Vertical Enforcement and Prosecution Report - March 2016

Introduction and Brief History

Effective January 1, 2006, the Medical Board of California (Board) and the Department of Justice Health Quality Enforcement Section (HQES) were required by the Legislature to implement a vertical enforcement and prosecution model (VE/P) for conducting investigations and prosecutions. The Board and HQES have been operating under this model since that date.

The VE/P model requires the joint and simultaneous assignment of a complaint to a Board investigator and a deputy attorney general (DAG), who are to handle the matter for its duration. The assigned Board investigator, under the direction of a DAG, is responsible for obtaining the evidence needed to permit a decision to be made regarding whether to prosecute the matter. The Legislature clearly contemplated that VE/P would be a collaborative team approach to enforcement and prosecution. The Board and HQES have created a joint manual and modified it several times in an attempt to foster this collaborative team concept.

The Board has reported to the Legislature on the VE/P model in 2007, 2009, 2010 (as part of an evaluation of all of the Board's programs), 2012, and 2013 (as part of the supplement to the Sunset Review report). The Sunset Review report submitted in November 2012 contained only a narrative; the supplement submitted in spring 2013 contained the statistical data regarding the case processing timelines.

Effective July 1, 2014, SB 304 (Chap. 515, Stats. 2013) made a significant change to the VE/P model by moving the Board's sworn investigators from the Board to the Division of Investigation within the Department of Consumer Affairs (DCA). This action removed the Board's authority to supervise and direct investigations and transferred that authority to DCA. The Board now has authority only over the initial complaint intake phase and the final decision.

Costs

In Fiscal Year (FY) 2006-07, the Board received an augmentation of $2.5 million dollars to fund the Attorney General (AG) expenses to implement the VE/P model. As a result of this increase in its legal services budget, the Department of Justice (DOJ) redirected two attorney positions to assist in evaluating and screening complaints and seven attorney positions to implement the VE/P model.

Additional funding was required due to an increase in the attorney hourly billing rate in FY 2009-10. To date the Board has spent $18.6 million implementing the VE/P model, as summarized below.

Attorney General - Vertical Enforcement and Prosecution Cost

Fiscal Years	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	Total
Administrative/ Prosecution Costs	$4,249,107	$5,452,751	$5,672,572	$5,056,973	$5,659,588	$6,010,600	$6,825,814	$5,689,727	$6,561,224	$5,854,443	**$57,032,798**
VE/P Investigation Costs*	$94,713	$723,097	$1,667,688	$2,233,166	$2,903,709	$2,275,182	$2,396,296	$1,984,058	$2,176,666	$2,120,793	**$18,575,367**
Investigations Initiated	1,062	941	961	847	1,003	1,089	1,132	1,164	1,114	944	10,257
Total	**$4,343,820**	**$6,175,848**	**$7,340,260**	**$7,290,139**	**$8,563,297**	**$8,285,783**	**$9,222,110**	**$7,673,785**	**$8,737,890**	**$7,975,236**	**$75,608,165**

**This represents the costs incurred by HQES to direct investigations. It does not include Board or DCA's Health Quality Investigation Unit (HQIU) costs to conduct investigations. The cost for HQIU in FY 14/15 (the year in which it came into existence) was $16,313,540.*

Statistics and Analysis

The primary benefits that the Legislature believed would come out of VE/P were described in the analyses prepared for the Legislature as: greater effectiveness, improved timeliness, and greater cost-effectiveness.

The first such analysis in the Senate Committee on Business, Professions, and Economic Development (April 25, 2005) for the bill that required the VE/P model (SB 231--Chap. 274, Stats. 2005) provided in pertinent part:

> *"Vertical prosecution teams allow lawyers and investigators to view each case as a whole, rather than as two, separate and independent steps: the investigation and then the prosecution. The problem is an obvious one to anyone who practices this kind (or any other kind) of law - investigating a case and litigating a case are not*

independent at all; one informs the success or failure of the other. The two are entirely interrelated and interdependent."

* * *

"In addition to its effectiveness, Vertical Prosecution can be more cost-effective for the Board. With an attorney keeping an eye on developing evidence - or lack of evidence - the Vertical Prosecution team can discover poor or unwarranted cases earlier, and not waste their joint time in pursuing them. This would have the additional benefit of clearing the license of an accused physician earlier."

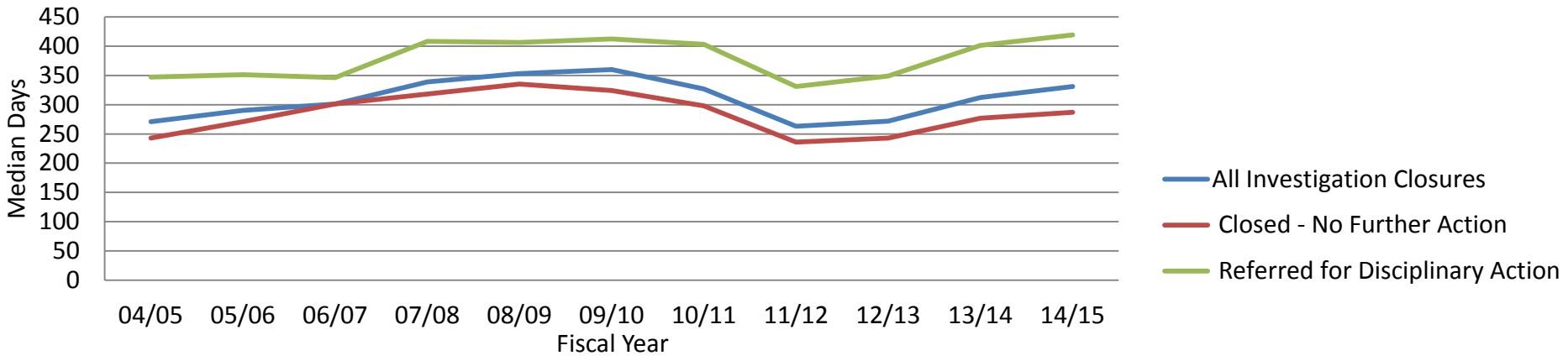
"There is a 'compromise' proposal currently in existence, called Deputy in District Office (or DIDO). . . . Under this program, attorneys work part-time in Board district offices, and can help investigators work up cases. However, this program falls far short of true Vertical Prosecution. As the Report notes, after more than eight years in operation, the half-measure has proved to have many flaws, and has not delivered the true benefits that Vertical Prosecution would."

VE/P has been in operation for almost 10 years. The Legislature anticipated that use of a VE/P model would improve timeliness of prosecution and an increase in the number of cases prosecuted, as well as be more cost-effective.

This report focuses on the number of cases and the median processing times. The Board selected the median number of days (rather than the average) to provide a truer picture of the time frames. The data contained in the graphs on the following pages and table (Appendix A) are derived from the Board's records only. The Board recognizes that different agencies will have a different focus when compiling data. The Board's records indicate that VE/P, as currently practiced, has not resulted in significant improvement in the length of time it takes to prosecute a case. However, there was an increase in the number of accusations filed.

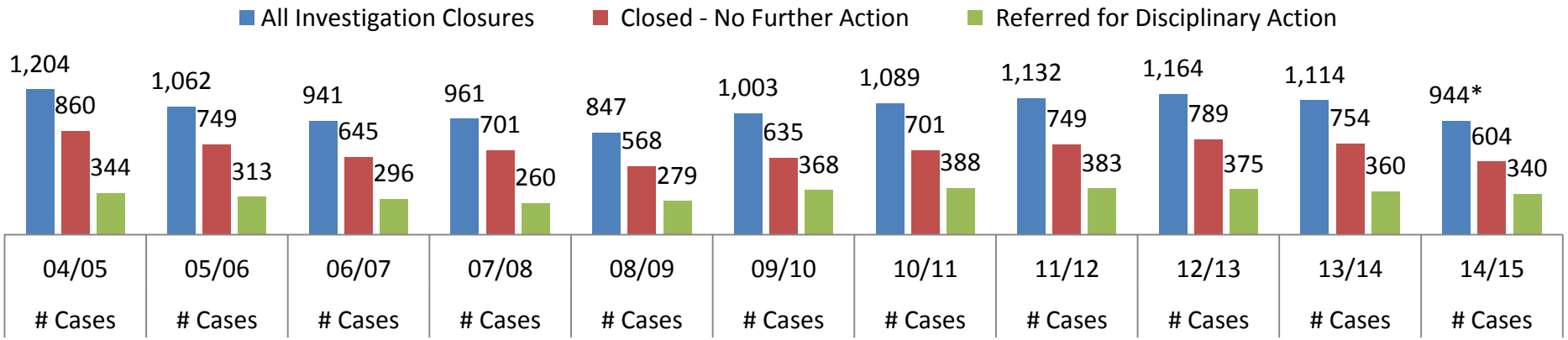
There are factors that impact the median day graphs on the following pages and Appendix A. A factor is the vacancy rate within the investigative unit. With respect to the graphs on pages 6 and 7, and the table in Appendix A, the median days reported reflect another factor. This factor is the time attributable to the administrative hearing portion of the disciplinary process, managed by the Office of Administrative Hearings, which is intended to provide due process to physicians. Neither HQES, HQIU, nor the Board has any control over this time.

All Investigation Closures - Median Days



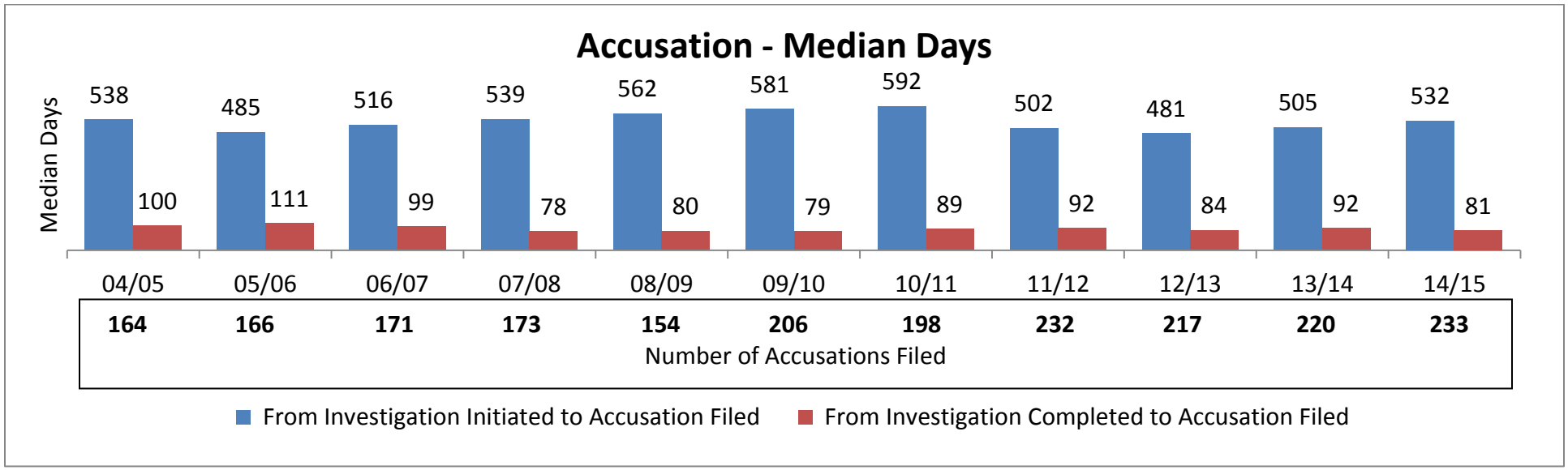
Median days - From the date the case was assigned to the Investigator/Deputy Attorney General to closure or referral to the Attorney General's Office for prosecution.

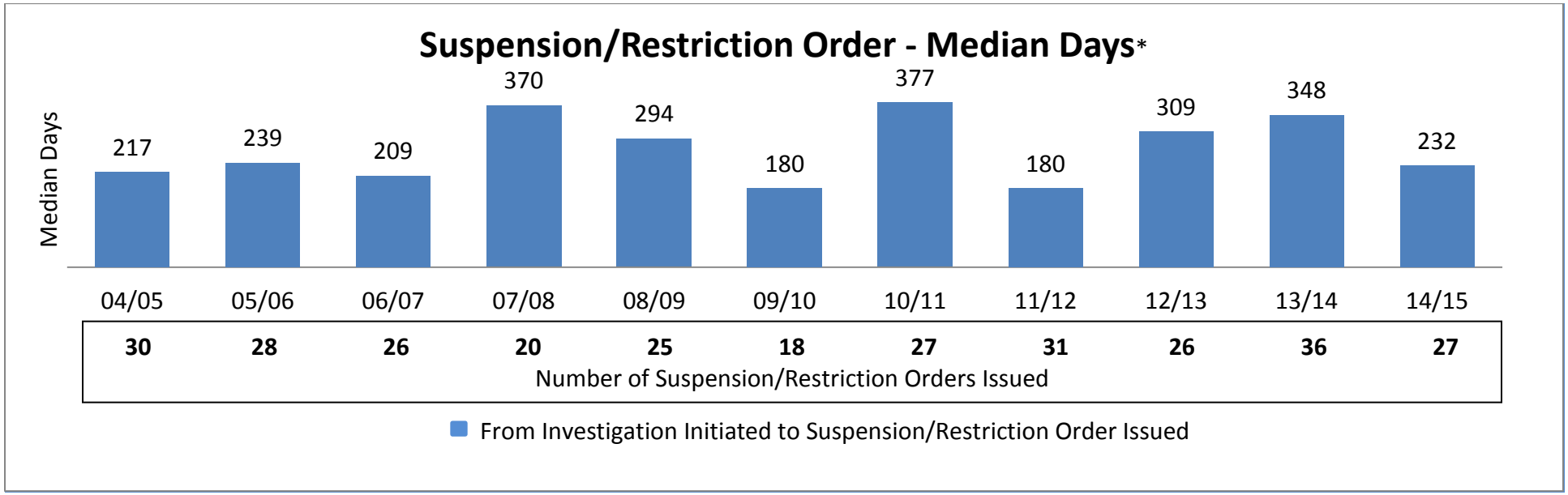
All Investigation Closures - Number of Cases



* This decrease is due to the Board initiating, in July 2014, a complaint investigation office of non-sworn special investigators who began investigating cases that would have been sent to HQIU.

The graphs above exclude the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. They also exclude all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P.





* This data includes: interim suspension orders, Penal Code section 23 restrictions, stipulated agreements to restrictions/suspension, and temporary restraining orders. It does not include out-of-state suspension orders, automatic suspension orders, or orders to cease practice while on probation.

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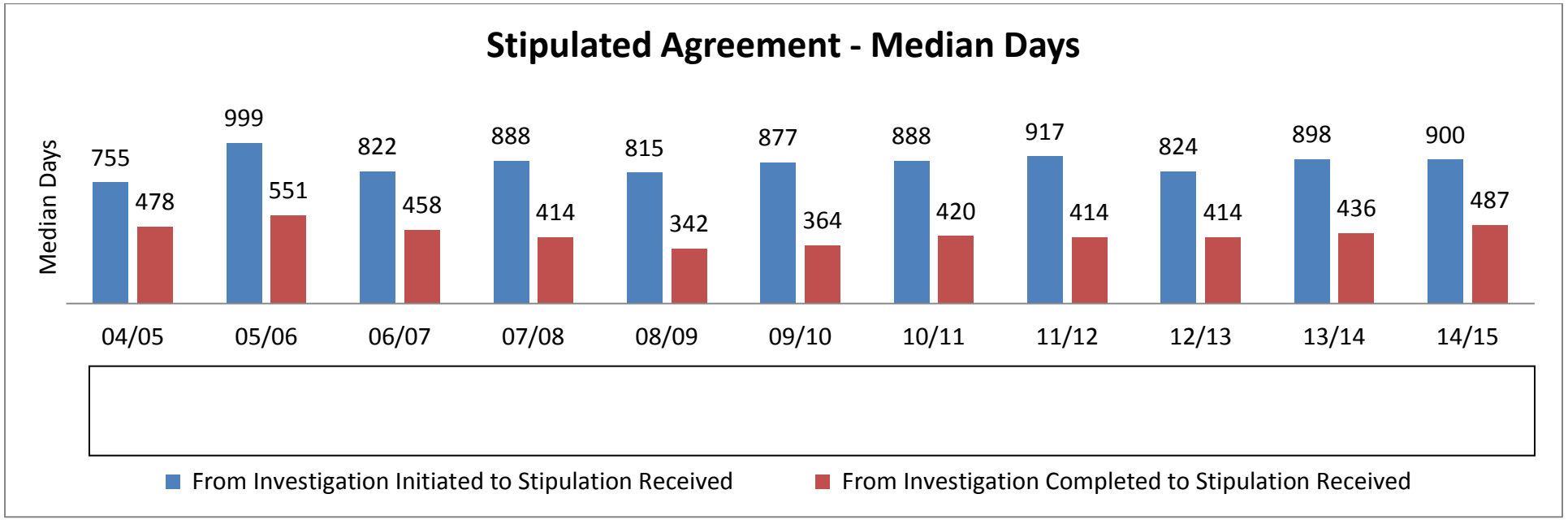

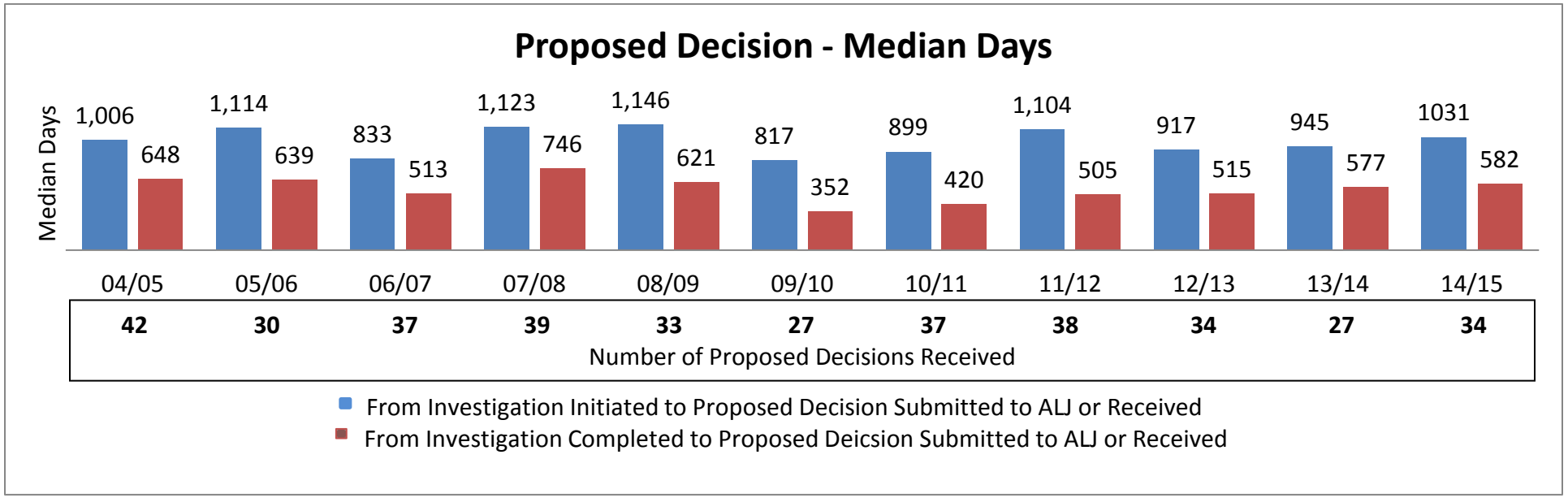

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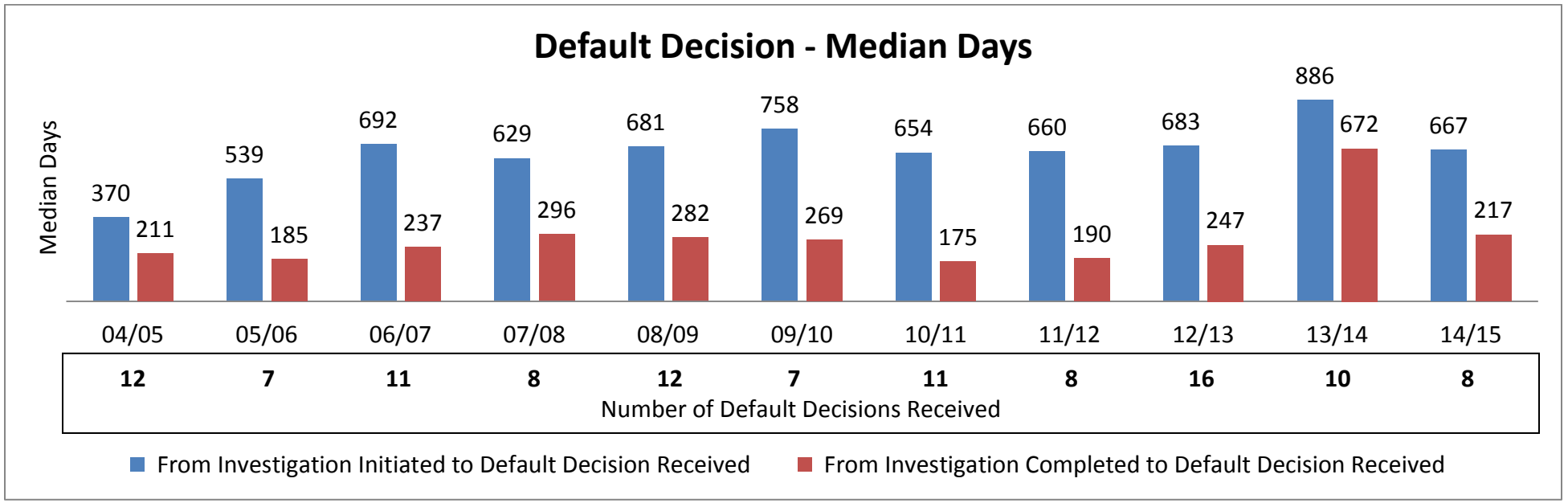

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Improvements Since the Last Report

1. The Board and HQES utilized protocols contained in a joint manual to implement the VE/P model. With the transfer on July 1, 2014, of the Board's sworn investigators to HQIU, a revised manual was needed. The Board, DCA, HQES, and HQIU worked together to create a new protocol. Effective July 1, 2015, this new protocol implements the recommendation from the 2013 Sunset Review Report that those who are part of the VE/P team take steps to improve their collaborative relationship.

2. Joint training was delivered to HQE and HQIU staff on the new 2015 Vertical Enforcement and Prosecution Protocol. One training session was held in Sacramento on July 14, 2015, and two were held in Los Angeles on July 20, 2015. Each session was approximately two hours long. The training sessions covered the highlights of the new protocol, including: the shared goal of protecting the public; a fresh start to teamwork; the importance of communication between team members; excellence and professionalism; and the rationale behind changes to certain parts of the new protocol. The sessions invited questions to clarify the roles and activities of each team member in the VE/P process.

3. Two joint training sessions on 805 investigations are currently planned for March 2016. They will each be approximately four hours long and will cover the filing requirements set forth in the law, peer review files, and an overview of a typical 805 investigation.

4. Increasing computer capabilities and compatibilities with HQES in order to share case information. In the VE/P model, it is imperative that investigators and attorneys be able to share case information. However, the agencies involved in the VE/P process have their own separate computer systems that do not communicate with each other. In furtherance of the legislative requirements contained in Gov. Code Section 12529.6(e)(1), the HQES contracted with a publicly traded company to provide a secure cloud-based content sharing solution, which facilitates real-time sharing of confidential evidentiary material between investigators in HQIU and DAGs in HQES, as well as permitting client oversight by the Medical Board's executive director and her staff. The security and functionality of the service was first vetted by the Attorney General's Department of Criminal Justice Information Services. This program (and the procedures to utilize it) are in the process of being developed.

Recommendations

The recommendations listed below are those offered by the Board. The Department of Justice and the Department of Consumer Affairs are encouraged to separately bring to the Legislature whatever additional recommendations they might have regarding VE/P.

1. Govt. Code Section 12529.6(b) (Appendix B) requires that the investigator assigned to a case shall, "under the direction but not the supervision of the deputy attorney general," be responsible for obtaining evidence in the matter. The Board recognizes that this provision may interfere with the investigators and attorneys being a true team and recommends that a mechanism be found to more fully utilize the expertise brought to the team by both the investigator and the DAG.

2. VE/P does not apply to cases handled in-house by the Board's non-sworn staff. There are times when Board staff would benefit from being able to consult with HQES while processing those matters. Therefore, the Board recommends that Gov. Code Section 12529.6(b) be modified to clearly permit the Board's staff, at its discretion, to consult with HQES on cases handled by its non-sworn staff.

3. Delete the reference to the Board contained in Government Code Section 12529.6(e) to reflect the transition of investigators from the Board to DCA.

4. DCA and HQES should utilize the new joint manual and develop additional strategies and procedures to assist investigators and attorneys to further improve the VE/P model.

Appendix A

Investigation Time Frames - Median Days

The table below excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. It also excludes all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P.

	04/05		05/06		06/07		07/08		08/09		09/10		10/11		11/12		12/13		13/14		14/15	
	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
All Investigation Closures	271	1,204	290	1,062	301	941	339	961	353	847	360	1,003	327	1,089	263	1,132	272	1,164	312	1,114	331	944
Closed - No Further Action	243	860	271	749	301	645	318	701	335	568	324	635	298	701	236	749	243	789	277	754	287	604
Referred for Disciplinary Action	347	344	351	313	346	296	408	260	406	279	412	368	403	388	331	383	349	375	401	360	419	340
Accusations	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
From Investigation Initiated to Accusation Filed	538	164	485	166	516	171	539	173	562	154	581	206	592	198	502	232	481	217	505	220	532	233
From Investigation Completed to Accusation Filed	100		111		99		78		80		79		89		92		84		92		81	
Suspension/Restriction Orders	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
From Investigation Initiated to Suspension/Restriction Order Issued	217	30	239	28	209	26	370	20	294	25	180	18	377	27	180	31	309	26	348	36	232	27
Stipulated Agreements	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
From Investigation Initiated to Stipulation Received	755	156	999	141	822	143	888	145	815	118	877	135	888	120	917	160	824	165	898	168	900	179
From Investigation Completed to Stipulation Received	478		551		458		414		342		364		420		414		414		436		487	
Proposed Decisions	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
From Investigation Initiated to Proposed Decision Submitted to ALJ or Received	1,006	42	1,114	30	833	37	1,123	39	1,146	33	817	27	899	37	1,104	38	917	34	945	27	1031	34
From Investigation Completed to Proposed Decision Submitted to ALJ or Received	648		639		513		746		621		352		420		505		515		577		582	
Default Decisions	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
From Investigation Initiated to Default Decision Received	370	12	539	7	692	11	629	8	681	12	758	7	654	11	660	8	683	16	886	10	667	8
From Investigation Completed to Default Decision Received	211		185		237		296		282		269		175		190		247		672		217	

Appendix B

California Government Code Section 12529.6

12529.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical enforcement and prosecution model for those investigations is in the best interests of the people of California.

(b) Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction but not the supervision of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.

(c) The Medical Board of California, the Department of Consumer Affairs, and the Office of the Attorney General shall, if necessary, enter into an interagency agreement to implement this section.

(d) This section does not affect the requirements of Section 12529.5 as applied to the Medical Board of California where complaints that have not been assigned to a field office for investigation are concerned.

(e) It is the intent of the Legislature to enhance the vertical enforcement and prosecution model as set forth in subdivision (a).

The Medical Board of California shall do all of the following:

(1) Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.

(2) Establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model.

(3) Establish and implement a plan to assist in team building between its enforcement staff and the staff of the Health Quality Enforcement Section in order to ensure a common and consistent knowledge base.