# 2012

# Medical Board of California

## Report to the Legislature
## Vertical Enforcement and Prosecution Model

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## March 2012

Report to the Legislature

Vertical Enforcement and Prosecution Model

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# Executive Summary

The Medical Board of California (Board) is required to submit a report to the Legislature by March 1, 2012, offering recommendations to the Governor and the Legislature on the "vertical enforcement and prosecution model" (VE/P). The purpose of the VE/P model is to increase public protection by improving coordination, teamwork, increasing efficiency, and reducing investigative completion delays. The VE/P model was implemented by the Board and the Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) on January 1, 2006.

The Board submitted a report, prepared by Integrated Solutions for Business & Government, Inc., to the Legislature on the VE/P model in June 2009. The 2009 report provided extensive statistical Board data showing select data markers for the period January 2005 to December 2008. It also recommended continuing the VE/P model with modifications.

An August 2010 report, by Benjamin Frank LLC Management Consultants, evaluated the Board's programs. This Frank report suggested implementing 14 recommendations to improve the VE/P model.

This 2012 report will focus on a total of 21 recommendations proposed in the 2009 and 2010 evaluation reports and the Board's actions in implementing them.

The Board and HQES continue to jointly work on strengthening the VE/P model. The revised VE/P manual (Third Edition, July 2011) provides clarification on responsibilities of Board and HQES staff. Further, it states the expected time-frames to complete milestone events during the investigation and prosecution processes. A joint statewide training for all Deputy Attorneys General (DAGs) and Board investigators was held in April 2011. The training included discussions on consistency in administering the VE/P model, processing subpoenas, and techniques for promptly acquiring medical records. Many other enhancements to the VE/P model have been realized by the joint efforts of the Board and HQES staff. The Expert Reviewer Program has been reinforced with an interactive 8-hour training course for experts set to roll out in May 2012. The Board and HQES have been energetically working toward reconciling their different methods of reporting certain data markers.

Ten of the 21 recommendations from the two reports have been implemented. The July 2011 VE/P manual has been updated to incorporate suggestions in the recommendations regarding communication, clarity of roles, and statewide consistent/unified administration of the VE/P process. A joint, Board and HQES, training was held and the Expert Reviewer Program has been strengthened. Phase one of the BreEZe integrated computer system is due to be implemented by the Board in Fall 2012. An interface for DCA Boards/Bureaus and DOJ is not scheduled to be

implemented in the first phase. Discussions are continuing for the Board/DOJ interface to be released in the third quarter of 2013.

Progress has been made in filling staff vacancies, developing new positions, reviewing factors for turnover, and developing plans to minimize attrition. Attention is now being focused on ways to fill vacancies in hard to recruit areas of the State and establish incentives to retain current staff. The Board is seeking approval for six non-sworn, Special Investigator I positions. A re-alignment of the investigator classification will aid in the retention of staff.

A detailed report, fully analyzing the VE/P model, data and its effectiveness, will be provided to the Legislature during the Board's upcoming sunset review period. The impending report will provide Board and HQES integrated data needed to determine the effectiveness of the VE/P model.

# Introduction

The Board is required to submit a report to the Legislature offering recommendations to the Governor and the Legislature on the VE/P model. In the VE/P model, the trial attorney and the Board investigator are assigned as a team to handle a case as soon as a formal investigation is opened. The purpose of the VE/P model is to increase public protection by reducing the time to conduct an investigation, leading to reduction in the time to file and prosecute disciplinary actions.

The VE/P model was a recommendation from the Board's ***Enforcement Monitor Report – November 2005***. It was implemented by the Board and HQES on January 1, 2006 when Senate Bill 231 (Chapter 674, Statutes of 2005) became effective. SB 231 codified the use of the VE/P model until July 1, 2008 and required the Board to report and make recommendations to the Governor and the Legislature on the VE/P model by July 1, 2007.

The Board's November 2007 ***Report to the Legislature on Vertical Enforcement*** states there was an overall decrease of 10 days in the average time to complete an investigation, excluding all pending cases prior to the implementation of the VE/P model, during the initial period of the VE/P model. However, this was not a sufficient period of time to fully evaluate the change in time to complete prosecutions. Since Board investigations exceed one year to complete, prosecution cases are not begun until completion of investigation and thus could not analyzed as a part of this report.

This report also included a copy of the Vertical Prosecution Manual (Second Edition, November 2006), a compilation of policies and procedures to assist in the implementation of the VE/P model developed by the Board and HQES. It further recommended continuing the VE/P model with the execution of specified recommendations to further assess the effectiveness of the model.

To further study the impact of the VE/P model, SB 797 (Chapter 33, Statutes of 2008) was enacted to continue the VE/P model until July 1, 2010 and required the Board to report on the effectiveness of the VE/P model by July 1, 2009.

The June 2009 ***Report to the Legislature on Vertical Enforcement Model*** prepared by Integrated Solutions for Business & Government, Inc. provided extensive statistical Board data for the period January 1, 2005 (Pre-VE/P) through December 31, 2008 showing a variety of figures for select data markers. Further, it provided an overview of the enforcement process, information on interviews conducted on select Board and HQES staff, and a variety of recommendations for a more successful VE/P model.

The 2009 report showed there was an increase in the average days from 322 days to 398 days from assignment of an investigation to completion of an investigation between 2005 and 2008. For that same time period, there was an increase in the average days from 451 days to 549 days from assignment of an investigation to all outcomes of an investigation. Outcomes range from case closed with no resulting prosecution to case closed with disciplinary action taken. One factor identified that may have contributed to the increase in timeframes was Board staffing issues. In addition there were a variety of challenges in processing times for certain investigative events due to various constraints, including difficulty in obtaining medical records, needing subpoenas, and time delay in conducting interviews.

In an effort to reduce delays in physician interviews, the Board sponsored legislation to make it unprofessional conduct for a physician to willfully fail to participate in a scheduled interview with the Board. Assembly Bill 1127 Brownley (Statutes 2011, Chapter 115) enacted this legislation that constitutes unprofessional conduct for a physician who, absent good cause, fails to repeatedly participate in a scheduled interview with the Board. The Board's compromise on this legislation may not make it as effective as desired. Further, AB 1070 (Chapter 505, Statutes of 2009) required all medical records requested by the Board be certified. This has eliminated the Board requesting records a second time when the initial records received were not certified.

In October 2009, the Board awarded a contract to Benjamin Frank LLC Management Consultants to evaluate the Board's programs including assessing fiscal and performance impacts resulting from implementation of VE/P. The August 31, 2010 report: ***Medical Board of California – Program Evaluation Volume I Summary Report*** presented to the Board at its November 2010 quarterly meeting included recommendations for improvement relating to VE/P.

AB 1070 also continued the VE/P model until January 1, 2013 and requires the Board to report on the effectiveness of the VE/P model by March 1, 2012. This date would have coincided with the Board's sunset review hearings but the sunset date was changed for the Board. However, the dates for the VE/P report and VE/P extension were not changed.

Due to limited integrated data received from HQES, the Board was not able to do data analysis for this report. Thus, this report will only focus on:

- Various recommendations that have been proposed in the 2009 and 2010 evaluation reports;
- Board's progress in implementing the recommendations; and
- Board's continued evaluation of the recommendations.

A detailed report, which will include data from HQES, will be provided to the Legislature during the Board's upcoming sunset review period. The impending report will provide data needed to determine the effectiveness of the VE/P model. Further, the report will provide a comprehensive review of VE/P over the full 6 years the model has been in place. The next two sections will discuss what the Board has done to implement the recommendations.

# Recommendations - June 2009 Report

The June 2009 ***Report to the Legislature on Vertical Enforcement Model*** recommended continuing VE/P and addressing the following recommendations:

- Zero Tolerance of Negative Communication
- Clarity of Roles
- Consistent and Unified VE/P Process
- Consider Limiting VE/P to Specified Types or Categories of Cases or Circumstances
- Joint Statewide Training
- Staffing Vacancies
- Common Server

## Recommendation #1: Zero Tolerance of Negative Communication

*While both the MBC and HQES have made considerable progress in their working relationship, additional work is necessary to ensure mutual respect and appreciation for the vital roles each bring to the process and, ultimately, to public protection. Staff interviewed identified this as a major and continuing issue directly or indirectly impacting staff statewide. Based on the statements and the level of frustration that was observed during the interviews, it was concluded that this was a major issue impacting the success of VE. In addition, there was a lack of commonly understood and mutually accepted appreciation of each other's roles and professional contributions towards resolving cases in the VE model. Since interpersonal communications between MBC investigators and HQES attorneys is key to the success of VE, it is recommended that the tone be uniformly set by executive management and every manager and supervisor of both departments that all staff work together as partners in a professional and respectful manner, and that all communications demonstrate mutual respect, courtesy and responsiveness, without exception. Any inappropriate communication must be addressed immediately, fairly and effectively.*

*Consideration should be given to engaging a knowledgeable outside consultant respected by both MBC and HQES to help identify, isolate and eliminate the cause(s) of such negative communications.*

### Board Action:

HQES's June 17, 2009 written response to this recommendation contends there were isolated incidents involving disagreements between Board investigators and HQES attorneys. HQES suggested this issue should have been categorized as a management issue not a systemic issue that warrants this recommendation. HQES further commented that this issue was addressed in the Joint Vertical Enforcement Guidelines (First Edition, April 2008) in the "Courtesy and Cooperation" section.

HQES and Board management met with supervisors and managers to: enforce the policy on good communication, discuss that this was a perceived issue by the reviewing entity, and address compliance with the policy.

In a continued effort to improve communications, the VE/P manual was updated July 2011 to include additional expectations and guidelines for interpersonal communications between the Board's investigators and HQES attorneys. This manual was approved for release by DOJ on December 27, 2011 and copies of the manual were distributed to Board staff in January 2012. Board supervisors were instructed to review the manual with staff for full implementation by March 1, 2012.

Changes reflected in the July 2011 VE/P manual were made to section: "Cooperation and Consultation in Direction and Supervision". This section now includes the expectation that investigators and attorneys treat each other respectfully and resolve disagreements in a professional manner.

In addition, several sections were added to the July 2011 VE/P manual including "Responsiveness to Communications" and "Email Communications". These sections were adapted from the existing Joint VE/P Guidelines (First Edition, April 2008). They stress the importance of Board investigators and HQES attorneys responding to telephone messages and emails promptly as well as designating a responsible person in their absence for continuity of investigation and prosecution of cases.

These changes and additions have enhanced the expectation of mutual cooperation in the VE/P process.

## Recommendation #2: Clarity of Roles

*It is recommended that clear and consistent direction be provided by top management regarding the roles of DAGs and MBC staff at all levels. Although the VPM identifies the VE team members and their respective roles, many of those interviewed from both departments stated that there needs to be a greater clarity and understanding of each others roles.*

*The meaning of Government Code (GC) Section 12529.6 wording "under the direction of" must be clearly defined and adhered to throughout both departments in a consistent manner that emphasizes teamwork and recognizes the unique training, expertise and contributions of all members of the team. If necessary, legislative changes should be sought to provide additional clarity.*

*Although HQES management stated that it has been HQES' position that MBC is the client, interview responses indicate that this is neither clearly understood nor accepted. Comments during the interviews indicate there is no common understanding or acceptance of the meaning of these terms at all levels in both departments. Staff*

*interviewed revealed continuing confusion, disagreement or acceptance of the meaning of "direction" and "client", including disagreement as to who is authorized to speak on behalf of the client on a statewide basis. Therefore, management must clarify and ensure a consistent understanding and application of the term, which should be included in the joint training recommended below and incorporated in all appropriate manuals.*

**Board Action:**

The Board was already aware that the roles of the DAGs and Board investigative staff needed to be clarified. The recommendation to clearly define "under the direction of" in Government Code Section 12529.6 had already been achieved through an amendment in law. SB 797 (Statutes 2008, Chapter 33) changed the language to state "under the direction of, but not the supervision of". The Board sponsored this amendment to the code to help define what was meant by "under the direction of" and define who was in charge. The Board and HQES had addressed the authority issue in the November 2006 VE/P manual and the April 2008 VE/P guidelines.

HQES and the Board continue to work toward cooperative implementation of VE/P statewide. The July 2011 version of the VE/P manual includes the clarifying language in the entitled section, "Vertical Enforcement and Prosecution Under Government Code Section 12529.6" changing "under the direction of the deputy attorney general" to "under the direction but not the supervision of the Deputy Attorney General". Many other components of the manual have been changed to clarify the roles and responsibilities of Board and HQES staff.

**Recommendation #3: Consistent and Unified VE/P Process**

*The Monitor stated that: "MBC investigators and HQE prosecutors should work together in a true vertical prosecution system featuring case teams established at the initiation of the investigation and remaining together until the case is fully litigated or resolved." As implemented, according to the Vertical Prosecution Manual (VPM), there is a lead prosecutor and a primary prosecutor assigned to each case. "The Lead Prosecutor shall be assigned to, and shall review, each complaint referred to the District Office for investigation. In addition to the Lead Prosecutor, a second deputy attorney general shall be assigned by the Supervising Deputy Attorney General to each complaint as well. The Lead Prosecutor shall act as the primary deputy attorney general on the case for all purposes until and unless replaced by the second deputy attorney general……" Whenever, the Lead Prosecutor determines, either upon review of the original complaint or as the investigation progresses, that it is a likely a violation of law may be found, the second deputy attorney general shall replace the Lead Prosecutor as the primary deputy attorney general on the case for all purposes."*

*Interviewees stated that this process causes confusion and unnecessary or repetitive assignments because it is not uncommon for the lead DAGs to request different investigative tasks than the primary DAGs. This also causes delays in the interview process because it is frequently not readily known if the primary or the lead prosecutor will participate in the interviews and the process as implemented varies from office to office.*

*Therefore, since the current VE model is not a true vertical process as recommended by the Monitor, varies from one office to the other, and results in confusion and delays in the investigation, it is recommended that a consistent and uniform statewide true VE process, with appropriate levels of approval, be adhered to in every office. Exceptions, if any, should require an appropriate basis and level of approval and be clearly documented and published to avoid the appearance of being arbitrary or unfair. It is further recommended that consideration be given to replacing the existing multiple manuals and implementing a single joint manual that addresses the entire VE process, based on input from all who are part of the VE process through a joint task force or committee, to ensure consistency and uniform understanding of the VE model and each person's role in the VE process. In addition, the VE process itself should be reviewed for efficiency to determine if there are unnecessary duplications and methods for streamlining the overall process.*

**Board Action:**

Legislation did not authorize a true VE/P model where investigators and attorneys would work jointly in one agency. However, a modified model was established in law where Board investigators and HQES attorneys are assigned as a team to handle an investigation.

During the Medical Board's July 2009 quarterly meeting, the Board's Chief of Enforcement stated she was working with DOJ's HQES Senior Assistant Attorney General to address the consistent uniformity of VE/P on both a case by case basis and district by district basis.

At the Board's January 2011 quarterly meeting, the Sr. Assistant Attorney General reported that HQES revised a section of its manual. The modification was made to redefine the role of the lead prosecutor as mentioned above in the recommendation. He stated this change was made to improve the VE/P process. Further, this change would eliminate the need for deputies in the Los Angeles area to travel as often to Board district offices, therefore, reducing travel time and costs.

The revision to the VE/P manual in July 2011 included several enhancements to further spell out the expectations of the VE/P process. Specifically, the duties and responsibilities of the Lead Prosecutor were defined in the "Lead Prosecutor" section of the manual. In addition, the following new sections were added:

- Investigation Completion Timelines – This section was added to specify the expected time frame by which an investigatory task should be completed. For example, the investigator is expected to request medical records within seven (7) business day of receiving a patient's authorization to obtain records.
- Selection of Expert Reviewers – The PDAG is responsible for ensuring the chosen expert is appropriate for the case, by reviewing the credentials of the expert.
- Receipt of Expert Opinion – The Investigator shall provide copies of the expert report to the assigned PDAG and medical consultant within one (1) business day of receiving the report.
- Probation Violation Cases - This section specifies that probation violation cases are not investigated under the VE/P model, so they may move more quickly to prosecution.

These changes and additions have enhanced the expectation of uniformity in the VE/P process.

**Recommendation #4: Consider Limiting VE/P to Specified Types or Categories of Cases or Circumstances**

*The data provided indicates that although there is a decrease in the time to complete a case once it is referred to the AG for prosecution, there is an overall increase in the investigatory phase of cases in the VE model.*

*As the Monitor noted, the vertical prosecution model is widely and successfully used by law enforcement, district attorney offices, and others for specialized or complex cases. However, not all cases necessarily require handling under the VE model. To improve efficiency and effectiveness in light of the demonstrated increase in the time to complete the investigatory phase that has resulted from inclusion of all cases in the VE model, it is recommended that consideration be given to identifying specific types or categories of cases or circumstances under which VE would likely be of benefit and limit its use to those situations.*

*A working group consisting of management and staff from both departments should evaluate and recommend the categories of cases, circumstances or guidelines for determining which cases warrant handling in the VE process. In addition, consideration should be given to designating an intake officer(s) in the field offices to determine cases warrant VE handling in accordance with the final guidelines. An outside consultant experienced in vertical prosecution should be considered to assist in this process.*

**Board Action:**

HQES's June 17, 2009 written response stated HQES is in agreement with this recommendation to limit VE/P to certain types of cases. Specifically, HQES

recommended excluding allied health care cases from the VE/P model.

The Board has not had an opportunity to fully examine this recommendation related to specified types or categories of cases, which may require a change in law in some instances. Once data from the Attorney General's Office is received and analyzed regarding costs and timeframes for various categories not related to allied health cases, this recommendation will be fully examined. This examination will include the feasibility of the VE/P process keeping cases involving sexual misconduct, 805 reporting, over prescribing, impairment, and multiple cases on the same subject and eliminating others.

**Recommendation #5: Joint Statewide Training**

*Although MBC management states that joint statewide training has been previously attempted, it is recommended that a mandated joint statewide training for all DAGs and investigators, regardless of their level, experience or past training, be held to assist in team building and ensure a common and consistent knowledge base. Based on the comments received from interviewees, such training should , at a minimum, include: effective and efficient communication; workload prioritization; roles, background and training of investigators, supervisors, lead and primary DAGs and Supervising Deputy Attorney Generals (SDAGs), and the need of each to efficiently and appropriately perform their functions; definition of "client" and "direction"; interviews and interview strategies; obtaining appropriate expert witnesses; subpoena use and preparation; administrative hearing process and investigator's role at a hearing; and the role and purpose of the Central Complaint Unit (CCU).*

*The primary purpose of the statewide training is to achieve a common foundation and understanding, as well as to foster team building between the staffs of both departments and their various field offices. Unless the training is designed and implemented to accomplish both of these critical goals, it will not be effective.*

**Board Action:**

During the Medical Board's July 2009 quarterly meeting, the Chief of Enforcement stated she was working with the Senior Assistant Attorney General to address the statewide training. The Governor's Executive Order (S-16-08) implemented two furlough days per month covering the periods of February 1, 2009 through June 30, 2010. On July 1, 2009, Executive Order (S-13-09) implemented three furlough days per month through June 30, 2010. This Order resulted in a loss of significant work hours per month in the Board's investigative section. The furloughs coupled with the State's fiscal crisis made it difficult to conduct joint statewide training during this time. The Board and HQES began working in 2010 on training modules for a joint statewide session. That training was held April 12-15, 2011. Board investigators and inspectors trained over a four day period, and HQES attorneys joined the training for one day.

A topic covered in the joint training included, "Medical Records Acquisition for the Investigator and Prosecutor". This item was presented by the Board's Deputy Chief of Enforcement and several HQES DAGs. This presentation emphasized successful techniques and the importance of obtaining medical records in a timely manner.

**Recommendation #6: Staffing Vacancies**

*Staff interviewed indicated that there were recruitment and retention issues. It is recommended that the departments continue to give priority to resolving any current staffing vacancy issues. Areas to pursue include: methods to increase investigators' salaries; use of overtime pay; use of telecommunication and alternate work schedules; and/or wage subsidization in high turnover, hard to fill vacancy locations.*

*Consideration should be given to engage a knowledgeable consultant with experience in state government and in working with control agencies to survey past and current employees to identify and, if appropriate, help resolve areas of dissatisfaction that are contributing to the problem.*

**Board Action:**

The staffing vacancies were in both the Board's sworn investigators and supervising investigators positions. Staffing difficulties were attributed to attrition and a lack of applicants in certain areas of the State. Further, more investigator responsibility in the VE/P model, and less pay than comparable investigator classifications in other state agencies, also contributed to the Board's inability to retain investigators. The Governor's hiring freeze in 2009 severely impacted the ability to fill vacancies.

The Board contracted with CPS Human Resource Services to conduct an investigator classification review. The April 2009 report concluded a new investigator classification would not be appropriate. From this report, several recommendations were made including consolidating the investigator and senior/journey level investigator classifications. This approved re-alignment will aid in the retention of Board investigators. Investigators will no longer have to take an examination for a promotion to the senior/journey level investigator classification as promotions will occur based upon time in service and evaluation of performance. In addition, during Fiscal Year 2010-2011 testing was made available on a continuous basis for new investigators to facilitate filling investigator vacancies.

In May 2009, there were 10 vacant investigator positions that equated to a 14 percent vacancy rate. The Board was able to fill some investigator vacancies during the second half of 2009, thereby lowering the investigator vacancy rate to 8 percent. The investigator vacancy rate varied from 7-10 percent in 2010 and fluctuated between 8-13 percent during 2011. Through obtaining approvals for hiring freeze exemption

requests, and eventually the lifting of the State hiring freeze in late November 2011, the Board was able to continuously conduct interviews to fill vacant positions.

At the February 2012 quarterly Board meeting, the Chief of Enforcement reported there are 92 sworn staff positions: 72 investigators and 20 supervisors. She stated the sworn vacancy rate, for investigators and supervisors/managers overall, was 18 percent. The investigator vacancy rate was 17 percent. The vacancy rate for supervisors/managers was 25 percent. Over 8 percent have been identified with candidates to fill the vacancies. Board management staff continues to strategize ways to fill vacancies in hard to recruit areas of the State.

## Recommendation #7: Common Server

*One of the recommendations of the Monitor's reports and previous Report to the Legislature, Vertical Enforcement, was to implement and "information technology system interoperable with the current system used at DOJ". The MBC and AG have agreed to an interoperable database and are in the process of obtaining necessary control agency approvals. Although immediate implementation may consequently not be feasible at this time, there was significant support from many of those interviewed for implementation of a common or shared server accessible to both DAGs and investigators for storage of common documents and their calendars as an interim measure.*

*It is recommended that a working group of both AG and MBC staff be established to explore an effective and efficient method of sharing documents and information to eliminate repetitive duplication of documents and unnecessary delays in scheduling and rescheduling of subject interviews.*

### Board Action:

The Board and HQES agreed it would be beneficial to share documents on a common system. However, due to the inability to obtain the necessary approvals and systems to have Board data and HQES' ProLaw System interface, this recommendation has not been implemented.

The Board pursued its own computer system in 2008 that might have had the capability to interface with DOJ. This undertaking was absorbed into the larger Department of Consumer Affairs (DCA) BreEZe computer project in late 2009. BreEZe is due to be released to the Board in Fall 2012. The interface for DCA Boards/Bureaus and DOJ is not scheduled to be completed in this first phase. Discussions are continuing for the interface to be included in the second phase of the project due to be implemented in the third quarter of 2013.

## Recommendations - August 2010 Report

The August 31, 2010 ***Medical Board of California – Program Evaluation Volume I Summary Report*** by Benjamin Frank LLC Management Consultants included recommendations to address improvements needed involving complaint intake and screening, investigations, prosecutions, and related organizational and management structures. However, this report will only discuss the following recommendations that relate to VE/P:

- Augment Medical Consultant staffing
- Augment Medical Expert pool and strengthen Medical Expert Program
- Review factors contributing to excessive investigator turnover and develop/implement plans to minimize attrition
- Establish independent panels to review all requests for supplemental investigations and all decline-to-file cases
- Restructure process of preparing accusations and surrender stipulations for Out-of-State cases
- Restructure handling of petitions for modification or termination of probation
- Amend law to clarify Board's sole authority to determine whether to continue an investigation
- Optimize HQES Attorney involvement in investigations and increase uniformity among regions
- Establish a new process for tracking the status of cases following referral to HQES for prosecution
- Establish a new process for tracking and reviewing charges for legal services
- Establish a new Board position to monitor and evaluate HQES costs
- Develop new monthly management reports and new quarterly reports for the Board
- Amend or repeal Section 12529.6(e) of the Government Code
- Conduct periodic performance reviews of the services, costs, and performance of HQES

### Recommendation #1: Augment Medical Consultant Staffing

*Medical Consultants should be available to all District offices all of the time (e.g., the equivalent of at least one full-time position per office, although actual availability will be less than full time due to vacations, sick leave and other time off). Because the Medical Consultant positions are classified as Permanent Intermittent, work hours can be adjusted to accommodate fluctuating workload demands, assuming a sufficient pool of resources is available to provide the services and the physicians are willing to work the number of hours needed. Offset costs for additional Medical Consultant positions by reducing expenditures for HQES investigation-related services (e.g., in the Los Angeles region).*

**Board Action:**

Based upon this recommendation, a budget change proposal (BCP) was initiated for Fiscal Year (FY) 2012/2013 to increase the number of medical consultants available to the Board. Subsequently, it was put on hold because the data did not support additional consultants. This was partially due to hiring freeze restrictions.

At the July 2011 quarterly Board meeting, the Chief of Enforcement reported that freeze exemptions were approved for medical consultant positions. This enabled the Board to increase the number of medical consultants in various areas of the State. However, the Board did not increase medical consultant positions or time base in district offices where there was no Supervising Investigator due to oversight and management issues. At the October 2011 quarterly Board meeting, the Chief of Enforcement reported that continuous testing for medical consultants had been implemented.

The Board will continue to evaluate the feasibility to pursue an augmentation in the future. For the first six months of FY 2011/2012, an average of 109 medical consultant hours was expended in each district office per month. This equates to approximately .65 personnel year (PY) in each office. As offices become fully staffed, the need for more consultant hours will increase.

**Recommendation #2: Augment Medical Expert pool and strengthen Medical Expert Program**

*Eliminate the limitation on reutilization of Medical Experts and augment the Medical Expert pool and enhance capabilities. In addition to strengthening Medical Expert oversight and overall Expert Reviewer Program management and administration, consider redirecting some funding currently used for HQES investigation-related services toward establishing a new program under which the Medical Board would contract for the services of a pool of physicians to provide Expert Review services (e.g., through an Interagency Agreement with one or more University of California Medical Centers, although this model may have its own problems relating to conflicts of interest).*

**Board Action:**

Regarding the first part of the recommendation, it is the Board's policy not to over utilize expert reviewers, and use of these experts is reported at the quarterly board meetings. Should the Board be unable to increase its pool of experts, this policy may be reconsidered.

In HQES's October 12, 2010 written response, a recommendation was made to reinstate procedures that were used in the past. These procedures included requiring prospective experts to meet with Board staff to review their qualifications and

determine whether they were sufficiently qualified to serve as an expert. Further, HQES offered to have a Supervising Deputy Attorney General (SDAG) serve on the interview panel.

The Board has taken various steps to improve the Expert Reviewer Program including increasing the number of experts available. Further, the Board continues to recruit experts in under-represented medical specialties. The Board developed an interactive training module for experts, and pursued new analyst positions to help with recruitment and training efforts.

In 2010, DCA began to implement a new Consumer Protection Enforcement Initiative (CPEI) to enhance the enforcement and disciplinary processes of all healing arts boards. The goal of this initiative is to reduce the average enforcement completion timeline from 36 months to between 12 and 18 months.

The Board is proposing that two positions gained through CPEI be reclassified to associate governmental program analysts. These positions would assist with expanding the pool of available experts with continuous recruitment and training, and assist with procuring experts for non-sworn investigator cases.

There continues to be a shortage of experts in the specialty areas of addiction medicine, pain management, and psychiatry. The Board works with the California Society on Addiction Medicine to advertise the need for experts in their newsletter. The California Medical Association (CMA) also assists the Board with obtaining medical specialists in all under-represented areas. Further, CMA encourages local medical societies to allow Board staff to attend their meetings and initiate training. The training would provide an opportunity to improve the quality of experts.

The Expert Reviewer Program has added more than 100 additional experts during 2010 and 2011. An advertisement in the Medical Board's July 2010 newsletter yielded over 120 applications for expert reviewers. As of January 3, 2012, there were 1,172 physicians on the active list in about 44 medical specialty and sub-specialty areas.

The Board's Enforcement Committee meeting on April 29, 2010 included a presentation on the history of the Expert Reviewer Program and ideas for enhancing the training module. The Board sought input on training from Board Members, medical consultants, investigators, and HQES staff. Several subsequent meetings were held to develop the training course. Board enforcement staff worked vigorously to develop and finalize an interactive training course for experts.

A preliminary test of the training course that includes participation from SDAGs and an Administrative Law Judge (ALJ) is expected to take place in April 2012 for Board investigators. Thereafter, the finalized 8-hour training course will be rolled out to current and potential experts throughout the State. The Board anticipates the first

training for Board experts will be held in May 2012 at the University of California, Davis Medical Center.

**Recommendation #3: Review factors contributing to excessive investigator turnover and develop/implement plans to minimize attrition**

*Develop and implement an Immediate Action Improvement Plan to address critical District office workload and work environment issues. Meet with District office staff at each office to present the Improvement Plan and to outline a process for identifying and implementing further improvements. Conduct a structured diagnostic review of factors contributing to excessive Investigator turnover during the past several years, and develop and implement a Longer-Term Improvement Plan to reduce Investigator attrition and rebuild the Enforcement Program's field investigation workforce capabilities and competencies.*

**Board Action:**

Board Enforcement supervisors and managers continue to meet with HQES staff quarterly to address issues. Most recently, a meeting was held on January 18, 2012. Included on the agenda were items regarding staffing updates, implementation of the revised July 2011 VE/P manual, strict adherence to its provisions, and statewide consistency regarding the investigations and prosecution of criminal cases.

In an effort to maintain an appropriate level and equally distributed workload throughout the district offices, an investigator caseload activity report for each district office is evaluated monthly. Supervising Investigators in the district offices review all cases that have been in the investigation stage for over a year. This review is done to assist the investigator in moving the case along in the process to closure or to prosecution. Further, "case age" council meetings are conducted by the Enforcement supervisors and managers along with HQES staff on a periodical basis. These meetings are held to discuss specific cases where investigators and attorneys have encountered obstacles preventing the movement of older, stalled cases.

The Board is seeking approval for six Special Investigator I (Non-Peace Officer) positions that were gained through CPEI. The duties for these positions would include conducting complex administrative and civil investigations that do not require the services of a sworn investigator. The addition of these positions will assist in reducing the current workload of sworn investigators, resulting in increased productivity and reduced timelines.

The approved re-alignment of the investigator classification will aid in the retention of Board investigators due to easier promotional opportunities. Investigators will no longer have to take an examination for a promotion to the senior/journey level

investigator classification. Upward movement will be based upon evaluated progress by the supervisor and time in service.

Other factors that still need to be examined for the retention of investigators would include incentive pay for extra duties such as, field training officer, range master, and defensive tactics instructor. The Board through the department will explore the possibility of pursuing the expansion of the types of bachelor degrees that are allowed for entry into the investigator classification.

**Recommendation #4: 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 #11] *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.*

**Board Action:**

Due to the State hiring freeze and State budgetary constraints, the Board has been unable to pursue the feasibility of this recommendation. When the Board and HQES have viable, comparative, statistical data that identify these types of cases, this recommendation may be further explored. The Board expects to have preliminary results of the evaluation of this recommendation by early 2013.

However, a dispute resolution process was developed in 2006 for handling supplemental investigation requests and decline-to-file cases. 90% of case disputes are resolved at the district level. If staff is unable to resolve the disputes at the district level, then the case is referred to the Regional Manager for resolution.

**Recommendation #5: Restructure process of preparing accusations and surrender stipulations for Out-of-State cases**

*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.*

**Board Action:**

This recommendation has not been implemented. With the impending positions the CPEI will create, the Board may consider the feasibility of this recommendation in the future.

**Recommendation #6: Restructure handling of petitions for modification or termination of probation**

*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.*

**Board Action:**

With positions approved through the CPEI, the Board plans to create a unit within the Office of Standards and Training to handle tasks that do not require sworn investigators. The unit will include six non-sworn investigators. The duties would include conducting investigations that require minimal field work and other duties that will reduce the workload of sworn investigators. These types of investigations could be the type assigned to this unit. This could help in reducing the current workload of sworn investigators, resulting in increased productivity and reduced timelines.

**Recommendation #7: Amend law to clarify Board's sole authority to determine whether to continue an investigation**

*Amend the statutes governing Vertical Enforcement to clarify the Medical Board's sole authority to determine whether to continue an investigation.*

**Board Action:**

This recommendation was discussed at the November 2010 quarterly Board meeting. Staff alternatively suggested, and the Board approved, revising the VE/P manual in conjunction with HQES as a better solution in making practical enhancements to the VE/P program, versus seeking legislation.

**Recommendation #8: Optimize HQES Attorney involvement in investigations and increase uniformity among regions**

*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.*

**Board Action:**

The Board did not seek legislation on the recommendations to amend statutes. Instead, HQES and the Board worked together to revise portions of the VE/P manual. Both continue to work toward more consistent implementation across regions.

The revision to the VE/P manual in July 2011 included several enhancements to spell out the expectations of the VE/P process. Specifically, the duties and responsibilities of the Lead Prosecutor were defined in the "Lead Prosecutor" section of the manual. In addition, the following new sections were added:

- Investigation Completion Timelines – This section was added to specify the expected time frame by which an investigatory task should be completed. For example, the investigator is expected to request medical records within seven (7) business day of receiving a patient's authorization to obtain records.
- Selection of Expert Reviewers – The PDAG is responsible for ensuring the chosen expert is appropriate for the case, by reviewing the credentials of the expert.
- Receipt of Expert Opinion – The Investigator shall provide copies of the expert report to the assigned PDAG and medical consultant within one (1) business day of receiving the report.
- Probation Violation Cases - This section specifies that probation violation cases are not investigated under the VE/P model, so they may move more quickly to prosecution.

These changes and additions have enhanced the expectation of uniformity in the VE/P process.

**Recommendation #9: Establish a new process for tracking the status of cases following referral to HQES for prosecution**

*Require HQES to inform the Medical Board Regional Manager, District office and HQES Services Monitor of the scheduled date for completing a pleading. The notice should be required to be provided within five (5) business days of referral of any case for prosecution. Also, require that all Medical Board Regional Managers meet (or conference) on a monthly basis with their HQES counterparts to review the status of all previously referred cases for which an accusation has not yet been filed.*

**Board Action:**

The Board and HQES have been energetically working toward reconciling their different reporting methods for certain data markers. The Chair of the Board's Enforcement Committee met with Board staff on September 14, 2011 to discuss a plan to assist with improving program timelines. He appointed an Enforcement Subcommittee, including himself, to work with HQES management staff to review statistics and processes in developing a plan.

The first Enforcement Subcommittee meeting was held January 9, 2012 to discuss ways to address reconciliation of Board and HQES data. The committee decided that monthly meetings for each district office will be conducted with SDAGs and Board Supervising Investigators in order to reconcile each agency's data and devise one report that will be presented to the Board.

Further, HQES will provide the Board with a report detailing unfiled cases. In addition, on a monthly basis, filed cases that remain open without a Notice of Defense filed by the physician will be reconciled. The Board will provide HQES with a report that specifies cases that have been submitted to HQES for over 60 days where an accusation has not been filed. The purpose of providing this report to HQES is to ensure that all cases are being tracked, reconciled, and issues resolved at the earliest opportunity so cases can be filed for prosecution or closed.

**Recommendation #10: Establish a new process for tracking and reviewing charges for legal services**

*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.*

**Board Action:**

On January 19, 2012 HQES provided a report to the Board specifying the average hours and fees between milestone events for FY 2009/2010, FY 2010/2011, and FY 2011/2012. The Board continues to work with HQES to obtain summary reports that provide essential information for Board assessment. These summary reports should include information on costs for all types of cases by each HQES area office. These reports are expected to be further developed during 2012, with comparison data available in early 2013.

**Recommendation #11: Establish a new Board position to monitor and evaluate HQES costs**

*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.*

**Board Action:**

The Board did not pursue the feasibility of this recommendation in the past, due to the hiring freeze. Although this position has not been established, Board supervisors and managers are monitoring and evaluating data in conjunction with HQES. The Board continues to work with HQES to obtain summary reports that provide essential information for Board assessment. These reports are expected to be further developed during 2012, with comparison data available in early 2013. The Board can further explore the feasibility of this recommendation at that time.

**Recommendation #12: Develop new monthly management reports and new quarterly reports for the Board**

*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.*

**Board Action:**

In January 2012, HQES and Board management met and agreed to have SDAGs and Supervising Investigators conduct monthly meetings for each district office in order to reconcile each agency's data and devise one report that will be presented to the Board. The Board is currently working on updating data markers with appropriate methodologies to accurately reflect outcomes. The Board plans to further develop these reports during 2012 and report outcomes at quarterly Board meetings.

**Recommendation #13: Amend or repeal Section 12529.6 (e) of the Government Code.**

*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.*

**Board Action:**

The Board considered this recommendation at its November 2010 quarterly Board meeting and determined this legislation was not necessary. The Board will be converting its computer tracking system to the DCA's BreEZe computer system. Further, a revision has been made to the VE/P manual to delete the language regarding co-location of investigators and attorneys.

Section 12529.6 of the Government Code will be repealed on January 1, 2013 unless a later enacted statute deletes or extends that date. The Board is proposing, in an omnibus bill for 2012, to extend the sunset date of VE/P to the same dates as the Board's sunset of January 1, 2014.

**Recommendation #14: Conduct periodic performance reviews of the services, costs, and performance of HQES**

*Conduct periodic performance reviews of the services, costs, and performance of HQES, including the performance of each HQES office. Provide results of the reviews to Department of Justice and Medical Board management and to oversight and control agencies.*

**Board Action:**

The Board has not yet pursued this specific recommendation. The Board plans to further review this recommendation in 2012 as it obtains the data from HQES. Findings from the evaluation of the data may in fact respond to this recommendation.

# Conclusion

This report's focus was to review the recommendations made to strengthen the VE/P model and the Board's actions in implementing those recommendations. A detailed report, analyzing the VE/P model and its effectiveness, will be provided to the Legislature during the Board's upcoming sunset review period. That report will provide an analysis of the Board's and HQES' integrated data, which is needed to evaluate the effectiveness of the VE/P model.

At that time, the Board will be in a better position to address some of the recommendations where a feasibility study is needed.

The Board looks forward to this examination of the data to provide the Legislature with the best possible evaluation in order for it to make a sound and appropriate decision regarding the permanence, continuation, or termination of the pilot vertical enforcement prosecution.

# APPENDIX A
# Response Letters

# HQES Response to 2009 Report

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June 17, 2009

Executive Committee
Medical Board of California
2005 Evergreen Street, Suite 1200
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RE: Response of the Health Quality Enforcement Section to the
Medical Board of California's Report to the Legislature (Second Draft 6-7-09)

Dear Executive Committee:

Thank you for the opportunity to review the second draft of the Medical Board of California's Report to the Governor and Legislature on the vertical enforcement and prosecution model created under Government Code section 12529.6.[1]

As you know, pursuant to the provisions of section 12529.7, the Report must be submitted to the Governor and Legislature by July 1, 2009. The Health Quality Enforcement Section (HQE) received the second draft of the Report on June 10, 2009. As a result, since the due date for HQE's written comments was set at June 18, 2009, our review of the second draft Report, and preparation of the following comments and recommendations, was expedited. HQE looks forward to the opportunity to review and comment on subsequent drafts of the Report so that it can then fulfill its consultation obligations under section 12529.7.

This response to the second draft of the Report will address the following subjects:

I. HQE's Response to Statistical Presentation;
II. Principal Reasons for Investigation Completion Delays;
III. HQE's Response to MBC's Recommendations;
IV. Continuing Successes of the VE program; and
V. HQE's Recommendations to Further Improve the VE program.

[1] All references are to the Government Code unless otherwise indicated.

I. HQE's Response to Statistical Presentation:

1. The 2009 draft Report includes statistics for other allied health agencies, along with multiple charts combining those statistics with statistics for physician cases, and setting them out separately as well. The Report consists of 307 pages, with a total of 242 pages devoted to statistical charts. The justification for including information related to other allied health agencies is that the combined data "provides a stronger basis from comparison." (Report, p. 33.) The inclusion of this additional information is outside the legislatively mandated scope of the Report.

   In the MBC's 2007 Report to the Legislature, statistics related to other allied health agencies were specifically excluded. The reason for doing so can be found in Government Code sections 12529.7, which requires a report to the Legislature "on the vertical enforcement and prosecution model," and 12529.6, which describes the VE model as "cases involving alleged misconduct by physicians and surgeons."

2. The statistics contained in the Report are presented in a percentage format, thus making the significance of the reported statistical variations difficult to understand. (See, e.g., Report, p. 47, Charts 7a and 7b, p. 47.)

3. The Report states that the statistical conclusions are based entirely on data provided by the MBC and no comparison has been made with data separately collected and maintained by HQE. (Report, p. 6.) However, previously, there have been significant differences between the MBC's statistical information when compared with data separately collected and maintained by HQE in the ProLaw database. For example, HQE recently presented the MBC with a statistical breakdown of the number of days it takes HQE from the date of acceptance of a case for prosecution to the date an accusation is sent to the agency for filing. Those statistics establish a statewide average of 53 days, and a statewide average of 70 days from referred to filed. Unfortunately, this important statistical measure of the continuing success of the VE program is not found in the draft Report.

4. The Report also contains several new statistical measures, including: (1) date investigation assigned to date investigation closed with no prosecution; (2) date investigation assigned to completed investigation; (3) date investigation assigned to all outcomes; (4) date investigation was completed (not accepted for prosecution, but completed) to date accusation filed (not sent for filing, filed); (5) date accusation filed to date case submitted to an ALJ; (6) date accusation filed to date of various outcomes.

   In contrast, statistics reported in the MBC's 2007 Report to the Legislature showed that "the number of cases closed without prosecution was reduced from 145 days to 139 days; obtaining medical records was decreased from 74 days to 36 days; conducting physician

interviews reduced from 60 days to 40 days; obtaining medical expert opinions went from 69 days to 36 days; filing accusations by HQES decreased from 241 to 212 days; and obtaining interim suspension orders or temporary restraining orders decreased from 91 days to 30 days." (Report, p. 6.)

There are no comparable, straightforward statistical measures in the 2009 Report. As such, as currently drafted, the 2009 Report does not allow for a direct and easy comparison of the statistics reported to the Legislature in 2007 with those being reported in 2009.

II. Principal Reasons for Investigation Completion Delays:

The primary finding of the Report is that "[w]hile the data collected suggests overall reductions have occurred in the prosecution phase of [complaints against licensee's of the MBC], the investigation phase has not realized such benefits, and, as a result, the overall time to resolve complaints with a disciplinary outcome has only minimally improved." (Report, page 252.) HQE agrees that, under the VE model, the overall time for HQE to complete the prosecution phase of MBC cases has decreased while, at the same time, the overall time for the MBC to complete the investigation phase has increased. However, the Report entirely omits information that explains some of the principal reasons underlying the increased timelines for the MBC to complete investigations. Those reasons include:

1. Investigator vacancy rate of 14%. The absence of trained, experienced investigators appears to be the principal reason undermining the MBC's ability to complete investigations on a timely basis.

2. The constant turn-over of investigators at the MBC results in a significant loss of productivity as pending investigations are transferred from one investigator to another and, often, from one district office to another as well. This loss of productivity also continues for a considerable period of time as newly hired investigators go through the Academy and then complete their on-the-job training.

3. Some of the most experienced and productive investigators have been reassigned to train new investigators. As a result, these experienced and productive investigators have carried a reduced investigation caseload, thus contributing to additional delays in the MBC's timely completion of investigations.

4. The extremely limited availability of medical consultants, some of whom are in the MBC district office only one day a week, has severely reduced the available dates for subject interviews and completion of medical consultant work, resulting in even further delays.

5. Finally, the issuance of the Governor's Executive Order in 2008 disrupted the MBC's enforcement program by prohibiting contracting with medical consultants and expert witnesses, thus significantly delaying the timely completion of investigations statewide.

These five reasons are some of the principal causes for the delay in the MBC's timely completion of investigations. However, of those five reasons, only the vacancy rate is mentioned in the Report and then not in a way that directly links the vacancy rate to the significant delay in the timely completion of investigations. This critical information, which explains some of the principal reasons underlying the increased timelines for the MBC to complete investigations, should be included the MBC's 2009 Report to the Governor and Legislature.

III. HQE's Response to MBC's Recommendations:

The Report begins with an Executive Summary consisting of the first 11 pages which, in all likelihood, will be the primary focus of the reader. The following is HQE's response to those recommendations.

1. The first recommendation relates to "poor interpersonal communications" between some MBC investigators and HQE attorneys which is reportedly aggravated by lack of appreciation and respect for each other. The highlighting of isolated instances of disagreement between a few MBC investigators and HQE attorneys inappropriately elevates what should be viewed as a management issue to the primary recommendation of the Report itself. This issue has already been specifically addressed in the Joint Vertical Enforcement Guidelines (JVEG) (First Edition, April 2008). (See JVEG, Section 10, p. 8, entitled "Courtesy and Cooperation.") HQE agrees with the recommendation that there should be zero tolerance of negative communication. Both HQE and MBC staff should renew their continuing efforts to ensure this important aspect of the VE program is scrupulously adhered to by their respective staff.

2. Recommendation #2 is an effort to further define the phrase "under the direction of" as contained in Government Code section 12529.6, as that statute was originally enacted in 2006. However, section 12529.6 was later amended by the Legislature to further define this phrase to mean "under the direction, but not the supervision of" the deputy attorney general. (Stats. 2008, c. 33 (S.B. 797), eff. June 23, 2008.) Thus, the Legislature has already done what the Report now recommends it do again.

   In addition, HQE and the MBC have exhaustively addressed the implementation of the direction authority by DAGs, and the supervision authority by supervising investigators, in Section III of the Vertical Prosecution Manual (Second Edition, November 2006). The balance between the DAG's direction authority and the

supervision authority of supervising investigators is also reflected in numerous provisions of the JVEG issued in April of 2008. (See, e.g, JVEG, Section 2, regarding Investigation Plans and Progress Reports, and Section 3, regarding subpoena duces tecum procedures and emphasizing the importance of teamwork between investigators and DAGs.) Accordingly, while the phrase "under the direction, but not the supervision of" as used in section 12529.6 does not require further definition, both the MBC and HQE should continue their efforts to ensure uniform application of this legislative mandate statewide, in accordance with the applicable provisions contained in the VP Manual, as supplemented by the JVEG.

Recommendation #2 also includes the comment that "[t]he departments must also resolve the question of who is the client and ensure consistent understanding and application of the resolution." (See also, p. 243.) However, the identity of the client in MBC cases, which has remained unchanged for decades, is defined by law. During the administrative prosecution phase of an MBC case, the client is the Executive Director of the Medical Board of California. (See Cal. Code Regs., tit. 16, § 1356.) Historically, the Executive Director has also delegated various duties and responsibilities to client representatives who, in turn, act on his or her behalf for specified purposes. Examples include the Deputy Director, who has been delegated settlement authority for all administrative prosecutions in Southern California, as well as the Chief of Enforcement. Such delegations of authority in state licensing agencies are common in California. Following issuance of a final decision and order by the Medical Board, and upon the physician's filing of a petition for administrative mandamus in the superior court under Code of Civil Procedure section 1094.5 challenging that final decision and order, the client is the Medical Board itself. While the Legislature's adoption of the VE model effectuated numerous changes to the MBC's Enforcement Program, as well as to the duties and responsibilities of HQE DAGs statewide, at the same time it has not altered the legal definition of HQE's client during the administrative prosecution phase, or judicial review, of MBC cases.

Of course, whenever the MBC, individual board members or Board staff, including investigators, are sued in state or federal court for actions taken in their official capacity, the MBC itself or such named individuals are the client for purposes of that litigation. Examples include civil actions filed in state superior court challenging the constitutionality of state statutes or regulations the MBC is charged with enforcing, as well as federal civil rights actions filed in federal district court challenging actions taken by the MBC with respect to licensed physicians.

3. Recommendation #3 puts forth the idea that the VE process should be uniform statewide. HQE agrees with this recommendation and, to that end, recommends that both HQE and the MBC renew their joint efforts to ensure uniform application of the VP Manual, as supplemented by the JVEG, to reach that important goal.

Recommendation #3 also puts forth the additional suggestion that what HQE and MBC need is another "joint manual." The MBC and HQE already have the VP Manual and JVEG, and the MBC also has its EOM. Both the VP Manual and JVEG are up-to-date, in no need of revision and are entirely consistent in content. These two documents answer most, if not all questions, on how the VE program is to be administered and should be followed statewide to ensure uniformity. Thus, while there is no need for another "joint manual," there is a strong need for HQE and MBC managers to ensure uniform application statewide of the policies and procedures already contained in the existing manual and guidelines.

4. Recommendation #4 recommends that the VE model be limited to only certain classes of cases. HQE agrees with this recommendation. In this regard, HQE recommends that cases involving other allied health care agencies be excluded from the VE program. The VE program was enacted by the Legislature to address "cases involving alleged misconduct by physicians and surgeons" (see Gov. Code, § 12529.6, subd. (a)), not cases involving other allied health care agencies. Including such cases within the VE program requires the expenditure of valuable investigator and attorney time on non-physician cases that are not mandated by the VE model as enacted by the Legislature. Also, since some allied health care agencies routinely exhaust their enforcement budget prior to the end of the fiscal year, the inclusion of such cases within the VE program results in statistics that may show significant delays in the timely completion of the investigations in those cases; thus, perhaps presenting an inaccurate statistical measure of the overall success of the program.

5. Recommendation #5 recommends a new joint statewide training program. HQE agrees with this recommendation. However, the current statewide fiscal crisis presents a significant challenge to the implementation of this recommendation. As an alternative to a joint statewide training program, a uniform training program to be conducted at each of Department of Justice offices, and in the MBC district offices, would probably present a more fiscally viable option.

6. Recommendation #6 recommends that "the departments" give priority to resolving current staffing vacancies and then goes on to identify four areas to pursue, all which pertain to the problem of MBC investigator vacancies. The inability of the MBC to retain experienced investigators is a well-documented problem that predates implementation of the VE program. (See 2007 Report to the Legislature, at pages 25-26.) This ongoing problem continues to severely undermine the MBC's ability to complete investigations on a timely basis. Until and unless this critical problem is successfully resolved, the MBC will continue to experience significant delays in their timely completion of investigations of alleged misconduct by physicians and surgeons.

Finally, on page 8 of the Executive Summary, the statement is made "Both HQES and MBC are experiencing retention problems." As it applies to HQE, this statement is incorrect and should be revised.

7. Recommendation #7 recommends that a working group from both the Attorney General's Office and MBC be established to explore an efficient method of sharing documents. HQE agrees with this recommendation, which was originally made by the Enforcement Monitor in her Final Report to the Legislature in 2005. (See Final Report, Recommendation #3, page 203.)

8. The final recommendation (unnumbered in the second draft) is that "the most prudent course of action at this time is the continuation of the pilot with the modifications contained in Recommendations 1 through 7 to improve the implementation of the VE model, and a reassessment of its success after two years." (Report, p. 11.) HQE agrees with the recommendation that the pilot be extended for two years. HQE has already provided its responses to Recommendations 1 through 7, above.

IV. Continuing Successes of the VE Program:

In its 2007 Report to the Legislature, the MBC stated:

> "Reducing investigation completion delays, however, is only one method of measuring improved public protection. The VE pilot was implemented by the Legislature in recognition of '. . . the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons,' [and because of] '. . . the evidentiary burden in the board's disciplinary cases . . .' (Gov. Code, § 12529.6, subd. (a).) While difficult to objectively measure through statistics, improving coordination and teamwork between investigators and prosecutors significantly improves the quality of the investigation of these complex cases. Implementation of the VE pilot mandated by SB 231 has resulted in improvement in all of these areas. . . ." (MBC's 2007 Report to the Legislature, "Executive Summary," at p. 2.)

The improvement in coordination and teamwork cited by the MBC in its 2007 Report has continued, with a resultant improvement in the overall quality of MBC investigations. This, in turn, has been a significant contributing factor in HQE's successful reduction statewide in the number of days it takes HQE from the date of acceptance of a case for prosecution to the date an accusation is sent to the agency for filing. While MBC investigators have encountered significant challenges in the past two years including, among other things, the high investigator vacancy rate statewide, limited availability of medical consultants, as well as issuance of the Governor's Executive Order in 2008 prohibiting contracts with expert witnesses to review cases,

in HQE's view, MBC investigators are to be highly commended for their hard work, dedication, professionalism and strong commitment to public protection. These, and other, important continuing successes of the VE program should be included in the MBC's 2009 Report to the Legislature.

V. HQE's Recommendations to Further Improve the VE Program:

Like any government program, the VE program can be improved. Accordingly, HQE presents the following three recommendations for possible inclusion in the MBC's Report.

1. Interagency Contract for the Attorney General's Office to provide the MBC with Investigative Services: As noted above, the inability of the MBC to retain experienced investigators is a well-documented problem that predates implementation of the VE program. Currently, the MBC has a 14% investigator vacancy rate. HQE recommends that the MBC consider entering into an interagency contract for the Attorney General's Office to provide investigative services to the MBC, in addition to the legal services it currently provides. Funds that would otherwise be used by the MBC to pay the salaries of the currently vacant investigator positions could be used for this purpose.

2. Video Conferencing: Under the VE Model, HQE has assumed the burden of the majority of required travel statewide between the various Attorney General's Offices and MBC district offices. As a result, DAGs spend hundreds of hours a year traveling on California freeways in order to confer with investigators, review documents and attend interviews. Implementation of a video conferencing network statewide would eliminate the necessity of some of this required travel, reduce the number of attorney hours expended driving rather than performing legal work, provide a convenient method for investigators and DAGs to readily confer when more than a simple telephone call is required and, from an environmental standpoint, would reduce the negative impact such travel places on the environment overall. HQE recommends that HQE and MBC work together to implement a video conferencing network statewide to further improve the VE program.

3. Require Physician Cooperation with MBC Investigations: A significant factor preventing the timely completion of investigations is the refusal of some physicians to cooperate during an MBC investigation. This refusal to cooperate routinely results in significant scheduling problems and delays, countless hours wasted serving and enforcing subpoenas, and delays resulting from the refusal to produce medical records or answer questions during subject interviews.

Other states have long required their licensees to cooperate with investigations being conducted by disciplinary authorities. (See, e.g., Ariz. Rev. Stat., § 32-1401, subd. 27(dd) [defining unprofessional conduct by a physician as including, among other things, "[f]ailing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board."]; Ohio Rev. Code Ann., § 4731.22, subd. (B)(34) [authorizing state medical board to discipline physician for failure to cooperate in an investigation conducted by the board, including failure to comply with a subpoena or order issued by the board or failure to answer truthfully a question presented by the board at a deposition or in written interrogatories]; MD Health Occ. Code, § 14-404, subd. (a)(33) [authorizing disciplinary action against any physician who "[f]ails to cooperate with a lawful investigation conducted by the Board."]; Wash. Rev. Code Ann., § 18.130.180 [defining unprofessional conduct to include, among other things, failure of a health care professional to cooperate with disciplinary authority by, among other things, not furnishing papers, documents, records or other items, not furnishing a full and complete explanation in writing of the complaint filed with the disciplinary authority, and not responding to subpoenas issued by the disciplinary authority]; Tenn. Code, § 63-1-117, subd. (e) ["A health care provider's willful disregard of the request for medical records pursuant to this section is grounds for disciplinary action by the licensing board that regulates the health care provider."]; also compare Cal. Bus. & Prof. Code, § 6068, subd. (i) [establishing duty of an attorney "[t]o cooperate and participate in any disciplinary investigation or other regulatory or disciplinary proceeding pending against himself or herself. . . ."].)

The enactment of such a statutory requirement in California would significantly reduce the substantial delays that result of a physician's failure to cooperate during an MBC investigation which, unfortunately, have now become routine statewide.

HQE's Recommendations #1 and #2 can be implemented immediately. Permitting the Attorney General's Office to provide investigative services to the MBC would help to resolve the principal reason undermining the MBC's inability to complete investigations on a timely basis by providing trained, experienced investigators to compliment the job that is being performed by MBC investigators. At the same time, implementation of a video conferencing network statewide would result in significant savings in both investigator and attorney time, thus further improving the efficiency of the VE program. While HQE's Recommendation #3 will require legislative action, requiring physician cooperation during MBC investigations would significantly reduce not only the delays resulting from a physician's refusal to cooperate, but also save the substantial time and expense required to seek and obtain necessary court orders to enforce subpoenas, produce medical records or require physicians to answer questions during subject interviews.

In conclusion, thank you for the opportunity to consult on the drafts of the MBC's 2009 Report to the Governor and Legislature on the VE model. HQE looks forward to the opportunity to review and comment on subsequent drafts of the Report so that it can then fulfill its consultation obligations under section 12529.7.

Sincerely,

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# HQES Response to 2010 Report

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RE: Initial Response of the Health Quality Enforcement Section (HQE) to the Medical Board Program Evaluation Conducted By Ben Frank and HQE's Comprehensive Report to the Medical Board Regarding Physician Discipline under the Vertical Enforcement Program

Dear Board Members:

Thank you for the opportunity to review the original Program Evaluation dated July 6, 2010, the draft Summary Report dated July 21, 2010, and the latest Summary Report dated August 2, 2010, prepared by Ben Frank, which document his findings, conclusions and recommendations following his review of the Medical Board's programs.[1]

As you know, the Medical Board originally authorized its Executive Director "to undertake a comprehensive, independent evaluation of the Medical Board."[2] In this regard, the stated purpose of the evaluation was "to conduct an independent and unbiased review of the Medical Board's organizational structure and core programs to identify strengths and weaknesses of current operations and develop recommendations for improvements."[3] That would soon change. Shortly after commencement of the evaluation, "it was jointly determined, in consultation with Medical Board management, that the primary focus of [the] assessment [would] be on (1) identifying and

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[1] The original Program Evaluation dated July 6, 2010, will be referred to herein as "Frank Report I" followed by the page number. The draft Summary Report dated July 21, 2010, will be referred to herein as "Frank Report II" followed by the page number. Finally, the latest Summary Report dated August 2, 2010, will be referred to herein as "Frank Report III," followed by the page number. When referred to generally, all three reports will be referred to herein collectively as simply the "Frank Report."

[2] Frank Report I, at p. I-1; Frank Report II, at p. I-1; and Frank Report III, at p. I-1.

[3] Frank Report I, at p. I-2; Frank Report II, at p. I-2; and Frank Report III, at p. I-2.

assessing the impacts of the VE Pilot Project[[4]] on the Enforcement Program, (2) identifying and assessing the benefits provided from the increased expenditures for VE-related legal services, (3) identifying and assessing other factors contributing to deteriorating Enforcement Program performance, and (4) developing an *Enforcement Program Improvement Plan*."[5]

As a result of this joint determination, the *primary focus* of Mr. Frank's evaluation shifted away from the Medical Board's organizational structure and programs as specified in the original Request for Offers and, instead, centered on the Office of the Attorney General and, more specifically, on the Health Quality Enforcement Section (HQE). The joint determination of Mr. Frank and Medical Board management to conduct an evaluation of HQE, and its activities spanning over several years, was made without the knowledge, input or involvement of the Office of the Attorney General or HQE. Thereafter, Mr. Frank's evaluation of HQE was based on extremely limited information from HQE itself and, regrettably, the comprehensive, reliable statistical data provided by HQE to Mr. Frank at his request was virtually ignored. Additionally, notwithstanding representations that he would consult with me, as HQE's Senior Assistant Attorney General, at the conclusion of his evaluation, Mr. Frank did not do so. In short, the evaluation of HQE conducted by Mr. Frank was completed with little input from HQE, and reached the conclusion that the Medical Board's Enforcement Program is deteriorating largely for reasons attributed to HQE, with little or no assessment of the long-standing and unresolved problems within the Medical Board's Enforcement Program itself that continue to affect investigator performance and investigation completion timelines.[6]

The purpose of this response by HQE to the Frank Report is threefold. First, this response will identify and address some of the flaws in the Frank Report, demonstrating how some of its key findings, conclusions and recommendations are incorrect as a matter of fact, law or both. Had HQE been permitted to fully participate in the evaluation of its own activities, it is anticipated that these flaws could have been eliminated from the Frank Report before it was submitted to the Medical Board. Second, this response will present HQE's comprehensive report to the Medical Board, entitled "Physician Discipline under the Vertical Enforcement Program," based on the statistical data contained on the ProLaw database maintained by the Office of the Attorney General. As this report will demonstrate, while further improvement should definitely be pursued, the VE program has improved, and continues to improve, public protection of patients receiving medical services in California while, at the same time, protecting physicians from unwarranted or needlessly protracted investigations and prosecutions. Finally, this response will report on significant steps that HQE has already taken in its continuing efforts to further improve its own performance, and also present

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[4] "VE" refers to the "vertical enforcement and prosecution model" mandated by the Legislature in Government Code section 12529.6 which defines the manner in which allegations of unprofessional conduct by physicians and surgeons are to be investigated and, if warranted by the evidence, prosecuted by the Health Quality Enforcement Section. At this point, the VE program is not a "pilot program," having been repeatedly extended by the Legislature, nor is it referred to as such in Government Code section 12529.6.

[5] Frank Report I, at p. I-3; italics original; footnote added; Frank Report II, at p. I-2; and Frank Report III, at p. I-2.

[6] It should be noted that the Frank Report comes virtually on the heels of the Medical Board's Report to the Governor and the Legislature dated June 2009 (which was actually submitted later in 2009), wherein the Medical Board was statutorily required to "report and make recommendations . . . on the vertical enforcement and prosecution model created under Section 12529.6." (Gov. Code, § 12529.7.)

HQE's recommendations on important ways that the VE program can be further improved to address some of the long-standing, systemic problems within the Medical Board's Enforcement Program.

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## I. Flaws in the Frank Report

### 1. The Statistical Basis of the Frank Report is Unreliable

The Frank Report relies almost entirely on information obtained from the Medical Board's Case Tracking System ("CAS"), which is a management information system shared by other agencies in the Department of Consumer Affairs. However, information regarding Medical Board investigations and prosecutions contained in the CAS system has long been criticized and continues, at times, to be unreliable. For example, almost six years ago, in November 2004, the Medical Board's Enforcement Monitor[7] noted that the CAS system "suffers from numerous inadequacies and problems impeding MBC's licensing and enforcement programs, and undermining its public disclosure program."[8] Later, in her Final Report in November 2005, the Enforcement Monitor specifically recommended that the Medical Board and HQE upgrade their information management systems, noting that "MBC is studying [management information systems] improvements with [the Department of Consumer Affairs]; ProLaw is now in use at HQE . . ."[9] While HQE has fully implemented its ProLaw case management system, over the last six years the Medical Board continues to utilize the CAS system.

Indeed, the Frank Report itself specifically notes some of the significant problems that demonstrate the unreliability of information maintained by the Medical Board in the CAS system. For example, "it appears that some updates to CAS are not always consistently posted by District Office staff for various interim investigation activities, including activities involving: Medical records requests[,] Complainant and Subject interviews[,] [and] Medical

[7] Business and Professions Code section 2220.1 provided for the appointment of a "Medical Board Enforcement Program Monitor" to monitor and evaluate "the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system." (Added by Stats. 2002, c. 1085, (Sen. Bill No. 1950), § 18; repealed by Stats. 2004, c. 909 (Sen. Bill No. 136), § 3, operative Jan. 1, 2006.)

[8] Initial Report, Executive Summary, at p. ES-12.

[9] Final Report, Conclusions and Recommendations for the Future, at p. 203.

Consultant case reviews."[10] There are other problems as well.[11] "In some cases CAS is updated to show when the activity commenced (e.g., requested medical records, requested or scheduled a Complainant or Subject interview, or submitted records for review by the Medical Consultant or a Medical Expert, but CAS is not updated to show when the activity was completed). In other cases CAS is updated only when the activity is completed, or not updated to show either initiation or completion of the activity."[12] Notwithstanding these significant problems, the Frank Report relies, almost entirely, on information obtained from the CAS system.

On or about March 3, 2010,[13] Mr. Frank requested statistical information from HQE covering multiple aspects and stages of Medical Board investigations and prosecutions covering the period of 2005 through and including 2009.[14] On June 20, 2010, after much effort, HQE provided Mr. Frank with a comprehensive response to his requests for case specific information for each of the calendar years of 2005 through 2009.[15] In total, HQE provided detailed case specific information to Mr. Frank on a total of 1,899 cases.[16] Finally, the requested information was provided to Mr. Frank first in .pdf format, and then in Excel spreadsheets.

The Frank Report virtually disregards the reliable statistical information obtained from the ProLaw database, admitting that "with some isolated exceptions, [it] was not used."[17] The justifications offered for disregarding the information provided by HQE

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[10] Frank Report I, at p. I-8; see also Frank Report II, at p. I-4; and Frank Report III, at p. I-3 and I-4.

[11] For example, the Frank Report notes that the statistical measures of the average time elapsed to complete interim investigation activities "may not be representative of actual performance" and, further, that "[t]he measures related to obtaining [m]edical [r]ecords are especially limited." (Frank Report I, at p. I-9.) With respect to procuring medical records, the Frank Report also notes that "[t]he Medical Board's measures count the records as received irrespective of the completeness or quality of the records provided, and do not account for supplemental submissions." (Frank Report I, at I-9; Frank Report II, at p. I-4; and Frank Report III, at p. I-4.)

[12] Frank Report I, at pp. I-8 and I-9.

[13] The Frank Report states that a revised data request was submitted to HQE on March 9, 2010, but later claims the date was March 7, 2010. (Frank Report I, at p. I-11; Frank Report II, at p. I-5.) The date of this request is changed yet again in Frank Report III, this time to April 22, 2010. (Frank Report III, at p. I-6.)

[14] Frank Report I, at p. I-10; Frank Report II, at p. I-5; and Frank Report III, at p. I-5.

[15] The information for each case that was provided to Mr. Frank included: (1) the ProLaw matter number; (2) matter description; (3) investigation number; (4) type of administrative matter; (5) the date the matter was opened; (6) the date the matter was accepted for prosecution; (7) the date the pleading was sent to the Medical Board for filing; (8) the number of days between the date the matter was accepted for prosecution and the date the pleading was sent to the Medical Board of filing; (9) the date the pleading was signed by the Executive Director; (10) the number of days between the date the pleading was sent to the Medical Board for filing and the date the pleading was signed by the Executive Director; (11) the number of days between the date the pleading was sent the Medical Board for filing and the date the stipulated settlement was sent to the Medical Board; (12) where applicable, the date the matter was rejected for prosecution; and (13) if the case was rejected, the date it was returned to the Medical Board.

[16] The 1,899 total cases are broken down per year as follows: CY 2005 - 409 cases; CY 2006 - 387 cases, CY 2007 - 354 cases, CY 2008 - 355 cases, and CY 2009 - 394.

[17] Frank Report II, cover letter, at p. 3; see also Frank Report II, cover letter, at p. 3.

vary.[18] Unfortunately, this is not the first time that reliable statistical information provided by HQE has been disregarded.

Accordingly, relying on the admittedly incomplete information obtained from the CAS system while, at the same time, disregarding the statistical information provided by HQE from the ProLaw database, calls into question the accuracy of the findings, conclusions and recommendations contained in the Frank Report.[19]

2. The Frank Report Does Not Assess the Single Most Important Cause for Investigation Completion Delays – Continuing High Investigator Vacancy Rates and Turnovers

The Frank Report documents, but does not assess in any meaningful fashion, the most significant flaw in the Medical Board's Enforcement Program, namely, the inability of the Medical Board's Enforcement Program to recruit and retain experienced investigators.[20] This long-standing, problem, which has been fully documented many times over the past decade, continues to have a significant negative impact on both investigator performance and investigation completion timelines.

In her Initial Report back in 2004, the Enforcement Monitor correctly observed that:

> "Recruitment and retention problems plague personnel management at the Medical Board. Supervisors and field investigators uniformly report that valuable, experienced investigators are lost and well-qualified applicants go elsewhere because of salary disparities between the pay of the MBC and other agencies hiring peace officers. MBC regularly loses in competition with other agencies over highly qualified investigative personnel."[21]

Later, in her Final Report in 2005, the Enforcement Monitor again noted that:

> "Compounding the loss of 19 sworn investigator positions during the 2001–04 hiring freeze, MBC continues to lose highly trained and experienced investigators and well-qualified applicants to other agencies because of disparities between MBC investigator salaries and those at other agencies

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[18] Originally, the reasons for this decision were reportedly that "much of the data provided by HQE was not provided until near the conclusion of the assessment," and "much of the data provided was incomplete and of limited utility . . ." (Frank Report II, cover letter, at p. 3.) Those reasons were later revised to add that "much of the data was *unavailable*, incomplete and of limited utility." (Frank Report III, cover letter, at p. 3; italics added.) It is unclear how the statistical information provided by HQE to Mr. Frank was "unavailable."

[19] While the Frank Report states that "[w]e filtered, compiled, summarized, and analyzed the data provided as needed for purposes of this study" (Frank Report II, at p. I-3; Frank Report III, at p. I-3), there is no description of the methodology that was used to compile the statistics presented in the report.

[20] Frank Report I, at pp. VI-44 and VI-45; Frank Report II, at p. VI-19; Frank Report III, at p. VI-19 and VI-20.

[21] Initial Report, Executive Summary, at p. ES-24.

> hiring peace officers. The Monitor urged MBC to continue its efforts to reinstate its lost enforcement program positions and to upgrade the salaries of its investigators commensurate with the competition.
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> "...
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> "The related problems of investigator recruitment and retention can ultimately be addressed by full implementation of the integrated vertical prosecution system envisioned in SB 231. Upon a showing of the success of the vertical prosecution system, and with the Legislature's affirmative approval after review of the 2007 report, the transfer of the MBC investigators to HQE will eventually result in special agent status for MBC's sworn personnel and a concomitant increase in pay and career recognition.[22] Morale and productivity will be boosted, and MBC's ability to recruit and retain highly qualified investigators will be dramatically improved."[23]

Very little has changed in the last five years. Simply stated, the Enforcement Monitor's description of the inability of the Medical Board to successfully recruit and retain experienced investigators is as true today as it was in 2005.

The Enforcement Monitor's Final Report in 2005 also clearly shows that the long-standing morale and productivity problems that have continually plagued the Medical Board Enforcement Program, and its inability to recruit and retain highly qualified investigators, unquestionably predate the January 1, 2006, implementation of the "vertical prosecution and enforcement model" mandated by the Legislature in Government Code section 12529.6. Less than one year ago, HQE identified the top three reasons for investigation completion delays as:

> "Investigator vacancy rate of 14%.[24] The absence of trained, experienced investigators appears to be the principal reason undermining the MBC's ability to complete investigations on a timely basis.
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> "The constant turn-over of investigators at the MBC results in a significant loss of productivity as pending investigations are transferred from one investigator to another and, often, from one district office to another as well. This loss of productivity also continues for a considerable period of time as

[22] At the last minute, Senate Bill 231 was changed to eliminate the contemplated transfer of Medical Board investigators to the Office of the Attorney General. As a result, the anticipated increase in pay and career recognition that would have accompanied the proposed transfer never happened.

[23] Final Report, Executive Summary, at p. ES-20; footnote added.

[24] As of late 2009, the investigator vacancy rate has now reportedly climbed to 16%. (Frank Report I, p. II-51; Frank Report II, at II-15; Frank Report III, at p. II-16.)

> newly hired investigators go through the Academy and then complete their on-the-job training.
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> "Some of the most experienced and productive investigators have been reassigned to train new investigators, rather than having the Supervising Investigator I in each district office conduct this training for new hires. As a result, these experienced and productive investigators have carried a reduced investigation caseload, thus contributing to additional delays in the MBC's timely completion of investigations."[25]

The vacancy rate of experienced investigators fluctuates but continues today. For example, two experienced and productive Medical Board investigators have recently indicated their intention to transfer to other state agency investigator positions in order to receive a promotion to the "senior investigator" classification. New investigators will ultimately have to be hired to fill those positions, then go through the Academy and finally complete their on-the-job training. Approximately one year after their hire date, they will become fully productive as Medical Board investigators, only to leave for desired promotions, or be recruited by other state agencies, which will start the process all over again.

The Frank Report correctly notes "[i]t is unlikely that Enforcement Program performance will improve unless Investigator workforce capability and competency levels are stabilized and, eventually restored to the levels that existed earlier in the decade."[26] This is true, as it has been for almost a decade. At the same time, however, the Frank Report contains no statistical analysis of the continuing impact that the high investigator vacancy rate and turn-over continues to have on investigator performance and investigation completion timelines.[27] To better assess the impact of investigator vacancy rates on the completion of investigations, on May 3, 2010, HQE requested from MBC substantially the same data MBC provided to Mr. Frank. MBC staff is currently working to produce this data.

Recognizing that some investigations were simply taking too long to complete, in July 2009, the Enforcement Program's Executive Management created a new "Case Aging Council" whose tasks include, among other things, the review of aging investigations in order to identify and resolve the various reasons for investigation completion delays in those matters.

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[25] Response of the Health Quality Enforcement Section to the Medical Board of California's Report to the Governor and Legislature (Second Draft 6-7-09), at p. 3; footnotes added.

[26] Frank Report I, at p. VI-44; Frank Report II, at p. VI-19. In Frank Report III, this finding was significantly changed to read as follows: "It is unlikely that Enforcement Program performance will improve significantly unless *Investigator workforce capability levels are stabilized*." (Frank Report III, at p. VI-19; italics added.)

[27] For example, the Frank Report contains no analysis of the impact of the constant reassignment of investigations from one investigator to another, or of the more recent development of investigations being transferred by Medical Board management from one District Office to another. This latter practice is particularly disruptive to the orderly and timely completion of investigations since it requires an investigator remotely located from the event or incident to familiarize him/herself with the case, and then to complete the investigation. Such transfers of investigations are also routinely ordered without any advance notification to, or input from, HQE, which, in turn, results in corresponding shifts in HQE caseloads that are often inconsistent with HQE staffing.

Greater efficiency and productivity by investigators will not, however, directly address the root cause for aging investigations, namely, the inability of the Medical Board to recruit and retain experienced investigators.

While only the Medical Board can solve the high investigator vacancy and turnover problems that have plagued its Enforcement Program for almost a decade, HQE has offered assistance in an effort to ameliorate the effects of these problems. Beginning in 2006 and continuing to 2009, HQE has offered to provide investigator services to the Medical Board in order to help reduce investigation completion delays. While HQE's offer has not been accepted, HQE recommends that the Medical Board consider this option, especially if no reasonable alternative presents itself.

3. The Frank Report Does Not Assess the "Chronic Weakness" in the Medical Board's Enforcement Program – its Expert Reviewer Program

The Frank Report mentions, but again fails to analyze in any meaningful fashion, the second most significant flaw in the Medical Board's Enforcement Program, namely, the "chronic weakness in the Medical Board's Expert Reviewer Program . . ."[28] The continuing debilitating effect of this "chronic weakness" in the Medical Board's Enforcement Program simply cannot be overstated.

Both Frank Report I and Frank Report II correctly state that "in recent years little attention has been given to chronic weaknesses in the Medical Board's Expert Reviewer Program, except to authorize an increase in the billing rate for review services from $100 to $150 per hour."[29] Those chronic weaknesses are identified as "deficiencies involving the insufficient availability of Medical Experts, particularly in specialized areas, the extended timeframes needed by the Medical Experts to complete their reviews, the quality of the Medical Expert's reports, and the effectiveness of the Medical Experts providing testimony as an Expert Witness at a hearing (when needed)."[30] However, Frank Report III deletes these stated deficiencies in their entirety and, instead, simply recommends that the Board's policy restricting the use of experts to no more than three times per year be eliminated.[31] While elimination of this board-imposed restriction, which does not similarly restrict defense counsel, will make the most qualified experts more readily available, it will not, standing alone, sufficiently address all of the deficiencies correctly noted in Frank Reports I and II.

Expert opinions rendered by a Medical Board expert, following his/her review of the evidence gathered during the investigation, are the very heart of a quality-of-care case. The decision to recommend the filing of an accusation against a physician in a quality-of-care

[28] Frank Report I, at p. VI-44.

[29] Frank Report I, at p. VI-44; Frank Report II, at p. VI-18.

[30] Frank Report I, at p. VI-44; Frank Report II, at p. VI-18.

[31] Frank Report III, at p. VI-19.

case rests, in large part, on the expert opinions provided to the assigned HQE deputy attorney general. And, as has often been demonstrated in the past, these cases will stand, or fall, based on the quality and soundness of those expert opinions.

It must be remembered that HQE has as strong an interest in protecting physicians against the unwarranted filing of disciplinary charges against their medical licenses as it does in the fair prosecution of those cases where, based on the evidence, disciplinary charges are warranted. It is for this reason that the quality and soundness of expert opinions submitted to HQE in quality-of-care cases are so very important.

When meeting with an expert witness to prepare her or him for the hearing, HQE deputy attorneys general are often informed that the expert witness has never testified before and that the upcoming hearing will be their first time doing so. Following such meetings, HQE deputy attorneys general occasionally return to the Attorney General's Office following such meetings with serious concerns regarding the expert's understanding the case, ability to articulate the basis for his/her expert opinions, or willingness to testify at the upcoming hearing.

HQE has brought up with Medical Board executive staff the continuing problems that exist within the Medical Board's Expert Review Program. Years ago, it was reportedly the practice of the Medical Board to meet with prospective experts to review their qualifications and to determine whether, in addition to meeting the minimum requirements,[32] they were sufficiently qualified to serve as an expert in the Medical Board's Expert Reviewer Program. Unfortunately, that procedure was discontinued long ago. In late 2009, HQE recommended that the Medical Board reinstate this procedure as part of the selection process for Medical Board experts and, further, offered to have a Supervising Deputy Attorney General participate on the interview panel.[33] To date, HQE's recommendation and offer have not been accepted.[34]

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[32] The minimum requirements for a physician to participate as an expert in the Medical Board's Expert Reviewer Program are: (1) possession of a current California medical license in good standing with no prior discipline, no Accusation pending, and no complaint history within the last three years; (2) Board certification in one of the 24 ABMS specialties (the American Board of Facial Plastic & Reconstructive Surgery, the American Board of Pain Medicine, the American Board of Sleep Medicine and the American Board of Spine Surgery are also recognized) with a minimum of three years of practice in the specialty area after obtaining Board certification; and (3) have an active practice (defined as at least 80 hours a month in direct patient care, clinical activity, or teaching, at least 40 hours of which is in direct patient care). (See http://www.mbc.ca.gov/licensee/expert_reviewer.html)

[33] In addition to careful selection of only those qualified to serve as experts, the Medical Board should seriously consider two additional improvements to the program as well. First, consideration should to be given to increasing the compensation (currently set at $150 per hour for case review/consultation and $200 for providing expert testimony) in order to attract more qualified expert reviewers. Simply stated, a physician should not have to suffer an economic penalty for agreeing to participate as a Medical Board expert. Second, before they are assigned to review any case, physicians accepted by the Medical Board's Expert Reviewer Program should be required to attend a comprehensive training conference to be conducted, in part, by HQE in order to ensure that they are adequately trained and prepared to fulfill their duties and responsibilities as an expert for the Medical Board.

[34] The Medical Board recently published an advertisement seeking applications from physicians who meet the minimum qualification and currently practice in California and are interested in providing expert reviewer services for the Board. (See Medical Board Newsletter, Vol. 115, July 2010, at p. 7.)

4. The Frank Report Does not Assess Another Leading Cause of Investigation Completion Delays – the Unavailability of Medical Consultants in the District Offices

The Frank Report mentions, but again fails to analyze in any meaningful fashion, another flaw in the Medical Board's Enforcement Program, namely, the unavailability of Medical Consultants in the District Offices.[35]

In her Initial Report in 2004, the Enforcement Monitor observed that:

> "Medical consultants play a vital and varied role in the Medical Board's complaint handling and investigation process. The Monitor believes problems of medical consultant availability, training and proper use contribute significantly to lengthy investigations and inefficient operations."[36]

Unfortunately, as the Frank Report correctly notes, nothing has changed in the last six years. "Since publication of the Enforcement Monitor's reports there has been very little change in the availability of Medical Consultants."[37] The Frank Report also notes that "Needs in this area have not been emphasized."[38] This leading cause for investigation completion delays simply must be addressed.

Medical consultants across the State continue to be unavailable in the District Office, often for the majority of the work week. Investigations are stalled, subject interviews delayed, medical records are unreviewed, medical consultant memorandums remain unwritten, and the whole process grinds to a halt as the entire VE team awaits the return of the Medical Consultant to the District Office. As noted by the Enforcement Monitor years ago, the unavailability of Medical Consultants contributes significantly to lengthy investigations and inefficient operations. Unfortunately, very little has changed in the last six years to correct this continuing cause of investigation completion delays.[39]

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[35] Frank Report I, at pp. VI-42 and VI-43; Frank Report II, at pp. VI-17 and VI-18; Frank Report III, at pp. VI-16 and VI-18.

[36] Initial Report, at p. 144; emphasis added.

[37] Frank Report I, at p. VII-43; Frank Report II, at p. VI-18; Frank Report III, at p. VI-18. The Frank Report states that "no additional funding for Medical Consultants was included in th[e] package [that established the VE program or in the 2010/11 budget]." (Frank Report I, at VI-43; Frank Report II, at p. VI-18; Frank Report III, at p. VI-18.) However, as far back as 2005, it was contemplated that a portion of the increased initial and biennial fees paid by licensees would be used for this purpose. Specifically, in her Final Report, the Enforcement Monitor noted that "SB 231 (Figueroa) increases initial and biennial renewal fees by 30%. MBC management staff plans to use some of these additional funds to increase medical consultant hours." (Final Report, at p. 87.) It is unknown whether that was ever done.

[38] Frank Report II, at p. VI-18; Frank Report III, at p. VI-18.

[39] The Medical Board recently submitted a budget augmentation request to address this problem, but this request has not been approved.

5. The Frank Report Does Not Recognize HQE's Legislatively-Mandated Oversight Responsibility Over Investigations and Prosecutions of Medical Board Cases

HQE agrees that investigation completion delays continue to be a significant problem in the Medical Board's Enforcement Program. However, rather than analyzing the impact of the most significant reasons for those delays (i.e., the continuing high investigator vacancy rates and turnover, shortage of qualified experts, and unavailability of medical consultants), the Frank Report concludes that the higher level of involvement by HQE deputy attorneys general at the investigation stage, mandated by the Legislature in Government Code section 12529.6, is the real cause for these delays. Again, this is error.

At the outset it is important to recognize that the Legislature has created a partnership between the Medical Board's Enforcement Program and the HQE Section of the Office of the Attorney General. It is also important to recognize that HQE has a legislatively-mandated oversight responsibility over investigations and prosecution of Medical Board cases. Over the last two decades, the Legislature has increased HQE's oversight role, gradually shifting more and more responsibility to HQE in the process. In 1991, the Legislature created HQE within the Office of Attorney General and charged it with "primary responsibility" to prosecute administrative disciplinary proceedings before the Medical Board.[40] Later, in 2006, the Legislature expanded HQE's role by shifting primary responsibility for investigations of alleged misconduct by physicians and surgeons to HQE.[41] At the same time, the Legislature also mandated that those investigations be conducted using the "vertical prosecution model"[42] under which the assigned HQE deputy attorney general is required to direct[43] the investigator who is "responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action."[44]

As part of its oversight responsibility, HQE is responsible for ensuring that no physician is charged with unprofessional conduct unless those charges are supported by clear and

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[40] Gov. Code, § 12529, as added by Stats. 1990, c. 1597 (S.B. 2375).

[41] Gov. Code, § 12529.5, as added by Stats. 2005, c. 674 (S.B. 231).

[42] In 2008, the model was renamed the "vertical enforcement and prosecution model." (Gov. Code, § 12529.6, subd. (a), as amended by Stats. 2008, c. 33 (S.B. 797).

[43] HQE has long taken the position that the direction authority conferred under Government Code section 12529.6 does not include supervision authority. Said another way, while the assigned HQE deputy attorney general is statutorily authorized and required to direct the assigned investigator in the accumulation of the required evidence, he or she does not actually supervise the investigator which, instead, is the responsibility of the supervising investigator in the District Office. Consistent with HQE's position, in 2008, Government Code section 12529.6 was amended to clarify that the investigator works under "the direction but not the supervision" of the assigned HQE deputy attorney general.

[44] Gov. Code, § 12529.6., subd. (a), as added by Stats. 2005, c. 674 (S.B. 231).

convincing evidence to a reasonable certainty.[45] In exercising that responsibility, whenever an HQE deputy attorney general concludes that an investigation has not produced clear and convincing evidence of any violation of the Medical Practice Act, he/she issues a memorandum declining to accept the case and directs that the investigation be closed. This cannot be a shared responsibility between the assigned investigator and the HQE deputy attorney general. Rather, it is a legal determination, made as part of the practice of law which only a member of the State Bar of California can make, and part of HQE's oversight role over Medical Board investigations to ensure that only meritorious cases are filed. The prevention of unwarranted investigations and prosecutions is an important part of HQE's oversight role which is especially important today, since many of the Medical Board's new investigators lack significant experience in the investigation of Medical Board cases.

Apparently, without recognizing the foregoing, the Frank Report suggests that "the statutes governing Vertical Enforcement [be amended] to clarify the Medical Board's [investigators] sole authority to determine whether to continue an investigation."[46] The only manner by which that could be accomplished would be for the Legislature to overhaul the various statutes that currently govern the investigation and prosecution of Medical Board cases, and return the primary responsibility for investigations of allegations of misconduct by physicians and surgeons to the Medical Board investigators.

Additionally, the Frank Report also recommends that "independent panels [be established] to review all requests for supplemental investigations and all decline to file cases."[47] It is further recommended that the Chief of Enforcement and HQE Senior Assistant Attorney General be "advise[d] . . . as to the results of their review, including recommended disposition of the matter."[48] Again, this recommendation does not recognize that the legal determination that further evidence is required in order to properly evaluate a case, and the legal determination declining to file charges where not warranted by the evidence cannot be a shared responsibility between HQE and the Medical Board investigators. Rather, such legal determinations constitute the practice of law which only a member of the State Bar of California can make, and are a part of HQE's oversight role over Medical Board investigations to ensure that only meritorious cases are filed.

Finally, the Frank Report recommends the creation of a "new HQES Services Monitor" to, among other things, "continuously monitor and evaluate HQE's performance and costs, resolve conflicts that arise between the agencies, and prepare and provide regular reports to the Executive Management, the Medical Board, and oversight and control agencies."[49]

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[45] *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856 [holding that "the proper standard of proof in an administrative hearing to revoke or suspend a doctor's license should be *clear and convincing proof to a reasonable certainty* and not a mere *preponderance of the evidence*." (Italics original)].)

[46] Frank Report I, at p. X-7; Frank Report II, at p. X-2; Frank Report III, at p. X-2.

[47] Frank Report I, at ES-3; Frank Report II, at p. VII-17; Frank Report III, at p. VII-21.

[48] Frank Report I, at ES-3; Frank Report II, at p. VII-17; Frank Report III, at p. VII-21.

[49] Frank Report I, at p. ES-4; Frank Report II, at p. X-5; Frank Report III, at p. X-5.

However, both HQE and the Medical Board have already developed policies and procedures for the timely resolution of any conflicts that may arise.[50] More importantly, as HQE's Senior Assistant Attorney General, it continues to be my responsibility within the Department of Justice to monitor and evaluate HQE's performance. Accordingly, issues, questions or concerns regarding the performance of any HQE deputy attorney general have been, and should continue to be, brought to my immediate attention for investigation and resolution.

6. The Frank Report Does Not Mention or Assess, the Significant Travel Burden Placed on HQE Deputy Attorneys General Under the VE Program

In 2005, Senate Bill 231 (Figueroa) originally contemplated the transfer of Medical Board investigators to Office of the Attorney General which would, in turn, would have brought about a consolidation of the investigators and HQE deputy attorneys general in the same offices in many parts of the state. However, the contemplated transfer of investigators to the Attorney General's Office never happened and, instead, both the Medical Board and HQE were left to implement the VE program with their respective personnel located in offices remotely located from each other.[51]

Originally, in late 2005/early 2006, it was agreed that both the Medical Board and HQE would share the travel burden created by the VE program. Under this agreement, investigators would travel to the Office of the Attorney General, as necessary, and HQE deputy attorneys general would travel to the District Office, as necessary. Unfortunately, since the very beginning of the program, the travel burden has fallen almost entirely on HQE deputy attorneys general who are required to travel to District Offices to meet with investigators, review evidence, participate in witness and subject interviews, and complete a myriad of other tasks and responsibilities.+

To illustrate the extent of the significant travel burden placed on HQE under the VE program, the following table lists the distance (in miles), driving time (in minutes), and cost per hour (based on a per hour cost of $170.00) for travel by HQE deputy attorneys general from the Office of the Attorney General in Los Angeles to each of the five Medical Board District Offices within its geographical area of responsibility.[52]

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[50] See Vertical Prosecution Manual (Second Edition, November 2006) at Section XXII, page 12, entitled "Disagreements."

[51] Recognizing the geographical obstacles, the Legislature has mandated that "[t]he Medical Board shall . . . [e]stablish an implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model." (Gov. Code, § 12529.6, subd. (c)(3).)

[52] Distances and times are based on data obtained from http://www.mapquest.com on August 9, 2010. The cost per hour for attorney services set by the Department of Justice for the fiscal year 2009/10 is $170.00. (DOJ Administrative Bulletin No. 09-25, issued June 26, 2009.)

Travel By Office of the Attorney General

| Destination: MBC District Office | Round trip distance (miles) | Round trip driving time (minutes) | Cost of Attorney Time for One Round Trip |
|---|---|---|---|
| Valencia | 77.8 | 90 | $255 |
| Glendale | 22.48 | 32 | $90.67 |
| Diamond Bar | 53.16 | 66 | $187 |
| Cerritos | 41.04 | 56 | $158.67 |
| Tustin | 71.7 | 88 | $249.33 |

In order to save attorney hours, improve efficiency, and significantly reduce travel costs to the Medical Board, HQE has previously proposed the following solution to the geographical obstacles created by the VE program. In HQE's response to the Medical Board's 2009 Report to the Governor and Legislature, we recommended:

> "Video Conferencing: Under the VE Model, HQE has assumed the burden of the majority of required travel statewide between the various Attorney General's Offices and MBC district offices. As a result, DAGs spend hundreds of hours a year traveling on California freeways in order to confer with investigators, review documents and attend interviews. Implementation of a video conferencing network statewide would eliminate the necessity of some of this required travel, reduce the number of attorney hours expended driving rather than performing legal work, provide a convenient method for investigators and DAGs to readily confer when more than a simple telephone call is required and, from an environmental standpoint, would reduce the negative impact such travel places on the environment overall. HQE recommends that HQE and MBC work together to implement a video conferencing network statewide to further improve the VE program."[53]

To date, HQE's video conferencing recommendation has not been accepted by the Medical Board. HQE recommends that the Medical Board consider accepting this recommendation, especially if no reasonable alternative presents itself.

[53] Response of the Health Quality Enforcement Section to the Medical Board of California's Report to the Governor and Legislature (Second Draft 6-7-09), at p. 2.

7. The Frank Report's Allegation of "Potential Overcharges" by HQE is Unsupported by Evidence, and Raised Outside of the Established Procedure and Appropriate Forum for Addressing Such Questions, Concerns and Issues

The Frank Report claims to have "identified potential internal control issues involving HQES' billings to the Medical Board, and potential overcharges for HQES services."[54] The "evidence" for this serious allegation appears to be the Frank Report's identification of "two (2) cases in which HQE Attorneys appear to have misreported a significant portion of their time during 2008/09."[55] In both cases, the "evidence" consisted, in part, of a Medical Board supervising investigator expressing his/her opinion to Mr. Frank that "the time charges appeared to be significantly overstated."[56] It hardly seems necessary to state that the opinions of supervising investigators, one of whom has admitted "that she didn't have complete knowledge of other activities in which the Lead Prosecutor might have been involved during these periods," is not the type of evidence that responsible persons rely upon to make such a serious allegation. Also, in one of the two cases, an HQE Supervising Deputy Attorney General offered to research the issue for Mr. Frank "and provide additional information that would account for all the time charged."[57] However, Mr. Frank declined to ask for that research "because further investigation of this issue was outside of the scope of our assessment."[58]

Notwithstanding the lack of evidence to support such a serious allegation, the Frank Report nevertheless states that "during 2008/09, and possibly in some prior years and subsequently, the Medical Board may have been charged for some time that was not spent on Medical Board matters."[59]

Historically, any questions, concerns or inquiries regarding the billing of any HQE deputy attorney general has been brought to my attention by the Executive Director or Chief of Enforcement. The precise billing(s) that are under examination are identified and the matter is referred to the appropriate Supervising Deputy Attorney General to investigate the matter, review the case file, evaluate the billing, and report back to me. Once all the appropriate information has been gathered, and a determination has been made whether any adjustment is required, I contact the Executive Director or Chief of Enforcement to report my findings and the matter is appropriately resolved, with or without an adjustment to the identified

[54] Frank Report I, at p. III-1; Frank Report II, at p. III-4; Frank Report III, at p. III-4.

[55] Frank Report I, at p. III-8.

[56] Frank Report I, at p. III-9.

[57] Frank Report I, at p. III-9.

[58] Frank Report I, at p. III-9. It is difficult to understand how alleging potential overcharges to the Medical Board by HQE based on two cases is within the scope of the Frank Report's assessment but, at the same time, receiving additional information in one of those cases that would account for all the time charged is not.

[59] Frank Report I, at p. III-13.

billing. This process, which has been used successfully for years, continues to be the established procedure and the appropriate forum to address any billing questions, concerns or inquiries.[60] Indeed, the present executive director recently availed herself of this procedure to discuss and resolve a billing matter.

The speculation of "potential overcharges" by HQE contained in the Frank Report is both unfounded and inappropriately raised outside the established procedure and appropriate forum for addressing billing questions, concerns or inquiries. Accordingly, HQE requests that it be withdrawn from the Frank Report and, if there are any questions, concerns or inquires regarding any billing by any member of HQE, such matters should be brought to my immediate attention for investigation and resolution.

Lastly, it should be noted that, each month, the Case Management Section of the Division of Administrative Services of the Office of the Attorney General provides each HQE Supervising Deputy Attorney General with a report regarding the billing of each HQE deputy attorneys general under his or her supervision. Supervising Deputy Attorneys General are expected to review those billings in order to ensure appropriate billing. According to the Frank Report, surprisingly, HQE's monthly billings to the Medical Board "are not reviewed by Medical Board staff, except at an aggregate level as needed for budget tracking purposes."[61] HQE urges Medical Board staff to review HQE's monthly billing and, if there are any questions, concerns or inquiries regarding any of those billings, to bring the matter to my immediate attention in the appropriate forum for investigation and resolution.

In conclusion, in the section above, HQE identified and addressed some of the flaws in the Frank Report, explaining how some of its key findings, conclusions and recommendations are incorrect as a matter of fact, law or both. Turning now from the Frank Report, in the following section, HQE will present an accurate picture of "Physician Discipline under the Vertical Enforcement Program" for the years of 2005 through 2009, based on the reliable statistical information contained in the ProLaw database.

## II. Physician Discipline under the Vertical Enforcement Program

In order to assess the actual state of physician discipline in California for the period of 2005 through 2009, it is important to first identify the key statistical measures that will provide the most accurate assessment, and then present those statistical measures in a format that the reader can quickly and easily review to obtain the necessary information. Accordingly, HQE's report to the Medical Board on the state of physician discipline in California for the period of 2005 through 2009 will present statistical information on the following five key statistical measures:

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[60] This is the same process utilized by Dave Thornton, in his capacity as Chief of Enforcement and Executive Director, to address billing questions.

[61] Frank Report I, at p. III-13.

1. Average number of days from date of receipt of complaint at the Medical Board District Office to the date the investigation is closed, either for insufficiency of evidence, or because the case has been accepted for prosecution;
2. Average number of days from the date the case is accepted by HQE for prosecution to the date the accusation is sent to the Medical Board for filing;
3. Average number of days from the date the case is accepted for prosecution by HQE to the date the case is ultimately resolved at the administrative level, either by way of a stipulated settlement or decision following litigation;
4. Average number of days from date of receipt of complaint at the Medical Board District Office to the date the case is ultimately resolved at the administrative level by stipulated settlement or decision; and
5. Disciplinary outcomes under the VE Program.

The **first key statistical measure** is the average number of days from date of receipt of complaint at the Medical Board District Office to the date the investigation is closed, either for insufficiency of evidence, or because the case has been accepted for prosecution. This statistical measure allows the Medical Board to accurately determine the overall length of time it has taken for the Medical Board's Enforcement Program to complete investigations from the date the consumer complaint is first received at the District Office to the date the investigation is closed or accepted for prosecution for all Medical Board cases from 2005 to 2009.

**Average Number of Days from "Received at District Office" to "Matter Closed"**

| Calendar Year | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|
| Statewide | 430.55 | 419.12 | 392.66 | 259.60 |

This first key statistical measure shows that, since implementation of the VE program on January 1, 2006, to the end of the calendar year 2009, there has been an overall 39.7% statewide reduction in the average number of days from date of receipt of complaint at the Medical Board District Office to the date the investigation is closed, either for insufficiency of evidence, or because the case has been accepted for prosecution.[62]

The **second key statistical measure** is the average number of days from the date the case is accepted by HQE for prosecution to the date the accusation is sent to the Medical Board for filing. This statistical measure allows the Medical Board to assess how long it has taken HQE, statewide, to prepare proposed accusations for the period of 2005 to 2009.

[62] The methodology utilized for this first key statistical measure is as follows: Using the "Opened" date in Prolaw for each year, average number of days was calculated from the date the consumer complaint was "Received at District Office" to the date "Matter Closed." "Matter Closed" included cases that were: (1) Closed: No Violation; (2) Closed: Insufficient Evidence; (3) Accepted for Prosecution; or (4) Citation or PLR issued. The following cases were omitted from the calculations above: (1) Closed: pending criminal resolution; (2) Closed: subject entered into Diversion; (3) Closed: unlicensed individual; (4) Closed: statute of limitations expired; and Non-MBC cases. Calculations were done using matters that had been resolved.

**Average Number of Days from "Accepted for Prosecution" to "Pleading Sent"**
**Accusations Only**

| Calendar Year | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Los Angeles | 76.98 | 106.2 | 87.74 | 48.28 | 60.42 |
| San Diego | 97.3 | 89.4 | 59.67 | 72.63 | 50.55 |
| Sacramento | 64.53 | 82.77 | 56.64 | 89 | 104.5 |
| San Francisco | 39.53 | 35.44 | 27.91 | 44.71 | 36.48 |
| **Statewide** | **69.79** | **75.36** | **54.87** | **58.5** | **53.19** |

As the above chart shows, since implementation of the VE program on January 1, 2006, through the end of the calendar year 2009, HQE has reduced its overall average filing time from 69.79 days to 53.19 days. This represents an overall 24% statewide reduction in filing times since implementation of the VE program.[63]

When cases that involve a combined Accusation/Petition to Revoke Probation are reviewed for the period of 2005 through 2009, the statistical improvement is even greater.

**Average Number of Days from "Accepted for Prosecution" to "Pleading Sent"**
**Accusations/Petitions to Revoke Probation Only**

| Calendar Year | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Los Angeles | 120 | 88.5 | 68.5 | 55.33 | 69.43 |
| San Diego | 61.54 | 93.67 | 104.4 | 23 | 25 |
| Sacramento | 137 | 131.5 | 22 | 19 | 49.5 |
| San Francisco | 8 | 33 | 2 | 55.4 | 18.75 |
| **Statewide** | **88.44** | **95.07** | **68.5** | **40.93** | **42.63** |

When cases that involve Accusations only are combined with the cases involving Accusations/Petitions to Revoke Probation for the period of 2005 through 2009, the statistical improvement is likewise clearly shown.

[63] The methodology utilized for this second key statistical measure is as follows: Using the "Opened" date in Prolaw for each year, the average number of days was calculated from the date the case was "Accepted for Prosecution" to the date "Pleading Sent" to the Medical Board for filing. Administrative cases that were initially "Accepted for Prosecution," only to be reviewed and returned to the Medical Board District Office for additional investigation, have been calculated separately deleting the time period of investigation. The cases reflected in the chart include out-of-state discipline cases. Calculations were done using matters that had been resolved.

**Average Number of Days from "Accepted for Prosecution" to "Pleading Sent"**
**Accusations and Accusations/Petitions to Revoke Probation Combined**

| Calendar Year | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Statewide | 71.54 | 76.51 | 55.47 | 57.5 | 52.45 |

Finally, when all of the various types of administrative cases are combined for the period of 2005 through 2009, the statistical improvement is again clearly shown.[64]

**Average Number of Days from "Accepted for Prosecution" to "Pleading Sent"**
**All Administrative Matters**

| Calendar Year | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Los Angeles | 72.7 | 97.8 | 76.95 | 45.11 | 54 |
| San Diego | 87.5 | 85.83 | 65.92 | 63.52 | 47.27 |
| Sacramento | 65 | 73.75 | 46.65 | 80.15 | 88.56 |
| San Francisco | 39 | 33.39 | 26.81 | 45.65 | 35.46 |
| Statewide | 67.5 | 71.03 | 54.28 | 54.7 | 49.48 |

The following **third key statistical measure** is the average number of days from the date the case is accepted for prosecution by HQE to the date the case is ultimately resolved at the administrative level, either by way of a stipulated settlement or decision following litigation. This statistical measure allows the Medical Board to accurately determine the overall length of time it has taken HQE to complete the prosecution of physician discipline cases at the administrative level, statewide, from 2005 to 2009.

**Average Number of Days from "Accepted for Prosecution" to "Decision Signed by Client"**
**Accusations and Accusations/Petitions to Revoke Probation**

| Calendar Year | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Statewide | 496.82 | 455.22 | 403.61 | 341.51 | 263.90 |

As the above chart clearly shows, since implementation of the VE program on January 1, 2006, through the end of the calendar year 2009, there has been an overall 47% statewide reduction in the length of time it has taken to complete and entire investigation and, if warranted by the evidence, the entire administrative disciplinary process, for all Medical Board cases from 2005 to 2009.[65]

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[64] The administrative matters included in this calculation include the following: (1) Interim Order of Suspension cases; (2) Penal Code Section 23 appearances; (3) Business and Professions Code section 820 cases; (4) Petitions to Compel Competency Examination cases; (5) Accusation cases; (6) Accusation and Petition to Revoke Probation cases; (7) Petitions to Revoke Probation cases; and (8) Statement of Issues cases. Automatic suspension orders were not included in this calculation. Calculations were done using matters that had been resolved.

[65] The methodology utilized for this third key statistical measure is as follows: Using the "Opened" date in Prolaw for each year, the average number of days was calculated from date the case was "Accepted for Prosecution" to the date "Decision Signed by Client." Every effort was made to delete duplicate cases and multiple administrative matters that were consolidated into one Decision signed by the client. In addition, administrative cases that were initially "Accepted

The **fourth key statistical measure** is average number of days from date of receipt of complaint at the Medical Board District Office to the date the case is ultimately resolved at the administrative level by stipulated settlement or decision. This statistical measure allows the Medical Board to accurately determine the overall length of time it has taken to complete the entire investigation and, if warranted by the evidence, the entire administrative disciplinary process for all Medical Board cases from 2006 to 2009.

**Average Number of Days from "Received at District Office" to "Decision Signed by Client Accusations and Accusations/Petitions to Revoke Probation**

| Calendar Year | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|
| Statewide | 906.57 | 795.47 | 586.65 | 327.38 |

As this statistical measure demonstrates, since implementation of the VE program, there has been a 63.88% overall reduction in the overall length of time it has taken to complete the entire investigation and administrative disciplinary process for all Medical Board cases from 2006 to 2009.[66]

Finally, any assessment of the state of physician discipline in California necessarily requires an examination of **disciplinary outcomes**. Under the Medical Practice Act, disciplinary outcomes range from the most severe – outright revocation or surrender of licensure – to revocation stayed with a period of probation – and finally to lowest level of post-accusation discipline, a public reprimand with or without educational courses. The following statistical measure allows the Medical Board to accurately determine the overall effectiveness of the VE program in obtaining the most severe disciplinary penalties, outright revocation, license surrenders, and revocation, stayed, with probation.

**Accusations Resulting in "Serious Discipline"**

| Calendar Year | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|
| Los Angeles | 65.6% | 68.1% | 72.7% | 82.4% |
| Sacramento | 61.0% | 72.7% | 64.0% | 75.0% |
| San Francisco | 65.4% | 61.3% | 54.5% | 80.0% |
| San Diego | 59.3% | 50.9% | 72.3% | 64.3% |
| State total | 62.7% | 61.1% | 67.1% | 73.5% |

for Prosecution," only to be reviewed and returned to the Medical Board District Office for additional investigation, have been calculated separately deleting the time period of investigation. The calculations for this statistical measure include out-of-state discipline cases. Calculations were done using matters that had been resolved.

[66] The methodology utilized for this fourth key statistical measure is as follows: Using the "Opened" date in Prolaw for each year, the average number of days was calculated from date the consumer complaint was "Received at District Office" to the date "Decision Signed by Client." For multiple investigation matters resulting in a single administrative matter (by amendment to the existing Accusation and/or Accusation/Petition to Revoke Probation), the earliest date "Received at District Office" was used. The calculations used for this statistical measure include matters investigated under the VE program. Calculations were done using matters that had been resolved.

Significantly, during the past two years, imposition of the most serious disciplinary action in cases handled by HQE – Los Angeles, where attorneys presently have greater involvement during the investigation stage, has increased 14.3%. This statistic, standing alone, undermines a central premise of the Frank Report, namely, that greater attorney involvement under the VE program has not translated into greater public protection. As this final statistical measure clearly demonstrates, since implementation of the VE program, imposition of the most severe disciplinary outcomes has increased 10.8% statewide from the pre-VE time period, with the resulting increase in public protection.[67]

In conclusion, notwithstanding the problems that continue to plague the Medical Board's Enforcement Program, implementation of the VE program has resulted in overall improvements in the four key statistical measures that provide the most accurate picture of the state of physician discipline in California. Disciplinary outcomes over the same time period have significantly improved as well.

While the VE program continues to represent a vast improvement over the prior "Deputy-In-The-District-Office" Program, there is still nevertheless room for further improvement. In the next and final section of this response, HQE will report on the significant steps it has already taken in its continuing efforts to further improve its own performance, and also present its recommendations on important additional ways that the VE program can be further improved.

## III. Important Steps HQE has taken to Improve its own Performance, and Recommendations on How the Medical Board's Enforcement Program Can be Further Improved

The staff of HQE – Los Angeles presently consists of twenty-two deputy attorneys general, one paralegal, and two supervising deputy attorneys general. It is by far the largest section in HQE statewide. In order increase the efficiency and productivity of HQE – Los Angeles, and further improve the quality of legal services provided to the Medical Board by that office, a third supervising deputy attorney general position has been transferred from HQE – San Diego to HQE – Los Angeles. That new position has been advertised, applications have been accepted, and it is anticipated that interviews will be conducted in the near future.

HQE has also recently published its new "HQE Section Manual" for use by all staff in HQE statewide. While the manual will not be disseminated outside the Office of the Attorney General, in summary, it provides all HQE staff with a comprehensive set of policies and procedures that govern the legal work of the section, along with departmental policies and procedures, and will also be a valuable training resources for new deputy attorneys general who join the section in the future. It is anticipated that the new "HQE Section Manual" will also help to further promote uniformity in the handling of various legal issues by HQE staff statewide as well.

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[67] The methodology utilized to calculate serious discipline is as follows: "Serious discipline" is defined as: (1) outright revocation of licensure; (2) surrender of licensure; and (3) revocation of licensure, stayed, with a period of probation of at least one year. Using the "Opened" date in ProLaw for each calendar year, "serious discipline" was calculated using the above definition. In calculating each outcome, cases that were "declined to prosecute" and cases that did not reach an administrative outcome (i.e., Accusations filed but waiting administrative hearing) were omitted from the calculations. Out-of-state discipline cases were also omitted from the calculations.

In addition to these important steps that HQE has taken to improve its own performance, the following are HQE's recommendations on important ways that the VE program can be further improved to address some of the long-standing, systemic problems within the Medical Board's Enforcement Program.

1. Consider Entering into an Interagency Contract for the Attorney General's Office to Provide the Medical Board with Investigative Services

   The inability of the Medical Board to retain experienced investigators is a well-documented, longstanding problem that predates implementation of the VE program. As of 2009, the investigator vacancy rate was 16%. That unacceptably high vacancy rate, together with the high rate of investigator turnover, continues to seriously undermine the VE program. Permitting the Attorney General's Office to provide investigative services to the Medical Board would help to resolve the principal reason undermining the Medical Board's Enforcement Program's ability to complete investigations on a timely basis by providing trained, experienced investigators to compliment the job currently being performed by Medical Board investigators. For this reason, the HQE strongly recommends that the Medical Board consider entering into an interagency contract for the Attorney General's Office to provide investigative services to the Board, in addition to the legal services it currently provides. Funds that would otherwise be used by the Medical Board to pay the salaries of the currently vacant investigator positions could be used for this purpose.

2. Take Concrete Steps to Improve the Medical Board's Expert Reviewer Program

   Earlier this year, the Medical Board established the Enforcement Committee and one of its goals is to enhance the expert reviewer training program. The committee should consider developing an outreach program to attract more qualified expert reviewers to participate in its Expert Reviewer Program. The committee should also consider reinstating its prior procedure under which prospective experts were actually interviewed to review their qualifications and to determine whether, in addition to meeting the minimum requirements, they are sufficiently qualified to serve as an expert in the Expert Reviewer Program. The Medical Board should also accept HQE's offer to have a Supervising Deputy Attorney General participate on the interview panel as well.

   Consideration should also be given to increasing the compensation (currently set at $150 per hour for case review/consultation and $200 for providing expert testimony) in order to attract more qualified expert reviewers. Simply stated, a physician should not have to suffer an economic penalty for agreeing to participate as a Medical Board expert. Finally, before they are assigned to review any case, physicians accepted by the Medical Board's Expert Reviewer Program should be required to attend a comprehensive training conference to be conducted, in part, by HQE in order to ensure that they are adequately trained and prepared to fulfill their duties and responsibilities as an expert for the Medical Board.

3. Increase Medical Consultant Availability in the District Offices

The unavailability of medical consultants in the District Offices continues to be one of the leading causes for investigation completion delays. The Medical Board should take immediate steps to significantly increase medical consultant availability in the District Offices in order to reduce these continuing delays.

4. Utilize Video Conferencing to Reduce Required Travel Under the VE Program

Under the VE program, HQE has assumed the burden of the majority of required travel statewide between the various Attorney General's offices and Medical Board District Offices. As a result, HQE deputy attorneys general spend hundreds of hours a year traveling on California freeways in order to confer with investigators, review documents and attend interviews. This travel burden should be shared equally between HQE and the Medical Board's Enforcement Program, especially since the Board provides investigators with motor vehicles to use for all required travel. In addition, implementation of a video conferencing network statewide would eliminate the necessity of some of this required travel, reduce the number of attorney hours expended driving rather than performing legal work, and provide a convenient method for investigators and deputy attorneys general to readily confer when more than a simple telephone call is required. From an environmental standpoint, it would also reduce the negative impact such travel places on the environment overall. HQE recommends that HQE and the Medical Board work together to implement a video conferencing network statewide to further improve the VE program.

5. Foster an Environment of Cooperation and Support for the VE Program within the Medical Board's Enforcement Program

In some areas of the state, the VE program is working well, with HQE deputy attorneys general and Medical Board investigators working cooperatively and productively, and investigations and prosecutions being completed expeditiously. In other parts of the state, however, the program is not working as well as it could. However, the Frank Report's statement that "[t]here is a high level of conflict between Medical Board and HQE management and staff throughout much of the State" (Frank Report I, at p. X-6; Frank Report II, at p. X-1) is an overstatement of the occasional disagreements that have arisen under the VE program. In Frank Report III, this statement was revised to state that: "[c]onflicts have arisen among Board and HQES at all levels throughout the state, but particularly in the Los Angeles region. Conversely, in some offices, staff is respectful of each other's roles in the process and there is greater productivity." (Frank Report III, at p. X-1.) The importance of courtesy and cooperation which, in turn, fosters greater teamwork and productivity, has already been addressed and emphasized by both HQE and the Medical Board in the *Joint Vertical Enforcement Guidelines* (JVEG) (First Edition, April 2008). (See JVEG, Section 10, p. 8, entitled "Courtesy and Cooperation.")

It is important to recognize that at any given time there are over one thousand investigations or cases in which deputy attorneys general and Medical Board investigators are collaborating. It is also important to understand that only a handful of disputes arise each year and that all of these disputes are resolved either informally or by the dispute resolution process set forth in the *Vertical Enforcement Manual*. Indeed, over the twelve months, the number of conflicts requiring the formal dispute resolution process has almost been completely eliminated.

HQE and Medical Board's Enforcement Program should renew their efforts to achieve consistency and uniform implementation of the VE program in all of its District Offices statewide. By fostering an environment of cooperation and support for the VE program within the Medical Board's Enforcement Program, the Medical Board would send a strong signal that it supports the program and fully expects that all those within its Enforcement Program do the same.

In conclusion, thank you for the opportunity to review the Frank Report, as well as the opportunity for HQE to present its comprehensive report entitled "Physician Discipline Under the Vertical Enforcement Program." HQE looks forward to working with the Medical Board to further improve the VE program assist the Medical Board to reduce investigation completion delays, and implement much needed improvements to its Enforcement Program.

Sincerely,

CARLOS RAMIREZ
Senior Assistant Attorney General

For EDMUND G. BROWN JR.
Attorney General

cc: David C. Chaney
Chief Assistant Attorney General
Civil Law Division
Los Angeles

Linda Whitney
Executive Director
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# APPENDIX B
# Abbreviations

# ABBREVIATIONS

| | |
|---|---|
| AG | Office of Attorney General |
| ALJ | Administrative Law Judge |
| Board | Medical Board of California |
| BreEZe | Department of Consumer Affairs' new computer system |
| BCP | Budget Change Proposal |
| CAS | Consumer Affairs System (current computer system) |
| CCU | Central Complaint Unit |
| CMA | California Medical Association |
| CPEI | Consumer Protection Enforcement Initiative |
| DAG | Deputy Attorney General |
| DCA | Department of Consumer Affairs |
| DCU | Discipline Coordination Unit |
| DEA | Drug Enforcement Agency |
| DOJ | Department of Justice |
| FY | Fiscal Year |
| GC | Government Code |
| HQE | Health Quality Enforcement Section |
| HQES | Health Quality Enforcement Section |
| MBC | Medical Board of California |
| Monitor | Enforcement Program Monitor |
| PDAG | Primary Deputy Attorney General |
| PY | Personnel Year |
| SDAG | Senior Deputy Attorney General |
| VE | Vertical Enforcement and Prosecution |
| VE/P | Vertical Enforcement and Prosecution |
| Vertical Prosecution | Vertical Enforcement and Prosecution |
| VPM | Vertical Enforcement and Prosecution Manual |