7	1			8	3	3	1	3		3		13		1			23			24
2007/08				9	1			10	3	1	2	7	2	1		16			1		12			13
2008/09	2			15	1			18				1	1			2					25			25

[1] Based upon the Identifier assigned to the case when transmitted to HQES. In some cases, subsequent actions are handled by HQES offices in other regions.

Prosecution Process Outputs and Performance Measures[1]
2003/04 through 2008/09

Fiscal Year	Compelled Examinations Passed								Practice Restriction Stipulations								Pre-Filing Public Letters of Reprimand							
	District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers				
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total
2003/04	2	6	2	1				11								0	4	4	4	17				29
2004/05	1	1	2					4	2							2	8	4	7	18		1		38
2005/06	1						1	2	3		1	1				5	15	4	10	8				37
2006/07		5						5	4							4	10		3	14				27
2007/08		2	1					3		1	1					2	1	2		32				35
2008/09	2	1	1					4	1	1	1					3	4	2	1	24				31

Fiscal Year	Ratio: STIPs Submitted to PDs Submitted								Ratio: Appeals to Adopted/Non-Adopted Decisions								Ratio: Decisions Upheld to Total Dispositions							
	District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers					District Office IDENTs			Other Identifiers				
	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total	Northern California	Los Angeles Metro	Other Southern California	Out of State (16)	Probation (D's)	Headquarters (20)	Other (21 to 27)	Total
2003/04 to 2004/05	4.3	4.0	2.9	4.6	2.3	0.0	1.5	2.6	18%	42%	52%	15%	40%	14%	200%	32%	58%	32%	73%	20%	33%	100%	NMF	51%
2005/06 to 2006/07	6.4	3.2	3.6	4.0	3.9	0.0	NMF	2.8	25%	38%	52%	44%	20%	24%	NMF	34%	75%	50%	73%	13%	80%	67%	100%	59%
2007/08 to 2008/09	4.1	3.5	3.5	3.6	2.4	0.2	0.2	2.6	39%	54%	23%	7%	38%	15%	0%	29%	50%	44%	78%	43%	100%	71%	100%	61%
2003/04 to 2005/06 (3 Years)	5.0	3.8	3.2	4.1	2.7	0.0	3.0	2.6	27%	42%	50%	24%	37%	20%	200%	34%	64%	32%	73%	14%	50%	63%	100%	53%
2006/07 to 2008/09 (3 Years)	4.3	3.3	3.4	4.0	2.9	0.1	0.8	2.7	27%	48%	33%	25%	29%	16%	0%	29%	50%	50%	77%	31%	100%	82%	100%	61%

[1] Based upon the Identifier assigned to the case when transmitted to HQES. In some cases, subsequent actions are handled by HQES offices in other regions.

VII. Prosecutions and Disciplinary Outcomes

Key output and performance variances between geographic regions, and significant changes that occurred during the past several years, include the following:

Accusations Filed – The number of accusations filed increased significantly in the Northern California region and, concurrently, decreased significantly in the Los Angeles Metro and Other Southern California regions. In the Northern California region more than 60 accusations were filed each of the past three (3) years compared to only 50 accusations filed per year during the preceding two (2) years. In contrast, during this same period the Los Angeles Metro and Other Southern California regions, each of which previously filed more than 60 accusations per year, filed an average of fewer than 55 accusations per year. During 2008/09 the Los Angeles Metro and the Other Southern California regions each filed only 40 accusations. The number of accusations filed for Out-of-State cases fluctuated between 40 and 60 cases per year throughout the past six (6) years, and consistently averaged about 50 cases per year. All (or nearly all) of these accusations are prepared and filed by HQES' San Francisco office.

Post-Filing Stipulations Received – During 2008/09, 156 post-filing stipulations were received, a significant decrease from the levels attained during prior years which averaged about 200 stipulations per year. The decrease during 2008/09 is attributable primarily to a large decrease in the number of post-filing stipulations submitted by the Other Southern California region. There were also decreases in the number of post-filing stipulations submitted for probation revocation and Out-of-State cases. The decline in post-filing stipulations submitted for Out-of-State cases may be inversely correlated with the comparatively high number of Out-of-State cases resolved by issuance of a pre-filing public letter of reprimand (PLR) during 2007/08 and 2008/09 (28 PLRs issued per year compared to an average of 14 PLRs issued per year during the preceding four (4) years).

Ratio of Stipulations Received to Proposed Decisions Received – Historically, the Northern California region has had a significantly higher ratio of stipulations received to proposed decisions received than either the Los Angeles Metro or Other Southern California regions. In recent years this differential narrowed somewhat, but the ratio for the Northern California region was still significantly higher than the ratio for either of the other two regions (4.3 stipulations per proposed decision for the Northern California region compared to 3.4 stipulations per proposed decision for the Los Angeles Metro region and 3.3 stipulations per proposed decision for the Other Southern California region).

Appeals to Superior Court – The number of appeals to Superior Court, and related outcome measures, are too small to provide a valid basis for drawing conclusions, except to note that, on average, a few more cases per year are usually appealed in the Los Angeles Metro and Other Southern California regions than are appealed in the Northern California region. However, the number of appeals in all three (3) regions is very low (e.g., during 2008/09, there were only three (3) appeals of cases that were investigated by each of the three (3) regions, plus three (3) additional appeals involving probation revocation cases).

C. Accusations Filed and Average Elapsed Times from Transmittal to HQES to Accusation Filed

Exhibit VII-3, on the next page, shows average elapsed times from transmittal of the case to HQES to accusation filed, by year, from 2004 through 2009, by Identifier. All (or almost all) Out-of-State cases are handled by HQES' San Francisco office and, as shown by Exhibit VII-3, accusations for these cases are consistently filed within an average elapsed time of not more than about two (2) months. For cases with District office Identifiers, the average elapsed times from transmittal to filing are longer and, for these cases, the average elapsed times from transmittal to filing decreased by about six (6) weeks since 2005, but are unchanged compared to 2004. The decrease since 2005 in the average elapsed time to file accusations is attributable nearly entirely to a decrease during the past four (4) years in the average elapsed time to file accusations in the Los Angeles Metro region. In the Los Angeles Metro region the average elapsed time to file accusations decreased from nearly eight (8) months during 2005 to about five (5) months during 2009. However, the average elapsed time shown for the Los Angeles Metro region for 2005 (7.8 months) was 3.4 months (77 percent) longer than the average elapsed time for the region during the prior year.

During 2005, just prior to implementation of the VE, the average elapsed time to file accusations in the Los Angeles Metro region suddenly spiked up, and continued to increase in subsequent years, eventually reaching a peak of more than nine (9) months during 2007, before decreasing to lower levels during 2008 and 2009. **Table VII-1**, below, shows average elapsed times from transmittal to filing for cases Investigated by each of the Los Angeles Metro region's District offices from 2004 through 2009. As shown by Table VII-1, the variances in the aggregate regional data are also evident at each of the Los Angeles Metro region's four (4) District offices.

Table VII-1 Average Elasped Time from Transmittal of Case to HQES to Accusation Filed
Los Angeles Metro District Offices

District Office	2004		2005		2006		2007		2008		2009	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
Valencia	14	4.4	14	8.3	10	8.1	15	6.4	13	6.8	11	7.8
Ceritos	23	5.2	21	7.7	16	9.2	18	7.6	20	4.0	17	4.4
Diamond Bar	10	1.9	9	7.3	9	7.3	13	16.4	7	4.5	12	2.5
Glendale	14	5.0	13	7.9	11	9.7	19	8.0	10	9.4	12	5.5
Total	61	4.4	57	7.8	46	8.7	65	9.2	50	5.9	52	4.9

Average Elapsed Times from Transmittal of Case to HQES to Accusation Filed, by Identifier
2004 through 2009

Including Cases with Timeframes Exceeding 18 Months

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	3.6	61	4.4	54	3.0	163	3.7
2005	56	4.6	57	7.8	71	4.0	184	5.4
2006	54	3.2	46	8.7	49	6.0	149	5.8
2007	66	4.1	65	9.2	67	3.1	198	5.4
2008	60	2.6	50	5.9	46	3.9	156	4.0
2009	72	4.0	52	4.9	63	3.0	187	3.9

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		Other (IDENT 20, 21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	49	2.3	3	1.9	10	3.2	225	3.3
2005	52	1.1	0	0.0	8	9.5	244	4.6
2006	50	1.3	2	6.5	3	1.0	204	4.6
2007	38	1.4	0	0.0	4	2.9	240	4.8
2008	59	2.0	2	2.5	6	5.4	223	3.5
2009	48	2.2	1	0.6	6	4.7	242	3.6

Excluding Cases with Timeframes Exceeding 18 Months

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	3.6	61	4.4	52	2.7	161	3.6
2005	55	4.1	55	6.9	70	3.8	180	4.8
2006	54	3.2	43	8.0	48	4.8	145	5.2
2007	65	3.8	55	7.1	66	2.9	186	4.5
2008	60	2.6	49	5.5	44	3.1	153	3.7
2009	71	3.6	49	3.8	61	2.5	181	3.3

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		Other (IDENT 20, 21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	47	0.8	3	1.9	10	3.2	221	3.0
2005	52	1.1	0	0.0	5	2.2	237	4.0
2006	50	1.3	2	6.5	3	1.0	200	4.1
2007	38	1.4	0	0.0	4	2.8	228	3.9
2008	59	2.2	2	2.5	5	1.4	219	3.2
2009	48	2.2	1	0.6	6	4.7	236	3.1

Exhibit VII-4, on the next two pages, provides frequency distributions of elapsed time from transmittal of the case to HQES to accusation filed, by Identifier. The data presented in Exhibit VII-4 show that, until recently, fewer than a dozen cases per year referred for prosecution to HQES' Los Angeles Metro office were filed within two (2) months of transmittal of the case. During 2007 only 15 Los Angeles Metro region cases were filed within four (4) months of transmittal of the case. In contrast, during this same year 43 accusations for Northern California region cases and 52 accusations for Other Southern California region cases were filed within four (4) months. More recently, during 2009, 32 Accusations were filed within four (4) months of transmittal for Los Angeles Metro region cases, a significant improvement for the Los Angeles Metro region. However, during 2009, much higher numbers of accusations were filed within four (4) months of transmittal in the other regions of the State (47 in the Northern California region and 54 in the Other Southern California region).

Among the most significant factors that appear to contribute to extended elapsed times from transmittal of a case to HQES to filing of the accusation are included:

1) Requests for supplemental investigations, *and*

2) Inactivity while the case is pending at HQES.

With the assistance of Medical Board staff we researched both of these sources of delay by researching the histories of nearly two (2) dozen individual cases. Results of this research illustrate the nature and magnitude of the problems and frustrations experienced during the past several years by Medical Board management and staff in the Los Angeles Metro region and, to a lesser extent, in other parts of the State. Furthermore, difficulties in handing off of cases for prosecution appear to be greatest in the Los Angeles Metro region where HQES Attorneys are most involved with investigations. These case histories also show that, in the Los Angeles Metro region, it is not at all unusual for cases to languish at HQES for periods of 6 to 8 months, or longer, before an accusation is filed.

Additionally, it is apparent from these case histories that neither HQES nor the Medical Board has developed effective processes for regularly tracking and following-up on filings that are not prepared on a timely basis. HQES does not provide the Medical Board with a planned filing date that could be used to ensure alignment of HQES and Medical Board expectations regarding the urgency of the case and then track whether the filings are past due. In the absence of effective status tracking processes, HQES Managers and Supervisors appear to operate under the false impression that a high percentage of accusations are prepared within 30 to 60 days, which is simply not true irrespective of how narrowly the measure is defined. The Medical Board distributes listings of all pending cases on a monthly basis to all Enforcement Program and HQES Managers and Supervisors, but Enforcement Program management does not regularly follow-up with HQES regarding pleadings that are past due (e.g., by specifically alerting HQES about cases where a pleading was not received within period of 45 to 60 days), and HQES does not provide the Medical Board with any reporting regarding the status of cases referred for prosecution where the pleadings have not yet been prepared or filed. Follow-ups on overdue pleadings, at least in the Los Angeles Metro region, appear to occur only when initiated by Los Angeles Metro region District office Investigators or Supervisors, and these follow-ups appear to occur on an ad-hoc, rather than regular, basis.

Frequency Distribution of Elapsed Times from Transmittal of Case to HQES to Accusation Filed
2005 to 2009

Case Identifier	Elapsed Time from Transmittal to Filing[1]	2005		2006		2007		2008		2009	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Northern California District Offices	2 Months or Less	18	33%	30	56%	28	43%	31	52%	26	37%
	3 to 4 Months	15	27%	9	17%	15	23%	17	28%	21	30%
	5 to 6 Months	8	15%	7	13%	7	11%	5	8%	12	17%
	7 to 12 Months	13	24%	7	13%	11	17%	7	12%	10	14%
	More than 12 Months	1	2%	1	2%	4	6%	0	0%	2	3%
	Total	55	100%	54	100%	65	100%	60	100%	71	100%
	Average Elapsed Time	4.1 Months		3.2 Months		3.8 Months		2.6 Months		3.6 Months	
Los Angeles Metro District Offices	2 Months or Less	9	16%	6	14%	7	13%	12	24%	20	41%
	3 to 4 Months	11	20%	4	9%	8	15%	11	22%	12	24%
	5 to 6 Months	6	11%	6	14%	11	20%	10	20%	6	12%
	7 to 12 Months	19	35%	15	35%	20	36%	10	20%	9	18%
	More than 12 Months	10	18%	12	28%	9	16%	6	12%	2	4%
	Total	55	100%	43	100%	55	100%	49	100%	49	100%
	Average Elapsed Time	6.9 Months		8.0 Months		7.1 Months		5.5 Months		3.8 Months	
Other Southern California District Offices	2 Months or Less	18	26%	13	27%	28	42%	26	59%	32	52%
	3 to 4 Months	29	41%	11	23%	24	36%	9	20%	22	36%
	5 to 6 Months	11	16%	9	19%	7	11%	4	9%	3	5%
	7 to 12 Months	11	16%	12	25%	7	11%	3	7%	3	5%
	More than 12 Months	1	1%	3	6%	0	0%	2	5%	1	2%
	Total	70	100%	48	100%	66	100%	44	100%	61	100%
	Average Elapsed Time	3.8 Months		4.8 Months		2.9 Months		3.1 Months		2.5 Months	

[1] Excludes 33 cases taking longer than eighteen (18) months to file, including 19 Los Angeles Metro region cases (58 percent).

Frequency Distribution of Elapsed Times from Transmittal of Case to HQES to Accusation Filed
2005 to 2009

Case Identifier	Elapsed Time from Transmittal to Filing[1]	2005		2006		2007		2008		2009	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All District Office Identifiers	2 Months or Less	45	25%	49	34%	63	34%	69	45%	78	43%
	3 to 4 Months	55	31%	24	17%	47	25%	37	24%	55	30%
	5 to 6 Months	25	14%	22	15%	25	13%	19	12%	21	12%
	7 to 12 Months	43	24%	34	23%	38	20%	20	13%	22	12%
	More than 12 Months	12	7%	16	11%	13	7%	8	5%	5	3%
	Total	180	100%	145	100%	186	100%	153	100%	181	100%
	Average Elapsed Time	4.8 Months		5.2 Months		4.5 Months		3.7 Months		3.3 Months	
Other Identifiers (IDENTS 16, 19, 20, 21, and 23)	2 Months or Less	48	84%	45	82%	33	79%	47	71%	38	69%
	3 to 4 Months	5	9%	8	15%	6	14%	8	12%	7	13%
	5 to 6 Months	3	5%	1	2%	3	7%	10	15%	4	7%
	7 to 12 Months	1	2%	1	2%	0	0%	1	2%	6	11%
	More than 12 Months	0	0%	0	0%	0	0%	0	0%	0	0%
	Total	57	100%	55	100%	42	100%	66	100%	55	100%
	Average Elapsed Time	2.2 Months		1.5 Months		1.5 Months		2.0 Months		2.5 Months	
Total Accusations Filed	2 Months or Less	93	39%	94	47%	96	42%	116	53%	116	49%
	3 to 4 Months	60	25%	32	16%	53	23%	45	21%	62	26%
	5 to 6 Months	28	12%	23	12%	28	12%	29	13%	25	11%
	7 to 12 Months	44	19%	35	18%	38	17%	21	10%	28	12%
	More than 12 Months	12	5%	16	8%	13	6%	8	4%	5	2%
	Total	237	100%	200	100%	228	100%	219	100%	236	100%
	Average Elapsed Time	4.0 Months		4.1 Months		3.9 Months		3.2 Months		3.1 Months	

[1] Excludes 33 cases taking longer than eighteen (18) months to file, including 19 Los Angeles Metro region cases (58 percent).

Below we present results of analyses we performed of both of these sources of delay in the filing of accusations.

1. Requests for Supplemental Investigations

Between 2004 and 2009, a total of 63 cases had one or more supplemental investigations completed by the District offices, statewide, but nearly 70 percent of these cases were assigned to Los Angeles Metro region offices. On average, the supplemental investigations took 3 to 4 months to complete. The total number of cases with supplemental investigations submitted by Los Angeles Metro region offices during 2005 (12) was more than double the number submitted during the prior year (5), and greater than the number of cases with supplemental investigations completed over the entire 6-year period in each of the other regions of the State. In subsequent years, the number of cases with supplemental investigations completed by Los Angeles Metro region offices remained at elevated levels, but gradually declined. During 2009, Los Angeles Metro District offices completed supplemental investigations for four (4) cases, more than completed by all other District offices throughout the rest of the State. The Diamond Bar and Cerritos District offices were responsible for most of these Los Angeles Metro region cases (15 and 13, respectively). Consequently, our review of supplemental investigations focused on Los Angeles Metro region cases.

Table VII-2, below, shows the number of supplemental investigations completed by each of the Los Angeles Metro region's four (4) District offices, by year. As shown by Table VII-2, the total number of completed supplemental investigations submitted by Los Angeles Metro region offices during 2005 (12) was more than double the number submitted during the prior year (5), and greater than the number of supplemental investigations completed over the entire 6-year period in each of the other regions of the State. In subsequent years the number of supplemental investigations completed by Los Angeles Metro region District offices remained at elevated levels, but gradually declined. During 2009 Los Angeles Metro District offices completed four (4) supplemental investigations, more than completed by all other District offices throughout the rest of the State. The Diamond Bar and Cerritos offices were responsible for completing most of the region's supplemental investigations.

Table VII-2. Completed Supplemental Investigations
Los Angeles Metro District Offices

District Office	2004	2005	2006	2007	2008	2009	Total
Valencia		2	1	2		1	6
Ceritos	1	7	4		1		13
Diamond Bar		2	1	4	5	3	15
Glendale	4	1	2	1			8
Total	5	12	8	7	6	4	42

VII. Prosecutions and Disciplinary Outcomes

With the assistance of Medical Board staff, we researched each of the 15 supplemental investigation cases assigned to the Diamond Bar office. These cases involved a mix of single and multiple-patient cases and various types of complaints, including cases involving quality of care issues, excessive testing or treatment, sexual misconduct, criminal violations, excessive prescribing, and fraud. With one exception, all of the supplemental investigations were requested and completed prior to the filing of an accusation. The scope of most of the supplemental investigations encompassed either (1) obtaining an additional Medical Expert opinion, or (2) obtaining an addendum to a Medical Expert opinion. Following completion of these supplemental investigation activities, HQES declined to file two (2) cases. In one of these cases the decline to file was issued after first requesting and obtaining a second Medical Expert opinion which found multiple extreme and simple departures. Accusations were filed for the remaining 11 cases. For these 11 cases, the average elapsed time from transmittal to filing of the accusation was 10 months. Nine (9) of these cases were settled without a hearing. None of the cases that had two (2) Medical Expert opinions went to hearing. Two (2) cases proceeded to hearing. One (1) of these cases was a single patient case and the other case was a multiple patient case. Both of these cases had just one (1) Medical Expert opinion. Both of the cases that proceeded to hearing were dismissed. It is not clear that either case was dismissed due to problems with the Medical Expert or with the quality of their opinion. However, in these cases the defense may have benefitted from have two (or possibly more) Medical Experts as compared to HQES' use of only a single Expert.

Key findings resulting from this research are presented below.

Overview of Expert Opinions Included with Transmittal – Of the 13 cases referred to HQES for prosecution, including two (2) consolidated cases, 12 included a Medical Expert opinion that supported referral of the case (e.g., one or more extreme departures, multiple simple departures, or a combination of extreme and simple departures). The one (1) exception was a criminal conviction case for which an Expert opinion was not required. Ten (10) cases had a single Medical Expert opinion and three (3) cases had two (2) Medical Expert opinions.

Cases Transmitted with a Single Expert Opinion – Of the 10 cases referred for prosecution with a single Expert opinion, in five (5) cases HQES deferred preparing and filing an accusation pending preparation and submission of a second Medical Expert opinion or, in one case, two (2) additional Medical Expert opinions. In three (3) of the five (5) cases, the second Medical Expert opinion was not requested by HQES until 7 to 9 months after the case was referred for prosecution. In three (3) other cases that initially had a single Medical Expert opinion, HQES deferred preparing and filing an accusation pending preparation of an addendum to the Medical Expert opinion. In two (2) of these cases, HQES did not request the Addendum until more than three (3) months after the case was referred for prosecution. HQES did not request either a second Medical Expert opinion or an addendum to the Medical Expert opinion in only two (2) of the 10 single Medical Expert cases.

Cases Transmitted with Two Expert Opinions – HQES deferred preparing and filing an accusation pending preparation and submission of addendums to the Medical Expert opinions in two (2) of three (3) cases referred for prosecution that had two (2) Medical Expert opinions. In both cases the addendums were not requested until more than three (3) months after transmittal of the case.

Additional Interview and Record Requests – HQES requested additional records in five (5) cases and additional interviews with the subject, patients, witnesses, or others in three (3) cases. In several instances these are the same cases. In several cases HQES did not submit these requests until several months after transmittal of the case. In several cases the additional interviews and records collection activities occurred after a second Medical Expert opinion or addendum had already been completed.

Supplemental Investigation Planning – In several cases, over an extended period of time, HQES submitted a sequential series of requests for additional interviews, records, and modified or additional Expert opinions. With better planning, some of these activities could possibly have been completed in parallel, thereby reducing the amount of calendar time needed to complete all supplemental investigation activities.

These case histories reflect a pattern of post-transmittal activity by some Los Angeles Metro region Attorneys that differs from the approach used by most Attorneys at other HQES offices. Most HQES Attorneys rarely request a second Expert opinion, even for single patient cases, unless a second medical specialty is involved or it is determined that a case will likely proceed to hearing and the departure is not obvious. This determination is usually made at some point after the accusation is filed. Also, most HQES Attorneys usually begin working collaboratively with the Medical Expert upon transmittal of a case, and do not usually decline to file or return a case to the District office Investigator solely to obtain an addendum. Instead, most HQES Attorneys usually discuss the case directly with the Expert during the process of drafting the accusation, and then provide the Expert with a draft of the accusation for their review. If an Addendum is needed, it is usually requested at a later point in the process. Additionally, other HQES Attorneys do not normally defer drafting and filing an accusation pending receipt of better quality, or certified, copies of records.

Occasionally, supplemental investigations are needed in advance of drafting and filing the accusation, a process used by all HQES offices to a limited extent. However, in the case of the Diamond Bar office, it appears that this process was used more frequently than would have occurred if the same cases had been referred for prosecution to HQES Attorneys outside the Los Angeles Metro region. When requested, a supplemental investigation does not necessarily result in a suspension of the process of drafting and filing the Accusation, as appears to have occurred with most of these Diamond Bar cases. Even among the Diamond Bar cases, there was one (1) case where additional witness interviews were completed after the accusation was filed and another case where an addendum to a Medical Expert's opinion was completed after the filing. In one (1) case the accusation was amended to consolidate another case.

These case histories show that HQES' use of the supplemental investigation process contributed to the extended elapsed times from transmittal to filing that occurred with Diamond Bar's cases beginning during 2005 and continuing, to a lesser extent, in subsequent years. The case histories also show that, in many instances, Diamond Bar's cases languished for an extended period following transmittal to HQES. It is unclear what, if any, consumer protection or other benefits were realized from HQES' requests for additional Medical Expert opinions and addendum reports, and associated delays in the drafting and filing of the accusations.

2. Extended Periods of Limited Activity While Cases are Pending at HQES

Enforcement Program Managers, Supervisors, and Investigators commented to us about persistent problems with cases languishing at HQES after referral for prosecution, especially in the Los Angeles Metro region. To substantiate their experience, Medical Board staff in the Los Angeles Metro region provided us with synopses of the following seven (7) cases which were recently transmitted to HQES' Los Angeles Metro office (mid- to late-2009). Accusations for six (6) these cases were not prepared by HQES until up to ten (10) months later in mid-2010 (one case is still pending). The cases involved two (2) District offices in the Los Angeles Metro region and several different Lead Prosecutors and Primary DAGs.

Case History VII-1 (9 Month Delay) – This case involved the Subject's failure to have a chaperone present when seeing children. The Subject was also on probation. The accusation was not filed until 9 months after transmittal of the case to HQES.

Case History VII-2 (7+ Month Delay) – This multiple patient case involved multiple extreme departures in connection with prescribing medications. After the District office Supervisor contacted the Lead Prosecutor to determine the status of the filing, HQES reassigned the case to a different Attorney. As of late-June 2010, the accusation had not yet been prepared (7 months after transmittal to HQES).

Case History VII-3 (6 Month Delay) – The Medical Expert in this case identified numerous extreme departures involving the Subject's care of patients. The accusation was expected to be filed about 6 months after transmittal of the case to HQES.

Case History VII-4 (9 Month Delay) – The Subject in this case was convicted twice of Driving Under the Influence (DUI). The accusation was not filed until nine (9) months after transmittal of the case to HQES.

Case History VII-5 (7 Month Delay) – This case involved a patient that had unnecessary surgery. Following a follow-up by the District office Supervisor, the Supervising DAG replied by email that:

> **"Our investigation on this subject was closed on (date). The investigation matter was assigned to DAG [Jane Doe]. We have no open administrative matter on this subject."**

The District office Supervisor escalated the matter to the Medical Board's Regional Manager. An accusation was filed seven (7) months after transmittal of the case to HQES.

Case History VII-6 (5 Month Delay) – This multiple patient case involved excessive prescribing, prescribing without an examination, and record-keeping issues. Following transmittal of the case for prosecution, at the request of the District office Supervisor, the Medical Expert was asked to expand a portion of their review to include additional treatment dates for one of the patients. The accusation was filed five (5) months after transmittal of the Medical Expert's addendum report.

Case History VII-7 (9+ Month Delay) – This single patient case involved unnecessary surgery and related complications. Two Medical Expert opinions found an extreme departure, but used somewhat different wording. Following completion of the investigation, the Primary DAG notified the District office Supervisor that he was closing the case with a recommendation to issue a citation and fine. The District office Supervisor requested clarification from the Primary DAG and Lead Prosecutor regarding their reasons for their rejection of the case and suggested that they consider requesting an addendum from one of the Medical Experts to clarify their report. A few days later HQES' Supervising DAG replied:

> **"Thank you for the update. Because we have closed our investigation matter, we are not in a position to provide input at this time."**

The District office Supervisor escalated the matter to their Area Manager and the Deputy Chief of Enforcement who directed the Supervisor to transmit the case to HQES. Four (4) months after transmittal of the case, HQES issued a Decline to File Memorandum and again recommended issuance of a citation and fine. Several months later an agreement was reached between the Medical Board and HQES to seek a clarification of the Medical Expert's report, as suggested previously by the District office Supervisor. The Medical Expert issued an addendum clarifying their extreme departure finding. As of mid-July, the case is still pending.

D. Stipulations Prepared and Average Elapsed Times from Accusation Filed to Stipulation Received

Exhibit VII-5, on the next page, shows average elapsed times from accusation filed to stipulation received, by year, by Identifier. The data shown in Exhibit VII-5 excludes Out-of-State (IDENT 16) cases transmitted by DCU directly to HQES, and cases involving petitions to revoke probation (IDENT 'D') which are believed to be distributed proportionately throughout the State.

As shown in VII-5, for cases with District office Identifiers the average elapsed time from accusation filed to stipulation received decreased during the last several years (from an average of about 15 months to an average of about 11 months). However, there were significant performance variations between the different geographic regions of the State. For the Northern California region, the elapsed times generally averaged about 10 months throughout the past six (6) years. The decrease in composite elapsed times during this period, to a statewide average of 11 months during the past two (2) years, is attributable to improved performance in the Los Angeles Metro and Other Southern California regions. However, even with this improvement, the average elapsed time for the Los Angeles Metro region during the past two (2) years lagged performance of the other two regions.

Exhibit VII-6 also shows average elapsed time data for cases with an Out-of-State Identifier that were settled, and one (1) case with a Headquarters Unit Identifier that was settled. As shown by Exhibit VII-5, only a few stipulations are received each year for these types of cases (or none at all).

Average Elapsed Times from Accusation Filed to Stipulation Received by Identifier - 2004 thorugh 2009

Excludes Petitions to Revoke Probation and Nearly All Out of State Cases

Including Cases with Timeframes Exceeding 3 Years

Fiscal Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)
2004	50	10	64	19	39	14	153	15
2005	36	10	49	17	50	14	135	14
2006[2]	40	12	66	18	38	16	144	16
2007	48	7	33	12	55	16	136	12
2008	30	10	45	10	44	12	119	11
2009	52	10	45	14	34	10	131	11

Fiscal Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20, 22, and 23)			
	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)
2004					1	1	154	15
2005	2	6	4	29	7	13	148	14
2006[2]					2	14	146	16
2007	4	3	2	13	2	5	144	12
2008	3	3	1	0	3	33	126	11
2009	1	24	1	5	1	9	134	11

Excluding Cases with Timeframes Exceeding 3 Years

Fiscal Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)
2004	48	8	63	18	39	14	150	14
2005	35	9	47	16	48	13	130	13
2006[2]	38	9	61	15	36	15	135	13
2007	48	7	32	11	52	14	132	11
2008	29	7	44	9	43	11	116	9
2009	50	9	42	11	33	9	125	10

Fiscal Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20,22, and 23)			
	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)	Number of STIPs	Average Time (Months)
2004					1	1	151	14
2005	2	6	2	14	7	13	141	13
2006[2]					2	14	137	13
2007	4	3	2	13	2	5	140	10
2008	3	3	1	0	3	33	123	10
2009	1	24	1	5	1	9	128	10

[1] Over the six-year period from 2004 through 2009, excludes 24 subsequent stipulation submissions related to the same complaint, 176 stipulations related to Out-of-State (IDENT 16) cases transmitted by DCU directly to HQES, and 82 cases involving petitions to revoke probation (IDENT 'D').

[2] The VE Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

E. Average Elapsed Time from Stipulation Received to Board Action

Table VII-3, below, shows the average elapsed time from stipulation received to the Board action, by year, for the past four (4) fiscal years. As shown by Table VII-3, this process takes an average of about three (3) months to complete for all stipulations, and also for just stipulations with a District office Identifier. In some cases this process can take as long as 5 to 6 years to complete. If extended cycle time cases are excluded, then the average elapsed time for the remaining cases decreases to about two (2) months.

Table VII-3. Average Elapsed Times from Stipulation Submitted to Board Action

Category	2005/06		2006/07		2007/08		2008/09	
	Number of STIPs	Average Elapsed Time (Months)	Number of STIPs	Average Elapsed Time (Months)	Number of STIPs	Average Elapsed Time (Months)	Number of STIPs	Average Elapsed Time (Months)
Total Stipulations with Board Action	191	2.9	198	2.9	190	3.3	159	2.7
Less: Stipulations with Out-of-State, Headquarters, and Probationer Identifiers (IDENTS 16, 19, 20, 23, and D)	54	1.4	63	2.2	61	3.6	43	1.1
Stipulations with District Identifiers (IDENTs 2 through 18, Excluding 16)	145	3.3	137	3.2	135	3.0	123	3.1
Less: Stipulations with Extended Elapsed Times (Longer than 1 Year)	8	22.1	2	70.7	6	26.7	7	18.0
Stipulations with District Identifiers, Excluding Extended Elapsed Time Cases	137	2.2	135	2.2	129	1.9	116	2.2

In some cases, Board action does not occur for an extended period following receipt of a proposed stipulation because the licensee is not available to attend the Board's Hearing on the matter due to failing health. More frequently, the Medical Board rejects the proposed Stipulation and refers the case back to HQES for re-negotiation. If the licensee is not agreeable to the Board's counter-proposal, the matter is re-scheduled for hearing. Prior to the Hearing a modified stipulation may be negotiated between HQES and the licensee. In these circumstances the elapsed time from receipt of the stipulation to Board action includes the elapsed time related to negotiating, preparing, submitting, and adopting the modified stipulation. Alternatively, the case proceeds to hearing and, following the hearing, a proposed decision is prepared and submitted to the Board. In these circumstances the elapsed time from receipt of the stipulation to Board action includes the elapsed time for conducting the hearing, and preparing, submitting, and adopting the proposed decision. If the licensee submits a petition for reconsideration or appeals the proposed decision, then the elapsed times from stipulation received to Board action will be further extended pending the outcome of these processes (see Section VII-G – *Average Elapsed Time from Proposed Decision Received to Board Action*).

F. Administrative Hearings and Average Elapsed Times from Accusation Filed to Decision Received

Exhibit VII-6, on the next page, shows the average elapsed times from accusation filed to proposed decision received, by year, by Identifier. The data shown in Exhibit VII-6 excludes cases involving petitions to revoke probation (IDENT 'D') which are believed to be distributed proportionately throughout the State. Only about 10 to 15 percent of cases proceed to hearing as most cases are settled prior to hearing. For cases with District office Identifiers, about 20 hearings are completed per year compared to an average of about 150 total case dispositions (stipulations plus proposed decisions).

For cases with District office Identifiers, during the past two (2) fiscal years (2007/08 and 2008/09) an average of 18 to 20 months elapsed from accusation filed to proposed decision received, about the same as the average for the preceding two (2) years (2005/06 and 2006/07). Also, the average elapsed times during the past two (2) years were about the same in all major geographic regions of the State (18 to 19 months). Due to the small numbers of cases involved (about a dozen cases per year for each region), it is unclear whether the average elapsed times have changed significantly in any of the three major geographic regions of the State.

Average Elasped Times from Accusation Filed to Proposed Decision Received, By Identifier
2005/06 through 2008/09

Fiscal Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)
2005/06	4	22	18	23	11	21	33	22
2006/07[2]	9	9	17	20	13	19	39	17
2007/08	9	19	14	18	15	21	38	19
2008/09	11	17	12	20	12	16	35	18

Fiscal Year	Cases with Other Identifiers[1]						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		Headquarters (IDENT 20)			
	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)	Number of Decisions	Average Time (Months)
2005/06	7	9					40	20
2006/07[2]	8	9			1	5	48	16
2007/08	5	11					43	18
2008/09	10	9			1	25	46	16

[1] Excludes cases also involving petitions to revoke probation (DAPF and DAVF Action Codes).

[2] The VE Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

G. Average Elapsed Time from Proposed Decision Received to Board Action

Table VII-4, below, shows the average elapsed times from proposed decision received to Board action, by year, for the past four (4) fiscal years. As shown by Table VII-4, this process takes an average of 4 to 6 months to complete for all proposed decisions, and also for just proposed decisions with a District office Identifier. In some cases the process can take as long as 5 to 6 years to complete. If extended cycle time cases are excluded, then the average elapsed time for the remaining cases decreases to or 2 to 4 months.

Table VII-4. Average Elapsed Times from Proposed Decision Received to Board Action

Category	2005/06		2006/07		2007/08		2008/09	
	Number of PDs	Average Elapsed Time (Months)	Number of PDs	Average Elapsed Time (Months)	Number of PDs	Average Elapsed Time (Months)	Number of PDs	Average Elapsed Time (Months)
Total Proposed Decisions with Board Action	71	4.7	71	6.7	70	5.6	63	4.4
Less: Proposed Decisions with Out-of-State, Headquarters, and Probationer Identifiers (IDENTS 16, 19, 20, 23, and D)	36	2.7	42	3.7	32	5.7	32	4.2
Proposed Decisions with District Identifiers (IDENTs 2 through 18, Excluding 16)	39	6.1	36	8.9	42	5.0	32	4.5
Less: Proposed Decisions with Extended Elapsed Times (Longer than 1 Year)	4	31.5	7	36.2	4	29.7	1	23.1
Proposed Desicions with District Identifiers, Excluding Extended Elapsed Time Cases	35	3.2	29	2.3	38	2.4	31	3.9

In some cases Board action does not occur for an extended period following receipt of a proposed decision because the licensee is not available to attend the Board's Hearing on the matter due to failing health. In other cases the Medical Board rejects the proposed decision and refers it back to OAH. In these circumstances the elapsed time from receipt of the proposed decision to Board action includes the elapsed time for preparing and resubmitting the modified proposed decision. Additionally, the licensee may elect to submit a petition for reconsideration or appeal the proposed decision to Superior Court. In these circumstances, the elapsed time from receipt of the proposed decision to Board action includes the elapsed time for these processes, during which action by the Board may be stayed, in some cases for a period of years.

H. Disciplinary Outcomes

Exhibit VII-7, on the next page, shows disciplinary actions, by type of discipline, by Identifier for (1) the 4-year period from 2003/04 through 2006/07, and (2) the 2-year period from 2007/08 through 2008/09. Additionally, Exhibit VII-8 shows the percentage of disciplinary actions requiring license revocation, surrender, suspension, or probation. As shown by Exhibit VII-7, during the past two (2) years there were significant variations in disciplinary outcomes between the different geographic regions of the State.

Northern California Region

Total Disciplinary Actions – The total number of disciplinary actions decreased by about 9 percent (from an average of 56 actions per year to an average of 51 actions per year).

Composition of Disciplinary Actions – The number of disciplinary actions requiring license revocation, surrender, suspension, or probation decreased by 7 percent (from an average of 40.25 actions per year to an average of 37.50 actions per year). The proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation increased marginally (from 72 percent to 74 percent).

Los Angeles Metro Region

Total Disciplinary Actions – The total number of disciplinary actions decreased by about 13 percent (from an average of 71 actions per year to an average of 62 actions per year).

Composition of Disciplinary Actions – The number of disciplinary actions requiring license revocation, surrender, suspension, or probation decreased by 20 percent (from an average of 52 actions per year to an average of 41.5 actions per year). The number of public reprimands issued changed very little. The proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation decreased from 74 percent to 67 percent.

Other Southern California Region

Total Disciplinary Actions – The total number of disciplinary actions increased by about 10 percent (from an average of 58 actions per year to an average of 66 actions per year).

Composition of Disciplinary Actions – There was a significant increase in the number of public reprimands issued (from an average of 15 per year to an average of 22 per year). The number of disciplinary actions requiring license revocation, surrender, suspension, or probation was unchanged. Due to the increase in number of public reprimands, the proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation decreased from 75 percent to 66 percent.

Disciplinary Outcomes by Identifier
2003/04 through 2008/09

2003/04 through 2006/07 (4 Years)

Disciplinary Outcome	Cases with District Office Identifiers								Cases with Other Identifiers						Total	
	Northern California		Los Angeles Metro		Other Southern CA		Total		Out of State (16)		Probation (19 & D's)		Other (20 to 23, 27)			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Revocation	11	5%	24	9%	23	10%	58	8%	46	22%	31	31%	7	13%	142	13%
Surrender	59	26%	46	16%	47	20%	152	21%	88	43%	33	33%	7	13%	280	26%
Suspension Only	0	0%	0	0%	3	1%	3	0%	0	0%	0	0%	0	0%	3	0%
Probation with Suspension	19	9%	35	12%	23	10%	77	10%	1	0%	9	9%	2	4%	89	8%
Probation Only	72	32%	103	37%	77	33%	252	34%	43	21%	27	27%	37	69%	359	33%
Public Reprimand	62	28%	74	26%	59	25%	195	26%	28	14%	1	1%	1	2%	225	20%
Total Disciplinary Outcomes	**223**	**100%**	**282**	**100%**	**232**	**100%**	**737**	**100%**	**206**	**100%**	**101**	**100%**	**54**	**100%**	**1,098**	**100%**
4-Year Average	56		71		58		184		52		25		14		275	
Revocation/Surrender/Probation %	72%		74%		75%		74%		86%		99%		98%		80%	

2007/08 through 2008/09 (2 Years)

Disciplinary Outcome	Cases with District Office Identifiers								Cases with Other Identifiers						Total	
	Northern California		Los Angeles Metro		Other Southern CA		Total		Out of State (16)		Probation (19 & D's)		Other (20 to 23, 27)			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Revocation	12	12%	14	11%	12	9%	38	11%	29	27%	10	27%	1	6%	78	15%
Surrender	19	19%	19	15%	21	16%	59	17%	31	28%	13	35%	2	13%	105	20%
Suspension Only	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Probation with Suspension	7	7%	10	8%	6	5%	23	6%	2	2%	2	5%	0	0%	27	5%
Probation Only	37	36%	40	32%	48	37%	125	35%	22	20%	12	32%	10	63%	169	33%
Public Reprimand	27	26%	41	33%	44	34%	112	31%	25	23%	0	0%	3	19%	140	27%
Total Disciplinary Outcomes	**102**	**100%**	**124**	**100%**	**131**	**100%**	**357**	**100%**	**109**	**100%**	**37**	**100%**	**16**	**100%**	**519**	**100%**
2-Year Average	51		62		66		179		55		19		8		260	
Revocation/Surrender/Probation %	74%		67%		66%		69%		77%		100%		81%		73%	

With respect to the Los Angles Metro region, it is unclear whether there is a correlation between:

- The decreased proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation for Los Angeles Metro cases, *and*
- The improved average elapsed times to reach settlement achieved in the Los Angeles Metro region during the past several years.

Additionally, if there is a correlation between these findings, it is unclear whether the correlation is due to weaker or less well-prepared cases, a change in the composition of the cases, less effective prosecution of the cases, or a combination of these factors.

VII. Prosecutions and Disciplinary Outcomes

I. Expenditures for HQES Prosecution Services

HQES Attorneys post time charges for prosecution-related activities to "Administrative" matters that are opened for each individual case. **Exhibit VII-8**, on the next page, summarizes HQES time charges to Administrative matters by year from 2005 through 2009. As shown by Exhibit VII-8, in four (4) of the past five (5) years, HQES charged between 31,000 and 34,000 hours to Administrative matters. The number of hours charged by HQES to Administrative matters during 2007 (38,000) was significantly higher than any of the other years. On a calendar year basis, during the past five (5) years the number of hours charged by Deputy Attorneys to Administrative matters:

- Increased by about 20 percent in the Northern California region (from about 11,000 hours to about 13,000 hours)
- Increased by about 30 percent in the Los Angeles Metro region (from about 10,000 hours to about 13,000 hours) and then decreased by about 23 percent (to about 10,000 hours)
- Increased by about 20 percent in the Other Southern California region (from about 9,000 hours to about 11,000 hours) and then decreased by about 18 percent (from about 11,000 hours to less than 9,000 hours).

On a fiscal year basis, the trends are the same, although less pronounced.

On a fiscal year basis, the trends are the same, although less pronounced. HQES' hourly billing rates for Attorney services during 2008/09 and 2009/10 were $158 and $170, respectively, or an average of $164 per hour. Assuming a $164 hourly billing rate for Attorney services, estimated billings during 2009 for prosecution-related services for cases assigned to the Northern California region were about $2.1 million compared to less than $1.6 million for cases assigned to the Los Angeles Metro and Other Southern California regions.

As discussed previously, there are significant variations between regions in the number of prosecutions completed, as well as variations in other output and performance metrics, such as the proportion of disciplinary actions requiring license revocation, surrender, suspension, or probation. **Exhibit VII-9**, following Exhibit VII-8, shows the number of prosecutions completed by year, by region, for (1) cases with District office Identifiers, (2) SOI-related stipulations and decisions, and (3) cases with Out-of-State Identifiers. Separate performance ratios are shown excluding, and including, Out-of-State cases which, when included, are weighted to reflect HQES staff estimates that, on average, these cases take about 15 percent as much time to complete as SOIs and cases with District office Identifiers. As shown by Exhibit VII-9, including a 15 percent weighting of Out-of-State cases, the number of hours charged by HQES Attorneys per completed case was about the same for each of the three major geographic regions of the State during both 2006/07 and 2008/09 (an average of about 150 hours per completed case). During 2007/08 the number of hours charged per completed case was much higher than this average for the Los Angeles Metro region (179 hours charged per completed case), and much lower than this average for both the Northern California and the Other Southern California regions (132 hours per completed case and 103 hours per completed case, respectively).

Hours Charged by HQES Staff to Administrative Matters - 2005 through 2009[1]

Classification	HQES Office(s)	Calendar Year (Actual)				
		2005	2006	2007	2008	2009
Deputy Attorneys	Northern California[1]	11,333	11,718	12,960	12,231	13,026
	Los Angeles Metro	10,150	9,696	12,937	11,820	9,823
	San Diego (Other Southern California)	9,220	8,290	11,265	8,144	8,923
	Total	30,703	29,704	37,161	32,195	31,772
Paralegals and Analysts	Northern California[1]	92	15	65	317	157
	Los Angeles Metro	579	835	463	514	1,191
	San Diego (Other Southern California)	151	98	81	133	263
	Total	822	947	608	964	1,610
Supervising DAGs	Northern California[1]	99	221	212	106	160
	Los Angeles Metro	36	7	127	0	0
	San Diego (Other Southern California)	343	207	43	113	198
	Total	477	436	382	219	358
Total	Northern California[1]	11,524	11,954	13,237	12,654	13,342
	Los Angeles Metro	10,765	10,538	13,527	12,334	11,014
	San Diego (Other Southern California)	9,713	8,595	11,388	8,391	9,384
	Total	32,002	31,086	38,151	33,378	33,740

Classification	HQES Office(s)	Fiscal Year (Interpolated)			
		2005/06	2006/07	2007/08	2008/09
Deputy Attorneys	Northern California[1]	11,525	12,339	12,596	12,628
	Los Angeles Metro	9,923	11,316	12,378	10,822
	San Diego (Other Southern California)	8,755	9,777	9,704	8,534
	Total	30,203	33,432	34,678	31,984
Paralegals and Analysts	Northern California[1]	54	40	191	237
	Los Angeles Metro	707	649	489	852
	San Diego (Other Southern California)	124	89	107	198
	Total	885	778	787	1,287
Supervising DAGs	Northern California[1]	160	217	159	133
	Los Angeles Metro	22	67	64	0
	San Diego (Other Southern California)	275	125	78	156
	Total	457	409	301	289
Total	Northern California[1]	11,739	12,596	12,946	12,998
	Los Angeles Metro	10,652	12,032	12,931	11,674
	San Diego (Other Southern California)	9,154	9,991	9,889	8,888
	Total	31,545	34,619	35,766	33,560

[1] Excludes hours charged to Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters

[2] Includes Fresno, Sacramento, Oakland, and San Francisco offices.

Estimated HQES Attorney Hours Charged per Completed Prosecution - 2006/07 through 2008/09

Output or Performance Indicator		2005/06 (Total)	2006/07				2007/08				2008/09			
			Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total
Hours Charged to Administrative Matters by HQES Deputy Attorneys[1]		30,203	12,339	11,316	9,777	33,432	12,596	12,378	9,704	34,678	12,628	10,822	8,534	31,984
Completed Cases with District Office Identifiers[2]	Default Decisions	6	2	0	3	5	5	3	2	10	1	6	5	12
	Accusations Withdrawn or Dismissed	22	5	4	6	15	11	6	19	36	8	8	4	20
	Post-Filing Stipulations Submitted	143	45	52	42	139	41	46	58	145	40	45	37	122
	Proposed Decisions Submitted	33	9	17	13	39	9	14	15	38	11	12	12	35
	Total Completed Cases with District Office Identifiers	204	61	73	64	198	66	69	94	229	60	71	58	189
Statement of Issues (SOI) - Stipulations and Proposed Decisions Submitted (IDENT 20)		27	16	0	0	16	21	0	0	21	15	0	0	15
Completed Cases with Out-of-State Identifiers	Default Decisions	12	7	0	0	7	9	0	0	9	17	0	0	17
	Accusations Withdrawn or Dismissed	2	5	0	0	5	10	0	0	10	3	0	0	3
	Post-Filing Stipulations Submitted	21	39	0	0	39	31	0	0	31	23	0	0	23
	Proposed Decisions Submitted	7	8	0	0	8	5	0	0	5	10	0	0	10
	Total Completed Cases with Out-of-State Identifiers	42	59	0	0	59	55	0	0	55	53	0	0	53
Total Completed Cases, Including SOIs and Cases with Out-of-State Identifiers (IDENT 16)		273	136	73	64	273	142	69	94	305	128	71	58	257
Ratio	HQES Attorney Hours Charged per Completed Prosecution Cases with District Identifiers and SOIs Only	131	160	155	153	156	145	179	103	139	168	152	147	157
	HQES Attorney Hours Charged per Completed Prosecution Cases with District or Out-of-State Identifiers and SOIs - Weighted[3]	127	144	155	153	150	132	179	103	134	152	152	147	151
Hourly Billing Rate for Attorney Services		$146	$158	$158	$158	$158	$158	$158	$158	$158	$158	$158	$158	$158
Average Attorney Cost per Case		$20,066	$22,752	$24,490	$24,174	$23,700	$20,856	$28,282	$16,274	$21,172	$24,016	$24,016	$23,226	$23,858

[1] Data shown excludes hours charged for cases classified as Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters.

[2] Data shown excludes cases involving Probationers, petitions for modification or termination of probation, petitions for reinstatement, and CME audit failure, Operation Safe Medicine, and Internet cases. The excluded cases are believed to be proportionately distributed throughout the State.

[3] Out-of-State cases which, on average, take substantially less Attorney time to complete, are weighted 15 percent.

During 2007/08, HQES' Los Angeles Metro office billed significantly more hours to Administrative matters than billed during both 2006/07 or 2008/09, but completed fewer prosecutions, resulting in a higher average number of hours billed per completed case. The especially low average number of hours billed during 2007/08 per completed case shown for HQES' San Diego office is partially attributable to withdrawal or dismissal of an unusually large number of cases (19) during 2007/08 (a non-positive outcome). However, due to the especially large total number of cases completed by the San Diego office, even if the performance ratio is adjusted to exclude most of the withdrawn/dismissed cases, the average number of hours billed per completed case would still be significantly lower than shown for both of the other regions.

In summary, a portion of the additional staffing resources authorized for HQES to support implementation of VE was utilized to provide higher levels of prosecution-related services. This is especially evident during 2007, and was concentrated primarily in HQES' Los Angeles Metro and San Diego (Other Southern California) offices. Subsequently, during 2008 and 2009, these HQES offices redirected some of these resources toward providing higher levels of Investigation-related services. There may also have been some shifting in the reporting of hours for the some prosecution-related activities (e.g., time spent on ISOs, TROs, and PC 23s and drafting accusations is sometime posted to Investigation matters). In contrast, in the Northern California region there were only minimal shifts during the past two (2) years in the allocation of Attorney resources between investigation and prosecution-related services. Additionally, although fewer hours were billed by the Los Angeles Metro office for prosecution services during 2008/09 compared to the prior two (2) years, the number of hours billed per completed case was still the same, or higher, than billed for cases handled in each of the other two geographic regions of the State (even without adjusting for time posted to Investigation matters for prosecution-related services, such as time spent on ISOs, TROs, and PC 23s and drafting accusations). Finally, during the past several years an average of less than 150 Attorney hours were billed per completed case (weighted) and the Medical Board's cost for these services averaged about $23,000 per case (weighted).

J. Recommendations for Improvement

Below we discuss several key recommendations for improving prosecution process performance. These recommendations concern (1) Supplemental Investigations, (2) Decline to File cases, and (3) Out-of-State cases. Additional recommendations that would impact prosecutions are included in Section X (*Organizational and Management Structures*), including recommendations involving:

- ✓ Restructuring the handling of Section 801 cases
- ✓ Restructuring the management of District office investigations
- ✓ Scaling back and optimizing HQES Attorney involvement in District office investigations
- ✓ Developing new organizational structures and processes for managing HQES expenditures and tracking cases following referral for prosecution
- ✓ Improving workload and performance reporting processes.

1. Supplemental Investigations and Decline to File Cases

In some cases, particularly in the Los Angeles Metro region, the supplemental investigation process is over-utilized and, to some extent, misused, resulting in unnecessary extension of the elapsed time to complete investigations, and delayed filing of Accusations. HQES Attorneys also sometimes decline to file cases that other Attorneys at the same or other HQES offices would accept and prosecute. When either of these events occurs, it sometimes triggers a dispute between HQES and Medical Board staff that can consume enormous amounts of resources at all levels throughout both organizations. Sometimes these disputes become very contentious, poisoning relationships not only between the parties involved in the dispute, but throughout both organizations. Alternatively, Enforcement Program staff acquiesce to HQES direction and either perform whatever additional investigative activities are requested, or close the case, even though they may disagree with this disposition. It is surprising that these types of disagreements can arise in a system that jointly assigns an Investigator an Attorney to each case at the onset of each investigation, and continuing through to its conclusion, especially in the Los Angeles Metro region where HQES Attorneys are most involved with the investigations. As the same types of disputes continue to surface, and continue to surface most frequently in the Los Angeles Metro region, it appears that the underlying causes of these disputes are not being addressed. A better process is needed to quickly, and impartially, resolve these disputes in a manner that reduces conflict and helps to prevent similar disputes from surfacing in the future.

Recommendation No. VII-1. *Establish independent panels to review all requests for supplemental investigations and all decline to file cases. The reviews should be completed expeditiously (e.g., within 1 to 2 days of issuance of the request for supplemental investigation or Decline to File Memorandum). For Northern California cases, the panel*

members should include a Regional Manager and Supervising DAG from the Southern California region, plus the Medical Board's HQES Services Monitor (see Recommendation No. X-6). For Southern California cases, the panel members should include a Regional Manager and Supervising DAG from the Northern California region, plus the Medical Board's HQES Services Monitor. The panels should review all decline to file cases and all requests for supplemental investigations for any cases where preparation of the pleading will be delayed pending completion of the supplemental investigation, and then advise the Chief of Enforcement, the Senior Assistant Attorney General, and all Medical Board and HQES Managers and Supervisors involved in the matter as to the results of their review, including recommended disposition of the matter.

2. Out-of-State Cases

The processes used to prepare Accusations for Out-of-State cases are currently working reasonably well. Some Out-of-State cases are currently handled by Medical Board staff without HQES involvement, but most cases are referred to HQES, which prepares an Accusation and, in most cases, negotiates a surrender of the Subject's license. It is unclear why an HQES Attorney is needed to perform these services for all of these cases. Additional staffing for DCU is expected to be authorized through the 2010/11 Budget which could provide DCU with the capability to draft many of these accusations, file the pleading, and negotiate related license surrenders. HQES Attorney involvement could be limited to reviewing the draft accusation and stipulation (on-line) and handling a limited number of more complex cases. Use of Medical Board staff in lieu of HQES Attorneys would reduce costs for these services and enable redirection of HQES resources to other cases.

Recommendation No. VII-2. *Restructure the processes used for preparing accusations for Out-of-State cases to reduce the number of cases referred to HQES. Utilize DCU staffing resources to draft accusations and license surrender stipulations for Out-of-State cases.*

VIII. Probation Program

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VIII. Probation Program

This section presents results of our assessment of the Probation Program. Results of this assessment show that the investigations and prosecutions of Probationers are being adversely impacted by the same factors as are impacting investigations and prosecutions of Non-Probationers. Additionally, needs exist to improve the processes used to ensure that on-going probation monitoring functions are regularly and properly performed.

The section is organized as follows:

Subsection	Title
A.	Investigations of Probationers and Petitions to Revoke Probation
B.	Probationer Intake and Monitoring
C.	Petitions for Modification or Termination of Probation.

VIII. Probation Program

A. Investigations of Probationers and Petitions to Revoke Probation

As shown by Exhibit VI-5, in Section VI, the Medical Board typically investigates about 50 cases per year involving Probationers (IDENT 19). In recent years, the average elapsed time to complete these investigations increased by about one (1) month (from 10 months to 11 months). Typically, about 30 cases are closed (60 percent), and the remaining cases (40 percent) are referred for prosecution. There is not a significant difference between the average elapsed time to complete investigations of cases that are closed and the average elapsed time to complete investigations of cases that are referred for prosecution. On average, investigations of Probationers take less time than investigations of Non-Probationers, possibly reflecting differences in the nature of many of these cases (e.g., a higher proportion of cases involving a violation of the terms of Probation). Additionally, prior to 2008/09, investigations of Probationers were not included in the VE Pilot Project.

Following referral for prosecution, if a petition to revoke probation is recommended, the Identifier on the case is changed to a 'D'. In some cases only a petition to revoke probation is filed, in other cases an accusation and a petition for revocation of probation are filed and, in rare cases, only an accusation is filed (e.g., if the term of the probation has expired). The absence of a District office Identifier for these cases (both 19s and Ds) makes it more difficult to determine the distribution of these cases by office or geographic region. However, the geographic distribution of cases involving Probationers is believed to be proportionate to the geographic distribution of Probationers, which is believed to be consistent with the geographic distribution of licensees and complaints referred for investigation.

As with referrals of non-Probationer cases to HQES, problems are sometimes experienced with referrals of Probationer cases to HQES, particularly in the Los Angeles Metro region. The following case summaries illustrate the some of the types of problems experienced with cases referred for prosecution to HQES' Los Angeles Metro office.

Case History VIII-1 (10 Month Delay). The Subject in this case was required to have a chaperone present when examining female patients. An investigation was completed that determined that the Subject did not have a chaperone present on numerous occasions when examining minor female patients. An accusation and petition to revoke probation were not filed until 10 months after referral of the case for prosecution.

Case History VIII-2 (18+ Month Delay). The Subject in this case was non-compliant with multiple terms and conditions of their probation, including refusing to enroll in and attend PACE, failing to submit Quarterly Reports, and failing to attend quarterly meetings with the Probation Monitor. The Medical Board issued an automatic suspension order, which remains in effect, and referred the case for prosecution. HQES now claims that it does not have the package, which the Medical Board now plans to resubmit. The delay in this case has already exceeded 18 months.

Case History VIII-3 (8+ Month Delay). The Subject in this case was required to abstain from the use of alcohol, but tested positive for a controlled substance. More than eight (8) months after referral of the case for prosecution, HQES had not

declined to file the case or prepared an accusation/petition to revoke probation. There is a disagreement between HQES and the Medical Board regarding the District office's response to HQES' request for additional investigation of the case.

Case History VIII-4 (4+ Month Delay). The Subject in this case was non-compliant with payment of cost recovery and probation monitoring costs, which had not been paid for years. More than four (4) months after the case was referred for prosecution, and approaching the point at which the Medical Board could lose jurisdiction, HQES had not declined to file the case or prepared a petition to revoke probation.

Several recommendations for improvement that would impact the investigations and prosecutions of Probationers, and help to address the problems illustrated in these case histories, are included in Sections V (*Investigations*) and Section X (*Organizational and Management Structures*), including recommendations involving:

- ✓ Restructuring the management of District office investigations
- ✓ Scaling back and optimizing HQES Attorney involvement in District office investigations
- ✓ Developing new organizational structures and processes for managing HQES expenditures and tracking cases following referral for prosecution
- ✓ Improved workload and performance reporting processes.

B. Probationer Intake and Monitoring

The Medical Board's Probation Monitoring Unit is responsible for intake and monitoring of Probationers. The Probation Monitoring Unit is organized into three (3) regional business units, with 4 to 7 Inspectors and one (1) clerical support position allocated to each unit. The regional units are each supervised by an Inspector III who reports to the Probation Management Unit's Manager (an SSM I). Key activities performed by Probation Monitoring staff are summarized below.

1. Intake Interviews

Intake interviews are completed for all new Probationers. During the interview the Probation Monitor reviews all of the terms and conditions of probation with the Probationer. On an annual basis about 100 new Probations are assigned to the Probation Monitoring Program, plus about a dozen others who are based outside the State and are not monitored (referred to as "tolling"). Data are not currently captured regarding the number of Intake Interviews completed or the elapsed time from commencement of probation to completion of the Intake Interviews.

2. First Year Monitoring

During the first year of probation emphasis is typically placed on ensuring compliance with terms and conditions involving participation in PACE, education, obtaining a practice monitor, chaperones, biologic fluid testing, and other requirements. Typically, these terms and conditions are "front-loaded" by the Board's decision. Additionally, Probationers are required to submit Quarterly Reports and to meet on a quarterly basis with the Medical Board's Probation Monitor.

3. Subsequent Year Monitoring

Subsequent year monitoring is generally limited to reviewing Quarterly Reports submitted by the Probationer and meeting quarterly with the Probationer. Including first-year participants, about 450 In-State Probationers are currently monitored (an average of about 30 to 35 cases per position, depending on vacancies).

4. Performance Reporting

Probation Program performance reporting focuses exclusively on tracking the number of Probationers, and new assignments, reassignments, and terminations or completions. More recently, attention has begun to focus on the completion of Intake Interviews, and the elapsed time from commencement of probation to completion of the Intake Interview.

VIII. Probation Program

The Medical Board does not currently capture data regarding the scheduling and completion of Quarterly Reviews with Probationers. Consequently, data are not available, without reviewing individual case files regarding any of the following:

- The extent to which Quarterly Reviews are completed on a quarterly basis, as scheduled
- The number and proportion of Quarterly Reviews completed on-site at the Probationer's office
- The number and proportion of Quarterly Reviews completed at other locations
- The number and proportion of Quarterly Reviews completed without meeting with the Probationer
- The number of random visits completed (e.g., to the offices of sole practitioners).

Needs exist to improve the processes used ensure that Probationer monitoring functions are regularly and properly performed.

Recommendation No. VIII-1. *Develop systems for tracking and reporting completion of quarterly reviews, random office visits, and other key probation monitoring activities.*

C. Petitions for Modification or Termination of Probation

Petitions for modification or termination of probation are submitted to DCU which forwards the petitions and supporting documentation to the Probation Unit Manager who researches the cases and determines whether to assign the petitions to Probation Unit staff or refer to the District offices for investigation. Cases involving Probationers with compliance deficiencies or another active Investigation are referred to the District offices. Otherwise, the cases are assigned to staff within the Probation Units. Cases referred to the District offices are handled as VE cases, with joint assignment of an HQES Attorney and an Investigator to each case. Following investigation by either the Probation Unit or the District office, and irrespective of the Probationer's compliance record or the nature of the requested changes to the terms and conditions of their probation, the petitions are transmitted to HQES which presents the cases for hearing.

It is unclear why cases referred to the District offices are included in the VE Pilot Project as they are not complaints and the basic character of these cases, and the types of unvestigations performed, are completely different from complaints. It is also unclear why hearings are required for all of these matters. A Medical Board analyst could potentially review the cases prior to referral to HQES, and make a determination, in some cases, as to whether to accept the Petition and then present it directly to the Board, without any involvement of HQES and OAH. The remaining cases could still be referred to HQES for hearing.

Recommendation No. VIII-2. *Restructure the processes used for investigating petitions for modification or termination of probation. Exclude cases referred to the District offices from the VE Program, and screen out petitions from referral to HQES that do not need a hearing before an ALJ.*

IX. Integrated Assessment of Enforcement Program Performance

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IX. Integrated Assessment of Enforcement Program Performance

This section presents an integrated assessment of the performance of the Enforcement Program. The assessment highlights significant changes in outputs and performance that occurred during the past several years following implementation of VE. Key statistical measures of overall Enforcement Program performance are presented, including:

- ✓ Number of ISOs/TROs sought and granted
- ✓ Number of accusations filed and average elapsed time from referral for Investigation to accusation filed
- ✓ Number of stipulations received and average elapsed time from referral for Investigation to stipulation received
- ✓ Number of disciplinary actions, decomposed by level of discipline imposed.

Since implementation of VE during 2006 there has been a marked deterioration in overall enforcement process performance. Investigator turnover has increased, fewer interim suspension actions are taken, investigations take longer to complete, fewer cases are referred for prosecution, and there has not been any significant improvement in the the disciplinary outcomes achieved or the timeframe to achieve these outcomes. Concurrently, the Medical Board's costs for HQES legal services have increased due to rate increases and increased Attorney staffing authorized to support implementation of VE. Of particular concern is the increase in the amount of time needed to complete Quality of Care case investigations. These investigations already take an average of more than 18 months to complete for cases that are referred for prosecution.

The more intensive involvement of HQES Attorneys in investigations appears to be contributing to elevated attrition of seasoned Investigators and deteriorating Enforcement Program performance. These impacts are most apparent in the Los Angeles Metro region where HQES Attorney involvement is greatest (2 to 3 times higher than the level of involvement of HQES Attorneys in other regions of the State). Recently implemented policy changes requiring a second Medical Expert opinion for most (or all) single patient cases assigned to Los Angeles Metro District offices could further increase the amount of time needed to complete some quality of care case investigations, increase Investigator caseloads, reduce the availability of Medical Experts, particularly in specialized areas of practice, and increase Investigator turnover and Medical Board costs. Finally, as aged cases migrate from the Investigation Stage to the Prosecution Stage during 2009/10 and subsequent years, it is likely that average elapsed times from case referral for investigation to stipulation received will increase.

There are a number of factors over the past several years that have contributed to the Enforcement Program's inability to meet its goals. The loss of Investigators to a number of state agencies is likely to have contributed, although it is not possible to know whether or to what extent goals would have been met if fewer Investigators had separated from the Board. It is, however a fact that the Board has experienced a number of lateral transfers (non-promotional) to other State agencies subsequent to implementation of Vertical Enforcement. Some staff were disappointed that pay raises did not materialize, case levels did not decline as hoped, and the Investigators were not transferred to the Department of Justice. It is also a fact that there are tensions between Medical Board and HQES management, and a lack of consistency of VE implementation among regions. All parties involved are jointly responsible for ensuring stability and an

employment environment conducive to productivity, and it would appear that significant and continuing problems in this area have not been sufficiently addressed. Although current Enforcement Program staffing levels are higher than they have been in several years and the workforce is stable, likely due to current economic conditions, as the economy improves the Medical Board may again experience high attrition and vacancy rates if improvements are not made.

The remainder of this section is organized as follows:

Subsection	Title
A.	Complaints Handled and Average Elapsed Times from Initiation to Referral for Investigation
B.	ISOs/TROs Sought and Granted
C.	Accusations Filed and Average Elapsed Times from Referral for Investigation to Accusation Filed
D.	Accusations Withdrawn or Dismissed
E.	Stipulations Prepared and Average Elapsed Times from Referral for Investigation to Stipulation Submitted
F.	Efficiency of Investigations and Prosecutions
G.	Disciplinary Outcomes.

Recommendations for improvements are separately presented in Section V (*Complaint Intake and Screening*), Section VI (*Investigations*), Section VII (*Prosecutions and Disciplinary Outcomes*), Section VIII (*Probation Program*), and Section X (*Organizational and Management Structures*).

IX. Integrated Assessment of Enforcement Program Performance

A. Complaints Handled and Average Elapsed Times from Initiation to Referral for Investigation or Prosecution

As discussed in Section V, during 2008/09 the average elapsed time to close or refer complaints for investigation or prosecution was about 2.5 months, excluding a significant number of non-jurisdictional complaints closed during the Intake Stage. For complaints not reviewed by a Medical Specialist, the average elapsed time to close or refer complaints for investigation or prosecution was about two (2) months. For complaints reviewed by a Medical Specialist, the average time to close or refer the complaints was about four (4) months. Some high priority complaints are referred for investigation or prosecution with only limited screening. Consequently, for complaints referred for investigation or prosecution, the average elapsed time was shorter than the average elapsed time for complaints that are closed and referred for investigation or prosecution (about 2.1 months for complaints that are referred for investigation or prosecution compared to 2.6 months for complaints that are closed or referred). Reflecting additional time requirements to obtain records and have a Medical Consultant review the cases, the average elapsed time to close or refer quality of care complaints, which account for about one-half of all complaints, was about three (3) months. The average elapsed time to close or refer other complaints was less than two (2) months. Following implementation of requirements for review of all quality of care complaints by a Medical Specialist, the proportion of complaints referred for investigation or prosecution decreased by about 15 percent (from 20 percent to 17 percent). In recent years only about 17 percent of complaints were referred for investigation or prosecution.

During the past several years, the number of complaints opened decreased by about 5 percent, the number of complaints closed decreased by about 10 percent, and the number of complaints referred for investigation or prosecution decreased by about 15 percent. Concurrently, the number of pending complaints and the average elapsed time to close or refer cases increased by about 25 percent. Recent growth in the number of pending complaints and increases in average elapsed times to close or refer complaints appear unrelated to implementation of Specialty Review requirements earlier in the decade. Rather, these increases, which are concentrated in the past two (2) years, appear to be primarily a result of:

- The reduced availability of staffing resources due to restrictions on the use of overtime, staff turnover and vacancies, and work furloughs
- Changes in the composition of complaints, including significant decreases in Out-of-State and Medical Board-originated cases which, on average, are closed or referred for investigation or prosecution much more quickly than other complaints.

B. ISOs/TROs Sought and Granted

It was anticipated that, as a result of earlier involvement of HQES Attorneys in case investigations, increased numbers of ISOs and TROs would be sought and granted, which would enhance consumer protection by more quickly restricting the physician's practice of medicine. **Table IX-1**, below, shows the number of ISOs and TROs sought and granted, by year, for the past six (6) fiscal years. During the past several years, significantly fewer ISOs and TROs were sought. Also, significantly fewer were granted.

Table IX-1. ISOs/TROs Sought and Granted

Fiscal Year	ISO/TRO Sought								ISO/TRO Granted							
	District Office Identifiers				Other Identifiers				District Office Identifiers				Other Identifiers			
	Northern California	Los Angeles Metro	Other Southern California	Total	Out of State (16)	Probation (D's)	Headquarters (20)	Total	Northern California	Los Angeles Metro	Other Southern California	Total	Out of State (16)	Probation (D's)	Headquarters (20)	Total
2003/04	5	4	15	24	0	1	1	26	6	1	9	16	1	5		22
2004/05	6	15	15	36	1	1	1	39	8	5	7	20	1	8		29
2005/06	10	3	10	23				23	10	1	9	20		4		24
3-Year Average	7	7	13	28	1	1	1	29	8	2	8	19	1	6		25
2006/07	11	2	9	22				22	10	2	4	16		2		18
2007/08	6	8	4	18		2		20	5	6	2	13		2		15
2008/09	10	4	1	15		3		18	9	2	1	12	1	3		16
3-Year Average	9	5	5	18		3		20	8	3	2	14	1	2		16

Implementation of VE has not increased the number of ISOs and TROs sought and granted, notwithstanding higher levels of Attorney involvement in the investigations. Instead, since implementation of VE, the number of ISOs and TROs sought and granted has decreased by more than 30 percent. This decrease significantly exceeds any decrease that could be attributed to reductions in the number of cases referred for investigation.

C. Accusations Filed and Average Elapsed Times from Referral for Investigation to Accusation Filed

Another anticipated benefit of VE was a reduction in elapsed times from referral of a case for investigation to filing of the accusation. For example, it was expected that with HQES Attorneys more involved with investigations, that it would take less time to obtain medical and other records needed to determine the merits of a complaint. Also, cases that were not viable could be identified and closed more quickly, thereby enabling redirection of resources to other cases, and accelerating completion of the Investigations while concurrently improving the quality of the cases. Finally, because an HQES Attorney was already very familiar with their cases and had directed various investigative activities, including the gathering of evidence, interviewing patients, witnesses, and subjects, and selecting a Medical Expert, and reviewing the evidence and the Medical Consultant's and Medical Expert's reports, and the reports of investigation prepared by the Investigator, it would take them significantly less time to prepare the accusation, which provides notice to the public of alleged negligence or misconduct by a licensee

As shown by **Exhibit IX-1**, on the next page, these expected performance improvements have not been realized. For cases with District office Identifiers, the average elapsed time from referral for investigation to accusation filed increased by two (2) months during the past several years. Average elapsed times from referred for investigation to accusation filed increased in all three (3) geographic regions. However, there were significant performance variances between the regions. The Northern California and Other Southern California regions had much shorter average elapsed times than the Los Angeles Metro region (17 to 19 months for the Northern California and Other Southern California regions compared to 22 to 23 months for the Los Angeles Metro region, a difference of 5 to 6 months). From this data it is abundantly clear that the much higher level of involvement of HQES Attorneys in Los Angeles Metro region cases has not provided any differential benefit in terms of achieving lower average elapsed times from referral of a case for Investigation to filing of the accusation. The higher level of involvement of HQES Attorneys in Other Southern California region cases, as compared to the level of involvement of HQES Attorneys in Northern California region cases, also has not provided any differential benefit in terms of achieving lower average elapsed times from referral a case for Investigation to filing of the accusation.

Average Elapsed Times from Referral to Investigation to Accusation Filed, by Identifier
2004 through 2009

Including Cases with Transmittal to Filing Timeframes Exceeding 18 Months

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	17	61	19	54	14	163	17
2005	56	19	56	22	71	16	183	19
2006[2]	54	17	45	21	50	17	149	18
2007	66	17	65	22	67	16	198	18
2008	60	18	50	21	45	18	155	19
2009	72	19	51	21	64	19	187	20

Year	Cases with Other Identifiers[1]						Total All Case Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ, CME Audit, and Internet (IDENT 20,21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	2	13	3	19	10	11	178	16
2005	2	8	0	0	5	27	190	19
2006[2]	3	9	1	35	0	0	153	18
2007	5	12	0	0	1	18	204	18
2008	4	10	2	23	0	0	161	19
2009	0	0	1	36	6	15	194	19

Excluding Cases with Transmittal to Filing Timeframes Exceeding 18 Months

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	17	61	19	53	14	162	17
2005	55	18	55	21	71	16	181	18
2006[2]	54	17	43	21	48	16	145	18
2007	65	16	55	20	66	16	186	17
2008	60	18	49	20	43	18	152	19
2009	71	18	48	20	61	19	180	19

Year	Cases with Other Identifiers[1]						Total All Case Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ, CME Audit, and Internet (IDENT 20,21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	2	13	3	19	10	11	177	16
2005	2	8			2	17	185	18
2006[2]	3	9	1	35			149	18
2007	5	12			1	18	192	17
2008	4	10	2	23			158	18
2009			1	36	6	15	187	19

[1] Over the six-year period from 2004 through 2009, excludes 279 accuations filed related to Out-of-State (IDENT 16) cases transmitted by DUC directly to HQES, and 16 accusations filed related to Headquarters, CME audit failure, and Internet cases (IDENTs 20, 21, and 23) transmitted by various Headquarters Units directly to HQES. Also excludes five (5) cases involving petitions to revoke probation (IDENT 'D').

[2] The Vertical Enforcement Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

D. Accusations Withdrawn or Dismissed

With greater HQES Attorney involvement in investigations, it might be expected that fewer accusations would be withdrawn or dismissed. However, the number of accusations withdrawn or dismissed is small in comparison to the total number of accusations filed (about 10 percent), and accusations may be withdrawn or dismissed due to changing circumstances and other factors that are outside of the control of both the Medical Board and HQES (e.g., successful completion of the Diversion Program, death of the Subject, etc.).

A review of the statistical data appears to show that dismissals and withdrawals have remained essentially constant over the past five years. Changes appear to be due to statistical spikes only, and do not reflect any continuous trend or pattern.

As shown by **Table IX-2**, below, during the past five (5) fiscal years there has not been any sustained change in the number of accusations withdrawn, and the number of accusations dismissed recently increased. Due to a one-year spike in accusations withdrawn and dismissed during 2007/08, the average number of accusations withdrawn or dismissed during the past two (2) years (29 cases per year) was significantly higher than the average number of accusations withdrawn or dismissed during the preceding three (3) years (21 cases per year).

Table IX-2. Accusations Withdrawn and Dismissed

Fiscal Year	Cases with District Office Identifiers Withdrawn or Dismissed			
	Northern California	Los Angeles Metro	Other Southern California	Total
2004/05	6	10	10	26
2005/06	6	9	7	22
2006/07	5	4	6	15
3-Year Average	6	8	8	22
2007/08	11	6	19	36
2008/09	8	8	4	20
2-Year Average	10	7	12	29

Most of the accusations that were withdrawn or dismissed during 2007/08 involved cases that were investigated by District offices in the Northern California or Other Southern California regions. During 2007/08, 26 accusations were withdrawn and 10 were dismissed. About a dozen cases were withdrawn after determining that there was not sufficient evidence to prevail at a hearing. Other causes for these withdrawals included:

- The Medical Expert changed their opinion (about a half-dozen cases)

- The license was cancelled, the respondent died, or the statute of limitations ran (several cases)
- A citation or public letter of reprimand was issued in lieu of discipline (2 cases)
- The Subject successfully completed the Diversion Program (2 cases).

The unusually high number of accusations withdrawn during 2007/08 did not persist into 2008/09.

E. Stipulations Prepared and Average Elapsed Times from Referral for Investigation to Stipulation Received

Implementation of VE was expected to reduce average elapsed times from referral of a case for investigation to stipulation received, which effectively represents completion of the prosecution phase of the enforcement process. It was anticipated, for example, that in addition to reducing the average elapsed time to complete investigations and to file accusations, that implementation of VE might (1) marginally increase the proportion of cases that are settled without a hearing, and (2) reduce the average elapsed time to negotiate a settlement and prepare the stipulation.

With respect to increasing the proportion of cases that settle rather than proceed to hearing, about 80 to 85 percent of cases usually settle without a hearing. Thus, it was considered unlikely that implementation of VE would significantly increase the proportion of cases that might settle without a hearing. On an annual basis for the past six (6) years, the proportion of cases that did not settle, and proceeded to hearing, fluctuated between 15 and 20 percent. There is no evidence that implementation of VE had any significant beneficial impact in terms of increasing the proportion of cases that settle without a hearing.

As shown by **Exhibit IX-2**, on the next page, for cases with District office Identifiers:

- The number of stipulations submitted decreased during the last several years, particularly in the Los Angeles Metro and Other Southern California regions
- The average elapsed times from referral for investigation to stipulation received changed very little and, for all regions, this performance measure was only marginally lower during the past three (3) years during the preceding three (3) years.

However, as aged cases migrate from the Investigation Stage to the Prosecution Stage during 2009/10 and subsequent years, it is likely that the average elapsed times from referral for investigation to stipulation received will increase. Additionally, as shown by Exhibit IX-2, there are significant performance variations between geographic regions of the State. For example, the Los Angeles Metro region consistently had significantly higher average elapsed times from referral for investigation to stipulation received than the other regions. During the past two (2) years the average elapsed time for the Los Angeles Metro region was about seven (7) months longer than the average elapsed time for the Northern California region, and about three (3) months longer than the average elapsed time for the Other Southern California region.

Average Elapsed Times from Referral for Investigation to Stipulation Submitted, by Identifier
2004 through 2009

Including Cases with Post-Investigation Elapsed Times Exceeding 3 Years

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004	50	2.2	64	3.1	39	2.5	153	2.7
2005	36	2.4	49	3.1	50	2.4	135	2.7
2006[2]	40	2.4	66	3.1	38	2.7	144	2.8
2007	48	2.0	33	2.9	55	2.8	136	2.5
2008	30	2.1	45	2.6	44	2.4	119	2.4
2009	52	2.2	45	3.0	34	2.4	131	2.5

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20, 22, and 23)			
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004					1	0.6	154	2.6
2005	2	1.3	4	4.0	7	2.4	148	2.7
2006[2]					2	4.0	146	2.8
2007	4	1.1	2	3.6	2	0.7	144	2.5
2008	3	1.4	1	1.3	3	2.8	126	2.4
2009	1	3.3	1	2.9	1	0.9	134	2.5

Excluding Cases with Post-Investigation Elapsed Times Exceeding 3 Years

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004	48	2.1	60	3.0	39	2.5	147	2.6
2005	34	2.3	43	2.9	49	2.4	126	2.5
2006[2]	37	2.1	59	2.9	33	2.3	129	2.5
2007	48	2.0	32	2.8	51	2.5	131	2.4
2008	29	1.9	41	2.5	41	2.3	111	2.3
2009	50	2.1	41	2.8	33	2.4	124	2.4

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20, 22, and 23)			
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004					1	0.6	148	2.6
2005	2	1.4	2	3.1	7	2.4	137	2.5
2006[2]					1	3.8	130	2.5
2007	4	1.1	2	3.6	2	0.7	139	2.3
2008	3	1.4	1	1.3	2	1.6	117	2.2
2009	1	3.2	1	2.9	1	0.9	127	2.4

[1] Over the six-year period from 2004 through 2009, excludes 24 subsequent submissions related to the same complaint, 176 stipulations related to Out-of-State (IDENT 16) cases transmitted by DCU directly to HQES, and 82 cases involving petitions to revoke probation (IDENT 'D').

[2] The Vertical Enforcement Pilot Project was jointly implemented by the Medical Board and HQES during January 2006.

Finally, as shown by **Table IX-3**, below, during the past several years the average elapsed times from referral for investigation to stipulation received have changed very little for either quality of care or for other cases. It was anticipated that the elapsed times for quality of care cases would be impacted most by implementation of VE (e.g., by reducing the time taken to obtain medical and other records).

Table IX-3. Average Elapsed Times from Referral for Investigation to Stipulation Received, by Type of Case[1] - 2005 through 2009

Calendar Year	Quality of Care Cases		Other Cases		Total	
	Number of Stipulations	Average Elapsed Time	Number of Stipulations	Average Elapsed Time	Number of Stipulations	Average Elapsed Time
2005	102	2.8 Years	35	2.2 Years	137	2.6 Years
2006[2]	102	3.2 Years	42	1.9 Years	144	2.8 Years
2007	98	2.7 Years	42	2.2 Years	140	2.5 Years
2008	90	2.7 Years	32	1.7 Years	122	2.4 Years
2009	88	2.8 Years	44	2.1 Years	132	2.6 Years

[1] Over the five-year period from 2005 through 2009, excludes 24 subsequent stipulation submittals related to the same complaint, 141 stipulations related to Out-of-State (IDENT 16) cases transmitted by DCU directly to HQES, eight (8) cases involving probationers (IDENT 19), fifteen (15) cases originated by various Headquarters Units (IDENTs 20, 22, and 23), and 65 cases involving petitions to revoke probation (IDENT 'D').

[2] The Vertical Enforcement Pilot Project was jointly implemented by the Medical Board and HQES beginning during January 2006.

Table IX-3 shows that the average elapsed time to investigate and prosecute quality of care cases remains at least eight (8) months longer than the average elapsed time for other cases (i.e., an average of about 2.7 years, or longer, for quality of care cases compared to an average of about 2.0 years for other cases).

F. Efficiency of Investigations and Prosecutions

Expectations that implementation of VE would improve efficiency have not been realized. To support implementation of VE, eight (8) additional Investigator and Assistant Investigator positions and 10 additional HQES Attorney positions were authorized. These additional positions increased Investigator staffing by about 10 percent and increased HQES Attorney staffing my more than 20 percent. Following implementation of VE, the number of investigations completed, the number of cases referred for prosecution, the number of accusations filed, and the number of stipulations prepared have all declined by 15 percent or more. Additionally, during this period the number of pending investigations and the number of pending legal cases both increased by more than 15 percent. In summary, higher levels of resources are now being used to produce increasingly lower levels of output.

G. Disciplinary Outcomes

Exhibit IX-3, on the next page, shows disciplinary outcomes by referral source for (1) a baseline period of four (4) years from 2003/04 through 2006/07, and (2) the most recent two (2) fiscal years. As shown by Exhibit IX-3, the total number of disciplinary actions decreased from an average of 312 per year during the 4-year baseline period to an average of 292 per year for the past two (2) years. Additionally, the decrease in numbers of disciplinary actions is even greater if Out-of-State cases, which are rarely handled by the District offices, are excluded. Disciplinary outcomes have not improved since implementation of VE.

As discussed previously in Section VII, there was no change in the number disciplinary actions requiring license revocation, surrender, suspension, or probation for Other Southern California region cases, and the number of public reprimands increased significantly (from an average of 15 per year, to an average of 22 per year). While the number of disciplinary actions taken involving Northern California region cases decreased by about 10 percent in recent years, there was only a minimal decrease in the number of disciplinary actions taken that required license revocation, surrender, suspension, or probation. In contrast, in recent years the number of disciplinary actions taken involving Los Angeles Metro cases decreased by 13 percent overall, and the number of disciplinary actions requiring license revocation, surrender, suspension, or probation decreased by 20 percent. The change in the number and types of disciplinary actions taken on cases investigated by Los Angeles Metro region offices was the largest contributor to the decreases that have recently occurred in (1) the overall number of disciplinary actions taken, and (2) the number of disciplinary actions taken requiring license revocation, surrender, suspension, and probation. These decreases were only partially offset by an increase in the number of public reprimand actions taken on cases investigated by District offices within the Other Southern California region.

In recent years the number of disciplinary actions taken involving cases investigated by Los Angeles Metro and Other Southern California region District offices each accounted for about 35 percent of all disciplinary actions taken on cases with District office Identifiers. In contrast, Northern California region cases accounted for only 28 percent of all disciplinary actions taken on cases with District office Identifiers. The comparatively lower proportion of disciplinary actions taken involving Northern California region cases reflects comparatively lower numbers of accusations filed in prior years. However, recent decreases in the number of accusations filed involving Los Angeles Metro and Other Southern California region cases will likely lead to fewer disciplinary actions taken in the future on cases investigated by District offices in both of these regions. In contrast, the number of accusations filed involving cases investigated by Northern California region offices increased in recent years, which will likely lead to an increase in disciplinary actions taken in the future.

HQES recently changed the geographic boundaries of its offices. Portions of the areas previously served by the Sacramento and San Diego offices were transferred to the Los Angeles Metro office. These shifts could complicate future efforts to compare regional performance over time.

Disciplinary Actions by Referral Source
(Average Annual Rate)

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Referral Source	Conventional Enforcement - 2003/04 to 2006/07					Vertical Enforcement - 2007/08 to 2008/09					Change				
	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions
Patient, Patient Advocate, Family Member or Friend, Including 801.01(E) Reports	11.8	5.3	15.8	20.5	53.4	10.5	1.5	11.5	21.0	44.5	(1.3)	(3.8)	(4.3)	0.5	(8.9)
Insurance Companies and Employers, Including 801.01(B&C) Reports	5.1	1.8	11.0	18.3	36.2	2.0	0.5	11.5	19.0	33.0	(3.1)	(1.3)	0.5	0.7	(3.2)
Health Facilities (Section 805 and Non-805 Reports)	9.8	2.0	11.0	5.5	28.3	9.5	2.0	13.0	3.0	27.5	(0.3)	0.0	2.0	(2.5)	(0.8)
California Department of Health Services (or Successor State Agency)	3.8	2.3	7.3	3.0	16.4	4.5	1.0	7.5	3.5	16.5	0.7	(1.3)	0.2	0.5	0.1
M.D., Pharmacist, Allied Health or Healing Arts Licensee, or Medical Society or Association	5.8	1.3	5.3	3.3	15.7	5.0	0.5	2.0	4.5	12.0	(0.8)	(0.8)	(3.3)	1.2	(3.7)
CII - Department of Justice, Criminal Identification and Information Bureau	4.5	0.5	2.0	0.8	7.8	5.5	0.0	3.5	1.0	10.0	1.0	(0.5)	1.5	0.2	2.2
Other Governmental Agencies, Including FDA, DEA, Other DCA Boards and Bureaus, and 801 Reports	4.1	2.1	4.0	2.6	12.8	3.5	1.5	3.5	1.5	10.0	(0.6)	(0.6)	(0.5)	(1.1)	(2.8)
Other[1]	7.0	1.8	2.8	2.6	14.2	3.5	2.0	3.5	1.5	10.5	(3.5)	0.2	0.7	(1.1)	(3.7)
Police/Sheriff Department, Coroner's Office, District Attorney, and Courts (803 Reports, Criminal Filings, and Non-Felony and Felony Conviction Reports)	5.3	1.3	3.0	0.5	10.1	3.0	0.5	2.0	0.5	6.0	(2.3)	(0.8)	(1.0)	0.0	(4.1)
Licensee Self-Reporting (2240(A), 801.01, 802.01, 802.1 and Misdemeanor Conviction Reports)	0.3	1.0	0.8	4.5	6.6	0.5	0.5	1.0	2.5	4.5	0.2	(0.5)	0.2	(2.0)	(2.1)
California Attorney General and Department of Justice, Including Medi-Cal Fraud and Narcotics Enforcement Bureaus	0.8	0.3	0.8	0.3	2.2	2.0	0.0	1.0	0.5	3.5	1.2	(0.3)	0.2	0.2	1.3
Total, Excluding Out of State and Medical Board Originated Cases	58.3	19.7	63.8	61.9	203.7	49.5	10.0	60.0	58.5	178.0	(8.8)	(9.7)	(3.8)	(3.4)	(25.7)
Out of State Medical/Osteopathic Boards	34.1	0.5	11.0	20.8	66.4	31.0	1.0	11.0	40.0	83.0	(3.1)	0.5	0.0	19.2	16.6
Medical Board Originated Cases	16.0	3.3	15.0	7.6	41.9	11.0	2.5	13.5	4.5	31.5	(5.0)	(0.8)	(1.5)	(3.1)	(10.4)
Total, Including Out of State and Medical Board Originated Cases	108.4	23.5	89.8	90.3	312.0	91.5	13.5	84.5	103.0	292.5	(16.9)	(10.0)	(5.3)	12.7	(19.5)

[1] Includes CA Medical Review Inc., 803.6, 364.1, and NPDB reports, Jury Verdict Weekly, HEAL, MQRC District, WE Tip, Consumer or Industry Group, Employee, Co-worker, Witness, Informant, Anonymous, and Unknown.

X. Organizational and Management Structure

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X. Organizational and Management Structures

This section presents results of our analysis of the Medical Board's organizational and management structures. Our analyses focused primarily on Enforcement Program organizational structures and management issues. Organizational structure and management issues concerning the Licensing Program are addressed separately in Section XI (*Licensing Program*). The section is organized as follows:

Subsection	Title
A.	Organization of Section 801 Case Investigations
B.	Management of District Office Investigations
C.	Management of Cases Referred for Prosecution and HQES Expenditures
D.	Workload and Performance Reporting
E.	Government Code Section 12529.6(e) Requirements
F.	Oversight of HQES Services.

X. Organizational and Management Structures

A. Investigations of Section 801 Cases

The Medical Board is currently planning to establish a new Sacramento-based unit that will use non-sworn staff to investigate Section 801 and selected other cases. Section 801 cases are distinguished from other cases because they involve a reported settlement of a malpractice case, and a substantial portion of the investigative activity involves identifying, collecting, and reviewing medical and other records, such as transcripts of depositions or court proceedings. Medical Board management believe that investigations of many of these cases can be completed by non-sworn staff, working jointly with HQES Attorneys, without referring the cases to District offices for investigation by a sworn Investigator. Non-sworn staff and clerical support resources are expected to become available in stages during 2010/11 and 2011/12 as part of a currently pending BCP that is expected to be included in the State's 2010/11 Budget. Section 801 cases currently account for about 10 percent of all cases referred to the District offices for investigation.

Recommendation X-1. *Restructure the handling of Section 801 cases by establishing a centralized unit comprised of non-sworn staff to investigate Section 801 and selected other cases.*

B. Management of District Office Investigations

The current management of field investigations differs among regions. Vertical Enforcement has been implemented differently in different offices with varied success. Conflicts have arisen among Board and HQES at all levels throughout the State, but particularly in the Los Angeles region. Conversely, in some offices staff are respectful of each other's roles in the process and there is greater productivity. The level of DAG involvement with investigators also varies, with the Los Angeles office by far having the most DAG involvement in investigations while referring fewer cases for prosecution.

While problems with some critical investigative activities have always been experienced, and are to be expected (scheduling of interviews), they appeared to have not been helped by the implementation of VE, and may have been made worse. Disagreements about the need for supplemental investigation activities and the need for second Medical Expert opinions create conflicts that have not been finally resolved, and continue to fuel disagreements. The conflicts need a final resolution based on best practices.

The statutes and policies governing VE should be amended to establish the best practices indentified and as implemented in the Northern and Other Southern California regions. Currently, the statutes "permit the Attorney General to advise the Board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action." Different regions have interpreted this code differently, giving rise to different investigation practices by MBC and HQES staff. This ambiguity should be addressed so that there is a uniform understanding of everyone's role in the process. Without such clarification, the Medical Board will continue to have responsibility for investigations while having little authority over their direction.

The Medical Board should be clearly identified in statute as the sole, final authority for purposes of determining whether to continue an investigation. HQES' responsibility regarding such decisions should be limited, as provided by current statutes, to providing advice to the Board. In cases where the Medical Board elects to continue an investigation, HQES Attorneys should be available and supportive of these efforts, irrespective of any prior advice or decision. If the case is again referred for prosecution after the investigation is completed, then HQES can always reject the case at that time.

Recommendation No. X-2. *Amend the statutes governing Vertical Enforcement to clarify the Medical Board's sole authority to determine whether to continue an investigation.*

Another significant problem with the management of District office investigations involves the extent of HQES Attorney involvement with the investigations, irrespective of the nature or complexity of the case. A high level of Attorney involvement in some investigations is warranted and beneficial to many, but not all, investigations. Prior to implementation of VE, the availability of HQES Attorneys to provide substantive legal support services was limited to only a small percentage of cases. Now, in some cases, the pendulum has swung too far in the other direction. In some cases HQES Attorneys are now substantively involved in completing investigations where a lesser level of involvement would be just as beneficial while avoiding many of the communication and coordination problems that otherwise arise.

Currently, in some parts of the State the HQES Lead Prosecutor, who may also be a Supervising DAG, generally works collaboratively with the Medical Board's District office Supervisor, reviews incoming cases (usually only one or two cases per week per office), regularly attends Quarterly Case Review meetings, and spends a few hours one or two days per week at the District office providing general consultation services to District office staff. In consultation with the District office Supervisor, needs are jointly identified for assignment of a Primary DAG to provide more substantive legal support services for specific cases on an exception basis. For other cases, the HQES Lead Prosecutor or Supervising DAG, along with the District office Supervisor, continues to monitor the status and progress of the cases and provides ad-hoc legal advice and consultation regarding the course of the investigation. With this approach an HQES Attorney would, for example, attend a Subject interview in only selected cases.

In contrast with this approach, in some parts of the State a Primary DAG is usually assigned to each new case, and is then expected to be substantively involved throughout the investigation. In some cases this extends to participation, not just in Subject Interviews, but also to interviews with complainants, witnesses, and others, and not just for cases involving sexual misconduct. The activities of the Primary DAGs also can include conducting detailed reviews and analysis of medical and other records, review of the qualifications of potential Medical Experts, preparation of the instructions for the Medical Expert, review of the package submitted to the Medical Expert, and numerous other activities. With this approach, communications and coordination between all of the different team members, for all of the cases, necessarily becomes much more cumbersome and complex. With this approach, for example, a Subject interview generally would not be completed without the Primary DAG present, which complicates the process of just trying to schedule the interview, or, alternatively, the LP may attend the Subject Interview on behalf of the Primary, or the Medical Board may obtain the Primary DAG's or Lead Prosecutor's consent to conduct the Subject interview without an Attorney present. This type of continuous coordination activity continues throughout the course of the investigation, and can become especially complicated when the Primary DAG is focused primarily on other cases (e.g., preparing for or attending a hearing), is on vacation, or is otherwise either unavailable or non-responsive.

Another dimension of this problem involves conflicts related to the use of Lead Prosecutors (LPs). The statutes governing VE require that each investigation referred to a District office "be simultaneously and jointly assigned to an investigator and to the deputy attorney general in (HQES) responsible for prosecuting the case if the investigation results in the filing of an accusation." The interim assignment of the LP to most cases at some District offices does not appear to be fully consistent with this requirement. The use of LPs was not included in the VE model recommended by the Enforcement Monitor. It was created to address problems experienced after VE was

implemented, including logistical, resource availability, and other problems associated with reviewing and assigning incoming cases and resolving communication problems and conflicts between District office and HQES staff.

In some cases a Supervising DAG has served as the LP. This approach can reduce communication and coordination problems because the Supervising DAG has direct supervising authority over subordinate Attorneys. However, Supervising DAGs are apparently not always sufficiently available to perform the LP role for all District offices. Consequently, the Supervising DAGs usually assign a subordinate Attorney to serve as the LP. The ability of the assigned Attorney to effectively perform some key LP duties appears to be highly dependent on (1) the authority delegated to the LP by their Supervising DAG, (2) the ability of the LP to exercise the authority delegated to them, and (3) the relationships between the LPs and their peers. Thus, the effectiveness of the LP appears to be highly dependent on the management style of their Supervising DAG and the individual personality characteristics and interpersonal skills of the LP.

To reduce these conflicts, the statutes should be modified to eliminate mandatory requirements for joint assignment of a DAG for all cases referred for investigation. As a practical matter it cannot usually be determined when a District office investigation is opened whether the case will proceed to prosecution (most do not). Additionally, it is completely unrealistic to expect that the assignment of a DAG to a case will exist “for the duration of the disciplinary matter”, although it is preferable to minimize such changes. While it is beneficial to have an Attorney regularly available to review new investigations, attend case review meetings, monitor the status of pending investigations, and provide ad-hoc legal advice and assistance to Investigators, the mandatory assignment of a Primary DAG to all investigations is excessive and results in a multi-million dollar waste of valuable resources that could be better utilized for other purposes. Every case referred for investigation should not have to be “double-teamed”.

The assignment of Primary DAGs to cases during the Investigation Stage should be permissive, based primarily on the complexity and needs of the case as jointly determined by the District office Supervisor and the Supervising DAG (or their designees). Assignment decisions should be made with due care, taking into consideration all of the other, sometimes conflicting, workload and resource demands of both the Medical Board and HQES. If not needed, a Primary DAG should not be assigned to a case. Management judgment should be exercised in making case assignment decisions, rather than mechanistically applying a one-size-fits-all approach to all investigations which results in higher Attorney caseloads, sub-optimal utilization of staffing resources, and poor overall performance. The assignment of a Primary DAG to all cases is as bad, or worse, than the pre-VE system where HQES Attorneys were largely unavailable to assist Medical Board Investigators during the Investigation Stage. There can, and should be, a more balanced approach between these two extremes that enables higher levels of Attorney support during the Investigation Stage when more intensive involvement is needed (not just because an Attorney is assigned, is available, and chooses to spend time working on the case).

Recommendation No. X-3. *Implement the best practices, indentified and as implemented in the Northern and Other Southern California regions, statewide to optimize effective HQES Attorney involvement in investigations. Amend the statutes and policies governing Vertical Enforcement to establish the best practices identified in the Northern and Other Southern California regions. It would be helpful to amend the statute to make primary DAG assignments permissive, allowing Medical Board and HQES supervisors to jointly review incoming investigations to identify which cases would benefit from VE. Clarifying the statute as to the agencies' roles, responsibilities, and authority over investigations would help assure greater uniformity of investigations among regions.*

C. Management of HQES Expenditures and Cases Referred for Prosecution

There are significant deficiencies with both Medical Board and HQES management of cases referred for prosecution. The processes currently used for identifying and tracking the status of cases after they are referred for prosecution are frequently failing, particularly in the Los Angeles Metro region. These processes appear, particularly in the Los Angeles Metro region, to be largely dependent on individual District office Investigator or Supervisor detection and follow-up of past due cases. These follow-ups sometimes do not occur until several months after a case is referred for prosecution, or longer. Failures by the Medical Board to transmit cases and failures by HQES to acknowledge receipt of a referred case, and to communicate its acceptance or rejection of the case, exacerbates and further complicates this problem. However, even without these other problems, the absence of a planned completion date from HQES regarding when a pleading will be prepared makes it difficult for anybody to know which cases are being treated as urgent matters and whether the pleadings are past due. Similar problems sometimes occur after the pleading is filed (e.g., when several months elapse before a Request to Set is submitted on a case that the Medical Board considers urgent because the Subject poses a significant risk).

Recommendation No. X-4. *Require HQES to inform the Medical Board Regional Manager and HQES Services Monitor of the planned date for completing a pleading. The notice should be required to be provided within five (5) business days of referral of any case for prosecution. Also, require that all Medical Board Regional Managers meet (or conference) on a monthly basis with their HQES counterparts to review the status of all previously referred cases for which an accusation has not yet been filed.*

There also are significant deficiencies with both Medical and HQES oversight and management of HQES' expenditures for legal services (both investigation and prosecution). Currently, it appears that nobody at either HQES or the Medical Board closely reviews or analyzes the 700 to 900 page Invoice Report that the Attorney General provides to the Medical Board each month to support their charges (which are paid automatically by a funds transfer by the State Controller's Office from the Medical Board's fund to the Department of Justice). Instead, the Invoice Report appears to go directly from an administrative services unit in the Department of Justice to the Medical Board's fiscal unit, which maintains a cumulative tabulation of total expenditures for budget status tracking purposes and then files the report.

Needs exist to develop and implement a process that requires that the Supervising DAGs, Deputy Assistant Attorney General, District office Supervisors, and Regional Managers review and approve the reasonableness of HQES' charges to all matters billed each month. The scope of the review should include verification that that the charges are posted to the correct cases. The Supervising DAGs should review and approve the time charges posted to Investigation and Administrative matters, or note exceptions that require correction, and then submit their portions of the Invoice Report to the Deputy Assistant Attorney General for final approval and submission to the Medical Board's HQES Services Monitor. Concurrently, District office Supervisors should confirm that the time charges posted to Investigation matters are consistent with the Investigation activities performed during the reporting period, note any exceptions that require correction or further evaluation, and then submit their portions of the Invoice Report to their Regional Manager. The Regional

Managers should review the charges posted to pending Administrative matters as part of their responsibilities related to tracking the status of pending accusations (see Recommendation No. XII-4, above), note any exceptions that require correction or further research, and then submit their region's portion of the Invoice Report to the Medical Board's HQES Services Monitor. The Medical Board's HQES Services Monitor should monitor completion of all of the supervisory and management reviews and, in consultation with the Senior Assistant Attorney General, initiate corrective actions to address any exceptions or other problems identified as a result of completing the reviews.

Recommendation No. X-5. *Develop and implement an HQES Invoice Report review and approval process that provides for review of the reasonableness of HQES time charges. As necessary, require that HQES create new summary templates that display time charge data in a summary format that facilities completion of these reviews.*

Recommendation No. X-6. *Establish a new HQES Services Monitor position within the Medical Board's Enforcement Program to coordinate the provision of services to the Medical Board by HQES, continuously monitor and evaluate HQES performance and costs, resolve conflicts that arise between the agencies, and prepare and provide regular reports to Executive Management, the Medical Board, and oversight and control agencies..*

D. Management Reports

New monthly management reports should be developed and provided to Enforcement Program and HQES Managers and Supervisors, and Medical Board Executive Management. At a minimum, the reports should provide the following summary level output and performance measures for the reporting period, and for the preceding 12 months period:

- ✓ Number of investigations closed, by Identifier, and average elapsed time from referred for investigation to closure
- ✓ Number of investigations referred for prosecution, by Identifier, and average elapsed time from referred for investigation to referred for prosecution
- ✓ Total number of investigations closed or referred for prosecution, by identifier, and average elapsed time from referred for investigation to closed or referred for prosecution
- ✓ Number of accusations filed, by Identifier, average elapsed time from referred for prosecution to accusation filed, and average elapsed time from referred for investigation to accusation filed
- ✓ Number of stipulations received, by Identifier, average elapsed time from accusation filed to stipulation received, and average elapsed time from referred for investigation to stipulation received
- ✓ Number of proposed decisions received, by Identifier, average elapsed time from accusation filed to proposed decision received, and average elapsed time from referred for investigation to proposed decision received.

Additionally, the monthly performance reports should provide consolidated output and performance data by geographic region and for the State as a whole (Northern California, Los Angeles Metro, and Other Southern California). Quarterly summaries of this same information should be prepared and provided to the Medical Board. The quarterly summaries should also include fiscal year-to-date totals and time series data for the preceding three (3) fiscal years. Finally, all of the reports should possibly include a limited number of selected other output and performance measures, such as data regarding interim suspension activities (e.g., ISOs and PC 23s), petitions to revoke probation, compelled competency examinations, or disciplinary outcomes.

Recommendation No. X-7. *Develop new monthly management reports showing key output and performance measures by business unit and for the State as a whole. (Presently, data is provided to the Board on a statewide basis only). Provide the monthly reports to all Enforcement Program and HQES Managers and Supervisors and to designated Medical Board Executive Office Managers and staff. Develop and provide the Board with quarterly Enforcement Program Output and Performance Summary reports that include data for the most recently completed quarter and time series data for the preceding three (3) fiscal years.*

E. Government Code Section 12529.6(e) Requirements

To carry out the Legislatures intent in requiring use of the Vertical Enforcement Model, and to enhance the Vertical Enforcement process, Section 12529.6 of the Government Code requires that the Medical Board:

- Increase its computer capabilities and compatibilities with HQES in order to share case information
- Establish and implement a plan to locate its Enforcement Program staff and HQES staff in the same offices, as appropriate
- Establish and implement a plan to assist in team building between its Enforcement Program staff and HQES staff to ensure a common and consistent knowledge base.

All of these requirements should be modified, or repealed. Each of these requirements is briefly discussed below.

Computer Capabilities and Case Information Sharing – The Medical Board is currently supporting DCA's efforts to develop the BREEZE2 System which would completely replace the Medical Board's legacy Application Tracking System (ATS) and also the Complaint Tracking System (CAS). The Medical Board should not invest additional resources in CAS to make it compatible with HQES' ProLaw System. However, the Medical Board should provide HQES with standard reports available from CAS to enable HQES to monitor the status of pending investigations and prosecutions. Additionally, the Medical Board should provide HQES with summary level *Enforcement Program Output and Performance Reports* (see Recommendation No. X-7).

Co-location of District Office and HQES Staff – Co-location of District office and HQES staff would be inconsistent with our recommendations for more selective application of VE. Instead, as practiced currently, the Medical Board should be required to provide suitable space for Lead Prosecutors and Primary DAGs to work at its District offices, when needed (e.g., using "hoteling").

Team Building and Development of a Common and Consistent Knowledge Base – The Medical Board and HQES should be jointly responsible for developing training programs and providing them to their respective staff as needed to provide staff in both agencies with a common and consistent knowledge base. Requirements related to team-building should be addressed as part of the structured diagnostic review of factors contributing to elevated attrition of Medical Board Investigators that is recommended in Section VI (See Recommendation No. VI-3).

Recommendation No. X-8. *Amend or repeal Subsection(e) of Section 12529.6 of the Government Code. The Medical Board should not invest in CAS to make it more compatible with HQES' ProLaw System and should not permanently co*-locate Medical Board Investigators and HQES Attorneys.

F. Oversight of HQES Services

When it was created during 1990, HQES was authorized 22 DAG positions. Following its formation, HQES also established a goal to file all accusations within 60 days of receipt of a completed investigation. The Legislation creating HQES also required that DAGs work on-site at the Medical Board's offices to assist with complaint handling and investigations. However, HQES determined that it was severely understaffed, and did not comply with this latter requirement. During 1992 and 1993 the Medical Board provided funding for 22 additional DAG positions (44 total Attorney positions). Subsequently, during the late-1990s, the Deputy in District Office (DIDO) Program was introduced whereby a DAG worked at each District office one or two days per week to provide prosecutorial guidance during investigations. However, the DIDO Program was not always consistently implemented at all District offices.

To support implementation of VE, an additional ten (10) Attorney positions were authorized for in 2006. In addition to the Senior Assistant Attorney General, HQES is currently authorized 53 Attorney positions, plus four (4) Analyst positions. HQES also has seven (7) filled Secretary positions. However, even with these resources, and notwithstanding declines in the number of cases referred for prosecution, HQES continues to experience significant delays in filing accusations and in performing post-filing prosecutorial activities. In recent years HQES has filed fewer accusations and the number of interim suspensions also has declined. Concurrently, the number of pending accusations and the number of pending legal actions have increased.

The results of this assessment show that issues concerning HQES' performance have persisted for the past 20 years, notwithstanding authorization and funding of significant staffing increases. Results of the assessment also show that output and performance levels of HQES' Los Angeles Metro office are significantly lower than in other regions of the State, even though available staffing resources are disproportionately allocated to that office. The types of performance problems occurring in HQES' Los Angeles Metro office, as illustrated by the various case histories reviewed as part of this assessment, are especially disturbing, and cannot be attributed to differences in the types of cases investigated by Los Angeles Metro District offices or differences in the quality of those offices' completed investigations. While HQES' Los Angeles Metro office presumably has many very competent and dedicated Attorney's on its staff, the problems identified, unfortunately, reflect poorly on the entire office. Also, the problems occurring at HQES' Los Angeles office should not color perceptions of the organization as a whole, although similar problems may sometimes occur at the other offices,

The Medical Board, and even the Department of Consumer Affairs, is limited in its ability to exercise oversight of HQES services because it is entirely dependent on HQES to provide legal support services and must work collaboratively with them on an ongoing basis. Periodic reviews of HQES' services, costs, and performance should be completed by an independent entity, and results of the review should be provided to Department of Justice and Medical Board management as well as to oversight and control agencies.

Recommendation No. X-9. *Conduct periodic performance reviews of the services, costs, and performance of HQES, including the performance of each HQES office. Provide results of the audits to Department of Justice and Medical Board management and to oversight and control agencies.*

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XI. Licensing Program

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XI. Licensing Program

This section presents results of our assessment of the Business Process Reengineering (BPR) study of the Licensing Program recently completed by Hubbert Systems Consulting, Inc. (HSC). The Medical Board contracted with HSC to perform the study during August 2009, nearly a year after determining that an evaluation of the Licensing Program was needed. Award of the contract was delayed by the State's General Fund fiscal crisis. The evaluation of the Licensing Program was intended to complement other improvement initiatives already undertaken or planned by Licensing Program management. HSC was expected to complete the study over a period of four (4) months. HSC submitted a draft *Final Report* to the Medical Board on January 19, 2010. The draft report was never finalized.

This section is organized as follows:

Subsection	Title
A.	HSC Study Purpose, Scope, and Approach
B.	Results of HSC's Analysis
C.	Analysis of HSC's Recommendations
D.	Recommendations for Improvements.

XI. Licensing Program

A. HSC Study Purpose, Scope, and Approach

The purpose of HSC's assessment was to identify improvements in the Licensing Program to increase efficiency, facilitate compliance with governing statutes and regulations, and improve customer service. The focus of the study was on the Licensing Program's license application processes. These services are largely provided by two Physician and Surgeon Licensing Sections within the Medical Board's Division of Licensing. The scope of the study also encompassed other Licensing Division business units that support these processes, including the Consumer Information Unit (CIU) Call Center and Cashiering Unit, both of which are organized within the Licensing Division's Licensing Operations Section. The study scope also encompassed support services provided by the Medical Board's Information Systems Branch (ISB) and Graduate Medical Education (GME) Outreach Unit, both of which report administratively to the Medical Board's Executive Office. The study scope excluded the Medical Board's Mailroom Unit and the DCA's Mailroom and Cashiering Units, all of which are involved in license application and renewal processing. The study scope also excluded other Licensing Program services generally provided by business units within the Licensing Operations Section, including services involving the issuance of Fictitious Name Permits, approval of Ambulatory Surgery Center Accrediting Agencies, licensing of Allied Health Licensing Program (AHLP) professionals (Registered Dispensing Opticians, Research Psychoanalysts, and Midwives), and recognition of International Medical Schools. In total, the study scope encompassed more than 80 percent of the Licensing Division's authorized permanent positions, and all of the Licensing Division's Temporary Help (Retired Annuitant and Student Assistant) positions.

HSC's technical approach to performing the study included the following major tasks:

- Research and review of the Medical Board's licensing and renewal processes and related Internet applications
- Research and review of statistical data covering the period from 2002 through mid-2009, including data regarding numbers of applications received and reviewed, and elapsed times to complete the reviews
- Review of a *Policies and Procedures Manual* recently drafted by Medical Board staff
- Preparation of maps and flow diagrams of the licensing and renewal processes
- Research and review of staff roles and responsibilities and analysis of staffing levels
- Identification and definition of reports needed to effectively manage application review workload and workflows
- Development of a draft *Business Plan* to improve efficiency and performance
- Development of recommendations for organizational and staffing changes needed to support implementation of the *Business Plan*
- Development of an *Implementation Plan*, a *Communications Plan*, and a *Training Plan*. The *Training Plan* was developed by Medical Board staff.

B. Results of HSC's Analysis

HSC's draft *Final Report* included 31 recommendations for improvement. The recommendations are grouped into three (3) major categories for (1) Infrastructure, (2) Information Technology, and (3) Resources.

Infrastructure (16 recommendations) – The Infrastructure recommendations are organized into eight (8) subcategories, as follows:

Processes and Procedures – Includes recommendations to continue development of *Policies and Procedures Manuals*, strengthen Quality Assurance processes, create a Staff Suggestion System, implement a Continuous Improvement Program, and increase uninterrupted time for application review staff.

Licensing Application – Includes recommendations to revise the license application and accompanying instructions, implement a new application set-up Sheet, revise the fee schedule and licensing invoice letter, and create a new application update form for use in lieu of the application form.

Forms – Includes recommendations to continue the use of eTranscripts and acceptance of FCVS documents, and to implement iPickup for FSCV documents. Also includes recommendations to assess the use of an alternative approach for obtaining credentialing verifications.

Postgraduate Training Authorization Letters (PTAL) – Recommends resolution of multiple PTAL issues, without specifying how the issues should be resolved.

Website – Recommends several specific modifications to the Medical Board's Web site content (e.g., separating the application from the instructions, adding a PTAL tab, and creating new email options for users)

Consumer Information Unit (CIU) Call Center – Recommends several specific enhancements of CIU services, such as conducting periodic reviews of outcomes and call tree activity.

Graduate Medical Education (GME) – Recommends assessment of the potential use of AMA's Physician Professional Database to obtain information on residents enrolled in GME programs.

Other – Recommends evaluation of the viability of a Postgraduate Training Permit Concept. References evaluations previously completed during 1997 and 2006.

Information Technology (7 recommendations) – Includes recommendations to develop more than 20 new tracking reports and logs, and to modify the Application Tracking System (ATS) to enhance functionality and improve application workload and workflow tracking capabilities. Additionally, HSC recommended increasing eCommunications with applicants and others, in lieu of hard copy communications, and completing an assessment of the feasibility of developing a secured portal for submission of Certificate of Completion (L3A/B) data. Also recommends that the Medical Board actively support DCA's development of the BREEZE2 System to replace ATS and evaluate the potential use of a Document Management System that would use imaging of application documents to improve workflow tracking and reporting.

Resources (8 recommendations) – Includes recommendations to fill four (4) additional proposed positions identified in a 2010/11 Budget Change Proposal (BCP) on an accelerated basis in 2009/10, and to obtain approval for seven (7) additional authorized positions through a future BCP. Also includes recommendations to reorganize the Licensing Division (e.g., separate US/CAN from International Medical School Graduate (IMG) applications, consolidate Infrastructure-related functions, and create two new sections and an additional level of management). Additionally, recommends changing the name of the CIU, realigning some tasks, continuing to create and deploy staff training programs, and establishing performance objectives and continuing to work toward achieving these objectives.

HSC assigned a "High" priority to recommendations involving:

- Continued development of *Policy and Procedures Manuals*
- Strengthening Quality Assurance processes
- Revising the Application form and accompanying Instructions
- Revising the Fee Schedule and Licensing Invoice Letter
- Implementing a PTAL/License Application Update form
- Resolving PTAL issues
- Updating content on the Medical Board's Web site
- Implementing CIU Call Center enhancements
- Implementing new management reports
- Enhancing ATS
- Supporting DCA's development of the BREEZE2 system
- Augmenting and reorganizing Licensing Division staff
- Changing the name of the CIU
- Establishing performance objectives and continuing to work toward achieving these objectives.

HSC identifies potential costs and performance improvement benefits associated with implementing each recommendation, and "metrics" that could be used to measure the benefits actually achieved. In most cases the identified costs and benefits are not quantified.

C. Analysis of HSC's Recommendations

Many of HSC's High priority recommendations, and many lower priority recommendations, are focused improvements targeted on a narrow or limited improvement needs. Examples include recommendations for relatively minor changes or updates to business unit names, standard forms, procedures, and the Medical Board's Web site. Many of these recommendations, if implemented, would likely improve effectiveness, efficiency, or service levels, but would not have a substantive impact on overall Licensing Program performance. Several other High priority recommendations, and others with a lower priority, recommend continuation of ongoing Licensing Program management activities, such as developing a *Policy and Procedures Manual*, strengthening the Quality Assurance process, and supporting DCA's development of the BREEZE2 system. A few of the recommendations lack meaningful specificity, such as the recommendation to resolve PTAL issues.

In terms of potential impact on overall Licensing Program costs and performance, HSC's most substantive recommendations for improvement include the following:

- ✓ Evaluate sse of a Document Management System (DMS)
- ✓ Augment, reorganize, and train staff
- ✓ Establish performance objectives and implement new management and performance reports.

Below we provide an analysis of HSC's recommendations in each of these areas.

1. Evaluate Use of a Document Management System (DMS)

HSC assigned this recommendation a Medium priority and discussed needs for significant planning, resources, and training, and a strong infrastructure, to support successful implementation. HSC did not find any prior reports or other documentation suggesting a DMS was ever previously considered for the Licensing Program. HSC indicated that, in the past, these types of systems were used exclusively for large, paper-intensive applications. HSC's report includes data showing that the Medical Board receives more than 6,200 applications per year and HSC stated that an average of about 50 different documents. Many of these documents are submitted over an extended period of time and, as received, each document must be physically married with each application file, potentially prompting needs for additional review of the application file at that time. However, the estimated total number of licensing application documents handled (300,000 per year) is characterized as "relatively small". Also, the wide variety of documents involved and the possibility that the documents will be submitted without reference to the applicant's license application number, or other unique identifier, could complicate DMS development and implementation. DMS would replace the Medical Board's current paper-based licensing processes, and would not necessarily impact the electronic ATS or successor BREEZE2 system, although there could be interfaces with these other systems. Potential benefits of DMS include (1) streamlined processes, (2) improved workflow, (3) enhanced tracking, and (4)

reduced processing times. HSC's staffing recommendations include resources to assess the feasibility of a DMS. HSC did not provide any quantified estimates of the potential costs of DMS or the potential impacts of DMS on Licensing Program performance. In the California State Government environment, a period of several years (or longer) would likely be needed to fully implement a DMS solution, but such a system could help to reduce needs for additional staffing resources as license application workloads increase over time.

2. Augment, Reorganize, and Train Staff

HSC assigned these recommendations a High priority and recommended increasing the number of authorized permanent Licensing Section positions by 54 percent (from 26 positions to 41 positions, an increase of 15 positions). Partially offsetting this proposed increase, HSC also proposed eliminating four (4) half-time Retired Annuitant positions (equivalent to 2 full-time positions) and eight (8) part-time Student Assistant positions (equivalent to 6 full-time positions, assuming all of the Student Assistants work a maximum of 30 hours per week). With these offsets, a net increase of at least seven (7) full-time-equivalent positions was recommended (representing a 27 percent net increase in authorized staffing for the Licensing Section). With these recommendations, total authorized permanent positions for the Licensing Program would increase by 33 percent (from about 45 positions to 60 positions, excluding offsets for the elimination of Retired Annuitants and Student Assistants). The proposed new permanent positions include a new Assistant Division Chief (Staff Services Manager II) position and three (3) new Section Supervisor (Staff Services Manager I) positions (resulting in a total of 7 first level supervisor positions, including 1 Officer Service Supervisor II position). The eleven (11) remaining proposed new positions are classified as AGPAs (4 positions), SSAs (4 positions), and MSTs (3 positions). The four (4) proposed non-SSA positions were already filled. HSC also recommended upgrading two (2) Office Technician positions to MST. HSC's recommended replacement of part-time Student Assistants with permanent MST, SSA, and AGPA positions would represent a significant upgrading of the Licensing Program's workforce classifications and capabilities. Finally, HSC recommended significantly expanding training for all Licensing Program staff. HSC did quantify the potential costs or potential benefits of these recommended organizational and staffing changes.

In its study, HSC presented statistical data showing that the number of license applications received grew modestly from 2004/05 through 2008/09 (i.e., about 10 percent over 4 years, or less than 3 percent per year). During this period the number of US/CAN applications received was unchanged and the number of IMG applications received decreased. Concurrently, PTAL applications increased significantly, and accounted for all of the aggregate increase in applications received that occurred during this period. Also, as shown by HSC, there are recurring peaks in US/CAN application submissions during the third quarter of each fiscal year (January to March) which create a compression of activity during the following quarter (April to June). Finally, data presented by HSC showed that during 2004/05, and again during 2006/07, Licensing Program staff were largely able to keep pace with the flow of new applications, and backlog accumulations during both years were minimal. In contrast, during 2005/06 and, subsequently, during 2007/08 and 2008/09, large application

backlogs accumulated. HSC did not present any historical data showing Licensing Program staffing levels or overtime expenditures from 2004/05 through 2008/09, or data showing whether there was any correlation between (1) the Licensing Program's staffing levels and expenditures for overtime, and (2) program performance in terms of backlogged work and the timeframes needed to process license applications.

Prior to 2004/05, total authorized Licensing Program staffing was reduced from about 43 permanent positions to about 37 permanent positions. Authorized staffing for the Licensing Program remained at this same level through 2006/07. From the data presented in HSC's report it appears that, with additional overtime (which increased from $31,000 to $77,000), Licensing Program staff were largely able to keep pace with the flow of new applications during 2006/07, and prevent significant backlogs from accumulating. Use of Retired Annuitants and Student Assistants throughout this period was limited (less than 0.5 positions).

During 2007/08, three (3) additional clerical support (Office Technician) positions were authorized for the Licensing Program. Additionally, overtime expenditures increased marginally (to $88,000) and there was a small increase in the use of Retired Annuitants and Student Assistants. However, HSC's report shows a marked increase in license application backlogs during 2007/08. During the following year (2008/09), the Cashiering Unit, which consisted of six (6) authorized positions, was transferred to the Licensing Division. This transfer increased authorized Licensing Program staffing to about 45 total positions, but did not impact the number of staff available to process license applications. During 2008/09, license application backlogs increased further, to record levels, notwithstanding significant increases in expenditures for both overtime (to $196,000) and for Temporary Help (to 1.2 positions, from 0.4 positions, previously).

The HSC study does not appear to provide any substantive analysis of why authorized Licensing Program staffing resources (about 45 total authorized permanent positions, plus significant expenditures for Temporary Help and Overtime) were insufficient to keep pace with the flow of new applications during 2008 and 2009. The absence of an analysis of historical staffing and performance reduces the level of support for HSC's recommendation to increase authorized staffing for the Licensing Program by 15 permanent positions (with a likely cost of about $1 million per year, less offsetting savings from reductions in the use of Retired Annuitants and Student Assistants). HSC also did not provide any workload-based analysis supporting the need for the additional positions. Additionally, HSC based its recommendation for three (3) additional SSM I positions on the large number of subordinate positions reporting to the Licensing Section's current SSM Is (an average of about 20 subordinate staff per position). However, the subordinate positions included in this analysis included part-time Retired Annuitants and Student Assistants, and most of these positions would be eliminated. If part-time staff are excluded from the analysis, as they normally are for purposes of justifying new supervisory positions, then the spans of control of the Licensing Section's supervisors are much narrower (an average of about 12 subordinate staff per position). In the California State Government environment, this smaller span of control would still be considered high for this type of program.

As noted by HSC, during 2009/10 the Medical Board began filling eight (8) new positions proposed in a 2010/11 BCP that was not yet approved. DCA provided the Medical Board with a special authorization to fill these positions on an accelerated basis. At the time of HSC's study, four (4) of the positions had already been filled. Currently, seven (7) of the positions are filled, including one (1) new SSM I position. However, all of the positions were filled on a two-year, limited-term basis, pending formal approval of the pending BCP. Approval was also obtained from DCA to over-expend the amount budgeted for Temporary Help, the budget account used to fund these limited-term positions as well as costs for Retired Annuitants and Students Assistants). With these eight (8) additional limited-term positions, staffing for the Licensing Program now exceeds 52 total positions, excluding Retired Annuitants and Student Assistants, or 46 positions if staff assigned to the Cashiering Unit are excluded. Total authorized staffing resources for the Licensing Division, excluding Retired Annuitants and Student Assistants, is now 10 to 20 percent greater than previously authorized at any point during the 8-year period from 2000/01 through 2007/08.

As is evident from the above analysis, there is not a clear rationale for HSC's recommendation to seek authorization for seven (7) additional positions beyond the eight (8) additional positions requested as part of the currently pending 2010/11 BCP. Also, HSC provided no analysis of the cost-benefit trade-offs of using Permanent Intermittant positions, Temporary Help, such as Retired Annuitants and Student Assistants, and Overtime in lieu of additional full-time permanent positions, to address recurring seasonal workload peaks. Additionally, HSC's recommendation to upgrade two (2) of the Licensing Section's remaining three (3) Office Technician positions, and to completely eliminate the use of Student Assistants, would necessarily shift additional clerical and administrative support activities and workload to higher level staff. Finally, without HSC's proposed increases in SSM I positions, the recommendation to establish a new Assistant Division Chief position (SSM II) is not supported. Even with the additional SSM I positions, caution should still be exercised in establishing such a position because this type of management structure can simply fragment and dilute authority and accountability for Division and Section performance, and create an additional layer of bureaucracy that hinders, rather than enhances, effective decision-making, management of operations, and supervision of subordinate staff.

3. Establish Performance Objectives and Implement New Management and Performance Reports

In its reports HSC discusses the need to establish performance objectives for (1) application processing staff, (2) application review staff, and (3) administrative support staff, and indicates that their team worked with Licensing Program staff to develop performance objectives for Application Review staff. However, no specific performance objectives are presented in the report. HSC also discussed the need for performance metrics regarding actual work completed and indicated that, prior to the start of the BPR study, the Licensing Program established performance metrics for Application Review staff, based on manual counts. HSC also identified significant deficiencies with the Licensing Program's management reports, and the near complete absence of timely information regarding the Licensing Division's workload, workflow, and performance.

Additionally, some recently developed workload reports rely completely on manual counts of documents at various stages of processing.

HSC does not identify or define any specific performance objectives for Licensing Program staff that are not already largely set forth in governing statutes (i.e., elapsed times to complete the processing of license applications). To address the deficiencies with the Licensing Program's performance metrics and reporting, HSC recommended development of more than 20 new reports and logs. However, most of these reports and logs consist of only a single data element. HSC does not present in its report an integrated framework for planning and managing Licensing Program performance in terms of outputs produced, resources used, productivity and service levels achieved, and backlogs. However, many of the elements of such a framework appear to be contained within various recommendations for improvement presented by HSC.

4. Other Issues

It is apparent that the scope of HSC's review of the Licensing Program was limited, focusing largely on the License Application process. Thus, other components of the Licensing Program were not generally assessed. For example, there is no discussion in HSC's report of the processes used to ensure licensee compliance with Continuing Medical Education (CME) Program requirements. During the past seven (7) years, the Medical Board has completed very few audits of licensee compliance with CME requirements. More than 200 citations were issued the last time the Licensing Program audited compliance with CME requirements (2007). A minimum number of audits of compliance with CME requirements should be regularly completed to ensure that non-compliance rates remain low, with larger numbers of audits completed in areas where above-average levels of non-compliance are detected.

D. Recommendations for Improvement

Below we present and briefly discuss seven (7) recommendations resulting from our review of HSC's study of the Licensing Program and other related analyses performed as part of our assessment.

Recommendation No. XI-1. ***Implement HSC's Recommended Business Process Improvements***

Medical Board staff from the Licensing Program and other business units spent considerable time working with HSC to identify and assess the recommendations for improvement presented in HSC's report. Additionally, about $40,000 was expended for the study. Potential benefits associated with implementing HSC's recommendations for improvement should be lost. As determined appropriate, the Licensing Program should implement HSC's recommended business process improvements. If implemented, many of the recommendations could marginally improve internal effectiveness or efficiency, or the level of service provided to applicants, without incurring any significant additional costs.

Recommendation No. XI-2. ***Conduct a Limited, High-Level Business Case Analysis of Potential Benefits, Costs, and Risks of a Document Management System (DMS)***

The Medical Board should consider conducting a limited, high-level business case analysis of potential benefits and costs of a DMS. This analysis should include researching document management systems used by DCA or other California State Government agencies and departments, such as the Contractors State License Board. Additionally, the analysis should include obtaining information from potential vendors, but not necessarily development and issuance of a Request for Information (RFI) as suggested by HSC. The analysis should focus on identifying and quantifying, where practicable, potential efficiency and other improvements that might be achieved, developing order of magnitude estimates of costs to develop and maintain the system, and comparing the potential benefits with the estimated costs. Additionally, the analysis should include an analysis of significant risk factors associated with development and implementation of such a system. If supported, the Business Case Analysis can be used to support development of Feasibility Study Report (FSR), if needed.

Recommendation No. XI-3. ***Obtain Authorization to Convert Recently Established Limited-Term Positions to Permanent Status***

Based on the limited, high-level analysis of historical Licensing Program workload and staffing levels completed as part of our assessment, it appears that the eight (8) new positions proposed in the 2010/11 BCP would fully restore positions lost earlier in the decade and also provide additional positions justified on the basis of increased workloads since that time. Additionally, given the nature of the medical profession and health care industry needs for additional licensed physicians, it is highly unlikely that application workloads will diminish over time. Finally, when positions are classified as limited-term, there is a greater risk of higher staff turnover as incumbents transfer to other positions rather than risk losing their job in the event the position expires. Therefore, we recommend obtaining authorization to convert the recently established limited-term positions to a permanent status as soon as practicable. We understand that these positions were converted to a permanent status effective July 1, 2010.

Recommendation No. XI-3. ***Scale Back the Use of Retired Annuitants, Student Assistants, and Overtime, if Furloughs are Discontinued***

As discussed above, the recent addition of eight (8) new limited-term positions appears to be sufficient to fully restore positions lost earlier in the decade and also provide additional capabilities to process the larger number of license applications now submitted. Therefore, the Licensing Program should be able to significantly reduce its use of retired annuitants and student assistants, and overtime. We understand that the Medical Board has begun implementation of this recommendation.

Recommendation No. XI-5. ***Conduct a Detailed Analysis of Licensing Program Workload and Staffing Requirements***

The Licensing Program could potentially benefit from completion of a detailed analysis of Licensing Program workload and staffing requirements. Such an analysis could help Licensing Program management to (1) optimize the alignment of workload demands with available staffing capabilities and (2) determine how best to organize staff and needs for reclassification of existing positions, including determination of whether it would be beneficial to reclassify a rank and file position to the supervisory level to enhance management capabilities and further reduce supervisory spans of control. Implementation of this recommendation should be deferred pending appointment of a new Licensing Program Chief.

Recommendation No. XI-6. ***Develop an Integrated Framework for Planning and Managing Licensing Program Performance***

Licensing Program management should develop an integrated framework for planning and managing Licensing Program performance that encompasses (1) establishing program goals and objectives, (2) developing plans, (3) monitoring operations, and (4) reporting results. The framework should be developed around a common set of quantified measures of outputs produced, resources used, service levels provided, and performance levels achieved.

Recommendation No. XI-7. ***Resume Audits of Licensee Compliance with CME Requirements***

Audits of compliance with CME requirements are essential to ensure that licensee compliance levels do not deteriorate, and should be resumed as soon as practicable.

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