Medical Board of California

Program Evaluation

Volume I
Summary Report

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MANAGEMENT CONSULTANTS

August 31, 2010

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MANAGEMENT CONSULTANTS

August 31, 2010

Ms. Linda Whitney, Executive Director
Medical Board of California
2005 Evergreen Street, Suite 1200
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Program Evaluation
Volume I – Summary Report

Dear Ms. Whitney,

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

Preliminary Diagnostic Review

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

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

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Governing Board Structure and Composition

We prepared and disseminated a survey of board members to obtain members' input regarding the structure and composition of the Medical Board's governing board, board capabilities and effectiveness, and the effectiveness of training provided to board members. As of June 30, 2010, a sufficient number of completed surveys had not been returned to enable development of findings, conclusions, or recommendations for improvement in these areas.

License Fees and Fund Condition

Since increasing initial and biennial renewal fees for physicians and surgeons from $600 to $790, effective January 1, 2006, there have been continuing concerns regarding whether the higher fees are justified. Section 2435(h) of Article 20 of the *Medical Practice Act*, adopted in conjunction with the January 2006 fee increase, placed a statutory cap on the amount of reserves that the Medical Board could accumulate in its Contingent Fund. Section 2435(h) stated that "It is the intent of the Legislature that, in setting fees pursuant to this section, the board shall seek to maintain a reserve in the Contingent Fund of the Medical Board of California equal to approximately two months' operating expenditures." Subsequently, during 2009, Section 2435(h) was modified (AB 501, Emmerson) to enable the Medical Board to maintain a higher reserve fund balance equal to 2 to 4 months' operating expenditures.

Our assessment of the Medical Board's fiscal circumstances focused on compliance with Section 2435(h) of the *Medical Practice Act*. Results of our review show that, within 2 to 3 years, the Medical Board's reserves are likely to decrease to a level equivalent to less than four (4) months' operating expenditures. Consequently, an adjustment to the Medical Board's license fees, currently set at $783, would not be supported.

Licensing Program

During 2009 the Medical Board contracted with Hubbert Systems Consulting, Inc. (HSC) to conduct an assessment of the Licensing Program to identify effectiveness, efficiency, and other improvements that would facilitate compliance with governing statutes and regulations and improve customer service. The focus of HSC's study was on the license application process. We completed a critical review of HSC's report. We also incorporated results of analyses we performed in other related areas.

In addition to recommending various improvements to licensing-related business processes and technology support systems, HSC recommended increasing the number of authorized permanent Licensing Section positions by 54 percent (from 26 positions to 41 positions, an increase of 15 positions). Partially offsetting this proposed increase, HSC also proposed eliminating four (4) half-time retired annuitant positions (equivalent to 2 full-time positions) and eight (8) part-time student assistant positions (equivalent to 6 full-time positions, assuming all of the student assistants work a maximum of 30 hours per week). With these offsets, a net increase of at least seven (7) full-time-equivalent positions was recommended, representing a 27 percent increase in authorized staffing for the Licensing Section. With these recommendations, total authorized positions for the Licensing Program would increase by 33 percent (from about 45 to 60 positions, excluding offsets for the elimination of retired annuitants and student assistants).

As noted by HSC, during 2009/10 the Medical Board began filling eight (8) new positions proposed in a 2010/11 BCP that was not yet approved. The Department of Consumer Affairs (DCA) provided the Medical Board with a special authorization to fill these positions on an accelerated basis. At the time of HSC's study, four (4) of the positions had already been filled. As of early-July 2010, seven (7) of the positions were filled, including one (1) new SSM I position. With these eight (8) additional positions, authorized staffing for the Licensing Program now exceeds 52 total positions, excluding retired annuitants and student assistants. These additional resources fully restore positions lost earlier during the decade and would actually exceed, by 10 to 20 percent, the total number of positions authorized for the Licensing Division at any point during the 8-year period from 2000/01 through 2007/08. During this period, Licensing Division workload grew modestly (e.g., from 2004/05 through 2008/09, the number of license applications increased by about 10 percent).

Results of our analyses support the need for the additional eight (8) positions included in the 2010/11 BCP. However, there is not a clear rationale for HSC's recommendation to seek authorization for seven (7) additional positions beyond the additional positions included in the 2010/11 BCP. Also, HSC provided no analysis of the cost-benefit trade-offs of using permanent intermittent positions, temporary help, such as retired annuitants and student assistants, and overtime, in lieu of additional full-time permanent positions, to address recurring seasonal workload peaks. Additionally, HSC's recommendation to upgrade two (2) of the Licensing Section's remaining three (3) Office Technician positions, and to completely eliminate the use of student assistants, would shift clerical and administrative support activities and workload to higher level staff.

Enforcement Program

Our assessment of the Enforcement Program's business processes and performance, and related organizational, management, and staffing capabilities, focused on impacts of the Vertical Enforcement Pilot Project which the Medical Board and Health Quality Enforcement Section (HQES) jointly implemented beginning during 2006. Our analyses included collection and review of historical data, interviews with management and staff at both the Medical Board and HQES, and research of several dozen individual case histories.

To support our assessment, Medical Board staff produced several dozen sets of data pertaining to the intake, screening, investigation, and prosecution of complaints, disciplinary outcomes, and other related activities and events. We filtered, compiled, summarized, and analyzed the data provided as needed for purposes of this assessment. Where required, replacement or supplemental sets of data were requested and provided. Some statistical data was also provided by HQES, including data regarding time charges for investigation and prosecution-related services. Where appropriate, we incorporated HQES' data into our analyses, but much of the data provided by HQES was not provided until near the conclusion of the assessment. Also, much of the data provided was incomplete and of limited utility.

Overall, results of our assessment of the Enforcement Program show that Vertical Enforcement was implemented very differently in different geographic regions of the State, with differing impacts in terms of cost-effectiveness, service levels, and outcomes achieved. These differences provide an opportunity to identify best practices, reverse the deterioration in Enforcement Program performance that has occurred, and enhance consumer protection by instituting a more uniform and effective statewide approach to investigating and prosecuting complaints.

Impacts on Investigations

Results of our analyses show that fewer investigations are being completed by the District offices, the investigations are taking significantly longer to complete, and fewer cases are being referred for prosecution. Most concerning, is the increase in the time needed to complete quality of care case investigations, which already take an average of more than 18 months to complete for cases that are referred for prosecution. Also, performance levels have declined as much, or more, in the Los Angeles Metro region than in other regions of the State even though Los Angeles Metro region Attorneys are significantly more involved with investigations (2 to 3 times higher level of involvement than Attorneys in other regions of the State). Notwithstanding the much higher level of Attorney involvement in Los Angeles Metro area investigations, during 2008/09, and also during 2007/08, only about 75 cases per year were referred for prosecution. This compares to about 72 cases per year referred for prosecution in the Other Southern California region and more than 100 cases per year referred for prosecution in the Northern California region. Of particular concern, during the past two (2) years, only 25 percent of completed Los Angeles Metro region investigations were referred for prosecution. In contrast, in the Northern California region, 28 percent of completed investigations were referred for prosecution and, in the Other Southern California region, 32 percent of completed investigations were referred for prosecution.

Impact on Prosecution of Cases

Results of our assessment show that the number of accusations filed, the number of proposed stipulations and proposed decisions received, and the number of disciplinary actions, have all declined. Although the average time taken to file accusations has decreased, the decrease is largely attributable to activity in the Los Angeles region which, in prior years, took an abnormally long time to file. In the Los Angeles region, the average elapsed time to file accusations remains higher than in other regions due, in part, to (1) inconsistent use of requests for supplemental investigations, and (2) periods of limited activity while cases are pending at HQES following referral of the cases for prosecution.

The average elapsed time from filing to settlement (stipulation received) has also decreased. However, there are significant performance variations between regions. The decrease in composite elapsed times from filing to settlement, to a statewide average of 11 months during the past two (2) years, is attributable to improved performance in the Los Angeles Metro and Other Southern California regions. However, even with this improvement, the average elapsed time for the Los Angeles Metro region during the past two (2) years lagged performance of the other two regions. For the Northern California region, the elapsed times from filing to stipulation received generally averaged about ten (10) months throughout the past six (6) years.

Impact on Disciplinary Outcomes

During the 4-year period from 2003/04 through 2006/07, 312 disciplinary actions were taken per year. During the next two years (2007/08 and 2008/09), 292 disciplinary actions were taken per year. The decrease in number of disciplinary actions is greater if Out-of-State cases, which are rarely handled by the District offices, are excluded. During the past two (2) years, there were significant variations in disciplinary outcomes among the different geographic regions of the State. In the Northern California region, the total number of disciplinary actions decreased by about 9 percent, but the proportion of disciplinary actions involving license revocation,

surrender, suspension, or probation increased marginally (from 72 to 74 percent). In the Other Southern California region, the number of disciplinary actions increased by about 10 percent, due to a significant increase in the number of public reprimands – there was no change in the number of disciplinary actions involving license revocation, surrender, suspension, or probation. As a result, for the Other Southern California region, the proportion of disciplinary actions involving license revocation, surrender, suspension, or probation decreased (from 75 percent to 66 percent). In the Los Angeles Metro region, the total number of disciplinary actions decreased by 13 percent *and* the number of disciplinary actions involving license revocation, surrender, suspension, or probation decreased by 20 percent. As a result, in the Los Angeles Metro region, the proportion of disciplinary actions involving license revocation, surrender, suspension, or probation decreased from 74 percent to 67 percent. The changes in the number and composition of Los Angeles Metro region disciplinary actions were the largest contributors to the decreases that recently occurred in (1) the overall number of disciplinary actions taken, and (2) the number of disciplinary actions taken involving license revocation, surrender, suspension, or probation.

Impacts on Overall Enforcement Process Performance

Since implementation of VE there has been a marked deterioration in several overall indicators of enforcement process performance. For example, significantly fewer, rather than more, interim suspension actions are taken. Also, it was expected that, with HQES Attorneys more involved with investigations, the elapsed time from referral of a case for investigation to filing of the accusation would decrease. In fact, the average elapsed time from referral for investigation to accusation filed has increased by two (2) months during the past several years. The average elapsed times from referral for investigation to accusation filed increased in all three (3) geographic regions. However, there were significant performance variances among the regions. The Northern California and Other Southern California regions had much shorter average elapsed times than the Los Angeles Metro region (17 to 19 months for the Northern California and Other Southern California regions compared to 22 to 23 months for the Los Angeles Metro region, a difference of 5 to 6 months). From this data it is abundantly clear that the much higher level of involvement of Attorneys in Los Angeles Metro region investigations has not provided any differential benefit in terms of reducing average elapsed times from referral of a case for investigation to filing of the accusation, which provides notice to the public of alleged negligence or misconduct by a licensee.

Implementation of VE was also expected to reduce average elapsed times from referral of cases for investigation to stipulation received which, for most cases, effectively represents completion of the prosecution phase of the enforcement process. It was anticipated, for example, that in addition to reducing the average elapsed time to complete investigations and the average elapsed time to file accusations, that implementation of VE might (1) marginally increase the proportion of cases that settle without a hearing, and (2) reduce the average elapsed time to negotiate a settlement and prepare the stipulation.

With respect to increasing the proportion of cases that settle rather than proceed to hearing, about 80 to 85 percent of cases usually settle without a hearing. Thus, it was considered unlikely that implementation of VE would significantly increase the proportion of cases that settle without a hearing. On an annual basis for the past six (6) years, the proportion of cases that did not settle, and proceeded to hearing, fluctuated between 15 and 20 percent. There is no evidence that implementation of VE had any significant beneficial impact in terms of increasing the proportion of cases that settle without a hearing. With respect to reducing the average elapsed time from referral for investigation to stipulation received, for cases with District office Identifiers the average elapsed times changed very little in recent years and, for all regions, this performance measure was only marginally lower during the past three (3)

years than during the preceding three (3) years. However, as aged cases migrate from the Investigation Stage to the Prosecution Stage during 2009/10 and subsequent years, it is likely that the average elapsed time from referral for investigation to stipulation received will increase.

Finally, with respect to this key performance metric, there are significant performance variations among the regions. For example, the Los Angeles Metro region consistently had significantly higher average elapsed times from referral for investigation to stipulation received than the other regions. During the past two (2) years the average elapsed time for the Los Angeles Metro region was about seven (7) months longer than the average elapsed time for the Northern California region, and about three (3) months longer than the average elapsed time for the Other Southern California region.

Organizational and Workforce Development Impacts

There are a number of factors over the past several years that have contributed to the Enforcement Program's inability to meet its goals. The loss of Investigators to a number of state agencies is likely to have contributed, although it is not possible to know whether or to what extent goals would have been met if fewer Investigators had separated from the Board. It is, however a fact that the Board has experienced a number of lateral transfers (non-promotional) to other State agencies subsequent to implementation of Vertical Enforcement. Some staff were disappointed that pay raises did not materialize, case levels did not decline as hoped, and the Investigators were not transferred to the Department of Justice. It is also a fact that there are tensions between Medical Board and HQES management, and a lack of consistency of VE implementation among regions. All parties involved are jointly responsible for ensuring stability and an employment environment conducive to productivity, and it would appear that significant and continuing problems in this area have not been sufficiently addressed. Although current Enforcement Program staffing levels are higher than they have been in several years and the workforce is stable, likely due to current economic conditions, as the economy improves the Medical Board may again experience high attrition and vacancy rates if improvements are not made.

Fiscal Impacts

In recent years the Medical Board's costs for HQES legal services increased by $3.6 million (43 percent) due to rate increases and a 20 percent increase in Attorney staffing authorized to support implementation of VE. HQES currently charges the Medical Board more than $1 million per month for legal services ($13 million per year) and these charges now account for more than 25 percent of the Medical Board's entire budget. HQES' Los Angeles Metro office accounts for about two-thirds of HQES' increased costs. Some increased expenditures for additional Investigators also were incurred (about $0.7 million per year), but the Furlough Friday Program during 2009/10 temporarily offset these additional costs. The increased resources now being used to support the Enforcement Program are producing increasingly lower levels of output. Expectations that implementation of VE would improve efficiency have not been fully realized.

Enforcement Program Improvement Plan

Nineteen (19) recommendations are presented in the *Final Report* addressing improvement needs involving complaint intake and screening, investigations, prosecutions, probation monitoring, and related organizational and management structures. These recommendations for improvement include:

- ✓ Augmenting CCU's Specialist Reviewer pool in targeted medical specialties or providing flexibility to waive the requirement for review by a Medical Specialist
- ✓ Augmenting CCU workforce capabilities and training
- ✓ Augmenting Medical Consultant staffing
- ✓ Augmenting the Medical Expert pool
- ✓ Strengthening management and administration of the Medical Expert Program
- ✓ Conducting a structured diagnostic review of the factors contributing to excessive Investigator turnover and developing and implementing plans to minimize attrition
- ✓ Establishing independent panels to review all requests for supplemental investigations and decline to file cases
- ✓ Restructuring the processes used for preparing accusations and surrender stipulations for Out-of-State cases
- ✓ Restructuring the handling of petitions for modification or termination of probation
- ✓ Restructuring the handling of Section 801 (medical malpractice) cases
- ✓ Amending the statutes to clarify the Medical Board's sole authority to determine whether to continue an investigation
- ✓ Scaling back and optimizing Attorney involvement in investigations, and increasing uniformity among regions
- ✓ Establishing new processes for tracking the status of cases following referral to HQES for prosecution and reviewing charges for legal services
- ✓ Establishing a new position within the Medical Board to monitor spending, review HQES costs, and identify inconsistencies or anomalies
- ✓ Developing new monthly management reports and new quarterly reports for the Board
- ✓ Developing systems for tracking and reporting key probation monitoring activities.

* * * * * * * * *

We are grateful for all of the assistance provided to us by both Medical Board and HQES staff. In particular, we want to acknowledge the efforts of Janie Cordray, Nancy Smith, Sean Eichelkraut, Susan Cady, John Harai, Laura Guardhouse, Marianne Eckhoff, Debbie Titus, Jill Johnson, Carlos Ramirez, Gail Heppell, Jose Guerrero, Tom Lazar, and Liana Ashley. Without the support of these and many other Medical Board and HQES staff, completion of this assessment would have been substantially more difficult.

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

Very truly yours,

BENJAMIN FRANK, LLC

Ben Frank

Benjamin Frank
Chief Executive Officer

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I. Introduction

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I. Introduction

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

To address the above concerns, the Board directed the Executive Director to undertake a comprehensive, independent evaluation of the Medical Board. A Request for Offers was issued on August 25, 2009, the Medical Board completed its evaluation September 2009, and Benjamin Frank, LLC was awarded the contract on October 26, 2009 (extending to August 31, 2010). Work commenced on November 4, 2009.

This *Summary Report* is a condensed version of the *Final Report* which more fully documents the results of our assessment. The *Summary Report* is organized as follows:

Section	Title
I.	Introduction
II.	Overview of the Evolution of the Medical Board's Governance Structure, Licensing Fees, and Enforcement Program
III.	License Fees, Expenditures, and Fund Condition
IV.	Overview of Complaint Workload, Workflows, and Performance
V.	CCU Complaint Intake and Screening
VI.	Investigations
VII.	Prosecutions and Disciplinary Action
VIII.	Probation Program
IX.	Integrated Assessment of Enforcement Program Performance
X.	Organizational and Management Structures
XI.	Licensing Program.

A listing of all recommendations for improvement is provided in Appendix A. Additional technical information and analyses are presented in Volume II *(Final Report)*.

I. Introduction

A. Project Purpose and Scope

The purpose of this study was to conduct an independent and unbiased review of the Medical Board's organizational structure and core programs to identify strengths and weaknesses of current operations and develop recommendations for improvements. The scope of the review encompassed assessment of the Medical Board's governance structure and a review of the Medical Board's internal organizational and management structure. Additionally, the study scope included assessment of:

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

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

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

B. Medical Board Data Constraints and Effects

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

In the past, and currently, a major area of contention between the Medical Board and the Health Quality Enforcement Section (HQES) involves differences in how the two agencies account for the time that elapses between referral (or transmittal) of a case to HQES for prosecution and filing of an accusation. The Medical Board generally measures the elapsed time from transmittal of a case to HQES to the filing of an accusation. HQES generally measures the elapsed time from its acceptance of a case for prosecution to completion of its preparation of a pleading. These alternative measurement approaches can result in significant differences in resulting performance measures. Factors which contribute to the differences include the following:

- The Medical Board's measurement approach includes the elapsed time from transmittal of the case to HQES to HQES' acceptance of the case for prosecution. Generally, the difference between these two events should be limited to a period of just a few days, but can extend for somewhat longer periods as a result of delays due to the unavailability of staff to promptly review the case, case reassignments, or internal deliberations about whether or not to accept the case for prosecution. Additionally, HQES sometimes requests a supplemental investigation, and does not accept the case for prosecution until the supplemental investigation is completed and accepted. In some cases multiple supplemental investigations are requested. In these circumstances the elapsed time between transmittal of the case and filing of the accusation can include extended periods of additional time. This additional time is included in the Medical Board's elapsed time measures, but not in HQES' elapsed time measures.

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

While the data maintained in CAS appears to be reasonably complete and accurate for most data elements, it appears that some updates to CAS are not always consistently posted by District office staff for various interim investigation activities, including activities involving (1) medical records requests, (2) Complainant and Subject interviews, and (3) Medical Consultant case reviews. The output and performance measures related to obtaining medical records are especially limited. Medical records are sometimes requested from multiple sources for the same case, but the Medical Board's performance measures typically only account for one records request for each case. Also, in some cases the records submitted are incomplete or overly redacted and are re-requested. The Medical Board's measures count the records as received irrespective of the completeness or quality of the records provided, and do not account for supplemental submissions. Problems with obtaining complete records quickly have been ongoing over the years and are likely to continue as poor performers are also more likely to keep poor records or engage in maneuvers to avoid producing them. These problems may be addressed in the future by the universal use of electronic medical records.

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

Supplemental Investigations – If there is insufficient evidence to meet the burden of proof in a completed investigation, HQES can request a supplemental investigation to address the deficiencies. However, HQES Attorneys sometimes request supplemental investigations to strengthen a case even though another HQES Attorney might consider the initial submission sufficient without further investigation.

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

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

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

C. HQES Data Constraints and Effects

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Governing Board Structure and Composition

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

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

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

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

- Insurers and the insured report to BMQA the payment of judgments, settlements, and arbitration awards in medical malpractice actions (Sections 801 and 802 of the Business and Professions Code)
- Court clerks report to BMQA criminal charges and convictions against physicians (Section 803 of the Business and Professions Code)
- Hospitals and health care institutions report to BMQA adverse peer review actions taken against physicians (Section 805 of the Business and Professions Code).

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

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

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

B. License Fees and Expenditures

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

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

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

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

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

Historical and Budgeted Medical Board Expenditures

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

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

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

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

Over the 5-year period from 2004/05 through 2008/09, total expenditures increased by about $6.3 million (15 percent). **Table II-1**, below, shows the expenses that contributed most to these increased costs.

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

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

As shown by Table II-1, costs for legal services provided by the Attorney General increased significantly on both an absolute and percentage basis, and accounted for more than one-half of the total increase in expenditures during this period. In contrast, costs for services provided by OAH fluctuated between $0.9 million and $1.4 million during this same period, and the most recent year's costs for OAH services were about average for the period ($1.1 million). The increased costs for Attorney General services reflect the combined impacts of rate increases and the authorization of 10 additional Attorney positions to support implementation of the VE Pilot Project.

C. Complaint Intake and Screening

During the 1980s complaint intake and screening were handled by a handful of Customer Service Representatives (CSRs) dispersed across regional offices in Sacramento, San Francisco, Los Angeles, and San Bernardino/San Diego. Each regional office also had 1 to 2 full-time Medical Consultants who assisted the CSRs in determining which complaints should be referred for field investigation. During this period the Medical Board received fewer than 5,000 complaints per year, of which about one-half involved negligence/competency (quality of care) issues. About one-half of complaints received were referred to the District offices for investigation (2,500 per year).

During the early-1990s the Medical Board consolidated responsibility for complaint intake and screening in the Sacramento Headquarters Central Complaint Unit (CCU). Since that time the number of positions authorized for the CCU has grown. CCU is currently authorized 24 positions, about the same number as authorized at the beginning of the decade. About two-thirds of CCU staff are classified at the SSA or AGPA levels. AGPA is a higher classification level than CSR positions. In the early-2000s, CCU was reorganized into two specialized sections based on the type of complaint handled (Quality of Care and Physician Conduct). Most staff within the Quality of Care

Section are assigned to specific geographic regions of the State. Most staff within the Physician Conduct Section are assigned to specific types of complaints.

In the early 1990s, HQES Attorneys were assigned to work at CCU on a part-time basis to assist in evaluating and screening complaints. In October 2003 the assignment of this position was formalized in response to legislative requirements enacted 12 years earlier during 1991 (SB 2375, Presley). Also during 2003, CCU began implementing a new Specialty Reviewer process pursuant to requirements set forth in SB 1950 (Figueroa). The Specialty Reviewer requirement was enacted to help reduce the number of complaints referred for investigation, and related needs to conduct field investigations in cases where it might not be warranted. Prior to implementation of the Specialty Reviewer process, a physician not specializing in the subject physician's case may have reviewed the complaints, and, in some cases, were unable to make a preliminary determination regarding the merits of the complaint because they lacked knowledge of, and experience with, the medical specialty involved. In these circumstances the cases were referred for investigation where a more specialized medical professional would make a determination on the merits of the case as a part of the field investigation process.

CCU currently handles about 7,200 complaints per year involving physicians and surgeons, or about 50 percent more complaints than were handled during the 1980s. These complaints include about 1,000 mandated reports that are submitted to the Medical Board pursuant to statutory requirements that were not in effect prior to 1990. The number of complaints received by the Medical Board has grown modestly over time, but more slowly than the growth rate of the industry during this period. CCU now performs a much more rigorous review of complaints than was previously performed and, except for disputes involving the release of the patients records, does not attempt to mediate complaints. CCU currently refers fewer than 20 percent of complaints for investigation, including some high-priority complaints that are referred for investigation with only limited screening (e.g., Section 805 reports).

For some types of cases CCU works collaboratively with the Discipline Coordination Unit (DCU). For example, CCU receives a significant number of reports of physician discipline from licensing boards in other states. Following intake by CCU, these cases are forwarded directly to DCU which reviews each case and, if needed, requests additional records. DCU may then close the case, prepare a proposed settlement agreement with the licensee (referred to as a pre-filing stipulation), or refer the case to HQES' San Francisco office for prosecution. District offices are rarely involved with these cases, unless the licensee is practicing in California.

D. Investigations and Prosecutions

During the past 30 years several major comprehensive reform initiatives and numerous targeted changes and improvements have been implemented to strengthen discipline and reduce the time required to complete complaint intake/screening, investigation, and prosecutorial processes. These efforts included creating a new Health Quality Enforcement Section (HQES) within the Attorney General's office, organizationally separate from the Licensing Section, transferring responsibility for disciplinary hearings to the Office of Administrative Hearings (OAH) and then creating a new Medical Quality Hearing Panel (MQHP) within OAH to hear medical discipline cases, and restructuring the Medical Board's governance structure. These efforts had some success. For example, while the number of

cases referred for investigation decreased, the number of cases resulting in disciplinary action increased. However, concerns were raised nearly continuously throughout this period about the extended 2 to 3-year timeframes needed to complete investigations and prosecutions.

Most recently, during 2006 the VE Pilot Project was implemented, representing the third major restructuring of the Enforcement Program within a period of 20 years. VE was intended to address long-standing problems that contributed to the extended timeframes needed to complete investigations and prosecutions, and was expected to provide significant benefits, including all of the following:

- ✓ Improved efficiency and effectiveness
- ✓ Reduced case cycle times
- ✓ Improved Investigator and Prosecutor morale, recruitment, and retention
- ✓ Improved training for Investigators and Prosecutors
- ✓ Improved commitment to cases
- ✓ Improved perception of the fairness of the process *(this benefit would only accrue if Medical Board Investigators were transferred to the Department of Justice, which did not occur).*

To support implementation of VE, 10 additional Attorney positions were authorized for HQES, which fully restored six (6) HQES Attorney positions previously eliminated. Additionally, eight (8) new positions were authorized for the Enforcement Program (4 Investigators and 4 Assistant Investigators). The additional Investigator positions were authorized beginning with the 2006/07 fiscal year (6 months after implementation of VE commenced). The new Investigator positions only partially restored the 35 District office positions that had been eliminated since the beginning of the decade. Given the extended lead times to hire and train new staff, these additional resources were largely unavailable to support implementation of VE for the first full year following implementation of this new approach to conducting investigations. Subsequently, the Medical Board reclassified the four (4) new Assistant Investigator positions to Inspectors and assigned the positions to the Probation Units. Concurrently, a comparable number of Investigator positions assigned to the Probation Units were reassigned to the District offices along with a responsibility for investigating cases previously handled by the Probation Units.

At the time that VE was implemented (2006), staffing levels at the District offices were 25 percent lower than existed earlier in the decade. Additionally, Investigator caseloads were growing and the average time to complete investigations had been steadily increasing for several years. The Medical Board's District offices were not initially provided with any additional resources to assist them in responding to the additional workload demands associated with coordinating their investigation activities with HQES Attorneys and responding to the Attorneys' directions regarding the conduct of investigations.

To guide implementation of VE, the Medical Board and HQES jointly developed a *Vertical Prosecution Manual* that defined the roles and responsibilities of the members of the VE Team. Additionally, HQES created a new Lead Prosecutor (LP) designation for selected DAGs

to support implementation of VE. HQES assigned one (1) LP to each Medical Board District office to act as HQES' principal liaison to that office. The LP is jointly assigned to each case along with a second DAG. The LP is required to review all incoming complaints and determine whether the complaints warrant an investigation or should be closed without investigation. The determination of whether to close a complaint without investigation is required to be made in consultation with the District office Supervisor. If the LP determines that an investigation is warranted, they are required to inform the assigned Investigator and then review and approve the Investigator's Investigation Plan.

The LP is also required to identify cases in which an Interim Suspension Order (ISO) or Penal Code Section 23 (PC 23) appearance is necessary, and notify the Supervising DAG (SDAG). In such cases the SDAG is required to designate the second DAG as the Primary DAG responsible for the ISO or PC 23 appearance. The SDAG is also required to designate the second DAG as the Primary DAG for cases involving sexual abuse or misconduct, mental or physical illness, and complex criminal conviction cases. Finally, whenever the LP determines that it is likely a violation of law may be found, the second DAG is required to replace the LP as the Primary DAG on the case for all purposes. If the second DAG is assigned as Primary DAG, then the LP is required to monitor the progress of the investigation and the appropriateness of the direction provided by the Primary DAG. If the second DAG is not assigned by the SDAG as the Primary DAG, then the LP is required to act as the Primary DAG throughout the investigation and prosecution of the case. LPs are required to be physically present at their assigned District office to the extent necessary to fully discharge their responsibilities.

Subsequently, in April 2008 the Medical Board and HQES issued a set of *Joint Vertical Enforcement Guidelines* which supplement the policies and guidelines set forth in the *Vertical Prosecution Manual*. However, there are some disparities between the policies and guidelines established for the VE Pilot Project and actual case investigation practices, and considerable variability in how VE has been implemented in different regions throughout the State. For example:

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

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

Generally, the LP's review of a new complaint and their opening of a new Investigation matter in HQES' ProLaw System occur at some point after the opening of the investigation by the District office, after the District office Supervisor's assignment of an Investigator to the case, and, in some cases, after the initiation of investigation activities.

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

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

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

Subject Interviews – At some District offices the Primary DAG is expected to attend all Subject interviews. At other District offices either the LP attends most Subject interviews on behalf of the Primary DAGs or an HQES Attorney (usually either the LP or Primary DAG) only attends Subject interviews on an exception basis (e.g., cases involving sexual misconduct or if requested by the District office). At some District offices the LP rarely attends Subject interviews. Attorney practices regarding completion of pre-interview case file reviews, attendance at pre-interview planning meetings, and the extent of their participation during the interview vary greatly depending on individual Attorney personal preferences. Primary DAGs sometimes fail to show for Subject interviews that they were scheduled to attend.

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

exception basis. There is considerable variability in Medical Board and HQES practices related to the preparation and review of Expert packages.

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

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

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

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

E. HQES Staffing Resource Allocations

For the past several years, excluding temporary help (retired annuitants) and Secretaries (7 positions), 58 full-time, permanent positions were authorized for the HQES, including 1 Senior Assistant Attorney General, 6 Supervising Deputy Attorneys, 47 Deputy Attorneys (all levels), 3 Senior Legal Analysts, and 1 Associate Government Program Analyst (AGPA). Prior to implementation of Vertical Enforcement, HQES did not have an AGPA position and had nine (9) fewer Attorney positions. The Secretary positions are not shown as budgeted to HQES in the *Wage and Salary Supplements to the Governor's Budgets*.

Table II-2, below, shows allocations of authorized SDAG, DAG, and Senior Legal Analyst positions by HQES office during 2008/09 and 2009/10. The position allocations shown for 2009/10 reflect a reduction of four (4) authorized DAG positions. As shown by Table II-2, nearly one-half of authorized DAG positions are assigned to the Los Angeles Metro office, 30 percent are assigned to Northern California offices (Sacramento and San Francisco), and less than one-quarter are assigned to the San Diego office. During 2009/10, authorized DAG staffing for HQES was reduced by four (4) positions. All of the reductions were absorbed by the smaller Sacramento, San Francisco, and San Diego offices. Additionally, one (1) vacant DAG position was shifted to the Los Angeles Metro office to accommodate unrelated personnel placement needs at that location. To better balance workload between the various HQES offices, the geographic boundaries of the Los Angeles Metro office were recently extended, both North and South, to encompass portions of the areas served previously by HQES' Sacramento and San Diego offices.

Table II-2. Health Quality Enforcement Section Staff Allocations by Office

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

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

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

Table II-3. Hours Charged by HQES Attorneys to Investigation Matters

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

HQES Office(s)	2006	2007	2008	2009
Northern California[1]	6,610	6,085	5,007	5,168
Los Angeles Metro	6,349	6,388	13,528	17,084
San Diego (Other Southern California)	4,536	3,778	5,626	5,989
Total[2]	17,495	16,250	24,161	28,240

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

[2] Excludes Supervising Deputy Attorneys (SDAGs).

In contrast with the distribution of Attorney billings shown in Table II-3, **Table II-4**, on the next page, shows much smaller differences between geographic regions in the number of hours charged by HQES Attorneys to prosecutions. Generally, more hours are charged for prosecutions by HQES' Northern Region offices than are charged by HQES' other two regional offices. However, the San Francisco and Sacramento offices handle nearly all Out-of-State and SOI cases. In the Northern California and Other Southern California regions, HQES Attorneys charge significantly more hours to prosecutions than charged to investigations. In contrast, in the Los Angeles Metro region, the proportions of time charged to investigations and prosecutions are reversed, with significantly fewer hours charged to prosecutions during 2009 (9,823) than charged to investigations (17,084).

Table II-4. Hours Charged by HQES Attorneys to Administrative Matters
Excludes Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort Matters

HQES Office(s)	2005	2006	2007	2008	2009
Northern California[1]	11,333	11,718	12,960	12,231	13,026
Los Angeles Metro	10,150	9,696	12,937	11,820	9,823
San Diego (Other Southern California)	9,220	8,290	11,265	8,144	8,923
Total	30,703	29,704	37,161	32,195	31,772

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

[2] Excludes Supervising Deputy Attorneys (SDAGs).

The time charges by Los Angeles Metro office Attorneys are disproportionate to the geographic distribution of licensees. Only about 30 percent of active licensees are based in counties served by HQES' Los Angeles Metro office. Counties served by HQES' Northern California offices account for 44 percent of active licensees while counties served by HQES' San Diego office account for 25 percent of active licensees. The time charges by Los Angeles Metro office Attorneys are also disproportionate to the geographic distribution of investigations opened and cases referred for prosecution, which generally parallel the geographic distribution of licensees. The time charges are also inconsistent with data provided to us by HQES showing the number of Investigation matters opened by HQES. As shown by **Table II-5,** below, Investigation matters opened for Los Angeles Metro cases account for about one-third of all Investigation matters opened by HQES.

Table II-5. Investigation Matters Opened by HQES

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

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

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

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

Finally, as shown by **Table II-6**, below, the total hours charged by Attorneys assigned to HQES' offices in Northern California and San Diego (Other Southern California) offices for investigations and prosecutions have changed little during the past several years (18,000 hours and 15,000 hours per year, respectively). In contrast, the total hours charged by Los Angeles Metro office Attorneys increased by nearly 70 percent and, in 2009, exceeded the number of hours charged in each of the other two geographic regions by 50 to 80 percent.

Table II-6. Hours Charged by HQES Attorneys to Investigations and Prosecutions

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

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

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

[3] Excludes Supervising Deputy Attorneys (SDAGs).

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

F. Enforcement Program Attrition History

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

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

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

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

In summary, during the past four (4) years more than one-half of the Enforcement Program's Investigators, Senior Investigators, and Supervising Investigators separated from the Medical Board. Only about one-third of the separations were due to retirements (fewer than 5 positions per year). Thirty (30) Investigators, Senior Investigators, and Supervising Investigators (7.5 positions per year) transferred to other State agencies, including 14 who transferred to DCA's Division of Investigations. The staff that separated during this period were highly experienced, with an average of eight (8) years experience with the Medical Board prior to their separation. Geographically, a disproportionate share of the separations was from Northern Region District offices.

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

As of late-2009 the Medical Board had 13 vacant Investigator-series positions, representing 16 percent of total authorized Investigator positions. Typically, California State Government agencies operate with only about 5 percent of their positions vacant. The

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

G. Prior Analyses of the Impacts of Vertical Enforcement

Analyses of the impacts of Vertical Enforcement were previously completed during 2007 and 2009. Additionally, a one-page summary statistical report is provided on a quarterly basis to the Medical Board's Governing Board.

1. November 2007 Medical Board Analysis

In November 2007, the Medical Board reported to the Legislature that implementation of VE had (1) reduced the average time to complete investigations by 10 days, (2) reduced the average time to close cases without prosecution by six (6) days, and (3) reduced the average time for HQES to file accusations by 29 days.

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

During 2009 an independent consultant was retained to review Enforcement Program statistical data provided by the Medical Board from 2005 through 2008. In June 2009, the consultant reported that (1) significantly fewer investigations were completed during 2008 as compared to 2005, and (2) significantly fewer accusations were filed during 2008 as compared to 2005. The consultant also reported that (1) the average elapsed time to complete investigations that were not referred for prosecution had increased by more than three (3) months, (2) the average elapsed time to complete investigations that were referred for prosecution had increased by more than two (2) months, and (3) for cases with an accusation filed, the average elapsed time from assigned for investigation to filing of the accusation had increased by more than a month.

3. Quarterly Board Reports

These reports have been provided to the Medical Board since mid-2008. Recent reports show significant decreases, since implementation of VE, in (1) the number of suspension orders granted, and (2) the number of investigations completed. The reports show a significant increase in recent years in the average elapsed time to complete "All" investigations. The reports also show no significant change in the number of cases with a disciplinary outcome, and a limited (10 percent) decrease in the average elapsed time to investigate and prosecute these cases (from 38 months to 34 to 35 months).

H. Probation Program

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

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

In recent years the Medical Board referred for investigation an average of 48 complaints involving Probationers per year. Many of these cases were actually originated by Probation Program Investigators. On average, about two-thirds of these cases were closed following investigation and about one-third were referred to HQES for prosecution. The proportion of cases referred for prosecution is comparable to that for cases involving Non-Probationers. Additionally, over the past 10 years the Medical Board received an average of about 40 petitions for modification or termination of probation per year. The number of petitions for modification or termination of probation received fluctuated within a range of 30 to 50 petitions per year. Variations in the number of petitions for modification or termination of probation received appear to be correlated with the number of Probationers. During 2008/09, 40 petitions for modification or termination of probation were received. A portion of this workload is now handled by the District offices. Finally, over the past 10 years, the Medical Board received an average of about 16 petitions for reinstatement per year. The number of petitions for reinstatement received fluctuated within a range of 10 and 25 petitions per year. During 2008/09, 18 petitions for reinstatement were received. Over the past six (6) years, the total number of all petitions received fluctuated within a fairly narrow range (50 to 65 per year).

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

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

However, during 2008/09 the Medical Board transferred all of its Assistant Investigator positions to the Probation Program and reclassified the positions to Inspector I/II. Concurrently, the Probation Program's Supervisory and Management positions were reclassified to non-sworn classifications (i.e., the 3 Supervising Investigator positions were reclassified to Inspector III and the Supervising Investigator II position was reclassified to Staff Services Manager I). Subsequently, during 2009/10 three (3) new Inspector positions and one (1) new

support position were authorized for the Probation Program. Currently, the Probation Program is authorized a total of 26 positions, including, one (1) Staff Services Manager I, three (3) Inspector III, 16 Inspector I/II, and five (5) technical/clerical support staff.

Concurrent with the organizational restructuring of the Probation Program, responsibility for investigating complaints involving Probationers and petitions for reinstatement was transferred to the District offices. Also, petitions for modification or termination of probation were transferred to the District offices, except in cases where the Petitioner has generally been complying with the terms and conditions of their probation and there are not any pending investigations involving the Petitioner. The workload restructuring will enable Probation Program staff to focus their efforts on monitoring Probationer compliance with the terms and conditions of their probation.

I. Current Enforcement Program Organization and Staffing Resource Allocations

The Medical Board currently has 76 authorized Investigator and Senior Investigator positions, plus 19 Supervising Investigators (I or II). As shown by **Table II-7**, below, 10 of these positions are allocated to various Headquarters Units.

Table II-7. Investigator Positions Assigned to Headquarters Units

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

The Medical Board's District offices are organized into three (3) regional groups (Northern California, Los Angeles Metropolitan, and Other Southern California). Four (4) District offices are assigned to each region. A Regional Manager (Supervising Investigator II) oversees the operations of each region. Including the Regional Area Managers, District office Supervisors, Investigators and Senior Investigators, and clerical support staff, each of the three (3) regions is allocated 30 to 35 percent of total available staffing resources, with the fewest positions allocated to the Other Southern California region. These allocations are reasonably consistent with the geographic distribution of cases referred for investigation.

Within each District office, first level supervision is provided by a Supervising Investigator I. Subordinate staffing at each District office typically consists of six (6) full-time Investigator positions (Investigator or Senior Investigator) and 1 to 2 full-time clerical support positions (Office Technician or Office Assistant). A few offices have only five (5) Investigator positions. In total, 96 permanent, full-time positions are currently authorized for the District offices, including 12 Supervising Investigators, 70 Investigators or Senior Investigators, and 14 Office Technicians or Office Assistants.

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

J. Pending 2010/11 Budget Change Proposals

A currently pending Budget Change Proposal (BCP), if adopted, would increase authorized Enforcement Program staffing by 22.50 positions. The BCP would provide:

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

It is anticipated that the new "non-sworn" positions will be based at Headquarters and that the positions will be used to investigate Section 801 (medical malpractice) cases, plus possibly some petitions for modification or termination of probation, petitions for reinstatement, criminal conviction reports, and probation violation cases.

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III. License Fees, Expenditures, and Fund Condition

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III. License Fees, Expenditures, and Fund Condition

Since increasing initial and biennial renewal fees for physicians and surgeons from $600 to $790, effective January 1, 2006, there have been continuing concerns regarding whether the higher fees are justified. Section 2435(h) of Article 20 of the *Medical Practice Act,* adopted in conjunction with the January 2006 fee increase, placed a statutory cap on the amount of reserves that the Medical Board could accumulate in its Contingent Fund. Section 2435(h) stated that "It is the intent of the Legislature that, in setting fees pursuant to this section, the board shall seek to maintain a reserve in the Contingent Fund of the Medical Board of California equal to approximately two months' operating expenditures." Subsequently, during 2009, Section 2435(h) was modified to enable the Medical Board to maintain a higher reserve fund balance equal to two (2) to four (4) months operating expenditures (AB 501, Emmerson).

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

Exhibit III-1, on the next page, shows the amount of the surplus/(deficit) for the Medical Board Contingent Fund by year for the past five (5) years, and the projected surplus for 2009/10. Exhibit III-1 also shows end-of-year reserves for each year. As shown by Exhibit III-1, surpluses have been generated each year since implementation of the last fee increase during 2006. The amount of the surpluses ranged from $4.7 million during 2005/06 to $6.5 million during 2008/09. For 2009/10 a surplus of $1.9 million was projected. However, it is likely that the surplus for 2009/10 will be greater than $1.9 million due to:

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

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

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

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

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

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

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

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

III. License Fees, Expenditures, and Fund Condition

As shown by Exhibit III-1, end-of-year reserves were about $24 million for the last two (2) years, after excluding a $6 million loan to the General Fund, and reserves were projected to increase to $26.2 million at the end of 2009/10, assuming a $1.9 million surplus for that year. It is likely that reserves at the end of 2009/10 will be greater than $26.2 million because it is likely that the 2009/10 surplus will be greater than the $1.9 amount budgeted. An end-of-year reserve of $26.2 million would be equivalent to nearly six (6) months of projected 2010/11 expenditures, assuming:

- Total fee and revenue collections are the same as budgeted for 2009/10 ($50.3 million)
- $3.2 million in additional salary and benefit costs related to the expected elimination of the Furlough Friday Program (assumes 17 percent higher salary and benefit costs than budgeted for 2009/10)
- $0.9 million in additional salary and benefit costs for 17 new Enforcement Program positions included in DCA's Consumer Protection Enforcement Initiative BCP (assumes all positions start work on October 1, 2010, and an average annual cost of $70,000 per position)
- $0.5 million in additional salary and benefit costs for 7 new Licensing Program positions recently authorized by DCA (assumes all positions start work by July 1, 2010, and an average annual cost of $70,000 per position)
- $0.5 million in additional operating expenditures (e.g., major equipment replacements, service contracts, etc.)
- $1.1 million in cost-savings related to adoption of new salary and benefit cost containment programs (e.g., pay rate reductions)
- No offsetting reductions in expenditures for overtime or temporary help
- No new funding for six (6) new Operation Safe Medicine Unit positions and four (4) new Probation Program positions authorized during 2009/10.

With these assumptions total projected 2010/11 expenditures, net of reimbursement and cost recovery adjustments, would be about $52.4 million ($4.4 million per month). As has been the case for the past five (5) years, this level of reserves ($26.2 million) significantly exceeds the maximum amount current set forth in Section 2435(h) of the *Medical Practice Act*. It is likely that reserves at the end of 2009/10 will be greater than $26.2 million, and could approach a level equivalent to about 6.5 months of projected 2010/11 expenditures ($28.6 million). At 2009/10 budgeted expenditure levels, a two-month reserve would be about $8 million, or $18 million less than current reserves, excluding $6 million loaned to the General Fund. However, results of our review show that, within 2 to 3 years, the Medical Board's reserves are likely to decrease to a level equivalent to less than four (4) months' operating expenditures.

III. License Fees, Expenditures, and Fund Condition

As shown by **Table III-1**, below, if total expenditures increase by about 8 percent during 2010/11 (to $52.4 million), and increase by an additional $1.6 million per year (3 percent) for the next several years, reserves at the end of 2012/13 will still exceed the minimum set forth in statute, excluding the $6 million loan to the General Fund. The Medical Board's proposed budget for 2010/11 assumes a similar $4 million increase in total expenditures to $52.4 million.

Table III-1. Projected End-of-Year Reserves

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

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

Finally, we critically reviewed each major category of expenditures. Expenditures for HQES legal services have escalated rapidly in recent years, while other legal service costs declined. Costs for HQES legal services now exceed $1 million per month and account for more than 25 percent of total expenditures. We also identified potential internal control issues involving HQES' billings to the Medical Board, and potential overcharges for HQES' services.

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

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

IV. Overview of Complaint Workload, Workflows, and Performance

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IV. Overview of Complaint Workload, Workflows, and Performance

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

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

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

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

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

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

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

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

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

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

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

IV. Overview of Complaint Workload, Workflows, and Performance

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

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

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

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

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

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

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

IV. Overview of Complaint Workload, Workflows, and Performance

Various changes have occurred in the composition of complaints received since the early part of the decade (e.g., fewer medical malpractice reports, fewer Out-of-State reports, and fewer Medical Board-originated complaints). These changes appear to have had offsetting impacts on some aggregate complaint-handling performance measures. For example, over the past five (5) years the Medical Board has consistently closed about 83 to 84 percent of all complaints, and referred the remaining 16 to 17 percent for investigation or prosecution.

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

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

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

V. Complaint Intake and Screening

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V. Complaint Intake and Screening

A. Overview of Complaint Intake and Screening Outputs and Performance

CCU continues to do an outstanding job of administering and operating the Medical Board's complaint intake and screening processes. However, in recent years CCU has struggled to prevent growth in the number of pending complaints, which is beginning to adversely impact elapsed timeframes to close or refer complaints for investigation or prosecution. **Exhibit V-1**, on the next page, shows the total number of complaints closed and referred to investigation or prosecution during 2008/09, and the average elapsed time to close or refer the complaints. As shown by Exhibit V-1, during 2008/09:

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

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

Summary of 2008/09 CCU Processing Timeframes for All Complaints

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

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

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

V. Complaint Intake and Screening

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

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

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

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

The number of pending complaints recently increased, from about 1,308 open complaints at the end of June 2009, to 1,443 at the end of the year. The 10 percent increase in open complaints during this brief period is primarily attributable to staffing reductions resulting from implementation of the closure of the Medical Board's offices during the first three (3) Fridays of each month (Furlough Fridays). Since 2004/05, the number of pending CCU complaints has increased by more than 40 percent (from fewer than 1,000 complaints at the end of 2004/05 to more than 1,400 complaints at the end of the 2009).

B. Specialist Reviews

The average elapsed times to complete Medical Specialist reviews vary by specialty. For six (6) high volume specialties, which collectively account for nearly two-thirds of all reviews, the average elapsed time to complete the reviews is about one (1) month (31 days). This compares to an average elapsed time of about two (2) months for 14 moderate volume medical specialties that collectively account for most of the remaining reviews.

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

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

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

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

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

C. Recommendations for Improvement

The following recommendations are structured to enhance CCU's performance.

1. Medical Specialist Reviews

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

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

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

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

2. CCU Workforce Capability and Competency

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

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

3. Customer Satisfaction Metrics

CCU has not surveyed customers regarding the level of satisfaction with CCU services since the late-1990s. Monitoring customer satisfaction levels helps to maintain and improve the level of service provided to the public by linking changes in policies and procedures with measures of the impacts of these changes on the customer community. Other DCA-affiliated regulatory programs utilize a simple postcard survey for this purpose.

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

VI. Investigations

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VI. Investigations

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

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

A. Investigations Opened and Completed by Identifier

Exhibit **VI-1**, on the next page, shows the number of investigations opened and completed by Identifier, by fiscal year. As shown by Exhibit VI-1, in recent years the number of investigations with District office Identifiers that were opened, closed, and referred for prosecution decreased significantly. During this period there was little change in the overall percentage of cases referred for prosecution, which averaged 29 percent during this period. However, there were significant differences in performance between the three (3) regions to which District offices are assigned. For example:

- The number of cases referred for prosecution decreased significantly in the Los Angeles Metro and Other Southern California regions. In contrast, there was no decrease in the number of cases referred for prosecution by the Northern California region.
- During the past several years the Northern and Other Southern California regions both closed or referred more cases than were opened. In contrast, in the Los Angeles Metro region, fewer cases were closed or referred than were opened. However, during 2008/09 none of the three (3) regions closed or referred more cases than were opened.

Summary of Investigations Opened and Completed, by Identifier

2005/06 through 2008/09[1]

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

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

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

- In the Los Angeles region, the proportion of cases referred for prosecution decreased from 33 percent during 2005/06 to 25 percent during each of the past two (2) fiscal years. In contrast, the proportion of cases referred for prosecution by the Northern California region increased from 22 percent during 2005/06 to an average of 28 percent during the past several years. For the Other Southern California region, the proportion of cases referred for prosecution averaged about 35 percent during the past several years, a higher proportion than achieved by either of the other two regions.

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

B. Elapsed Time to Complete Investigations

Exhibit VI-2, on the next page, shows average elapsed times to investigate cases, by fiscal year, for quality of care and other cases. The data shown excludes cases closed or referred directly for prosecution by the originating Headquarters or Probation Unit without involvement of the District offices. During the past several years the average elapsed time to complete quality of care case investigations increased by 35 percent (from 11.3 months during 2005/06 to 15.2 months during 2008/09). For other cases, the average elapsed time to investigate the cases increased by 42 percent (from 7.4 months during 2005/06 to 10.5 months during 2008/09). The 35 percent increase over the past several years in the average elapsed time to complete quality of care case investigations is particularly surprising given the impacts that VE was expected to have on these types of cases. For example, HQES Attorney involvement was expected to significantly reduce the amount of time needed to obtain patient medical records needed to determine the viability of the cases, and that cases that were not viable would be closed more quickly, thereby enabling redeployment of Investigators to accelerate the processing of other cases.

Exhibit VI-3, following Exhibit VI-2, shows average elapsed times to investigate cases by District office Identifier, by fiscal year. The average elapsed time to investigate cases with District office Identifiers increased by 35 percent (from 10.2 months during 2005/06 to 13.7 months during 2008/09). Average elapsed times to complete investigations increased significantly in all three (3) regions. In the Other Southern California region the average elapsed time to complete investigations reached nearly 16 months and the number of cases closed or referred for prosecution decreased by 42 percent (to fewer than 200 completed investigations compared to more than 300 investigations completed in both of the other regions). For cases with other Identifiers, the number of completed investigations decreased during the past several years and the average elapsed time to investigate these cases increased significantly. Some of these cases were handled by Headquarters Units, some were handled by Probation Units, and some were handled by the District offices.

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

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

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

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

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

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

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

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

C. Elapsed Time to Refer Cases for Prosecution

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

Exhibit VI-5, following Exhibit VI-4, shows average elapsed times to investigate cases referred for prosecution, by Identifier, by fiscal year. As shown by Exhibit VI-5, the average elapsed time to investigate cases with District office Identifiers increased by 27 percent (from 11.9 months during 2005/06 to 15.1 months during 2008/09). The average elapsed time to investigate these cases increased significantly in all three (3) regions. During 2008/09 the average elapsed time to investigate cases in the Other Southern California region reached 15 months for cases referred for prosecution. This region also experienced a relatively large 29 percent decrease in the number of cases referred for prosecution. In contrast, in the Northern California region, the number of cases referred for prosecution, and the average elapsed time to complete these investigations, increased by 10 percent. In each of the last two fiscal years the Northern California region referred at least 30 percent more cases for prosecution than either the Los Angeles Metro or Other Southern California regions (100 cases referred for prosecution by the Northern California region compared to 76 or fewer cases in each of the other regions). For cases with other Identifiers, the number of cases referred for prosecution and the average elapsed time to complete the investigations increased during the past several years. Some of these cases were handled by Headquarters Units, some were handled by Probation Units, and some were handled by the District offices.

D. HQES Decline to File Cases

With a greater level of HQES Attorney involvement in investigations, it might be expected that the number of cases that HQES declined to file would decrease. During the past several years there were not any sustained changes in the number of cases that HQES declined to file. The average number of cases that HQES declined to file during the past two (2) years (20 cases per year) was about the same as the average number of cases that HQES declined to file during the preceding three (3) years (21 cases per year).

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

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

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

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

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

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

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

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

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

E. Expenditures for HQES Investigation Services

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

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

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

As discussed previously, there are significant variations between regions in the number of investigations completed, as well as variations in other output and performance measures, such as the proportion of completed investigations referred for prosecution. **Table VI-1**, on page VI-11, shows the number of investigations completed by year, by region. Also shown are corresponding ratios of the number of HQES Attorney hours charged per completed investigation based on the Attorney hours charged during each fiscal year as shown in Exhibit VI-6.

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

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

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

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

VI. Investigations

Table VI-1. HQES Attorney Hours Charged to Investigations per Completed Investigation

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

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

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

As shown by Table VI-1, during 2008/09 HQES Attorneys assigned to Los Angeles Metro region cases billed:

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

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

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

completed investigation for all completed investigations, statewide, billings to the Medical Board for Attorney services would have been about $6.5 million or nearly $2.35 million more than the estimated amount actually billed.

In an effort to better understand Los Angles Metro office Attorney charges for investigation-related services, we researched a sample of Los Angeles Metro office cases selected from HQES' June 2009 Invoice Report to the Medical Board. The Invoice Report shows time charges during the month for each matter that had time charged during the billing period, and also cumulative charges for fiscal year 2008/09, and cumulative charges for the matter including charges from prior fiscal years. We selected all cases that were included in the June 2009 billing with more than 40 hours billed during 2008/09, irrespective of the number of hours charged during June. Twenty-eight (28) cases were selected. Of the 28 cases, nine (9) were assigned to the Valencia office, 11 were assigned to the Cerritos office, three (3) were assigned to the Diamond Bar office, and four (4) were assigned to the Glendale office. Within these offices, the cases were assigned to various Investigators. The cases involved a mix of medical malpractice reports, Section 805 reports, sexual misconduct and impaired physician complaints, prescribing violations, and other quality of care and physician conduct matters. Of the 28 cases, seven (7) were assigned to one HQES Attorney, six (6) were assigned to another HQES Attorney, three (3) were assigned to a third HQES Attorney, and the remaining 12 cases were assigned to 10 other HQES Attorneys. **Table VI-2**, below, summarizes the disposition and current status of these 28 cases as of mid-June 2010 (1 year later).

Table VI-2. Disposition and Status of Selected Los Angeles Metro Cases with Attorney Time Charged During June 2009

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

VI. Investigations

With the assistance of Medical Board staff, we researched each of these 28 cases. The histories of several of these cases illustrate the benefits of having HQES Attorneys working jointly with Medical Board Investigators during the Investigation Stage. For example, HQES Attorneys helped to issue and enforce subpoenas for records, assisted in interviewing parties involved with the matter, provided advice and direction on the course and direction of the investigations, promptly prepared and filed pleadings, and sought adoption of disciplinary actions. However, the case histories also illustrate a number of significant, and troubling, problems with the services provided by HQES' Los Angeles Metro office. Some of these problems may also exist, to a lesser extent, at other HQES offices. These problems include:

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

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

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

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

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

Rejecting Completed Case Investigations – HQES' Los Angeles office declined to file a case that one of its Primary DAGs worked on extensively (more than 300 hours over three years). During the investigation the Subject was placed on probation following investigation of another complaint involving similar treatment issues. The Decline to File Memorandum was not

issued until just a few days before expiration of the statute of limitations. In consultation with HQES management, the HQES promptly transferred the case to another HQES office where a different Attorney came to work early the next day to prepare and file a pleading. Several months later the Medical Board accepted a settlement agreement negotiated by the second HQES office that imposed additional discipline.

The problems highlighted by the above case histories are not isolated cases. Additional analyses and case history summaries showing the prevalence of several of these problems, particularly in the Los Angeles region, are presented in Section VII (*Prosecutions and Disciplinary Actions*). Additionally, these cases highlight various internal control problems with the posting of Attorney time charges (e.g., time charges are sometimes posted to Investigation matters that reference a different Medical Board complaint from the case actually being investigated). The cases also highlight the outstanding work that HQES Attorneys are capable of performing, such as occurred when HQES' San Diego office accepted a case that the Los Angeles Metro office rejected, prepared and filed an accusation and petition to revoke probation within a day to avoid expiration of the statute of limitations on the case, and successfully negotiated additional discipline within a period of several months of the filing.

F. Medical Consultant and Outside Expert Services and Expenditures

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

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

During 2008/09 the District offices completed investigations of 550 quality of care cases and 404 other (physician conduct) cases. For cases involving quality of care issues, Medical Consultants are usually substantively involved in the investigations, provided they are available. Medical Consultants are usually involved less frequently with other cases. Medical Consultants spend an average of less than 25 hours working on each completed case in which they are involved, assuming that (1) at least 10 percent of the hours paid to Medical Consultants are for paid time off, and (2) substantive involvement with only about 500 completed cases per year, which is possibly

understated. The amount of time spent by the Medical Consultants on these cases includes performance of, or assistance with, all of the following activities:

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

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

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

On a statewide basis, only 38 percent of all Medical Expert reviews are completed within one (1) month, and 23 percent take longer than two (2) months. While there is some variability, the frequency distributions of elapsed times to complete these reviews at individual District offices are similar to the statewide distribution. More than 30 percent of the Medical Expert reviews took longer than two (2) months to complete at one District office in each of the three regions (Sacramento, Valencia, and San Diego). Overall, the average elapsed time to complete Medical Expert reviews was 48 days (about 7 weeks).

It is our understanding that, during the early-1990s, the Medical Board routinely obtained two (2) Medical Expert opinions for single patient cases, but that this practice was discontinued. However, it is evident that there have been ongoing disagreements regarding needs for obtaining more than one (1) Medical Expert opinion during the Investigation Stage, particularly in the Los Angeles Metro region, and that the disagreements are not limited to single patient cases. In some cases significant disputes with District office Supervisors and

Investigators have arisen over this issue primarily because of concerns about increased risks of harm to patients and the general public, but also because of adverse impacts on workflow, caseloads, costs, and the availability of Medical Experts to perform reviews of other cases.

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

It is our understanding that Enforcement Program and HQES management recently conferenced during April 2010 and reached an agreement to require two (2) Medical Expert opinions for all single patient cases. Although Enforcement Program and HQES management apparently reached an agreement to universally require two (2) Medical Expert opinions for all single patient cases, the actual practice in the field has not changed. District office Supervisors and HQES Supervising DAGs outside the Los Angeles Metro region rarely require a second Medical Expert opinion for single patient cases, except when an opinion is needed in a second specialty area or it appears likely.

G. Recommendations for Improvement

The recommendations presented below concern Medical Consultant staffing, the availability of outside Medical Experts, and retention of Investigators. Additional recommendations that would impact investigations are included in Section X (*Organizational and Management Structures*), including recommendations involving:

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

VI. Investigations

1. Medical Consultant Staffing

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

Perhaps most importantly, the Medical Consultant is a key (perhaps the key) participant in the process of assessing, prior to referral of a case to an outside Expert, whether the facts and circumstances of a case, particularly for quality of care cases, indicate that an extreme departure or multiple simple departures occurred and, hence, whether to close the case or continue the investigation. In fact, the Medical Consultant's involvement in reviewing the Expert's opinion, which is the last step in the investigation process, is only one of their many important responsibilities. If the Expert has clearly presented their opinion as to whether an extreme departure or multiple simple departures has occurred, and support for the opinion is clearly organized and presented, then subsequent involvement of the Medical Consultant will probably be minimal. However, if the Expert's opinion is not clearly stated or well-supported in their report, the Medical Consultant's role is key in assessing the Expert's report and determining whether, or how, to proceed from that point forward (e.g., collect additional evidence, obtain clarification of the opinion, close the case, refer the case for prosecution, etc.).

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

Since publication of the Enforcement Monitor's reports there has been very little change in the availability of Medical Consultants. Needs in this area have not been emphasized. Additional Attorney positions (10) were authorized for HQES, additional Investigator and Assistant Investigator positions (8) were authorized for the Medical Board, additional positions (6) were authorized to reestablish an OSM Unit, additional positions (4) were authorized for the Probation Program and, most

recently, new non-sworn positions (6) and a number of other Enforcement Program positions are expected to be authorized as part of the 2010/11 Budget, but no additional funding for Medical Consultants was included in this package.

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

2. Medical Expert Resources

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

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

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

3. Investigator Retention

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

- ✓ Reducing and simplifying Investigator caseloads
- ✓ Increasing the availability of Medical Consultants
- ✓ Targeting HQES Attorney involvement during investigations to those cases where such involvement is needed
- ✓ Limiting HQES Attorney involvement to activities that are appropriately performed by an Attorney (e.g., providing legal advice and direction)
- ✓ Promoting uniformity in the use of requests for supplemental investigations and decline to file cases to ensure that such requests and handling are reasonable and defensible, and do not unnecessarily delay the filing of accusations or result in inappropriate case closures.

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

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

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VII. Prosecutions and Disciplinary Outcomes

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VII. Prosecutions and Disciplinary Actions

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

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

A. Prosecutions Completed

In recent years, the number of completed prosecutions, as reflected by the number of proposed decisions and stipulations approved by the Medical Board, has decreased as compared to the number approved in prior years. There was little or no change in the number of default decisions or in the number of accusations withdrawn or dismissed.

B. Disciplinary Actions

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

C. Pending Accusations and Legal Cases

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

D. Elapsed Time to File Accusations and Complete Prosecutions

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

E. Regional Variations in Performance

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

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

Post-Filing Stipulations Received – During 2008/09, 156 post-filing stipulations were received, a significant decrease from the levels attained during prior years which averaged about 200 stipulations per year. The decrease during 2008/09 is attributable primarily to a large decrease in the number of post-filing stipulations submitted by the Other Southern California region. There were also decreases in the number of post-filing stipulations submitted for probation revocation and Out-of-State cases. The decline in post-filing stipulations submitted for Out-of-State cases may be inversely correlated with the comparatively high

number of Out-of-State cases resolved by issuance of a pre-filing public letter of reprimand (PLR) during 2007/08 and 2008/09 (28 PLRs issued per year compared to an average of 14 PLRs issued per year during the preceding four (4) years).

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

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

F. Average Elapsed Times from Transmittal to HQES to Accusation Filed

Exhibit VII-1, on the next page, shows average elapsed times from transmittal of the case to HQES to accusation filed, by year, from 2004 through 2009, by Identifier. All (or almost all) Out-of-State cases are handled by HQES' San Francisco office and, as shown by Exhibit VII-1, accusations for these cases are consistently filed within an average elapsed time of not more than about two (2) months. For cases with District office Identifiers, the average elapsed times from transmittal to filing are longer and, for these cases, the average elapsed time from transmittal to filing decreased by about six (6) weeks since 2005, but is unchanged compared to 2004. The decrease since 2005 in the average elapsed time to file accusations is attributable nearly entirely to a decrease during the past four (4) years in the average elapsed time to file accusations in the Los Angeles region. In the Los Angeles region the average elapsed time to file accusations decreased from nearly eight (8) months during 2005 to about five (5) months during 2009. However, the average elapsed time shown for the Los Angeles region for 2005 (7.8 months) was 3.4 months (77 percent) longer than the average elapsed time for the region during the prior year.

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

Including Cases with Timeframes Exceeding 18 Months

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

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

Excluding Cases with Timeframes Exceeding 18 Months

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

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

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

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

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

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

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

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

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

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

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

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

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

1) Requests for supplemental investigations, *and*

2) Limited activity while the case is pending at HQES.

With the assistance of Medical Board staff we researched both of these sources of delay by researching the histories of nearly two (2) dozen individual cases. Results of this research illustrate the nature and magnitude of the problems and frustrations experienced during the past several years by Medical Board management and staff in the Los Angeles region and, to a lesser extent, in other parts of the State. Furthermore, difficulties in handing off of cases for prosecution appear to be greatest in the Los Angeles region where HQES Attorneys are most involved with investigations. These case histories also show that, in the Los Angeles region, it is no at all unusual for cases to languish at HQES for periods of 6 to 8 months, or longer, before an accusation is filed.

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

1. Requests for Supplemental Investigations

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

supplemental investigations for four (4) cases, more than completed by all other District offices throughout the rest of the State. The Diamond Bar and Cerritos District offices were responsible for most of these Los Angeles region cases (15 and 13, respectively).

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

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

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

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

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

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

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

Only about 10 to 15 percent of cases proceed to hearing as most cases are settled prior to hearing. For cases with District office Identifiers, about 20 hearings are completed per year compared to an average of about 150 total case dispositions (stipulations plus proposed decisions). For cases with District office Identifiers, during the past two (2) fiscal years (2007/08 and 2008/09) an average of 18 to 20 months elapsed from accusation filed to proposed decision received, about the same as the average for the preceding two (2) years (2005/06 and 2006/07). Also, the average elapsed times during the past two (2) years were about the same in all major geographic regions of the State (18 to 19 months). Due to the small numbers of cases involved (about a dozen cases per year for each region), it is unclear whether the average elapsed times have changed significantly in any of the three major geographic regions of the State.

VII. Prosecutions and Disciplinary Actions

I. Disciplinary Outcomes by Region

Exhibit VII-3, on the next page, shows disciplinary actions, by type of discipline, by Identifier for (1) the 4-year period from 2003/04 through 2006/07, and (2) the 2-year period from 2007/08 through 2008/09. Additionally, Exhibit VII-3 shows the percentage of disciplinary actions involving license revocation, surrender, suspension, or probation. As shown by Exhibit VII-3, during the past two (2) years there were significant regional variations in disciplinary outcomes.

Northern California Region

Total Disciplinary Actions – The total number of disciplinary actions decreased by about 9 percent (from an average of 56 actions per year to an average of 51 actions per year).

Composition of Disciplinary Actions – The number of disciplinary actions involving license revocation, surrender, suspension, or probation decreased by 7 percent (from an average of 40.25 actions per year to an average of 37.50 actions per year). The proportion of disciplinary actions involving license revocation, surrender, suspension, or probation increased marginally (from 72 percent to 74 percent).

Los Angeles Region

Total Disciplinary Actions – The total number of disciplinary actions decreased by about 13 percent (from an average of 71 actions per year to an average of 62 actions per year).

Composition of Disciplinary Actions – The number of disciplinary actions involving license revocation, surrender, suspension, or probation decreased by 20 percent (from an average of 52 actions per year to an average of 41.5 actions per year). The number of public reprimands issued changed very little. The proportion of disciplinary actions involving license revocation, surrender, suspension, or probation decreased from 74 percent to 67 percent.

Other Southern California Region

Total Disciplinary Actions – The total number of disciplinary actions increased by about 10 percent (from an average of 58 actions per year to an average of 66 actions per year).

Composition of Disciplinary Actions – There was a significant increase in the number of public reprimands issued (from an average of 15 per year to an average of 22 per year). The number of disciplinary actions involving license revocation, surrender, suspension, or probation was unchanged. Due to the increase in number of public reprimands, the proportion of disciplinary actions involving license revocation, surrender, suspension, or probation decreased from 75 percent to 66 percent.

Disciplinary Outcomes by Identifier
2003/04 through 2008/09

2003/04 through 2006/07 (4 Years)

Disciplinary Outcome	Cases with District Office Identifiers								Cases with Other Identifiers						Total	
	Northern California		Los Angeles Metro		Other Southern CA		Total		Out of State (16)		Probation (19 & D's)		Other (20 to 23, 27)			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Revocation	11	5%	24	9%	23	10%	58	8%	46	22%	31	31%	7	13%	142	13%
Surrender	59	26%	46	16%	47	20%	152	21%	88	43%	33	33%	7	13%	280	26%
Suspension Only	0	0%	0	0%	3	1%	3	0%	0	0%	0	0%	0	0%	3	0%
Probation with Suspension	19	9%	35	12%	23	10%	77	10%	1	0%	9	9%	2	4%	89	8%
Probation Only	72	32%	103	37%	77	33%	252	34%	43	21%	27	27%	37	69%	359	33%
Public Reprimand	62	28%	74	26%	59	25%	195	26%	28	14%	1	1%	1	2%	225	20%
Total Disciplinary Outcomes	**223**	**100%**	**282**	**100%**	**232**	**100%**	**737**	**100%**	**206**	**100%**	**101**	**100%**	**54**	**100%**	**1,098**	**100%**
4-Year Average	56		71		58		184		52		25		14		275	
Revocation/Surrender/Probation %	72%		74%		75%		74%		86%		99%		98%		80%	

2007/08 through 2008/09 (2 Years)

Disciplinary Outcome	Cases with District Office Identifiers								Cases with Other Identifiers						Total	
	Northern California		Los Angeles Metro		Other Southern CA		Total		Out of State (16)		Probation (19 & D's)		Other (20 to 23, 27)			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Revocation	12	12%	14	11%	12	9%	38	11%	29	27%	10	27%	1	6%	78	15%
Surrender	19	19%	19	15%	21	16%	59	17%	31	28%	13	35%	2	13%	105	20%
Suspension Only	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Probation with Suspension	7	7%	10	8%	6	5%	23	6%	2	2%	2	5%	0	0%	27	5%
Probation Only	37	36%	40	32%	48	37%	125	35%	22	20%	12	32%	10	63%	169	33%
Public Reprimand	27	26%	41	33%	44	34%	112	31%	25	23%	0	0%	3	19%	140	27%
Total Disciplinary Outcomes	**102**	**100%**	**124**	**100%**	**131**	**100%**	**357**	**100%**	**109**	**100%**	**37**	**100%**	**16**	**100%**	**519**	**100%**
2-Year Average	51		62		66		179		55		19		8		260	
Revocation/Surrender/Probation %	74%		67%		66%		69%		77%		100%		81%		73%	

With respect to the Los Angeles region, it is unclear whether there is a correlation between:

1) The decreased proportion of disciplinary actions involving license revocation, surrender, suspension, or probation for Los Angeles cases, *and*

2) The improved average elapsed times to reach settlement achieved in the Los Angeles region during the past several years.

Additionally, if there is a correlation between these findings, it is unclear whether the correlation is due to weaker or less well-prepared cases, a change in the composition of the cases, less effective prosecution of the cases, or a combination of these factors.

J. Expenditures for HQES Prosecution Services

HQES Attorneys post time charges for prosecution-related activities to "Administrative" matters that are opened for each individual case. In four (4) of the past five (5) years, HQES Attorneys charged between 30,000 and 32,000 hours to Administrative matters. As shown by **Table VII-2**, on the next page, the number of hours charged by HQES to Administrative matters during 2007 (37,000) was significantly higher than any of the other years. On a calendar year basis, during the past five (5) years the number of hours charged by HQES Attorneys to Administrative matters:

1) Increased by about 20 percent in the Northern California region (from about 11,000 hours to about 13,000 hours)

2) Increased by about 30 percent in the Los Angeles region (from about 10,000 hours to about 13,000 hours) and then decreased by about 23 percent (to about 10,000 hours)

3) Increased by about 20 percent in the Other Southern California region (from about 9,000 hours to about 11,000 hours) and then decreased by about 18 percent (from about 11,000 hours to less than 9,000 hours).

On a fiscal year basis, the trends are the same, although less pronounced. HQES' hourly billing rates for Attorney services during 2008/09 and 2009/10 were $158 and $170, respectively, or an average of $164 per hour. Assuming a $164 hourly billing rate for Attorney services, estimated billings during 2009 for prosecution-related services for cases assigned to the Northern California region were about $2.1 million compared to less than $1.6 million for cases assigned to the Los Angeles and Other Southern California regions.

Table VII-2. Hours Charged by HQES Attorneys to Administrative Matters
2005 through 20091

HQES Office(s)	Calendar Year (Actual)				
	2005	2006	2007	2008	2009
Northern California[2]	11,333	11,718	12,960	12,231	13,026
Los Angeles Metro	10,150	9,696	12,937	11,820	9,823
San Diego (Other Southern California)	9,220	8,290	11,265	8,144	8,923
Total	30,703	29,704	37,161	32,195	31,772

HQES Office(s)	Fiscal Year (Interpolated)			
	2005/06	2006/07	2007/08	2008/09
Northern California[2]	11,525	12,339	12,596	12,628
Los Angeles Metro	9,923	11,316	12,378	10,822
San Diego (Other Southern California)	8,755	9,777	9,704	8,534
Total	30,203	33,432	34,678	31,984

[1] Excludes hours charged to Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters

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

As discussed previously, there are significant variations between regions in the number of prosecutions completed, as well as variations in other output and performance metrics, such as the proportion of disciplinary actions involving license revocation, surrender, suspension, or probation. **Exhibit VII-4**, on the next page, shows the number of prosecutions completed by year, by region, for (1) cases with District office Identifiers, (2) SOI-related stipulations and decisions, and (3) cases with Out-of-State Identifiers. Separate performance ratios are shown excluding, and including, Out-of-State cases which, when included, are weighted to reflect HQES staff estimates that, on average, these cases take about 15 percent as much time to complete as SOIs and cases with District office Identifiers. As shown by Exhibit VII-4, including a 15 percent weighting of Out-of-State cases, the number of hours charged by HQES Attorneys per completed case was about the same for each of the three major geographic regions of the State during both 2006/07 and 2008/09 (an average of about 150 hours per completed case). During 2007/08 the number of hours charged per completed case was much higher than this average for the Los Angeles region (179 hours charged per completed case), and much lower than this average for both the Northern California and the Other Southern California regions (132 hours per completed case and 103 hours per completed case, respectively).

Estimated HQES Attorney Hours Charged per Completed Prosecution - 2006/07 through 2008/09

Output or Performance Indicator		2005/06 (Total)	2006/07				2007/08				2008/09			
			Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total	Northern California	Los Angeles Metro	Other Southern California	Total
Hours Charged to Administrative Matters by HQES Attorneys[1]		30,203	12,339	11,316	9,777	33,432	12,596	12,378	9,704	34,678	12,628	10,822	8,534	31,984
Completed Cases with District Office Identifiers[2]	Default Decisions	6	2	0	3	5	5	3	2	10	1	6	5	12
	Accusations Withdrawn or Dismissed	22	5	4	6	15	11	6	19	36	8	8	4	20
	Post-Filing Stipulations Submitted	143	45	52	42	139	41	46	58	145	40	45	37	122
	Proposed Decisions Submitted	33	9	17	13	39	9	14	15	38	11	12	12	35
	Total Completed Cases with District Office Identifiers	204	61	73	64	198	66	69	94	229	60	71	58	189
Statement of Issues (SOI) - Stipulations and Proposed Decisions Submitted (IDENT 20)		27	16	0	0	16	21	0	0	21	15	0	0	15
Completed Cases with Out-of-State Identifiers	Default Decisions	12	7	0	0	7	9	0	0	9	17	0	0	17
	Accusations Withdrawn or Dismissed	2	5	0	0	5	10	0	0	10	3	0	0	3
	Post-Filing Stipulations Submitted	21	39	0	0	39	31	0	0	31	23	0	0	23
	Proposed Decisions Submitted	7	8	0	0	8	5	0	0	5	10	0	0	10
	Total Completed Cases with Out-of-State Identifiers	42	59	0	0	59	55	0	0	55	53	0	0	53
Total Completed Cases, Including SOIs and Cases with Out-of-State Identifiers (IDENT 16)		273	136	73	64	273	142	69	94	305	128	71	58	257
Ratio	HQES Attorney Hours Charged per Completed Prosecution Cases with District Identifiers and SOIs Only	131	160	155	153	156	145	179	103	139	168	152	147	157
	HQES Attorney Hours Charged per Completed Prosecution Cases with District or Out-of-State Identifiers and SOIs - Weighted[3]	127	144	155	153	150	132	179	103	134	152	152	147	151
Hourly Billing Rate for Attorney Services		$146	$158	$158	$158	$158	$158	$158	$158	$158	$158	$158	$158	$158
Average Attorney Cost per Case		$20,066	$22,752	$24,490	$24,174	$23,700	$20,856	$28,282	$16,274	$21,172	$24,016	$24,016	$23,226	$23,858

[1] Data shown excludes hours charged for cases classified as Appeals, Mandates, Civil-State, Civil-Federal, Civil Rights, Employment, and Tort matters.

[2] Data shown excludes cases involving Probationers, petitions for modification or termination of probation, petitions for reinstatement, and CME audit failure, Operation Safe Medicine, and Internet cases. The excluded cases are believed to be proportionately distributed throughout the State.

[3] Out-of-State cases which, on average, take substantially less Attorney time to complete, are weighted 15 percent.

During 2007/08, HQES' Los Angeles office billed significantly more hours to Administrative matters than billed during both 2006/07 or 2008/09, but completed fewer prosecutions, resulting in a higher average number of hours billed per completed case. The especially low average number of hours billed during 2007/08 per completed case shown for HQES' San Diego office is partially attributable to withdrawal or dismissal of an unusually large number of cases (19) during 2007/08 (a non-positive outcome). However, due to the especially large total number of cases completed by the San Diego office, even if the performance ratio is adjusted to exclude most of the withdrawn/dismissed cases, the average number of hours billed per completed case would still be significantly lower than shown for both of the other regions.

In summary, a portion of the additional staffing resources authorized for HQES to support implementation of VE was utilized to provide higher levels of prosecution-related services. This is especially evident during 2007, and was concentrated primarily in HQES' Los Angeles and San Diego (Other Southern California) offices. Subsequently, during 2008 and 2009, these HQES offices redirected some of these resources toward providing higher levels of investigation-related services. There may also have been some shifting in the reporting of hours for the some prosecution-related activities (e.g., time spent on ISOs, TROs, and PC 23s and drafting accusations is sometimes posted to Investigation matters). In contrast, in the Northern California region there were only minimal shifts during the past two (2) years in the allocation of Attorney resources between investigation and prosecution-related services. Additionally, although fewer hours were billed by the Los Angeles office for prosecution services during 2008/09 compared to the prior two (2) years, the number of hours billed per completed case was still the same, or higher, than billed for cases handled in each of the other two geographic regions of the State (even without adjusting for time posted to Investigation matters for prosecution-related services, such as time spent on ISOs, TROs, and PC 23s and drafting accusations). Finally, during the past several years an average of less than 150 Attorney hours were billed per completed case (weighted) and the Medical Board's cost for these services averaged about $23,000 per case (weighted).

K. Recommendations for Improvement

Below we discuss several key recommendations for improving prosecution process performance. These recommendations concern (1) supplemental investigations, (2) decline to file cases, and (3) Out-of-State cases. Additional recommendations that would impact prosecutions are included in Section X (*Organizational and Management Structures*), including recommendations involving:

- ✓ Identifing "Best Practices" in Vertical Enforcement from the data gathered, instituting these practices uniformly throughout the State, and amending the pilot to include these practices for further analysis
- ✓ Scaling back and optimizing HQES Attorney involvement in District office investigations
- ✓ Restructuring the management of District office investigations to create consistency of investigation handing under MBC/HQES functions under VE
- ✓ Restructuring the handling of Section 801 cases

- ✓ Developing new organizational structures and processes for managing HQES expenditures and tracking cases following referral for prosecution
- ✓ Improving workload and performance reporting processes.

1. Supplemental Investigations and Decline to File Cases

It is apparent from our review that HQES DAGs in Los Angeles request supplemental investigations and decline to file accusations more frequently than other offices. When a supplemental investigation is requested or an accusation filing is declined by Los Angeles while other HQES offices would accept and prosecute the same case, it triggers a dispute between HQES and Medical Board staff that consumes enormous amounts of resources at all levels throughout both organizations. These disputes are contentious and may poison working relationships. Ironically, these disputes primarily occur in the Los Angeles region where DAG involvement in the investigation process is greatest.

Recommendation No. VII-1. *Establish independent panels to review all requests for supplemental investigations and all decline to file cases. The reviews should be completed expeditiously (e.g., within 1 to 2 days of issuance of the request for supplemental investigation or Decline to File Memorandum). For Northern California cases, the panel members should include a Regional Manager and Supervising DAG from the Southern California region, plus the Medical Board's HQES Services Monitor (see Recommendation No. X-6). For Southern California cases, the panel members should include a Regional Manager and Supervising DAG from the Northern California region, plus the Medical Board's HQES Services Monitor. The panels should review all decline to file cases and all requests for supplemental investigations for any cases where preparation of the pleading will be delayed pending completion of the supplemental investigation, and then advise the Chief of Enforcement, the Senior Assistant Attorney General, and all Medical Board and HQES Managers and Supervisors involved in the matter as to the results of their review, including recommended disposition of the matter.*

2. Out-of-State Cases

The processes used to prepare accusations for Out-of-State cases are currently working reasonably well. Some Out-of-State cases are currently handled by Medical Board staff without HQES involvement, but most cases are referred to HQES, which prepares an accusation and, in most cases, negotiates a surrender of the Subject's license. It is unclear why an HQES Attorney is needed to perform these services for all of these cases. Additional staffing for DCU is expected to be authorized through the 2010/11 Budget which could provide DCU with the capability to draft many of these accusations, file the pleading, and negotiate related license surrenders. HQES Attorney involvement could be limited to reviewing the draft accusation and stipulation (on-line) and handling a limited number of more complex cases. Use of Medical Board staff in lieu of HQES Attorneys would reduce costs for these services and enable redirection of HQES resources to other cases.

Recommendation No. VII-2. *Restructure the processes used for preparing accusations for Out-of-State cases to reduce the number of cases referred to HQES. Utilize DCU staffing resources to draft accusations and license surrender stipulations for Out-of-State cases.*

VIII. Probation Program

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VIII. Probation Program

Results of this assessment show that the investigations and prosecutions of Probationers are being adversely impacted by the same factors as are impacting investigations and prosecutions of Non-Probationers. Recommendations for improvement that would impact the investigations and prosecutions of Probationers are included in Sections H (*Investigations*), and Section L (*Organizational and Management Structures*), including recommendations involving:

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

Additionally, needs exist to improve the processes used to ensure that on-going probation monitoring functions are regularly and properly performed.

Recommendation No. VIII-1. *Develop systems for tracking and reporting completion of quarterly reviews, random office visits, and other key probation monitoring activities.*

Currently, petitions for modification or termination of probation are submitted to DCU which forwards the petitions and supporting documentation to the Probation Unit Manager who researches the cases and determines whether to assign the petitions to Probation Unit staff or refer to the District offices for investigation. Cases involving Probationers with compliance deficiencies or another active investigation are referred to the District offices. Otherwise, the cases are assigned to staff within the Probation Units. Cases referred to the District offices are handled as VE cases, with joint assignment of an HQES Attorney and an Investigator to each case. Following investigation by either the Probation Unit or the District office, and irrespective of the Probationer's compliance record or the nature of the requested changes to the terms and conditions of their probation, the petitions are transmitted to HQES which presents the cases for hearing.

It is unclear why cases referred to the District offices are included in the VE Pilot Project as they are not complaints and the basic character of these cases, and the types of investigations performed, are completely different from complaints. It is also unclear why hearings are required for all of these matters. A Medical Board analyst could potentially review the cases prior to referral to HQES and make a determination, in some cases, as to whether to accept the petition and then present it directly to the Board, without any involvement of HQES and OAH. The remaining cases could still be referred to HQES for hearing.

Recommendation No. VIII-2. *Restructure the processes used for investigating petitions for modification or termination of probation. Exclude cases referred to the District offices from the VE Program, and screen out petitions from referral to HQES that do not need a hearing before an ALJ.*

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IX. Integrated Assessment of Enforcement Program Performance

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IX. Integrated Assessment of Enforcement Program Performance

This assessment highlights significant changes in overall Enforcement Program outputs and performance that occurred during the past several years following implementation of VE. Key statistical measures of overall Enforcement Program performance include:

- ✓ Number of ISOs/TROs sought and granted
- ✓ Number of accusations filed and average elapsed time from referral for investigation to accusation filed
- ✓ Number of stipulations received and average elapsed time from referral for investigation to stipulation received
- ✓ Number of disciplinary actions, decomposed by level of discipline imposed.

Since implementation of VE during 2006 there has been a marked deterioration in overall enforcement process performance. Investigator turnover has increased, fewer interim suspension actions are taken, investigations take longer to complete, fewer cases are referred for prosecution, and there has not been any significant improvement in the disciplinary outcomes achieved or the timeframe to achieve these outcomes. Concurrently, the Medical Board's costs for HQES legal services have increased due to rate increases and increased Attorney staffing authorized to support implementation of VE. Of particular concern is the increase in the amount of time needed to complete quality of care case investigations. These investigations already take an average of more than 18 months to complete for cases that are referred for prosecution.

The more intensive involvement of HQES Attorneys in investigations appears to be contributing to elevated attrition of seasoned Investigators and deteriorating Enforcement Program performance. These impacts are most apparent in the Los Angeles region where HQES Attorney involvement is greatest (2 to 3 times higher than the level of involvement of HQES Attorneys in other regions of the State). Recently implemented policy changes requiring a second Medical Expert opinion for most (or all) single patient cases assigned to Los Angeles District offices could further increase the amount of time needed to complete some quality of care case investigations, increase Investigator caseloads, reduce the availability of Medical Experts, particularly in specialized areas of practice, and increase Investigator turnover and Medical Board costs. Finally, as aged cases migrate from the Investigation Stage to the Prosecution Stage during 2009/10 and subsequent years, it is likely that average elapsed times from case referral for investigation to stipulation received will increase.

There are a number of factors over the past several years that have contributed to the Enforcement Program's inability to meet its goals. The loss of Investigators to a number of state agencies is likely to have contributed, although it is not possible to know whether or to what extent goals would have been met if fewer Investigators had separated from the Board. It is, however a fact that the Board has experienced a number of lateral transfers (non-promotional) to other State agencies subsequent to implementation of Vertical Enforcement. Some staff were disappointed that pay raises did not materialize, case levels did not decline as hoped, and the Investigators were not transferred to the Department of Justice. It is also a fact that there are tensions between Medical Board and HQES management, and a lack of consistency of VE implementation among regions. All parties involved are jointly responsible for ensuring stability and an

employment environment conducive to productivity, and it would appear that significant and continuing problems in this area have not been sufficiently addressed. Although current Enforcement Program staffing levels are higher than they have been in several years and the workforce is stable, likely due to current economic conditions, as the economy improves the Medical Board may again experience high attrition and vacancy rates if improvements are not made.

A. Complaints Handled and Average Elapsed Times from Initiation to Referral for Investigation or Prosecution

During 2008/09 the average elapsed time to close or refer complaints for investigation or prosecution was about 2.5 months, excluding a significant number of non-jurisdictional complaints closed during the Intake Stage. For complaints not reviewed by a Medical Specialist, the average elapsed time to close or refer complaints for investigation or prosecution was about two (2) months. For complaints reviewed by a Medical Specialist, the average time to close or refer the complaints was about four (4) months. Some High Priority complaints are referred for investigation or prosecution with only limited screening. Consequently, for complaints referred for investigation or prosecution, the average elapsed time was shorter than the average elapsed time for complaints that are closed and referred for investigation or prosecution (about 2.1 months for complaints that are referred for investigation or prosecution compared to 2.6 months for complaints that are closed or referred). Reflecting additional time requirements to obtain records and have a Medical Consultant review the cases, the average elapsed time to close or refer quality of care complaints, which account for about one-half of all complaints, was about three (3) months. The average elapsed time to close or refer other complaints was less than two (2) months. Following implementation of requirements for review of all quality of care complaints by a Medical Specialist, the proportion of complaints referred for investigation or prosecution decreased by about 15 percent (from 20 percent to 17 percent). In recent years only about 17 percent of complaints were referred for investigation or prosecution.

During the past several years, the number of complaints opened decreased by about 5 percent, the number of complaints closed decreased by about 10 percent, and the number of complaints referred for investigation or prosecution decreased by about 15 percent. Concurrently, the number of pending complaints and the average elapsed time to close or refer cases increased by about 25 percent. Recent growth in the number of pending complaints and increases in average elapsed times to close or refer complaints appear unrelated to implementation of Specialist review requirements earlier in the decade. Rather, these increases, which are concentrated in the past two (2) years, appear to be primarily a result of:

- The reduced availability of staffing resources due to restrictions on the use of overtime, staff turnover and vacancies, and work furloughs
- Changes in the composition of complaints, including significant decreases in Out-of-State and Medical Board-originated cases which, on average, are closed or referred for investigation or prosecution much more quickly than other complaints.

B. ISOs/TROs Sought and Granted

It was anticipated that, as a result of earlier involvement of HQES Attorneys in case investigations, increased numbers of ISOs and TROs would be sought and granted, which would enhance consumer protection by more quickly restricting the physician's practice of medicine. During the past several years, significantly fewer ISOs and TROs were sought. Also, significantly fewer were granted. Implementation of VE has not increased the number of ISOs and TROs sought and granted, notwithstanding higher levels of Attorney involvement in the investigations. Instead, since implementation of VE, the number of ISOs and TROs sought and granted has decreased by more than 30 percent. This decrease significantly exceeds any decrease that could be attributed to reductions in the number of cases referred for investigation.

C. Accusations Filed and Average Elapsed Times from Referral for Investigation to Accusation Filed

Another anticipated benefit of VE was a reduction in elapsed times from referral of a case for investigation to filing of the accusation. For example, it was expected that with HQES Attorneys more involved with investigations, it would take less time to obtain medical and other records needed to determine the merits of a complaint. Also, cases that were not viable could be identified and closed more quickly, thereby enabling redirection of resources to other cases, and accelerating completion of the investigations while concurrently improving the quality of the cases. Finally, because an HQES Attorney would have directed various investigative activities, including the gathering of evidence, interviewing patients, witnesses, and subjects, selecting a Medical Expert, and reviewing the Medical Consultant's and Medical Expert's reports, and reports prepared by the Investigator, it would take significantly less time to prepare the accusation, which provides notice to the public of alleged negligence or misconduct by a licensee.

As shown by **Exhibit IX-1**, on the next page, these expected performance improvements have not been realized. For cases with District office Identifiers, the average elapsed time from referral for investigation to accusation filed increased by two (2) months during the past several years. Average elapsed times from referred for investigation to accusation filed increased in all three (3) geographic regions. However, there were significant performance variances between the regions. The Northern California and Other Southern California regions had much shorter average elapsed times than the Los Angeles region (17 to 19 months for the Northern California and Other Southern California regions compared to 22 to 23 months for the Los Angeles region, a difference of 5 to 6 months). From this data it is abundantly clear that the much higher level of involvement of HQES Attorneys in Los Angeles region cases has not provided any differential benefit in terms of achieving lower average elapsed times from referral of a case for investigation to filing of the accusation. The higher level of involvement of HQES Attorneys in Other Southern California region cases, as compared to the level of involvement of HQES Attorneys in Northern California region cases, also has not provided any differential benefit in terms of achieving lower average elapsed times from referral a case for investigation to filing of the accusation.

Average Elapsed Times from Referral to Investigation to Accusation Filed, by Identifier
2004 through 2009

Including Cases with Transmittal to Filing Timeframes Exceeding 18 Months

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	17	61	19	54	14	163	17
2005	56	19	56	22	71	16	183	19
2006[2]	54	17	45	21	50	17	149	18
2007	66	17	65	22	67	16	198	18
2008	60	18	50	21	45	18	155	19
2009	72	19	51	21	64	19	187	20

Year	Cases with Other Identifiers[1]						Total All Case Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ, CME Audit, and Internet (IDENT 20,21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	2	13	3	19	10	11	178	16
2005	2	8	0	0	5	27	190	19
2006[2]	3	9	1	35	0	0	153	18
2007	5	12	0	0	1	18	204	18
2008	4	10	2	23	0	0	161	19
2009	0	0	1	36	6	15	194	19

Excluding Cases with Transmittal to Filing Timeframes Exceeding 18 Months

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	48	17	61	19	53	14	162	17
2005	55	18	55	21	71	16	181	18
2006[2]	54	17	43	21	48	16	145	18
2007	65	16	55	20	66	16	186	17
2008	60	18	49	20	43	18	152	19
2009	71	18	48	20	61	19	180	19

Year	Cases with Other Identifiers[1]						Total All Case Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ, CME Audit, and Internet (IDENT 20,21, and 23)			
	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)	Number of Filings	Average Time (Months)
2004	2	13	3	19	10	11	177	16
2005	2	8			2	17	185	18
2006[2]	3	9	1	35			149	18
2007	5	12			1	18	192	17
2008	4	10	2	23			158	18
2009			1	36	6	15	187	19

[1] Over the six-year period from 2004 through 2009, excludes 279 accuations filed related to Out-of-State (IDENT 16) cases transmitted by DUC directly to HQES, and 16 accusations filed related to Headquarters, CME audit failure, and Internet cases (IDENTs 20, 21, and 23) transmitted by various Headquarters Units directly to HQES. Also excludes five (5) cases involving petitions to revoke probation (IDENT 'D').

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

D. Accusations Withdrawn or Dismissed

With greater HQES Attorney involvement in investigations, it might be expected that fewer accusations would be withdrawn or dismissed. However, the number of accusations withdrawn or dismissed is small in comparison to the total number of accusations filed (about 10 percent), and accusations may be withdrawn or dismissed due to changing circumstances and other factors that are completely outside of the control of both the Medical Board and HQES (e.g., successful completion of the Diversion Program, death of the Subject, etc.).

A review of the statistical data appears to show that dismissals and withdrawals have remained essentially constant over the past five years. Changes appear to be due to statistical spikes only, and do not reflect any continuous trend or pattern.

During the past five (5) years there have not been any sustained changes in the number of accusations withdrawn, and the number of accusations dismissed recently increased. Due to a one-year spike in accusations withdrawn and dismissed during 2007/08, the average number of accusations withdrawn or dismissed during the past two (2) years (29 cases per year) was significantly higher than the average number of accusations withdrawn or dismissed during the preceding three (3) years (21 cases per year).

Most of the accusations that were withdrawn or dismissed during 2007/08 involved cases that were investigated by District offices in the Northern California or Other Southern California regions. During 2007/08, 26 accusations were withdrawn and 10 were dismissed. About a dozen cases were withdrawn after determining that there was not sufficient evidence to prevail at a hearing. Other causes for these withdrawals included:

- The Medical Expert changed their opinion (about a half-dozen cases)
- The license was cancelled, the respondent died, or the statute of limitations ran (several cases)
- The Subject successfully completed the Diversion Program (2 cases).

The unusually high number of accusations withdrawn during 2007/08 did not persist into 2008/09.

E. Stipulations Prepared and Average Elapsed Times from Referral for Investigation to Stipulation Received

Implementation of VE was expected to reduce average elapsed times from referral of a case for investigation to stipulation received, which effectively represents completion of the prosecution phase of the enforcement process. It was anticipated, for example, that in addition to reducing the average elapsed times to complete investigations and file accusations, that implementation of VE might (1) marginally increase the proportion of cases that are settled without a hearing, and (2) reduce the average elapsed time to negotiate a settlement and prepare the stipulation.

With respect to increasing the proportion of cases that settle rather than proceed to hearing, about 80 to 85 percent of cases usually settle without a hearing. Thus, it was considered unlikely that implementation of VE would significantly increase the proportion of cases that might settle without a hearing. On an annual basis for the past six (6) years, the proportion of cases that did not settle, and proceeded to hearing, fluctuated between 15 and 20 percent. There is no evidence that implementation of VE had any significant beneficial impact in terms of increasing the proportion of cases that settle without a hearing.

As shown by **Exhibit IX-2**, on the next page, for cases with District office Identifiers:

- The number of stipulations submitted decreased during the last several years, particularly in the Los Angeles and Other Southern California regions
- The average elapsed times from referral for investigation to stipulation received changed very little and, for all regions, this performance measure was only marginally lower during the past three (3) years than during the preceding three (3) years.

However, as aged cases migrate from the Investigation Stage to the Prosecution Stage during 2009/10 and subsequent years, it is likely that the average elapsed times from referral for investigation to stipulation received will increase. Additionally, there are significant performance variations between geographic regions of the State. For example, the Los Angeles region consistently had significantly higher average elapsed times from referral for investigation to stipulation received than the other regions. During the past two (2) years the average elapsed time for the Los Angeles region was about seven (7) months longer than the average elapsed time for the Northern California region, and about three (3) months longer than the average elapsed time for the Other Southern California region.

Average Elapsed Times from Referral for Investigation to Stipulation Received, by Identifier
2004 through 2009

Including Cases with Post-Investigation Elapsed Times Exceeding 3 Years

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004	50	2.2	64	3.1	39	2.5	153	2.7
2005	36	2.4	49	3.1	50	2.4	135	2.7
2006[2]	40	2.4	66	3.1	38	2.7	144	2.8
2007	48	2.0	33	2.9	55	2.8	136	2.5
2008	30	2.1	45	2.6	44	2.4	119	2.4
2009	52	2.2	45	3.0	34	2.4	131	2.5

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20, 22, and 23)			
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004					1	0.6	154	2.6
2005	2	1.3	4	4.0	7	2.4	148	2.7
2006[2]					2	4.0	146	2.8
2007	4	1.1	2	3.6	2	0.7	144	2.5
2008	3	1.4	1	1.3	3	2.8	126	2.4
2009	1	3.3	1	2.9	1	0.9	134	2.5

Excluding Cases with Post-Investigation Elapsed Times Exceeding 3 Years

Year	Cases with District Office Identifiers							
	Northern California		Los Angeles Metro		Other Southern California		Total	
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004	48	2.1	60	3.0	39	2.5	147	2.6
2005	34	2.3	43	2.9	49	2.4	126	2.5
2006[2]	37	2.1	59	2.9	33	2.3	129	2.5
2007	48	2.0	32	2.8	51	2.5	131	2.4
2008	29	1.9	41	2.5	41	2.3	111	2.3
2009	50	2.1	41	2.8	33	2.4	124	2.4

Year	Cases with Other Identifiers						Total All Identifiers	
	Out of State (IDENT 16)		Probation (IDENT 19)		HQ and Internet (IDENT 20, 22, and 23)			
	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)	Number of STIPs	Average Time (Years)
2004					1	0.6	148	2.6
2005	2	1.4	2	3.1	7	2.4	137	2.5
2006[2]					1	3.8	130	2.5
2007	4	1.1	2	3.6	2	0.7	139	2.3
2008	3	1.4	1	1.3	2	1.6	117	2.2
2009	1	3.2	1	2.9	1	0.9	127	2.4

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

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

Finally, as shown by **Table IX-1, below**, during the past several years average elapsed times from referral for investigation to stipulation received have changed very little for either quality of care or for other cases. It was anticipated that the elapsed times for quality of care cases would be impacted most by implementation of VE (e.g., by reducing the time taken to obtain medical and other records). The average elapsed time to investigate and prosecute quality of care cases remains at least eight (8) months longer than the average elapsed time for other cases (i.e., an average of about 2.7 years, or longer, for quality of care cases compared to an average of about 2.0 years for other cases).

Table IX-1. Average Elapsed Times from Referral for Investigation to Stipulation Received, by Type of Case[1] - 2005 through 2009

Calendar Year	Quality of Care Cases		Other Cases		Total	
	Number of Stipulations	Average Elapsed Time	Number of Stipulations	Average Elapsed Time	Number of Stipulations	Average Elapsed Time
2005	102	2.8 Years	35	2.2 Years	137	2.6 Years
2006[2]	102	3.2 Years	42	1.9 Years	144	2.8 Years
2007	98	2.7 Years	42	2.2 Years	140	2.5 Years
2008	90	2.7 Years	32	1.7 Years	122	2.4 Years
2009	88	2.8 Years	44	2.1 Years	132	2.6 Years

[1] Over the five-year period from 2005 through 2009, excludes 24 subsequent stipulation submittals related to the same complaint, 141 stipulations related to Out-of-State (IDENT 16) cases transmitted by DCU directly to HQES, eight (8) cases involving probationers (IDENT 19), fifteen (15) cases originated by various Headquarters Units (IDENTs 20, 22, and 23), and 65 cases involving petitions to revoke probation (IDENT 'D').

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

F. Efficiency of Investigations and Prosecutions

Expectations that implementation of VE would improve efficiency have not been realized. To support implementation of VE, eight (8) additional Investigator and Assistant Investigator positions and 10 additional HQES Attorney positions were authorized. These additional positions increased Investigator staffing by about 10 percent and increased HQES Attorney staffing my more than 20 percent. Following implementation of VE, the number of investigations completed, the number of cases referred for prosecution, the number of accusations filed, and the number of stipulations prepared have all declined by 15 percent or more. Additionally, during this period the number of pending investigations and the number of pending legal cases both increased by more than 15 percent. In summary, higher levels of resources are now being used to produce increasingly lower levels of output.

G. Disciplinary Outcomes

Exhibit IX-3, on the next page, shows disciplinary outcomes by referral source for (1) a baseline period of four years from 2003/04 through 2006/07, and (2) the most recent two fiscal years. As shown by Exhibit IX-3, the total number of disciplinary actions decreased from an average of 312 per year during the 4-year baseline period to an average of 292 per year for the past two years. Additionally, the decrease in numbers of disciplinary actions is even greater if Out-of-State cases, which are rarely handled by the District offices, are excluded. The data presented in Exhibit IX-3 show that disciplinary outcomes have not improved since implementation of VE.

As discussed previously, there was no change in the number disciplinary actions involving license revocation, surrender, suspension, or probation for Other Southern California region cases, and the number of public reprimands increased significantly (from an average of 15 per year, to an average of 22 per year). While the number of disciplinary actions taken involving Northern California region cases decreased by about 10 percent in recent years, there was only a minimal decrease in the number of disciplinary actions taken that required license revocation, surrender, suspension, or probation. In contrast, in recent years the number of disciplinary actions taken involving Los Angeles cases decreased by 13 percent overall, and the number of disciplinary actions involving license revocation, surrender, suspension, or probation decreased by 20 percent. The change in the number and types of disciplinary actions taken on cases investigated by Los Angeles region offices was the largest contributor to the decreases that have recently occurred in (1) the overall number of disciplinary actions taken, and (2) the number of disciplinary actions taken involving license revocation, surrender, suspension, and probation. These decreases were only partially offset by an increase in the number of public reprimand actions taken on cases investigated by District offices within the Other Southern California region.

In recent years the number of disciplinary actions taken involving cases investigated by Los Angeles and Other Southern California region District offices each accounted for about 35 percent of all disciplinary actions taken on cases with District office Identifiers. In contrast, Northern California region cases accounted for only 28 percent of all disciplinary actions taken on cases with District office Identifiers. The comparatively lower proportion of disciplinary actions taken involving Northern California region cases reflects comparatively lower numbers of accusations filed in prior years. However, recent decreases in the number of accusations filed involving Los Angeles and Other Southern California region cases will likely lead to fewer disciplinary actions taken in the future on cases investigated by District offices in both of these regions. In contrast, the number of accusations filed involving cases investigated by Northern California region offices increased in recent years, which will likely lead to an increase in disciplinary actions taken in the future.

HQES recently changed the geographic boundaries of its offices. Portions of the areas previously served by the Sacramento and San Diego offices were transferred to the Los Angeles office. These shifts could complicate future efforts to compare regional performance over time.

Disciplinary Actions by Referral Source
(Average Annual Rate)

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Referral Source	Conventional Enforcement - 2003/04 to 2006/07					Vertical Enforcement - 2007/08 to 2008/09					Change				
	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions	Revocation or Surrender	Probation with Suspension or Suspension Only	Probation Only	Reprimand	Total Disciplinary Actions
Patient, Patient Advocate, Family Member or Friend, Including 801.01(E) Reports	11.8	5.3	15.8	20.5	53.4	10.5	1.5	11.5	21.0	44.5	(1.3)	(3.8)	(4.3)	0.5	(8.9)
Insurance Companies and Employers, Including 801.01(B&C) Reports	5.1	1.8	11.0	18.3	36.2	2.0	0.5	11.5	19.0	33.0	(3.1)	(1.3)	0.5	0.7	(3.2)
Health Facilities (Section 805 and Non-805 Reports)	9.8	2.0	11.0	5.5	28.3	9.5	2.0	13.0	3.0	27.5	(0.3)	0.0	2.0	(2.5)	(0.8)
California Department of Health Services (or Successor State Agency)	3.8	2.3	7.3	3.0	16.4	4.5	1.0	7.5	3.5	16.5	0.7	(1.3)	0.2	0.5	0.1
M.D., Pharmacist, Allied Health or Healing Arts Licensee, or Medical Society or Association	5.8	1.3	5.3	3.3	15.7	5.0	0.5	2.0	4.5	12.0	(0.8)	(0.8)	(3.3)	1.2	(3.7)
CII - Department of Justice, Criminal Identification and Information Bureau	4.5	0.5	2.0	0.8	7.8	5.5	0.0	3.5	1.0	10.0	1.0	(0.5)	1.5	0.2	2.2
Other Governmental Agencies, Including FDA, DEA, Other DCA Boards and Bureaus, and 801 Reports	4.1	2.1	4.0	2.6	12.8	3.5	1.5	3.5	1.5	10.0	(0.6)	(0.6)	(0.5)	(1.1)	(2.8)
Other[1]	7.0	1.8	2.8	2.6	14.2	3.5	2.0	3.5	1.5	10.5	(3.5)	0.2	0.7	(1.1)	(3.7)
Police/Sheriff Department, Coroner's Office, District Attorney, and Courts (803 Reports, Criminal Filings, and Non-Felony and Felony Conviction Reports)	5.3	1.3	3.0	0.5	10.1	3.0	0.5	2.0	0.5	6.0	(2.3)	(0.8)	(1.0)	0.0	(4.1)
Licensee Self-Reporting (2240(A), 801.01, 802.01, 802.1 and Misdemeanor Conviction Reports)	0.3	1.0	0.8	4.5	6.6	0.5	0.5	1.0	2.5	4.5	0.2	(0.5)	0.2	(2.0)	(2.1)
California Attorney General and Department of Justice, Including Medi-Cal Fraud and Narcotics Enforcement Bureaus	0.8	0.3	0.8	0.3	2.2	2.0	0.0	1.0	0.5	3.5	1.2	(0.3)	0.2	0.2	1.3
Total, Excluding Out of State and Medical Board Originated Cases	58.3	19.7	63.8	61.9	203.7	49.5	10.0	60.0	58.5	178.0	(8.8)	(9.7)	(3.8)	(3.4)	(25.7)
Out of State Medical/Osteopathic Boards	34.1	0.5	11.0	20.8	66.4	31.0	1.0	11.0	40.0	83.0	(3.1)	0.5	0.0	19.2	16.6
Medical Board Originated Cases	16.0	3.3	15.0	7.6	41.9	11.0	2.5	13.5	4.5	31.5	(5.0)	(0.8)	(1.5)	(3.1)	(10.4)
Total, Including Out of State and Medical Board Originated Cases	108.4	23.5	89.8	90.3	312.0	91.5	13.5	84.5	103.0	292.5	(16.9)	(10.0)	(5.3)	12.7	(19.5)

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

X. Organizational and Management Structure

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X. Organizational and Management Structures

This section summarizes results of our analysis of the Medical Board's organizational and management structures. Our analyses focused primarily on Enforcement Program organizational structures and management issues. Organizational structure and management issues concerning the Licensing Program are addressed separately in Section XI (*Licensing Program*).

A. Investigations of Section 801 Cases

The Medical Board is currently planning to establish a new Sacramento-based unit that will use non-sworn staff to investigate Section 801 and selected other cases. Section 801 cases are distinguished from other cases because they involve a reported settlement of a malpractice case, and a substantial portion of the investigative activity involves identifying, collecting, and reviewing medical and other records, such as transcripts of depositions or court proceedings. Medical Board management believe that investigations of many of these cases can be completed by non-sworn staff, working jointly with HQES Attorneys, without referring the cases to District offices for investigation by a sworn Investigator. Non-sworn staff and clerical support resources are expected to become available in stages during 2010/11 and 2011/12 as part of a currently pending BCP that is expected to be included in the State's 2010/11 Budget. Section 801 cases currently account for about 10 percent of all cases referred to the District offices for investigation.

Recommendation X-1. *Restructure the handling of Section 801 cases by establishing a centralized unit comprised of non-sworn staff to investigate Section 801 and selected other cases.*

B. Management of District Office Investigations

The current management of field investigations differs among regions. Vertical Enforcement has been implemented differently in different offices with varied success. Conflicts have arisen among Board and HQES at all levels throughout the State, but particularly in the Los Angeles region. Conversely, in some offices staff are respectful of each other's roles in the process and there is greater productivity. The level of DAG involvement with investigators also varies, with the Los Angeles office by far having the most DAG involvement in investigations while referring fewer cases for prosecution.

While problems with some critical investigative activities have always been experienced, and are to be expected (scheduling of interviews), they appeared to have not been helped by the implementation of VE, and may have been made worse. Disagreements about the need for supplemental investigation activities and the need for second Medical Expert opinions create conflicts that have not been finally resolved, and continue to fuel disagreements. The conflicts need a final resolution based on best practices.

The statutes and policies governing VE should be amended to establish the best practices indentified and as implemented in the Northern and Other Southern California regions. Currently, the statutes "permit the Attorney General to advise the Board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action." Different regions have interpreted this code differently, giving rise to different investigation practices by MBC and HQES staff. This ambiguity should be addressed so that there is a uniform understanding of everyone's

role in the process. Without such clarification, the Medical Board will continue to have responsibility for investigations while having little authority over their direction.

The Medical Board should be clearly identified in statute as the sole, final authority for purposes of determining whether to continue an investigation. HQES' responsibility regarding such decisions should be limited, as provided by current statutes, to providing advice to the Board. In cases where the Medical Board elects to continue an investigation, HQES Attorneys should be available and supportive of these efforts, irrespective of any prior advice or decision. If the case is again referred for prosecution after the investigation is completed, then HQES can always reject the case at that time.

Recommendation No. X-2. *Amend the statutes governing Vertical Enforcement to clarify the Medical Board's sole authority to determine whether to continue an investigation.*

Another significant problem with the management of District office investigations involves the extent of HQES Attorney involvement with the investigations, irrespective of the nature or complexity of the case. A high level of Attorney involvement in some investigations is warranted and beneficial to many, but not all, investigations. Prior to implementation of VE, the availability of HQES Attorneys to provide substantive legal support for investigations was limited to only a small percentage of cases. Now, in some cases, the pendulum has swung too far in the other direction. In some cases HQES Attorneys are now substantively involved in investigations where a lesser level of involvement would be just as beneficial, while avoiding many of the communication and coordination problems that otherwise arise.

Currently, in some parts of the State the HQES Lead Prosecutor, who may also be a Supervising DAG, generally works collaboratively with the Medical Board's District office Supervisor, reviews incoming cases (usually only one or two cases per week per office), regularly attends Quarterly Case Review meetings, and spends a few hours one or two days per week at the District office providing general consultation services to District office staff. In consultation with the District office Supervisor, needs are jointly identified for assignment of a Primary DAG to provide more substantive legal support services for specific cases on an exception basis. For other cases, the HQES Lead Prosecutor or Supervising DAG, along with the District office Supervisor, continues to monitor the status and progress of the cases and provides ad-hoc legal advice and consultation regarding the course of the investigation. With this approach an HQES Attorney would, for example, attend a Subject interview in only selected cases.

In contrast with this approach, in some parts of the State a Primary DAG is usually assigned to each new case, and is then expected to be substantively involved throughout the investigation. In some cases this extends to participation, not just in Subject Interviews, but also to interviews with complainants, witnesses, and others, and not just for cases involving sexual misconduct. The activities of the Primary DAGs also can include conducting detailed reviews and analysis of medical and other records, review of the qualifications of potential Medical Experts, preparation of the instructions for the Medical Expert, review of the package submitted to the Medical Expert, and numerous other activities. With this approach, communications and coordination among all of the different team members, for all of the cases, necessarily becomes much more cumbersome and complex.

Another dimension of this problem involves conflicts related to the use of Lead Prosecutors (LPs). The statutes governing VE require that each investigation referred to a District office "be simultaneously and jointly assigned to an investigator and to the deputy attorney general in (HQES) responsible for prosecuting the case if the investigation results in the filing of an accusation." The interim assignment of the LP to most cases at some District offices does not appear to be fully consistent with this requirement. The use of LPs was not incorporated in the VE model recommended by the Enforcement Monitor. It was created to address problems experienced after VE was implemented, including logistical, resource availability, and other problems associated with reviewing and assigning incoming cases and resolving communication problems and conflicts between District office and HQES staff.

In some cases a Supervising DAG has served as the LP. This approach can reduce communication and coordination problems because the Supervising DAG has direct supervising authority over subordinate Attorneys. However, Supervising DAGs are apparently not always sufficiently available to perform the LP role for all District offices. Consequently, the Supervising DAG usually assign a subordinate Attorney to serve as the LP. The ability of the assigned Attorney to effectively perform some key LP duties appears to be highly dependent on (1) the authority delegated to the LP by their Supervising DAG, (2) the ability of the LP to exercise the authority delegated to them, and (3) the relationships between the LPs and their peers. Thus, the effectiveness of the LP appears to be highly dependent on the management style of their Supervising DAG and the individual personality characteristics and interpersonal skills of the LP.

To reduce these conflicts, the statutes should be modified to eliminate mandatory requirements for joint assignment of a DAG for all cases referred for investigation. As a practical matter it cannot usually be determined when a District office investigation is opened whether the case will proceed to prosecution (most do not). Additionally, it is completely unrealistic to expect that the assignment of a DAG to a case will exist "for the duration of the disciplinary matter", although it is preferable to minimize such changes. While it is beneficial to have an Attorney regularly available to review new investigations, attend case review meetings, monitor the status of pending investigations, and provide ad-hoc legal advice and assistance to Investigators, the mandatory assignment of a Primary DAG to all investigations is excessive and results in a multi-million dollar waste of valuable resources that could be better utilized for other purposes. Every case referred for investigation should not have to be "double-teamed".

The assignment of Primary DAGs to cases during the Investigation Stage should be permissive, based primarily on the complexity and needs of the case as jointly determined by the District office Supervisor and the Supervising DAG (or their designees). Assignment decisions should be made with due care, taking into consideration all of the other, sometimes conflicting, workload and resource demands of both the Medical Board and HQES. If not needed, a Primary DAG should not be assigned to a case. Management judgment should be exercised in making case assignment decisions, rather than mechanistically applying a one-size-fits-all approach to all investigations which results in higher Attorney caseloads, sub-optimal utilization of staffing resources, and poor overall performance. The assignment of a Primary DAG to all cases is as bad, or worse, than the pre-VE system where HQES Attorneys were largely unavailable to assist Medical Board Investigators during the Investigation Stage. There can, and should be, a more balanced approach between these two extremes that enables higher levels of Attorney support during the Investigation Stage when more intensive involvement is needed (not just because an Attorney is assigned, is available, and chooses to spend time working on the case).

Recommendation No. X-3. *Implement the best practices, indentified and as implemented in the Northern and Other Southern California regions, statewide to optimize effective HQES Attorney involvement in investigations. Amend the statutes and policies governing Vertical Enforcement to establish the best practices identified in the Northern and Other Southern California regions. It would be helpful to amend the statute to make primary DAG assignments permissive, allowing Medical Board and HQES supervisors to jointly review incoming investigations to identify which cases would benefit from VE. Clarifying the statute as to the agencies' roles, responsibilities, and authority over investigations would help assure greater uniformity of investigations among regions.*

C. Management of HQES Expenditures and Cases Referred for Prosecution

There are significant deficiencies with both Medical Board and HQES management of cases referred for prosecution. The processes currently used for identifying and tracking the status of cases after they are referred for prosecution are frequently failing, particularly in the Los Angeles region. These processes appear, particularly in the Los Angeles region, to be largely dependent on individual District office Investigator or Supervisor detection and follow-up of past due cases. These follow-ups sometimes do not occur until several months after a case is referred for prosecution, or longer. Failures by the Medical Board to transmit cases and failures by HQES to acknowledge receipt of a referred case, and to communicate its acceptance or rejection of the case, exacerbates and further complicates this problem. However, even without these other problems, the absence of a planned completion date from HQES regarding when a pleading will be prepared makes it difficult for anybody to know which cases are being treated as urgent matters and whether the pleadings are past due. Similar problems sometimes occur after the pleading is filed (e.g., when several months elapse before a Request to Set is submitted on a case that the Medical Board considers urgent because the Subject poses a significant risk).

Recommendation No. X-4. *Require HQES to inform the Medical Board Regional Manager and HQES Services Monitor of the planned date for completing a pleading. The notice should be required to be provided within five (5) business days of referral of any case for prosecution. Also, require that all Medical Board Regional Managers meet (or conference) on a monthly basis with their HQES counterparts to review the status of all previously referred cases for which an accusation has not yet been filed.*

There also are significant deficiencies with both Medical and HQES oversight and management of expenditures for legal services (both investigation and prosecution). Currently, it appears that nobody at either HQES or the Medical Board closely reviews or analyzes the 700 to 900 page Invoice Report that the Attorney General provides to the Medical Board each month to support their charges (which are paid automatically by a funds transfer by the State Controller's Office from the Medical Board's fund to the Department of Justice). Instead, the Invoice Report appears to go directly from an administrative services unit in the Department of Justice to the Medical Board's fiscal unit, which maintains a cumulative tabulation of total expenditures for budget status tracking purposes and then files the report.

Needs exist to develop and implement a process that requires that the Supervising DAGs, Deputy Assistant Attorney General, District office Supervisors, and Regional Managers review and approve the reasonableness of HQES' charges to all matters billed each month. The scope of the review should include verification that that the charges are posted to the correct cases. The Supervising DAGs should review and approve the time charges posted to Investigation and Administrative matters, or note exceptions that require correction, and then submit their portions of the Invoice Report to the Deputy Assistant Attorney General for final approval and submission to the Medical Board's HQES Services Monitor. Concurrently, District office Supervisors should confirm that the time charges posted to Investigation matters are consistent with the Investigation activities performed during the reporting period, note any exceptions that require correction or further evaluation, and then submit their portions of the Invoice Report to their Regional Manager. The Regional Managers should review the charges posted to pending Administrative matters as part of their responsibilities related to tracking the status of pending accusations (see Recommendation No. XII-4, above), note any exceptions that require correction or further research, and then submit their region's portion of the Invoice Report to the Medical Board's HQES Services Monitor. The Medical Board's HQES Services Monitor should monitor completion of all of the supervisory and management reviews and, in consultation with the Senior Assistant Attorney General, initiate corrective actions to address any exceptions or other problems identified as a result of completing the reviews.

Recommendation No. X-5. *Develop and implement an HQES Invoice Report review and approval process that provides for review of the reasonableness of HQES time charges. As necessary, require that HQES create new summary templates that display time charge data in a summary format that facilities completion of these reviews.*

Recommendation No. X-6. *Establish a new HQES Services Monitor position within the Medical Board's Enforcement Program to coordinate the provision of services to the Medical Board by HQES, continuously monitor and evaluate HQES performance and costs, resolve conflicts that arise between the agencies, and prepare and provide regular reports to Executive Management, the Medical Board, and oversight and control agencies.*

D. Management Reports

New monthly management reports should be developed and provided to Enforcement Program and HQES Managers and Supervisors, and Medical Board Executive Management. At a minimum, the reports should provide the following summary level output and performance measures for the reporting period, and for the preceding 12 months period:

- ✓ Number of investigations closed, by Identifier, and average elapsed time from referred for investigation to closure
- ✓ Number of investigations referred for prosecution, by Identifier, and average elapsed time from referred for investigation to referred for prosecution
- ✓ Total number of investigations closed or referred for prosecution, by identifier, and average elapsed time from referred for investigation to closed or referred for prosecution
- ✓ Number of accusations filed, by Identifier, average elapsed time from referred for prosecution to accusation filed, and average elapsed time from referred for investigation to accusation filed
- ✓ Number of stipulations received, by Identifier, average elapsed time from accusation filed to stipulation received, and average elapsed time from referred for investigation to stipulation received
- ✓ Number of proposed decisions received, by Identifier, average elapsed time from accusation filed to proposed decision received, and average elapsed time from referred for investigation to proposed decision received.

Additionally, the monthly performance reports should provide consolidated output and performance data by geographic region and for the State as a whole (Northern California, Los Angeles, and Other Southern California). Quarterly summaries of this same information should be prepared and provided to the Medical Board. The quarterly summaries should also include fiscal year-to-date totals and time series data for the preceding three (3) fiscal years. Finally, all of the reports should possibly include a limited number of selected other output and performance measures, such as data regarding interim suspension activities (e.g., ISOs and PC 23s), petitions to revoke probation, compelled competency examinations, or disciplinary outcomes.

Recommendation No. X-7. *Develop new monthly management reports showing key output and performance measures by business unit and for the State as a whole. (Presently, data is provided to the Board on a statewide basis only.) Provide the monthly reports to all Enforcement Program and HQES Managers and Supervisors and to designated Medical Board Executive Office Managers and staff. Develop and provide the Board with quarterly Enforcement Program Output and Performance Summary reports that include data for the most recently completed quarter and time series data for the preceding three (3) fiscal years.*

E. Government Code Section 12529.6(e) Requirements

To carry out the Legislatures intent in requiring use of the Vertical Enforcement Model, and to enhance the Vertical Enforcement process, Section 12529.6 of the Government Code requires that the Medical Board:

- Increase its computer capabilities and compatibilities with HQES in order to share case information
- Establish and implement a plan to locate its Enforcement Program staff and HQES staff in the same offices, as appropriate
- Establish and implement a plan to assist in team building between its Enforcement Program staff and HQES staff to ensure a common and consistent knowledge base.

All of these requirements should be modified, or repealed. Each of these requirements is briefly discussed below.

Computer Capabilities and Case Information Sharing – The Medical Board is currently supporting DCA's efforts to develop the BREEZE2 System which would completely replace the Medical Board's legacy Application Tracking System (ATS) and also the Complaint Tracking System (CAS). The Medical Board should not invest additional resources in CAS to make it compatible with HQES' ProLaw System. However, the Medical Board should provide HQES with standard reports available from CAS to enable HQES to monitor the status of pending investigations and prosecutions. Additionally, the Medical Board should provide HQES with summary level *Enforcement Program Output and Performance Reports* (see Recommendation No. X-7).

Co-location of District Office and HQES Staff – Co-location of District office and HQES staff would be inconsistent with our recommendations for more selective application of VE. Instead, as practiced currently, the Medical Board should be required to provide suitable space for Lead Prosecutors and Primary DAGs to work at its District offices, when needed (e.g., using "hoteling").

Team Building and Development of a Common and Consistent Knowledge Base – The Medical Board and HQES should be jointly responsible for developing training programs and providing them to their respective staff as needed to provide staff in both agencies with a common and consistent knowledge base. Requirements related to team-building should be addressed as part of the structured diagnostic review of factors contributing to elevated attrition of Medical Board Investigators that is recommended in Section VI (See Recommendation No. VI-3).

Recommendation No. X-8. *Amend or repeal Subsection(e) of Section 12529.6 of the Government Code. The Medical Board should not invest in CAS to make it more compatible with HQES' ProLaw System and should not permanently co-locate Medical Board Investigators and HQES Attorneys.*

F. Oversight of HQES Services

When it was created during 1990, HQES was authorized 22 DAG positions. Following its formation, HQES also established a goal to file all accusations within 60 days of receipt of a completed investigation. The Legislation creating HQES also required that DAGs work on-site at the Medical Board's offices to assist with complaint handling and investigations. However, HQES determined that it was severely understaffed, and did not comply with this latter requirement. During 1992 and 1993 the Medical Board provided funding for 22 additional DAG positions (44 total Attorney positions). Subsequently, during the late-1990s, the Deputy in District Office (DIDO) Program was introduced whereby a DAG worked at each District office one or two days per week to provide prosecutorial guidance during investigations. However, the DIDO Program was not always consistently implemented at all District offices.

To support implementation of VE, an additional ten (10) Attorney positions were authorized for in 2006. In addition to the Senior Assistant Attorney General, HQES is currently authorized 53 Attorney positions, plus four (4) Analyst positions. HQES also has seven (7) filled Secretary positions. However, even with these resources, and notwithstanding declines in the number of cases referred for prosecution, HQES continues to experience significant delays in filing accusations and in performing post-filing prosecutorial activities. In recent years HQES has filed fewer accusations and the number of interim suspensions also has declined. Concurrently, the number of pending accusations and the number of pending legal actions have increased.

The results of this assessment show that issues concerning HQES' performance have persisted for the past 20 years, notwithstanding authorization and funding of significant staffing increases. Results of the assessment also show that output and performance levels of HQES' Los Angeles office are significantly lower than in other regions of the State, even though available staffing resources are disproportionately allocated to that office. The types of performance problems occurring in HQES' Los Angeles office, as illustrated by the various case histories reviewed as part of this assessment, are especially disturbing, and cannot be attributed to differences in the types of cases investigated by Los Angeles District offices or differences in the quality of those offices' completed investigations. While HQES' Los Angeles office presumably has many very competent and dedicated Attorney's on its staff, the problems identified, unfortunately, reflect poorly on the entire office. Also, the problems occurring at HQES' Los Angeles office should not color perceptions of the organization as a whole, although similar problems may sometimes occur at the other offices,

The Medical Board, and even the Department of Consumer Affairs, is limited in its ability to exercise oversight of HQES services because it is entirely dependent on HQES to provide legal support services and must work collaboratively with them on an ongoing basis. Periodic reviews of HQES' services, costs, and performance should be completed by an independent entity, and results of the review should be provided to Department of Justice and Medical Board management as well as to oversight and control agencies.

Recommendation No. X-9. *Conduct periodic performance reviews of the services, costs, and performance of HQES, including the performance of each HQES office. Provide results of the reviews to Department of Justice and Medical Board management and to oversight and control agencies.*

XI. Licensing Program

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XI. Licensing Program

Below we present and briefly discuss seven (7) recommendations resulting from our review of HSC's study of the Licensing Program and other related analyses performed as part of our assessment.

Recommendation No. XI-1. *Implement HSC's Recommended Business Process Improvements*

Medical Board staff from the Licensing Program and other business units spent considerable time working with HSC to identify and assess the recommendations for improvement presented in HSC's report. Additionally, about $40,000 was expended for the study. Potential benefits associated with implementing HSC's recommendations for improvement should not be lost. As determined appropriate, the Licensing Program should implement HSC's recommended business process improvements. If implemented, many of the recommendations could marginally improve internal effectiveness or efficiency, or the level of service provided to applicants, without incurring any significant additional costs.

Recommendation No. XI-2. *Conduct a Limited, High-Level Business Case Analysis of Potential Benefits, Costs, and Risks of a Document Management System (DMS)*

The Medical Board should consider conducting a limited, high-level business case analysis of potential benefits and costs of a DMS. This analysis should include researching document management systems used by DCA or other California State Government agencies and departments, such as the Contractors State License Board. Additionally, the analysis should include obtaining information from potential vendors, but not necessarily development and issuance of a Request for Information (RFI) as suggested by HSC. The analysis should focus on identifying and quantifying, where practicable, potential efficiency and other improvements that might be achieved, developing order of magnitude estimates of costs to develop and maintain the system, and comparing the potential benefits with the estimated costs. Additionally, the analysis should include an analysis of significant risk factors associated with development and implementation of such a system. If supported, the Business Case Analysis can be used to support development of Feasibility Study Report (FSR), if needed.

Recommendation No. XI-3. *Obtain Authorization to Convert Recently Established Limited-Term Positions to Permanent Status*

Based on the limited, high-level analysis of historical Licensing Program workload and staffing completed as part of our assessment, it appears that the eight (8) new positions proposed in the 2010/11 BCP would fully restore positions lost earlier in the decade and also provide additional positions justified on the basis of increased workloads since that time. Additionally, given the nature of the medical profession and health care industry needs for additional licensed physicians, it is highly unlikely that application workloads will diminish over time. Finally, when positions are classified as limited-term, there is a greater risk of higher staff turnover as incumbents transfer to other positions rather than risk losing their job in the event the position expires. Therefore, we recommend obtaining authorization to convert the recently established limited-term positions to a permanent status as soon as practicable. We understand that these positions were converted to a permanent status effective July 1, 2010.

Recommendation No. XI-3. *Scale Back the Use of Retired Annuitants, Student Assistants, and Overtime, if Furloughs are Discontinued*

As discussed above, the recent addition of eight (8) new limited-term positions appears to be sufficient to fully restore positions lost earlier in the decade and also provide additional capabilities to process the larger number of license applications now submitted. Therefore, the Licensing Program should be able to significantly reduce its use of retired annuitants and student assistants, and overtime. We understand that Medical Board management has already begun implementing this recommendation.

Recommendation No. XI-5. *Conduct a Detailed Analysis of Licensing Program Workload and Staffing Requirements after a New Licensing Program Chief is Appointed*

The Licensing Program could potentially benefit from completion of a detailed analysis of Licensing Program workload and staffing requirements. Such an analysis could help Licensing Program management to (1) optimize the alignment of workload demands with available staffing capabilities and (2) determine how best to organize staff and needs for reclassification of existing positions, including determination of whether it would be beneficial to reclassify a rank and file position to the supervisory level to enhance management capabilities and further reduce supervisory spans of control. Implementation of this recommendation should be deferred until after a new Licensing Program Chief is appointed.

Recommendation No. XI-6. *Develop an Integrated Framework for Planning and Managing Licensing Program Performance*

Licensing Program management should develop an integrated framework for planning and managing Licensing Program performance that encompasses (1) establishing program goals and objectives, (2) developing plans, (3) monitoring operations, and (4) reporting results. The framework should be developed around a common set of quantified measures of outputs produced, resources used, service levels provided, and performance levels achieved.

Recommendation No. XI-7. *Resume Audits of Licensee Compliance with CME Requirements*

Audits of compliance with CME requirements are essential to ensure that licensee compliance levels do not deteriorate, and should be resumed as soon as practicable.

Appendix A
Summary Listing of Recommended Improvements

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Summary Listing of Recommendations for Improvements

Section III. License Fees, Expenditures, and Fund Condition

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

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

Section V. Complaint Intake and Screening

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

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

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

Section VI. Investigations

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

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

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

Summary Listing of Recommendations for Improvements

Section VII – Prosecutions and Disciplinary Actions

Recommendation No. VII-1. Establish independent panels to review all requests for supplemental investigations and all decline to file cases. The reviews should be completed expeditiously (e.g., within 1 to 2 days of issuance of the request for supplemental investigation or Decline to File Memorandum). For Northern California cases, the panel members should include a Regional Manager and Supervising DAG from the Southern California region, plus the Medical Board's HQES Services Monitor (see Recommendation No. X-6). For Southern California cases, the panel members should include a Regional Manager and Supervising DAG from the Northern California region, plus the Medical Board's HQES Services Monitor. The panels should review all decline to file cases and all requests for supplemental investigations for any cases where preparation of the pleading will be delayed pending completion of the supplemental investigation, and then advise the Chief of Enforcement, the Senior Assistant Attorney General, and all Medical Board and HQES managers and supervisors involved in the matter as to the results of their review, including recommended disposition of the matter.

Recommendation No. VII-2. Restructure the processes used for preparing accusations for Out-of-State cases to reduce the number of cases referred to HQES. Utilize DCU staffing resources to draft accusations and license surrender stipulations for Out-of-State cases.

Section VIII – Probation Program

Recommendation No. VIII-1. Develop systems for tracking and reporting completion of quarterly reviews, random office visits, and other key probation monitoring activities.

Recommendation No. VIII-2. Restructure the processes used for investigating petitions for modification or termination of probation. Exclude cases referred to the District offices from the VE Program, and screen out petitions from referral to HQES that do not need a hearing before an ALJ.

Section X – Organizational and Management Structures

Recommendation No. X-1. Restructure the handling of Section 801 cases by establishing a centralized unit comprised of non-sworn staff to investigate Section 801 and selected other cases.

Recommendation No. X-2. Amend the statutes governing Vertical Enforcement to clarify the Medical Board's sole authority to determine whether to continue an investigation.

Summary Listing of Recommendations for Improvements

Section X – Organizational and Management Structures *(continued)*

Recommendation No. X-3. Implement the best practices, 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.

Recommendation No. X-4. Require HQES to inform the Medical Board Regional Manager, District office and HQES Services Monitor of the scheduled date for completing a pleading. The notice should be required to be provided within five (5) business days of referral of any case for prosecution. Also, require that all Medical Board Regional Managers meet (or conference) on a monthly basis with their HQES counterparts to review the status of all previously referred cases for which an accusation has not yet been filed.

Recommendation No. X-5. Develop and implement an HQES Invoice Report review and approval process that provides for review of the reasonableness of HQES time charges. As necessary, require that HQES create new summary templates that display time charge data in a summary format that facilities completion of these reviews.

Recommendation No. X-6. Establish a new HQES Services Monitor position within the Medical Board's Enforcement Program to coordinate the provision of services to the Medical Board by HQES, continuously monitor and evaluate HQES performance and costs, resolve conflicts that arise between the agencies, and prepare and provide regular reports to Executive Management, the Medical Board, and oversight and control agencies.

Recommendation No. X-7. Develop new monthly management reports showing key output and performance measures by business unit and for the State as a whole. (Presently, data is provided to the Board on a statewide basis only). Provide the monthly reports to all Enforcement Program and HQES Managers and Supervisors and to designated Medical Board Executive Office Managers and staff. Develop and provide the Board with quarterly Enforcement Program Output and Performance Summary reports that include data for the most recently completed quarter and time series data for the preceding three (3) fiscal years.

Recommendation No. X-8. Amend or repeal Subsection(e) of Section 12529.6 of the Government Code. The Medical Board should not invest in CAS to make it more compatible with HQES' ProLaw System and should not permanently co-locate Medical Board Investigators and HQES Attorneys.

Recommendation No. X-9. Conduct periodic performance reviews of the services, costs, and performance of HQES, including the performance of each HQES office. Provide results of the reviews to Department of Justice and Medical Board management and to oversight and control agencies.

Summary Listing of Recommendations for Improvements

Section XI – Licensing Program

Recommendation No. XI-1. Implement HCS' recommended business process improvements.

Recommendation No. XI-2. Conduct a limited, high level business case analysis of potential benefits, costs, and risks of a Document Management System (DMS).

Recommendation No. XI-3. Obtain authorization to convert recently established limited-term positions to permanent status.

Recommendation No. XI-4. Scale back the use of retired annuitants, student assistants, and overtime, if furloughs are discontinued.

Recommendation No. XI-5. Conduct a detailed analysis of Licensing Program workload and staffing requirements after a new Licensing Program Chief is appointed.

Recommendation No. XI-6. Develop an integrated framework for planning and managing Licensing Program performance.

Recommendation No. XI-7. Resume audits of licensee compliance with CME requirements.