Report to the Legislature

Vertical Enforcement

November 21, 2007

Medical Board of California

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Executive Summary

Over the years, the Legislature has periodically reviewed the MBC's performance and taken important steps to refine its operations to further improve public protection. (*Refer to Appendix A for detailed history).* Notably, in 1990, major reforms were initiated by SB 2375 (Presley, ch.1597, Statutes of 1990), including the establishment of the Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ). In so doing, the legislature consistently has sought to bring investigators and prosecutors together to investigate allegations of misconduct by physicians and surgeons. During the 2005-2006 session, the Legislature took yet another important step in this process by directing the MBC and HQES to implement the "vertical prosecution model" (herein referred to as vertical enforcement or VE) for such investigations (SB 231 (2005 Reg. Sess.), § 28). The legislative goal of this two-year VE pilot is to bring MBC investigators and HQES deputy attorneys general together from the beginning of an investigation with the goal of increasing public protection by improving coordination and teamwork, increasing efficiency, and reducing investigative completion delays.

The MBC and HQES have worked closely to implement the VE model. The statistical data collected by the MBC during the first 16 months of the VE pilot shows, when modified to exclude cases prior to implementation of the pilot, an overall decrease of 10 days in the average time to complete an investigation. This decrease was even more significant when consideration is given to fact that the MBC had continued to operate without sufficient investigator staffing and, while it was working to implement the VE model, MBC investigators were saddled with over 1,000 pending pre-2006 investigations. While data is limited, the VE pilot showed significant promise in the following areas:

1. Cases Closed Without Prosecution – The average number of days to close pre-VE cases was 145 days; after VE, it was reduced to 139 days.

2. Obtaining Medical Records – Prior to the VE pilot, it took an average of 74 days to obtain medical records; after VE, it was reduced to 36 days.

3. Obtaining Physician Interviews – Prior to the VE pilot, the average time between the initial request for an interview and the actual interview was 60 days; after VE, it was reduced to 40 days.

4. Obtaining Medical Expert Opinions – Prior to the VE pilot, the average number of days to obtain a medical expert opinion was 69 days; after VE, it was reduced to 36 days.

5. Obtaining HQES Filing – Prior to the VE pilot, the average number of days from investigative completion to the filing of an accusation was 241 days; after VE, it was reduced to 212 days.

6. Interim Suspension Order (ISO) or Temporary Restraining Order (TRP) – Prior to the VE pilot, it took 91 days from the receipt of the investigation to the granting of an ISO or TRO; after VE, it was reduced to 30 days.

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

During much of the 2005 legislative process, SB 231 contained provisions that provided for the transfer of MBC investigators to the DOJ, with the goal of creating a pure VE model where investigators and prosecutors were employed by the same agency, and worked together under a single chain-of-command in a common location. Ultimately, however, the legislature elected not to take this final step and, instead, established VE as a two-year pilot with investigators continuing to be employed by the MBC. The decision not to transfer MBC investigators to the DOJ has presented significant challenges to both agencies as they have worked together to implement the VE pilot. It also has resulted in the loss of experienced MBC investigators who, uncertain over their careers, have elected to seek employment with other law enforcement agencies offering higher salaries and lower caseloads of lesser complexity. Although the Board recommended legislation to allow co-location, implementation of a new information technology system that is interoperable with the same system used by the Attorney General's office, and to increase MBC investigator salaries to align with the salaries of DOJ investigative staff, the legislation failed. Legislation currently pending to address the issues of co-location, and implementation of the

interoperable information technology system is uncertain. If the legislature fails to pass legislation to extend the pilot program, the current statutes will become inoperative on July 1, 2008 and are repealed on January 1, 2009. Nonetheless, MBC and HQES met and have committed to continue VE absent enabling statutes as VE has been determined to be a more efficient and effective means of investigating MBC complaints. The lack of enabling statutes may challenge how MBC and HQES moves forward with VE. Moreover, this issue of two investigation tracking systems would be resolved immediately as DAGs and investigators would use the current information technology system (ProLaw) used by DOJ.

With the change in dynamics, senior management from MBC and HQES have met and committed to a plan that includes the following elements:

- Where practical, agree to co-locate DAGs in MBC district offices or Investigators in HQESo offices. MBC and HQES continue to discuss the challenges of co-location including the facto that it may impact recruitment and retention of investigator staff at each field office.o Historically the MBC established the location of district offices to encourage recruitment ando retention, which was challenged by cost of living issues, the impact of heavy traffic patterns,o and geographic barriers. MBC and HQES have agreed to review each MBC lease renewalo opportunity to determine the appropriateness of co-location at each office location.o
- MBC should purchase the current information technology system used by DOJ as soon aso possible and convert from CAS to this interoperable system. Converting to this interoperableo system will eliminate two incompatible complaint/investigation tracking systems and allow easeo of interface between the two agencies.o
- The current Vertical Prosecution Manual should be eliminated and replaced by a manual similaro to the MBC Enforcement Operations Manual that is modified to incorporate the VE model fromo the receipt of complaint until the resolution of any administrative action. This should beo accomplished on or before December 31, 2008.o

Introduction

This report addresses the provisions of SB 231 (Figueroa, ch. 674, Statutes of 2005) that require the Medical Board of California (MBC or Board), in consultation with the Departments of Justice, Consumer Affairs, Finance and Personnel Administration, to make recommendations to the Governor and Legislature on the vertical prosecution pilot. (Gov. Code, § 12529.6) This landmark piece of legislation contained a number of legal and practical improvements to the Board's enforcement program, following a two-year study by the MBC's Enforcement Monitor.

Under SB 231, effective January 1, 2006, the MBC and the Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) were required to implement a vertical prosecution (VP) model to conduct its investigations and prosecutions. Under this legislatively defined VP model, each complaint referred to a MBC district office for investigation is simultaneously and jointly assigned to a MBC investigator ***and*** an HQES deputy. The goal of this model is to increase public protection by improving the quality of investigations, increasing teamwork and efficiency, and shortening the time to resolve assigned cases. Additionally, the Board hoped this new relationship between MBC and DOJ would enhance the Board's ability to recruit and retain experienced investigators.

Throughout much of the legislative process, SB 231 contained a provision which specified that MBC investigators would be transferred to the DOJ, thus creating a more streamlined and centralized enforcement system to achieve the public protection goal. However, shortly before it was enacted, SB 231 was amended and this proposed transfer of investigators was deleted. Instead, as amended, SB 231 created a VP pilot under which investigators continued to be employed and supervised by the MBC while, at the same time, they are responsible for conducting investigations under the direction of HQES deputy attorneys general. While implementation of this unanticipated hybrid VP pilot has presented significant challenges to both agencies, based on the statistical data collected over the first 16 months of this pilot, it appears that the legislative goal of increasing public protection through faster and more efficient case resolution is being achieved. By law, this VP pilot becomes inoperative on July 1, 2008, and is repealed on January 1, 2009, unless a later enacted statute deletes or extends it.

This report presents:

- the significant steps taken by both MBC and HQES in the implementation of the VP pilot;
- the overall findings and statistical data showing the results of the VP pilot for the period of January 1, 2006 to April 9, 2007;
- recommendations of the MBC regarding the VP pilot; and
- summarizes an historical overview of the MBC enforcement program.

NOTE: The new vertical prosecution model impacts both the ***investigative*** and the ***prosecutorial*** phases of enforcement. Unlike a county district attorney's office, which is solely engaged in criminal prosecution, not all MBC cases lead to prosecution; therefore, vertical prosecution is a misnomer. MBC refers to the new model as a **vertical *enforcement* (VE) model**. Throughout this report, the vertical prosecution model will be referred to as the vertical enforcement (VE) model.

Implementation

On January 1, 2006, the Medical Board of California (MBC) and Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) implemented the vertical prosecution model, as mandated by section 12529.6 of the Government Code *(Refer to Appendix B).* This model, a two-year pilot program, is a new concept never before implemented by another state agency. Implementation of this unique model, where members of the team are from two different governmental agencies with separate hiring authorities, communications systems, and chains-of-command, has presented significant challenges. To meet those challenges, MBC and HQES have taken significant steps, both individually and jointly, to successfully implement the program.

Vertical Enforcement as Defined in SB 231

Throughout much of the 2005 legislative process, SB 231 contained provisions, which specified that MBC investigators would be transferred to the DOJ, thus creating a more streamlined and centralized enforcement system. Since HQES is already statutorily responsible for prosecuting MBC cases, having the investigators under its jurisdiction seemed a logical choice. However, shortly before it was enacted, SB 231 was amended and this proposed transfer of MBC investigators was deleted. Instead, as amended, SB 231 created a pilot under which investigators continue to be employed and supervised by

MBC while, at the same time, they are responsible for conducting investigations under the direction of HQES deputy attorneys general. While the MBC investigative process is essentially unchanged under the VE model, the changes within HQES, both structurally and procedurally, have been more dramatic. For example, under the new VE model, HQES has been required to:

- Develop a database for all cases referred for investigation, not just those that are prosecutede
- Develop familiarity with all MBC policies pertaining to investigationse
- Become responsible for all elements of the investigative process on cases resulting in closure or prosecutione
- Provide case direction from the investigative stage through the prosecutorial stagee
- Prioritize a new workload, which included investigative and prosecutorial taskse

Implementation of this unique VE model mandated by SB 231 has proved challenging, with authority to direct investigators coming under HQES jurisdiction while, at the same time, authority for investigator supervision remaining with MBC. Both the MBC and HQES continue their efforts to meet and overcome these challenges, in a spirit of cooperation, to achieve the legislative goals of SB 231.

HQES and MBC met throughout calendar years 2005 and 2006 to discuss issues, such as: how to handle the large volume of pending pre-VE cases, protocols the agencies would utilize, how communication by the VE teams would be undertaken, and how success of the pilot would be measured. Senior management from both agencies discussed the global issues impacting the pilot, while task forces were established to examine pre-VE policies, create new procedures and select reporting formats.

Both agencies agreed the VE pilot included three basic elements. First, each complaint of alleged misconduct by a physician and surgeon referred to an MBC office for investigation must be simultaneously and jointly assigned to an MBC investigator and HQES deputy attorney general. Second, that joint assignment must exist for the duration of the case. Third, under the direction of a deputy attorney general, the assigned MBC investigator is responsible for obtaining the evidence required to permit the Attorney General to advise the MBC on legal matters such as whether a formal accusation should be file, dismiss the complaint, or take other appropriate legal action. (Gov. Code, § 12529.6.)

The MBC's Enforcement Operations Manual, a compilation of Enforcement Program policies and procedures, required modifications to comport with SB 231. After the revisions were made, they were carefully reviewed by both the MBC and HQES to ensure consistency and agreement. Because the Enforcement Monitor highlighted MBC's inability to meet the 180-day legislative goal for non-complex investigations and the one-year goal for complex investigations (Bus. & Prof. Code, §2319), efforts were undertaken to assess the MBC's policies. Consequently, new policies were developed to address delays encountered when seeking to obtain medical records and conducting physician interviews. MBC staff also defined the criteria for a "complex" investigation.[1] After applying this criteria to the current caseload, 40% of the caseload met the definition of "complex." SB 231 stated that investigations were under the "direction" of HQES; however, the statute did not define "direction" or provide guidance on how to implement the VE model. While initially unable to reach agreement on a joint manual, HQES, in January 2006, published its "Vertical Prosecution Manual for Investigations Conducted by Medical Board Investigators (First Edition, January 2006)," and both HQES and MBC published their "Joint HQE/MBC Vertical Prosecution Protocol (First Edition, January 2006)." HQES and MBC renewed their efforts to develop a joint manual and, in November 2006 successfully and jointly published their "Vertical Prosecution Manual (Second Edition, November 2006)." *(Refer to Appendix C.)*

The DOJ has also made significant modification to its ProLaw computer software used to track investigations and prosecutions. In an effort to overcome co-location barriers, HQES also installed upgraded computers in each MBC district office for use by the deputy attorneys general. A new investigative report format was instituted at the beginning of the VE model to enable investigators to advise DAGs of case progress on an ongoing basis. Minimally, the investigator and the assigned DAG will confer at three stages of an investigation: 1) upon initial case assignment; 2) prior to the interview with the subject physician, and 3) prior to the submission of case documents for an expert review.

Generally, new governmental programs are rarely implemented in a vacuum and the VE model was no exception to this rule. All new complaints received in MBC offices after January 1, 2006 have been investigated under the new VE model. However, as of December 31, 2005, there were 1,014 pending physician and surgeon cases under investigation. Thus, while HQES and MBC were in the process of

[1] On December 31, 2005, there were 140 allied health investigations in the MBC workload. This is also part of the MBC investigator workload from other DCA licensing boards and committees, in addition to the physician and surgeon cases which were the focus of the VE pilot.

implementing the VE model, they continued to handle this large volume of cases primarily under the former HQES Deputy-in-District-Office ("DIDO")[2] model, where, upon completion, the investigation was transmitted to HQES for prosecution. At the present time, the majority of these pre-VE cases have been resolved.

Findings and Analysis

SB 231 created a vertical enforcement (VE) pilot with investigative and prosecutorial team members in two separate agencies. While considerable progress has been made in developing new policies and procedures, defining participants' roles, and creating a team environment to implement the VE model, the fundamental structural barrier of having investigators employed by one agency, while their workload is being directed by employees of another agency, still remains. Notwithstanding those challenges, statistical data demonstrate that under the VE pilot, cases that should be closed are more quickly identified and egregious complaints are being handled more expeditiously – both resulting in a greater measure of public protection.

The statistical data collected by the MBC for the first 16 months of the VE pilot, when modified to exclude pending pre-2006 cases, shows an overall decrease of 10 days (from 146 to 136 days) in the average time to complete an investigation. Significantly, this decrease has been accomplished with existing staff, with no augmentation to restore the investigator positions lost during the FY 2002-2003.

The Legislature has established a goal that "...an average of no more than six months will elapse from the receipt of the complaint to the completion of the investigation." (Bus. & Prof. Code, § 2319.) That period is increased to one year for cases involving "...complex medical or fraud issues or complex recommendations to reduce investigative time lines, MBC identified those cases which would fit the definition of "complex" as discussed in the "Implementation" section of this report.

[2] Under the former Deputy-in-District-Office ("DIDO") program, which existed prior to the enactment of SB 231, a deputy attorney general was required to "frequently be available on location at each of the working offices at the major investigation centers of the Board, to provide consultation and related services and engage in case review with the Board's investigative, medical advisory, and intake staff." (Former Gov. Code, § 12529.5(b))

Initial statistical data from the pilot period identify trends which suggest the VE model can more quickly identify cases for closure and certain egregious complaints can be handled more expeditiously. The data also suggested progress in reducing the time frames to complete investigations. However, the pilot time frame was insufficient to address the Enforcement Monitor's concerns regarding the time to complete prosecutions. Since certain MBC investigations can take one year to conduct, the pilot time frame did not provide adequate time to measure the prosecutorial time line of such cases. It is anticipated that the time frame for the litigation phase will be lessened with the earlier involvement of the deputy attorney general in the case and the continuing availability of the investigator to assist at the hearing.

The MBC's Annual Reports and statistical data reported by the Enforcement Monitor were used to draw comparisons to the data accumulated during the VE pilot (January 1, 2006 through April 9, 2007).

MBC Annual Report Data Re: Time to Complete Investigations

The MBC's computerized data system, Consumer Affairs System (CAS), is used by the Board to gather data for its publications and Annual Report. As reported, the average number of days to complete an investigation was: 208 in FY 2002-03; 220 in FY 2003-04; 259 in FY 2004-05 and 277 in FY 2005-06. While this data shows an increase in the number of days to complete investigations, several significant factors which directly impact these numbers must be considered:

- Vacant and lost investigator positions lead to longer time lines to complete investigations. In FY 2002-03, the Governor's mandated staffing reduction lowered the number of investigators by 19.

- Beginning in FY 2002-03, and continuing to the present, MBC implemented changes pursuant to SB 1950 (Figueroa, ch. 1085, Statutes of 2002) which provided the Board with a new prioritization of complaints and investigations. The Board staff also took steps to reduce the number of cases sent to the district offices for investigation without impacting public safety concerns. Some complaints were resolved in the MBC Central Complaint Unit (CCU) via "cease and desist" letters; some complaints resulted in the issuance of citations: while other complaints e.g., violations involving criminal conviction, were forwarded directly to HQES. Elimination these simpler investigations from the district office workload has resulted in the field receiving only the more time-intensive and complex cases. Thus, the apparent increase in length of time necessary to complete investigations

appears to be the result, at least in part, the elimination of these less-complex investigations from the statistical data base.

- SB 1950, implemented in FY 2003-04, added section 2220.08 to the Business and Professions Code which requires CCU to have all quality-of -care complaints reviewed by a medical expert who is in the same specialty as the subject physician before these complaints were sent to the MBC district offices for formal investigation. This resulted in fewer cases being sent to the district offices. Some of these cases were marginal and often those cases were completed quickly when sent to the district office. With this procedural change, these cases were closed in CCU and impacted the average time for completion of investigations.

- Beginning in FY 2004-05, MBC instituted another procedural change to the way data was collected and reported. All citations initiated from CCU, including those stemming from a physician's failure to notify MBC of a change of address, were no longer reported as a complaint or an investigation. (They were only reported in the annual statistics as citations issued.) Previously these had been reported as cases opened and closed the same day, and impacted the average time for completed cases.

Monitor's Report: Cycle Time for Completed Investigations

The Enforcement Monitor focused attention on MBC's case cycle time (the time that elapses between receipt of a complaint to completion of the investigation related to that complaint). The Monitor's Initial Report presented time frames for completion of investigations by disposition and day range. Table 1 below indicates that, in FY 2003-04, the average elapsed time from receipt of an investigation to case resolution was 261 days, as reflected in the following chart:

Table 1 FY 2003-2004 Investigative Time Frames by Disposition and Day Range

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	83	7.0	144	23.8	227	12.7
1 to 3 Months	133	11.2	36	6.0	169	9.4
3 to 6 Months	239	20.2	80	13.2	319	17.8
6 to 9 Months	248	20.9	69	11.4	317	17.7
9 to 12 Months	195	16.5	80	13.2	275	15.4
12 to 18 Months	206	17.4	110	18.2	316	17.7
18 to 24 Months	67	5.7	67	11.1	134	7.5
More than 24 Months	14	1.2	19	3.1	33	1.8
Total	1185	100.0	605	100.00	1790	100.00
Average Time Frame	256 days		269 days		261 days	

To contrast the Monitor's data, the same criteria was applied to the CAS data, for calendar year 2006 (the VE pilot period). On December 31, 2005, 1,014 physician and surgeon investigations were pending in the MBC district offices. In calendar year 2006, 1,090 physician and surgeon cases were referred to the field. Thus, 2,104 cases were in varying stages of investigation during this pilot period and the average elapsed time from receipt of an investigation to case resolution was 282 days, as reflected in Table 2 below.

Table 2 **CY 2006 Investigative Time Frames by Disposition and Day Range**

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	25	3.3	107	24.7	132	11.0
1 to 3 Months	61	8.0	19	4.3	80	6.7
3 to 6 Months	128	16.7	68	15.7	196	16.4
6 to 9 Months	142	18.6	65	15.0	207	17.3
9 to 12 Months	164	21.4	44	10.1	208	17.3
12 to 18 Months	181	23.7	82	18.9	263	21.9
18 to 24 Months	52	6.8	36	8.3	88	7.3
More than 24 Months	12	1.5	13	3.0	25	2.1
Total	765	100.0	434	100.0	1199	100.0
Average Time Frame	296 days		256 days		282 days	

A comparison of Table 1 to Table 2 appears to reflect an increase in average case investigation time from 261 days (FY 03-04) to 282 days (CY 06). However, data modifications are necessary to both charts because they include a significant number of cases that were in the workload ***prior*** to the start of the time period under analysis. The 2003-04 chart also included workload that is no longer sent to the district offices, due to changes in MBC and CCU policies.

Table 3 below reflects these modifications. For cases that were initiated ***and*** completed during FY 2003-04, the average time to complete investigations was 146 days.

Table 3 **FY 2003-04 Investigative Time Frames by Disposition and Day Range for Investigations Initiated and Completed in FY 2003-2004 (This excludes out-of-state and headquarters cases.)**

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	24	6.8	29	24.2	53	11.1
1 to 3 Months	76	21.3	17	14.2	93	19.5
3 to 6 Months	128	36.0	30	25.0	158	33.2
6 to 9 Months	99	27.8	31	25.8	130	27.3
9 to 12 Months	29	8.1	13	10.8	42	8.8
12 to 18 Months	0	0	0	0	0	0
18 to 24 Months	0	0	0	0	0	0
More than 24 Months	0	0	0	0	0	0
Total	356	100.0	120	100.0	476	100.0
Average Time Frame	148 days		139 days		146 days	

Table 4 below reflects investigative time frames for cases referred for investigation in 2006. Table 4 reveals that, under the VE model the average time to complete an investigation is 136 days.

Table 4 **CY 2006 Investigative Time Frames by Disposition and Day Range for Investigations Initiated and Completed in CY 2006 (This excluded out-of – state and headquarters cases.)**

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	22	11.0	19	24.0	41	14.7
1 to 3 Months	47	23.5	13	26.5	60	21.5
3 to 6 Months	73	36.5	19	24.1	92	33.0
6 to 9 Months	38	19.0	22	27.8	60	21.5
9 to 12 Months	20	10.0	6	7.6	26	9.3
12 to 18 Months	0	0	0	0	0	0
18 to 24 Months	0	0	0	0	0	0
More than 24 Months	0	0	0	0	0	0
Total	200	100.0	79	100.0	279	100.0
Average Time Frame	136 days		133 days		136 days	

Table 4 data clearly indicates a reduced time for the disposition of all cases under the jurisdiction of the district offices.

Overview of Investigative Workload During the VE Pilot

The CAS data can be viewed in a different format to assess how investigations progressed during the VE pilot. Table 5 chart represents investigations that were in the system on January 1, 2006, as well as investigations which were added through December 31, 2006. The chart reflects the disposition of these investigations between January 1, 2006 and April 9, 2007:

Table 5 Investigation Dispositions CY 2006

Physician & Surgeon Investigations	Cases Closed with No Action			Citations Issued			Referred for Criminal Action			Referred for Prosecution				Investigations Pending	
	#	%	Avg Days	#	%	Avg days	#	%	Avg Days	# Primary Referral	# Consolidated Referrals	%	Avg Days	#	%
1014 pending on 1-1-07	569	56%	378	37	4%	380	17	2%	461	191	51	24%	447	149	14%
1090 opened between 1-1-06 & 12-31-06	305	28%	169	11	1%	198	9	1%	218	80	42	11%	186	643	59%

Investigations Pending on December 31, 2005

1,014 investigations were in the investigators' workload at the inception of the pilot. These investigations were in varying stages of development and may have had significant legal involvement under the former HQES DIDO program. While VE was being piloted, these cases also required attention from the newly formed VE teams. Table 5 above reveals that, of the 1,014 investigations, 569 or 56% of these investigations were closed, with an average completion time of 378 days. Of the remaining 445 investigations, action was taken as follows: 37 citations (4%) were issued; 17 investigations (2%) were referred for criminal action: and 242 investigations (51%) were identified for potential administrative action. Effective April 9, 2007, there were 149 pre-2006 investigations pending.

Investigations Opened After January 1, 2006

Table 5 above reveals that 1,090 investigations were opened and assigned to the VP teams during 2006 calendar year. The VE protocols were utilized in processing these investigations. Of the 1,090 investigations, 305 investigations (28%) were closed, with an average completion time of 169 days. Of the remaining 785 investigations, 13% resulted in the following actions: 11 citations (1%) were issued; nine investigations (1%) were referred for criminal action; and 122 investigations (11%) were accepted for administrative action. The data reveals that the average number of days from receipt of the investigation to the investigation completion and acceptance for administrative action averaged 186 days. Effective April 9, 2007, there were 643 investigations (59%) pending.

The data in Table 5 suggests that a large body of work was processed by the team members during this period of time. Of the 2,104 investigations, 874 investigations were closed, 48 citations were issued, 26 investigations were referred for criminal action, and 364 investigations were referred for administrative action. The VE teams worked on the older investigations in the system, as well as focused attention on the newer investigations.

In addition to decreased investigation completion and accusation filing times, the VE model has led to significant improvements in other areas that were the subject of concern by the Enforcement Monitor.

Comparison of Case Closure Data

Within the 2006 calendar year, it took an average of 135 days to close an investigation, which was determined to have "no violation," for those investigations opened during this same year. In FY 2003-04, it took 154 days. This data suggests the VE team is able to identify those investigations which should be removed from the investigative workload earlier in the time line.

During the VE pilot period, it took 139 days to close an investigation that had insufficient evidence to result in a prosecution, whereas in FY 2003-04 it took 145 days. This also suggests these types of investigations are being pulled out of the workload more quickly.

Delays in Obtaining Medical Records

The Enforcement Monitor reported there were significant delays in the time it took for MBC to obtain medical records. In FY 2003-04, the average time from a request for records by MBC to the receipt of all records was 74 days. Subsequently, the Enforcement Program instituted a zero-tolerance policy change for failure to provide medical records in a timely manner pursuant to Bus. & Prof. Code, § 2225 and § 2225.5. The policy was vetted through MBC and HQES, revised in the MBC Enforcement Operations Manual, and distributed to all investigative staff. For cases in the VE pilot assigned in calendar year 2006, the average time to retrieve records was 36 days.

MBC and HQES staff have been diligent to ensure the zero-tolerance policy is enforced and citations have been issued for failure to provide records in a timely manner. The VE pilot has enabled increased

participation by DAGs in record acquisition. It appears the involvement of the Department of Justice also has been instrumental in garnering cooperation from law offices, hospitals, physician offices and governmental entities in providing medical records expeditiously.

Delays in Physician Interviews

The Enforcement Monitor reported there were inconsistent MBC policies and, therefore, delays in conducting interviews with subject physicians. The average time between the initial request for an interview and the actual subject interview was 60 days. For investigations in the VE pilot assigned in calendar year 2006, the average time to request an interview with a physician to the completion of the physician interview was 40 days. The MBC and HQES staff have used their subpoena authority to compel a physician to appear for an interview when there have been delays in appearances.

Delays in Obtaining Medical Expert Opinions

The Enforcement Monitor reported MBC had a policy and a goal of obtaining the expert opinion in 30 days. In FY 03-04, the number of days between the time a completed investigation was sent to an expert reviewer and the time the expert opinion was returned to the investigator was 69 days. MBC data for the request and receipt of an expert opinion in the VE pilot is 36 days.

As part of the VE pilot, HQES DAGs were encouraged to interact with the medical consultants to ensure the appropriate medical expert was selected. This has reduced the number of times a subsequent expert opinion was necessary. The involvement of DAGs earlier in the investigation has served to identify the materials essential for the expert's review, thus elimination the need for the expert's review of unnecessary documents. When the expert opinion is returned, the DAG can quickly assess the opinion to determine if the expert has followed the guidelines and if the opinion has addressed all the substantive issues referenced in the complaint. If the expert opinion requires clarification, the DAG can readily request clarifying information, rather than waiting for the issue to be resolved at the time of trial. This also can eliminate the unnecessary filing of administrative charges.

Number of Accusations and Elapsed Time for HQES Filing

The Enforcement Monitor had concerns about the delays in filing accusations from the date HQES received the investigation. Table 6 below compares cases investigated from calendar year 2006 and accepted by HQES for administrative action between January 1, 2006 through April 9, 2007.

Table 6 Average days to file Accusation

	Accusations Filed				Number of accusations filed where the info from consolidated case is in Accusation (incl in Accusations filed also)	Amended Accusation filed based upon consolidated case information	Disciplinary Actions Taken	
	#	% of referred	Average days from completion of investigation to filing	Average days from completion of investigation to filing			#	Average days from completion of investigation to outcome
1014 investigations pending as of 1-1-06	102	53	569	110	23	9	36	217
1090 investigations were opened between 1-1-06 and 12-31-06	36	45	212	80	14	8	8	130

Investigations Pending on December 31, 2005[3]

Of the 1,014 (pre-VE) investigations pending in the MBC investigator workload, 242 investigations were accepted by HQE with an average of 447 days from the start of the investigation to the acceptance of the case. (Note: These include 191 primary referrals and 51 consolidated case referrals, which are subsequent cases on the same physician.) Table 6 above indicates that of the 242 investigations, 102 investigations (53% of the 191 primary referrals) resulted in the filing of an accusation by the end of CY 2006. The average number of days from the start of the investigation to this filing date was 569 days. The average time from investigation completion to the filing of administrative charges was 110 days. Final outcome was achieved for 36 investigations in an average of 217 days from the completion of the investigation to the final outcome.

[3] On December 31, 2005, there were 140 allied health investigations in the MBC workload. This is also part of the MBC investigator workload from other DCA licensing boards and committees, in addition to the physician and surgeon cases which were the focus of the VE pilot.

Investigations Opened After January 1, 2006[4]

Of the 1,090 investigations opened after January 1, 2006, 122 VE investigations were accepted by HQES for administrative action (80 primary referrals and 42 consolidated case referrals), with an average of 186 days from the start of the investigation to the acceptance of the case. Table 6 above indicates that of the 122 investigations, 36 investigations (45% of 80 primary referrals) resulted in the filing of an accusation by the end of CY 2006. The average time from the start of the investigation to this filing date was 212 days. (Note: As a comparison, for investigations opened in FY 2003-04 with filings within 15 months, it took an average of 241 days.) During the VE pilot, the average time from investigation completion to the filing of administrative charges was 80 days. (Note: In contrast, the FY 2003-04 Annual Report reflected 107 days for an investigation to progress to this point.) In the VE pilot, final outcome was achieved for eight investigations, in an average of 130 days form the completion of the investigation to the final outcome. (Note: As a comparison, for the investigations opened and resolved in calendar year 2004, with outcomes within 15 months, 161 was the average number of days.)

During the pilot, all prosecutorial time frames have decreased. It is significant to note that of the investigations initiated during calendar year 2006 which were accepted by HQES for the filing of an accusation, 45% already have an accusation filed. This suggests that having the legal review earlier in the investigation has led to quicker action on those cases that are filed.

ISO/TRO filings and Elapsed time for filing

The Enforcement Monitor was critical that MBC appeared to have underutilized the Interim Suspension Order (ISO) and Temporary Restraining Order, (TRO) tools that provide extraordinary relief from those physicians who may pose an imminent threat to public safety. Although the monitor did not measure elapsed time to obtain these orders, the time frame in FY 2003-04 from the receipt of the investigation to the granting of the orders was 283 days. In calendar year 2006, the elapsed time from the receipt of the investigation to the granting of these orders was 274 days. In FY 2003-04, the monitor noted 22 ISOs/TROs were granted, regardless of the date of when the investigation was initiated. From January

[4] During calendar year 2006, 183 new allied health investigations were opened. This is also part of the MBC investigative workload from other DCA licensing boards and committees, in addition to the physician and surgeon cases which were the focus of the VE pilot.

1, 2006 through December 31, 2006, 23 ISOs/TROs were obtained regardless of when the investigation was initiated. The numbers alone do not represent a significant increase. Upon further examination of the underlying case data, it was determined that six ISOs/TROs were granted in FY 2003-04 based upon investigations initiated during that same time frame and these took an average of 91 days. In contrast, in calendar year 2006, eight ISOs/TROs were granted based upon investigations initiated during this period, which took an average of 30 days. This data reflects a 67% reduction in the amount of time to obtain an ISO/TRO, thereby demonstrating enhanced public protection.

Successes, Challenges and Recommendations

Over the years, the Legislature has periodically reviewed the MBC's performance and taken important steps to refine its operations to further improve public protection. The implementation of the VE model mandated by SB 231 was another important step in that effort. The preliminary data suggests there have been decreases in all time frames relating to the investigation and prosecution of VE cases. This improvement has occurred even thought the MBC has experienced investigator retention and recruitment issues associated with the uncertainty of this pilot. HQES also had to fill nine vacancies and there is a learning curve associated with new employees. This suggests that in the future a full complement of experienced team members may lead to further decreases in the time frames of enforcement activities. There are positive and negative factors which impact the success of the current pilot, as detailed in the following pages:

Successes:

- 2,104 pending investigations were in process during the VE pilot period. 1,014 cases were pending prior to the VE pilot and 1,090 investigations were assigned during calendar year 2006. Of those, 1,312 reached disposition (865 pre-VE and 447 post-VE): 874 investigations were closed (569 pre-VE and 305 post-VE); 48 citations were issued (37 pre-VE and 11 post-VE); 26 investigations were referred for criminal action (17 pre-VE and nine post-VE); and 364 investigations were referred for disciplinary action (242 pre-VE and 122 post-VE).

- Investigations that result in a finding of no violation or insufficient evidence are being closed more quickly. In FY 03-04, it took 154 days to close "no violation" cases, while in calendar year 2006, it

took 135 days. In FY 03-04, it took 145 days to close "insufficient evidence" cases, while in calendar year 2006, it took 139 days. Both consumers and physicians directly benefit when such investigations are quickly resolved.

- Medical records are being obtained more quickly. In FY 03-04, it took an average of 74 days to obtain medical records. In calendar year 2006, it took an average of 36 days. Some of this reduction in time may be the result of law passed in 2005 giving MBC citation and fine authority for failure to provide records in 15 days. (Bus. & Prof. Code, § 2225 (d)).

- Physician interviews are occurring in a more timely manner. In FY 03-04, it took an average of 60 days to conduct interviews with subject physicians. In calendar year 2006, it took 40 days.

- The average time for receipt of a medical expert opinion has been reduced by 40%. In FY 03-04, it took an average of 69 days to obtain the medical expert opinion. In calendar year 2006, it took 36 days. Implementation of a new policy compelling physicians to appear through use of subpoena power may have contributed to this time savings along with the attorney participation in the VE pilot.

- Accusations are being filed faster. In FY 03-04 it took an average of 241 days from the date the case was initiated to the date an accusation was filed. In 45% of the investigations initiated during calendar year 2006 through April 9, 2007 and approved for filing by HQES, accusations were filed within an average time of 212 days.

- Petitions for Interim Suspension Orders (ISOs) and Temporary Restraining Orders (TROs) in emergency cases are being filed faster. ISOs/TROs initiated in FY 03-04 took an average of 91 days. In calendar year 2006, they took an average of 30 days. Clearly, the assumption is that early involvement of a DAG reduces the time to initiate these actions.

While the VE pilot has plainly demonstrated substantial public protection benefits, it is unclear whether further significant improvements can be obtained under the present model. The loss of experienced MBC investigators as a result of continuing the pilot in its present state may ultimately undermine the

very public protection goals it was originally enacted to achieve. In this regard, the MBC presents the following.

Challenges:

- There are retention problems with MBC investigative staff which have existed for many years due to factors common in many law enforcement agencies. Recruitment of entry level personnel followed by a number of years of training and experience creates a work force eligible for and interested in jobs found elsewhere outside of the MBC that, for a variety of reasons, including higher pay, may be more attractive. This problem may have been exacerbated recently with MBC investigators who were led to believe they might soon be transferred to DOJ (and receive a higher salary) and instead were engaged in a "pilot" study.

  (Note: On January 1, 2006, MBC had 92 sworn staff position comprised of 71 investigators and 21 supervisors. On July 1, 2006, SB 231 augmented staff by four investigator positions, bringing the total to 96. Of the 96 authorized positions, there was an average statewide vacancy rate of 12.3% during calendar year 2006, which equates to 11.6 positions being vacant thereby resulting in an increased workload for the remaining investigators. From January 2006 to present, there were 19 investigator separations [six retired, two resigned, and 11 transferred]. Of the 11 transfers, two went to DOJ; two went to Corrections; five went to D of I; one went to Lottery; and one went to DHS. Although this vacancy rate may be consistent with other state agencies, when it is coupled with the time required for backgrounds and training, the impact is magnified.)

- In conducting exit interviews, many investigators have cited the major reason for such a high rate of exodus as due to MBC's lower salaries and more complex workload than other agencies. In addition, many retired investigators indicated that they may have chosen to work for more years if the workload were reduced and the pay increased.

- Some experienced MBC investigators also have been attracted to the DOJ special agent classification due to the prestige and enhanced benefits associated with that classification.

- There is reason to believe the VE pilot may have hindered the recruitment efforts of MBC investigators. New applicants have questioned the future of the MBC investigator position and have been reluctant to join an investigative agency with such an uncertain future.

- Supervisory investigator positions have remained vacant for longer periods of time. Two supervisors chose to voluntarily demote and some investigators were reluctant to promote due to the changing environment and greater demands of VE.

- The VE pilot has led to some role confusion by DAGs and investigators as the terms "direction" and supervision," as used in the statute, were not clearly defined and are subject to interpretation.

Recommendation:

The statistical data collected by the MBC, while limited, has shown a decrease in all of the time periods related to the investigation and prosecution of cases under the VE model. MBC concludes that trends indicate benefits to both consumers and licensees are likely to continue to be achieved under a VE model and that this model should be fully and permanently integrated into the MBC operations. MBC shall monitor the measurable outcomes from this program to ensure consumer benefits continue to be demonstrated in the future. Additionally, the MBC should move forward with co-location, where appropriate, and implementation of an information technology system interoperable with the current system used at DOJ. The MBC and HQES should also work together to create a manual similar to the MBC Enforcement Operations Manual that is modified to incorporate the VE model from the receipt of complaint until the resolution of any administrative action.

Appendix A

History

Vertical Enforcement Defined

The term, "vertical prosecution" (VP), as defined in the Enforcement Monitor's Initial Report[4] refers to the continuous involvement of attorney and investigator team members as a case works its way through the investigative and prosecutorial process. Investigators and prosecutors work together in teams from the date a case is assigned for investigation. The purpose of this combined effort is to prepare complex investigations for trial or some other legal disposition. It is often visualized as a vertical chain of events beginning with investigation and proceeding to pleadings, preliminary examinations, pre-trial motions, trials and appeals. While these terms are common to criminal proceedings where VP is used, the majority of MBC cases will result in a disposition other than prosecution. The term "vertical enforcement" (VE) term more accurately describes the process of investigating MBC cases and includes those cases that will be closed without formal action.

In the VE model, the investigation benefits from having legal guidance and assistance from the HQES deputy attorney general at the initial assignment of the case. Under this model, the trial attorney and the investigator are assigned as a team to handle a complex case as soon as it is opened as a formal investigation. The team approach refers to the team assembled for a particular case, allowing for experts or certain specialists to be added to the case, as may be required. In some agencies, different teams are formed for different types of cases, thus maximizing training and the development of different working relationships.

While the prosecutor and the investigator work together during the investigative phase to develop the investigative plan and ensure the gathering of necessary evidence to prove the elements of the offense, they have very different roles. The prosecutor brings the expertise to anticipate legal defenses; provides legal analysis of the incoming evidence to help shape the direction of the case; assists with uncooperative subjects or third-party witnesses; deals directly with defense attorneys when issues arise; and addresses settlement or plea matters, which often arise early in such cases. In turn, the investigator contributes a peace officer's experience and insight into the investigative plan and case strategy; performs the field investigative tasks, including identification and location of witnesses and subjects; interviews witnesses and subjects; obtains and participates in the review of documentary and technical evidence; assesses criminal histories and other databases; identifies and assists with experts; plans and executes undercover operations; prepares affidavits and specifications for search warrants; serves warrants; makes arrests; assists with witnesses and evidence during the trial

[4]Enforcement Monitor *Initial Report,* November 2004, page 134 (including footnote #172)

phase; prepares investigative reports; and conducts other tasks usually associated with the work of trained peace officers and professional investigators.

Enforcement Monitor's Recommendation

SB 1950 (Figueroa, ch. 1085, Statutes of 2002) appointed an Enforcement Monitor to study the Medical Board of California's Enforcement Program. The study began in November 2003 and occurred over two years. During the first year, the study was devoted to 10 areas including: mission; resources; management structure; complaint, investigation and disciplinary processes; and the use of medical consultants and medical experts.

During the second year, emphasis was placed on measuring any changes implemented by the MBC during year one, analyzing the last year's fiscal year data and assistance with the drafting and advocacy of legislation introduced as a result of the Enforcement Monitor's recommendations. The Enforcement Monitor's Initial Report, released November 1, 2004, included 55 recommendations relevant to the Board's enforcement program. ***(Refer to http://www.mbc.ca.gov/Pubs_Enforcementrept.htm for the full Initial Report.)***

The Enforcement Monitor's report concluded that the board's enforcement program was impeded by: time delays in the investigative process; inadequate coordination and teamwork between MBC investigators and HQES prosecutors; delays in procurement of medical records; ineffective policies relating to physician interviews; inadequate medical consultant availability and utilization; weaknesses in the medical expert program; need for ongoing training for MBC investigative staff; need for improved coordination with state and local prosecutors; ongoing problems with recruitment and retention of MBC investigators; need to update existing MBC training manuals; and, MBC investigators could benefit from improved access to various databases. While some of these issues were addressed immediately as the MBC implemented new policies and procedures, others could not be addressed without legislation.

The Enforcement Monitor recognized how MBC cases might benefit from the VE model. The Enforcement Monitor envisioned early and continuing attorney/investigator teamwork that is typically utilized by many other prosecutorial offices when handling complicated cases. Certain complex and difficult law enforcement investigations naturally lend themselves to this model and many MBC cases involve highly technical medical issues, complicated facts, and multiple victims and witnesses.

The monitor envisioned elements of the vertical enforcement model to include:

- Early coordination of the efforts of attorneys, investigators, and other staff;
- Continuity of teamwork throughout the case;
- Mutual respect for the importance of the professional contributions of both attorneys and investigators and the value of having both available in all stages of the case; and
- Early designation of trial counsel, recognizing that the prosecutor who ultimately puts on the case must be assigned from the case's inception to help shape and guide it because any investigation may have a trial as its ultimate outcome.

The Enforcement Monitor described concerns affecting the existing inadequate attorney-investigator coordination and teamwork. "The performance of the MBC's investigative staff and HQES prosecutors, and the nature of the working relationship between the HQES and MBC, have been studied closely in this project. MBC investigators and HQES prosecutors are hard-working and skilled professionals, and much good disciplinary work is done every day by these dedicated public servants. All parties acknowledge good faith and good efforts on all sides. However, there is clearly room for improvement in the cost, speed, and effectiveness of the administrative enforcement system as presently constituted, as indicated by the lengthy case cycle times and comparatively modest case outputs noted by the state Legislature and other critiques."[5]

Vertical Enforcement as Defined in SB 231

Throughout much of the 2005 legislative process, SB 231 contained provisions which specified that MBC investigators would be transferred to the DOJ, thus creating a more streamlined and centralized enforcement system. Since HQES is already statutorily responsible for prosecuting MBC cases, having the investigators under its jurisdiction seemed a logical choice. However, shortly before it was enacted, SB 231 was amended and this proposed transfer of MBC investigators was deleted. Instead, as amended, SB 231 created a pilot under which investigators continue to be employed and supervised by MBC while, at the same time, are responsible for conducting investigations under the direction of HQES deputy attorneys general. While the MBC investigative process is essentially unchanged under the VE model, the changes within HQES, both structurally and procedurally, have been more dramatic. For example, under the new VE model, HQES has been required to:

[5]Enforcement Monitor's *Initial Report*, page 129

- Develop a database for all cases referred for investigation, not just those that are prosecuted
- Develop familiarity with all MBC policies pertaining to investigations
- Become responsible for all elements of the investigative process on cases resulting in closure or prosecution
- Provide case direction from the investigative stage through the prosecutorial stage
- Prioritize a new workload, which included investigative and prosecutorial tasks

Implementation of this unique VE model mandated by SB 231 has proved challenging, with authority to direct investigators coming under HQES jurisdiction while, at the same time, authority for investigator supervision remaining with MBC. Both the MBC and HQES continue their efforts to meet and overcome these challenges, in a spirit of cooperation, to achieve the legislative goals of SB 231.

Historical Review: MBC Investigations and Prosecutions

The Medical Board of California is a semi-autonomous occupational licensing agency located within the state Department of Consumer Affairs (DCA). It has been in existence since 1876 when the Legislature first passed the Medical Practice Act. From its inception, there existed a need for the MBC to protect healthcare consumers through the vigorous, objective enforcement of the Medical Practice Act. This remains the MBC's mission today. The MBC has two fundamental responsibilities: licensing applicants under the Division of Licensing (DOL) and the investigation of complaints against its licensees, under the Division of Medical Quality (DMQ). The Enforcement Program, housed under DMQ, has made many improvements over the years to maximize efficiency. This historical review will highlight major events which led to the current structure of the MBC's Enforcement Program with an emphasis on the evolving relationship between the MBC investigative staff and the HQES prosecutors.

MBC Investigations During the Early Years

From 1876 to 1913, the Board of Medical Examiners (later renamed MBC) spent most of its energies trying to establish itself as a legal entity with jurisdiction over the medical profession. Little was done to discipline the physician community during this time. The MBC's Enforcement Program was not created until 1913 and initially consisted of one chief counsel and two special agents.

In the decades of the 1920s and 1930s many MBC investigations focused on fraudulent diploma "mills" which issued medical credentials, diplomas and licenses for a price. The Enforcement Program staff of four grew to a force of 10 individuals during this period. The state was divided in half with a Northern and a Southern Department. Little change occurred during the next two decades.

In the 1960s, the MBC Enforcement Program was responsible for investigating physician licensees as well as certain allied health licensees, as there was a similarity in the types of violations that were investigated. Common offenses involved improper use of prescription drugs, intemperance, illegal abortions and practicing medicine without a license.

Under Governor Ronald Reagan, a proposal was made and approved to centralize the investigative staff from all the licensing boards into one pool of investigators who were assigned to the newly created Division of Investigation under the renamed Department of Consumer Affairs (DCA). This included all the MBC investigators. The restructuring would allow better organization and training of investigators, and the number of field offices could be expanded to certain geographic parts of the state which were under-served. With this reorganization, the Governor appointed a new chief over the Division of Investigation.

During this time, investigator caseloads often ranged from 75 to 100 cases, with a mix of violations. Cases involving physician misconduct could be discussed with the one medical consultant, who was available to the investigators periodically. In addition there was difficulty in monitoring the progress of investigations. By 1975, the number of DCA licensees had exceeded one million and the number of investigators had increased to more than 100. MBC complaints became backlogged over time and the Board was concerned about inadequate public protection.

MICRA and AB 1xx - 1975

In 1975, AB 1xx (Keene, 2nd Ex Sess., ch.1, Statutes of 1975), known as the Medical Injury Compensation Reform Act of 1975 (MICRA), was created to provide relief from high malpractice insurance premiums and also included provisions for a massive reorganization of MBC. The Board's name was changed from the Board of Medical Examiners to the Board of Medical Quality Assurance. The new name was intended to better reflect the goal of assuring quality medicine to the citizens of California. Most important, it bolstered the Enforcement Program by increasing its staff by 54 additional technical, consultant, investigative and support positions.

In 1975, biennial physician licensing fees were increased to $175. MBC had sufficient funds to hire investigators who would again specialize in medical

investigations. By 1976, approximately half of the investigators from the Division of Investigation were transferred, with their existing caseloads, to MBC, thus forming a new investigative unit.

In 1977, the Chief of Enforcement position was created. Under the direction of a supervising investigator, investigators worked with medical consultants who were now staffed in all field offices. If the evidence revealed a violation of law, the completed investigation was then transmitted, or "handed off," to a deputy attorney general (DAG) in the Department of Justice's Licensing Section.

These deputies were located in four major metropolitan areas within the state. The DAGs were not specialized and received assignments involving all licensees under the DCA. MBC cases were commingled with the cases from the Division of Investigation and MBC investigations often received the same priority as cases involving licensed hairdressers, tax preparers and security guards.

The assigned DAGs reviewed the case file to determine if the evidence supported the filing of administrative action against a physician's license. Typically, the investigator and the prosecutor performed their roles separately. The workload volume was high, discussion of case evidence on individual cases was often limited and, in some cases, only occurred if the case went forward to hearing.

Reduced Board Investigator Staffing and Increased Workload

In July 1988, MBC had 700 complaints awaiting investigation. The Chief of Enforcement reported that since the creation of the Enforcement Program in 1977, all efforts to increase the staff had been denied by the Department of Finance, with the exception of two new investigator positions assigned to the probation surveillance program in 1979. He reminded the Board that three program audits, conducted by the Little Hoover Commission, the Department of Finance and Arthur Young International, had all recommended increasing the staffing of the enforcement program. Because the number of MBC investigators was not increased, annual complaints climbed from 4,265 in 1977 to 6,293 in 1988. In 1977, 2,539 investigations were opened and 2,089 were closed, while in 1988, 2,658 cases were opened with 2,561 closed.

The investigator staffing situation was further complicated in 1988, when the Governor authorized a "golden handshake" retirement option. A significant number of tenured investigators exercised this option to retire early with enhanced benefits and reduced the number of MBC investigators to 40. Faced with a significant number of vacant investigator positions, MBC made a focused effort to recruit, hire and train investigator replacements. The timing of this effort, however, was difficult, as all other state investigative agencies were also faced with vacant positions.

Enforcement Program managers also recognized that some state agencies offered investigators caseloads of fewer than 10 cases while MBC investigators averaged 30 cases. Other state agencies were able to offer investigators significantly higher pay and some Board investigators took these offers of employment. Recruitment efforts, coupled with background investigations, also impacted the time span when a selected applicant could
begin employment. It was generally recognized that basic training for a new MBC investigator required close supervision for a minimum of one year before the new employee could undertake independent work. The combination of these factors led MBC to take a different approach to address the staffing problem.

In April 1989, when responding to the Legislature on the issue of creating a toll-free number for consumers, the Board took the opportunity to inform the Legislature of its staffing needs to safely protect the public. The Board submitted a report to the Joint Legislative Budget Committee entitled, "*Special Budget Report: Curing the Backlog.*" The report detailed complaint increases over a five-year period and noted that during this same period, MBC had submitted budget requests for 30 additional positions to handle the case growth and resulting backlog. The report recommended 18 permanent new investigator and support staff positions to accommodate case growth, eight limited-term investigator positions, and two limited-term Complaint Analyst positions to eliminate the backlog.

At this same time, the Center for Public Interest Law (CPIL) released its report, *Physician Discipline in California: A Code Blue Emergency.* The report reviewed the MBC Enforcement Program and observed that while more complaints were received, fewer actions were filed and fewer physicians had been disciplined.

The CPIL report was critical of the existing structure whereby MBC had no control over the Licensing Section or the Office of Administrative Hearings, and expressed concern about the time necessary to complete some disciplinary actions. The report offered suggestions for change, including the creation of a unit of prosecutors within the Office of the Attorney General to specialize in medical disciplinary cases. All of these suggestions required legislation.

In May 1989, the Chief of Enforcement advised the Board of the need for additional investigators and detailed efforts by the Enforcement Program to increase MBC investigator's salaries, to be in parity with other comparable state investigative agencies. Based on this discussion, MBC agreed to increase its licensing renewal fees from $175 (1976) to $360 biennially. Later in the year, 18 permanent positions and 10 limited-term positions were added to the enforcement program and two new district offices were created in areas where most of the backlogged cases existed.

AB 184 (Speier, ch. 886 Statutes of 1989) changed the Board's name to the Medical Board of California, effective January 1, 1990. At this same time, a toll-free phone line was installed to make the Board more accessible to consumers and a Centralized Complaint and Investigation Control Unit (later referred to as CCU) was created for more efficient processing of complaints. This new structure allowed for improved communication with consumers on the status of their complaints and eliminated the backlog of unprocessed complaints. The centralized handling of complaints eventually led to redistribution and even workload assignments to the various district offices and allowed for consistency in the types of complaints that were formally investigated.

Significance of SB 2375

In 1990, SB 2375 (Presley, ch. 1597, Statutes of 1990), also known as the Medical Judicial Procedure Improvement Act, was passed. This bill changed MBC's disciplinary process. It added Government Code § 12529 *et seq.* creating the Health Quality Enforcement Section (HQES) within the Department of Justice to specialize in prosecuting physicians and other health care practitioners. HQES was required to be "staffed with a sufficient number of experienced and able employees capable of handling the most complex and varied type of disciplinary actions against the licensees of the division or board." (Bus. & Prof. Code, § 12529) HQES was also required to assign attorneys "to work closely with each major intake and investigatory unit... to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." (Bus. & Prof. Code §12529.5)

SB 2375 also added Bus. & Prof. Code, § 2319 which required MBC to establish a goal that an average of no more than six months would elapse from receipt of a complaint to the completion of an investigation. Cases involving "complex medical or fraud issues or complex business or financial arrangements" had a goal of not more than one year from receipt to completion. Significantly SB 2375 amended Bus. & Prof. Code, § 2229, thereby redirecting the Board's primary priority from physician rehabilitation to public protection.

Recognizing the staff recruitment and retention difficulties of MBC, SB 2375 contained language stating, "It is also the intent of the Legislature that the pay scales for investigators of the Medical Board of California be equivalent to the pay scales for special investigative agents of the Department of Justice, in order to attract and retain experienced investigators." On April 20, 1990, MBC members voted to support SB 2375 with a specified amendment, which stated in part, "Add statutory provisions to raise Medical Board of California investigator salaries to prevent loss of experienced investigators to higher-paying agencies." The objective of the amendment was to get legislative intent recorded to say that the

pay scales of the investigators of the Medical Board of California be increased to within 5% of the pay scales for the special agents of the Department of Justice in order to stem the loss of experienced investigators to higher paying state agencies, and to attract new investigators. This amendment was not adopted, but the intent language stayed in the bill.

Efforts to Increase MBC Investigators' Salaries

Consistent with the intent language, in June 1990, the MBC took more action to increase investigators' salaries and provided detailed documentation to DCA outlining investigator vacancies and transfers. Analysis reflected that the duties and level of responsibility of the DCA Special Investigator series were comparable to the DOJ Attorney General investigator, who conducted Medi-Cal fraud investigations. However, in January 1991, DCA proposed that the salary level for the new DCA investigator classification series be aligned to the Department of Corporations investigator series. Three months later, the State Personnel Board established a new series for Investigator, DCA with a salary consistent with the Department of Corporations Investigator series. This represented a 10% salary increase, although MBC investigator salaries were still not aligned with the DOJ Special Agent series.

Response to SB 2375

In early 1991, all backlogged cases were assigned to MBC investigators. The MBC renewed its efforts to increase investigator staffing and received the support of both the Department of Finance and the State and Consumer Services Agency. Fourteen additional investigator positions and 10 support staff positions were requested. These positions were added to the new district offices and reduced caseloads from the 27-30 level, to the 20-23 level.

During this same year, the Office of the Attorney General implemented the provisions of Government Code §12529 and created the specialized HQES to handle disciplinary actions against physicians. Initially, the 22 deputies assigned to HQES set a goal of filing accusations within 60 days of receipt of a referred case. However, HQES was initially understaffed and cases became backlogged in its office.

In April 1991, an Auditor General report found that the MBC would be unable to complete investigations in a six-month period, noting that an average investigation took 14 months. This was attributed to an unusually high vacancy rate in MBC investigator positions and excessive caseloads. The report also found that HQES was taking approximately six months to file an accusation in a fully investigated case. In the Fall of 1991, the MBC raised its licensing renewal fees to $400 biennially, and agreed to consider another fee increase to finance additional HQES staff.

In 1992, HQES experienced significant delays in filing accusations (486 days). There appeared to be a miscalculation on the number of hours it would require a DAG to review a case, draft pleadings, litigate and follow up on a case. The discussion resulted in an agreement by MBC to fund 27 additional DAG positions and four paralegal positions. To fund these DAG positions as well as more time for administrative law judges, the Board increased its biennial licensing renewal fee to $500.

SB 916

In 1993, SB 916 (Presley, ch. 1267, Statutes of 1993) was passed and again revised the MBC's Enforcement Program. It included a number of provisions and authorized the MBC to increase its biennial licensing renewal fee from $500 to $600.

Investigator staffing problems were exacerbated in 1994 when DPA established a $200 recruitment and retention pay differential for Los Angeles County for incumbents in the Special Investigator and Senior Special classifications for the Department of Motor Vehicles and Employment Development Department. In 1995, the Department of Health Services was added. This same year, DCA submitted a request to DPA for investigator recruitment and differential pay; however, it was denied in 1996.

In March 1995, the Auditor General report, required by SB 916, noted that HQES deputies were assigned caseloads of 30. A backlog of unfiled cases was growing and HQES had requested funding to hire additional attorneys.

During this time, the MBC's Chief of Enforcement reported a 23% increase in complaint volume the prior two years, with no corresponding increase in staff. Investigator caseloads were growing, and there was a 10% vacancy rate in investigator positions because trained MBC investigators were leaving for other agencies with higher pay and lower workload of lesser complexity. The Chief of Enforcement urged a fee increase to finance investigator positions and attorney positions, but this was denied. In 1996, when the complaint volume further increased and the time for completed investigations increased, the Board voted to seek legislation to increase the biennial licensing renewal fees. At this time, the Board's new executive director sought other fiscal efficiencies in the program and avoided the need for increased fees.

Creation of the "DIDO" Program

In 1997, the "Deputy In the District Office" or "DIDO" program was implemented. This program required a DAG to work in the MBC Central Complaint Unit and in the 12 offices one or more days a week to provide legal

assistance and guidance throughout the "lifetime" of a complaint. Conceptually, the DAG would interact with board investigators, and give legal advice on a variety of matters. In CCU, the part-time DAG was primarily involved in the review of complaints and was asked to provide an opinion if a formal investigation was necessary. In the offices, the DAG assisted with active investigations (e.g., subpoena enforcement to help investigators obtain requested medical records; reviewing medical expert opinions to determine if the medical issues were sufficiently described; and reviewing all active cases before they were formally referred to HQES for prosecution).

HQES accusation filing time dropped from 134 days (in 1996) to 90 days as a result of the earlier involvement by an attorney in the investigative design and in the records procurement process. HQES met its goal of filing accusations in a more timely manner. However, the limited interaction allowed by the DIDO program was not always adequate to facilitate the complexity of the MBC investigations. The DAGs assigned to the DIDO Program also had other duties and responsibilities that sometimes prevented them from dedicating all their time to active MBC investigations. The DAGs were assigned active prosecution caseloads, which required them to review the case evidence, prepare legal correspondence, interact with defense counsel, prepare witnesses for testimony, draft subpoenas, prepare for settlement conferences and litigate cases. They were also required to present all cases through the appeals process before the Board, Superior Courts, Courts of Appeal, and Supreme Court. While balancing their trial calendar, DAGs would also provide legal assistance and guidance to investigators on active cases. (However, when cases were formally transmitted to HQES, a DAG, other than the DIDO was assigned to the case.) Legal strategies sometimes differed, and investigators were sometimes given new direction on these referred cases. As with any "hand-off" method that involves the transfer of a case from one attorney to another, the DIDO model often resulted in a duplication of efforts and delays.

In the fall of 1997, the MBC underwent "sunset" review by the Joint Legislative Sunset Review Committee. The average investigative time cycle to complete a case was 336 days and HQES averaged 134 days of elapsed time from receipt of a case to the filing of an accusation. The MBC investigator caseloads were still high.

In October 2001, Governor Davis imposed a hiring freeze. Although MBC is a special funded agency where salary savings would not assist the general fund deficit, MBC was required to cease the filling of any position which became vacant including investigator positions. During this year, MBC's Enforcement Program reduced the investigative cycle time to 204 days, and an average of 112 days elapsed between HQES receipt of a case and the filing of an accusation.

In Fall 2002, as a result of the continuing budget freeze and budget control language, MBC lost 15.5 positions, which included eight enforcement positions. The hiring freeze continued through FY 2002-03 and FY 2003-04 and imposed an additional 12% budget reduction in personnel. MBC lost a total of 44.8 positions (29 enforcement positions, which included 19 investigators and supervisors). MBC's investigator positions were reduced from 90 in FY 2000-01 to 71 by June 30, 2004, a 24% loss. Due to these same freezes, HQES lost six prosecutor positions assigned to the Los Angeles area.

Enforcement Monitor

In September 2002, SB 1950 (Figueroa, ch. 1085, Statutes of 2002) was signed and made a number of changes to the MBC Enforcement Program. It created an "Enforcement Monitor," who was to be appointed by the DCA Director for a two-year period to study the effectiveness of the MBC Enforcement Program and extended the existence of the MBC until the monitor's findings and recommendations could be evaluated. SB 1950 authorized the MBC to increase its biennial fees from $600 to $610.

In 2003, several changes were implemented in CCU, utilizing "cease & desist" letters and other mechanisms, which resulted in the field receiving only the more time-intensive and complex investigations.

In August 2003, the Enforcement Monitor was appointed pursuant to SB 1950, and provided two reports to the Legislature. The Monitor's Initial Report, released November 1, 2004, described the existing investigative process and contained 55 recommendations for improvement to the Board's enforcement program. MBC implemented many of these recommendations; however, certain changes could not be made without legislation.

SB 231

SB 231 (Figueroa, ch. 674, Statutes of 2005) signed by the Governor on October 7, 2005, made a number of significant amendments. An important part of this new legislation declared 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 prosecution model for those investigations is in the best interest of the people of California." When the Legislature closely studied this situation, they envisioned a need to improve the communication between the MBC investigators and DAGs with the goal of creating more efficient investigations and quicker case resolution.

Throughout calendar year 2005, MBC and HQES managers discussed options for implementing VE. The initial language in SB 231 contemplated the transfer of MBC investigators to HQES. Consideration was given to whether VE could be piloted in a designated geographic area, however this option posed several obstacles including investigator inequity, i.e., permitting a limited number of investigators to transfer to DOJ as special agents may be perceived as unfair by those investigators not permitted to transfer.

MBC researched what other VE models existed in state service. One of the few agencies utilizing a VE models is the DOJ's, Bureau of Medi-Cal Fraud (BMF). MBC recognized that the MBC structure was compatible with BMF and thus MBC could incorporate the BMF model. Major similarities exist between the MBC and BMF, as follows:

- BMF employs 106 sworn special agents, 31 deputy attorneys general (DAGs),
- 25 auditors and support staff *(MBC employs approximately 100 sworn investigators, and approximately 16 medical consultant positions. HQES is presently staffed with approximately 53 DAGs.)*
- BMF special agents and auditors are housed in 11 offices; prosecutors are located in four separate offices statewide *(MBC has 11 offices and prosecutors are located in four separate offices statewide).*
- The BMF VE triangle "team" consists of an agent, attorney and auditor and the triangle "spins" to focus attention on the lead person who is most responsible for the case at a given juncture. *(MBC's triangle team could consist of an investigator, attorney and, as necessary, a medical consultant.)*
- BMF cases are assigned to an intake special agent and a DAG via a DOJ software program called ProLaw, where documents, photos, audit reports, etc. can be scanned. *(MBC cases could be assigned via the CAS system which could be adapted to exchange information with ProLaw.)*
- BMF special agents and DAGs use computer docking stations and access ProLaw from various offices. *(MBC could acquire the equipment to implement this system.)*
- BMF case discussions are ongoing among the team members, are usually in person, and often take place where the evidence is located. DOJ supervisors can participate in any of these meetings. As necessary, team members communicate via their cell phone or by ProLaw. *(MBC could adopt this method of operation.)*

- BMF disputes regarding case resolution are resolved at the lowest level; however, the special agents can raise their concerns to the BMF Chief. The DAGs can raise their concerns to the BMF Chief DAG. Final dispute resolution rests with the Medi-Cal Fraud Director. *(MBC could adopt this resolution process.)*

SB 231 did not contemplate how the transfer of MBC sworn staff to DOJ would occur, nor was the discrepancy in classification addressed. MBC's Chief of Enforcement met with DOJ labor-relations personnel and learned that DOJ only has one classification for its sworn staff: Special Agent.

In September 2005, the Board's Executive Director met with the Senior Assistant Attorney General for HQES to consider a design for the VE relationship. They envisioned the replacement of the DIDO program with a team of deputies being assigned to each MBC office. They recognized that a significant number of MBC cases result in closure without disciplinary action, and therefore, vertical enforcement of these cases would not be necessary. The HQES team leader was construed to be an "advice and consultation" deputy, who in conjunction with the supervising investigator, would be responsible for assessing every case for its potential for administrative action. If a case was thought to present potential for prosecution, it would be assigned to a deputy to whom prosecutorial responsibility was attached. The major concern regarding the implementation of this model was the lack of sufficient staffing within the Los Angeles metropolitan area. The Senior Assistant Attorney General for HQES believed this model would be phased into various areas of the state as vacant DAG positions were filled.

On October 7, 2005, SB 231 was signed by the Governor. The final version of the law differed dramatically from what either MBC or HQES had envisioned. Throughout much of the legislative process, SB 231 contained a provision which specified investigators would be transferred to the Department of Justice, thus creating a more streamlined and centralized enforcement system. However, shortly before it was enacted, SB 231 was amended and this proposed transfer of investigators was deleted. Instead, as amended, SB 231 created the VE model under which investigators continue to be employed and supervised by the MBC while, at the same time, are responsible for conducting investigations under the direction of HQES deputy attorneys general. SB 231 created a two-year pilot and required this report on the VE model to be submitted to the Legislature by July 1, 2007.

At the November 4, 2005 DMQ meeting, the Chief of Enforcement reported that SB 231 had been signed and a two-year pilot would begin, effective January 1, 2006. This pilot was viewed as a "first step" in a process which would culminate when the investigators and prosecutors were in the same agency.

HQE created a Lead Prosecutor who would be assigned to each office to review all incoming cases and a Primary Deputy who would be assigned to cases where prosecution would go forward. Flexibility would be necessary when deputies were called into trial and to ensure urgent priorities were expeditiously handled. To ensure all members of the team understood their respective roles in the process, new joint operating protocols would be needed. The protocols would clearly define the roles and responsibility of each member while staying focused on the ultimate goal, which was the timely and efficient completion of investigations and, where violations were uncovered, prosecution of the case.

In December 2005, all HQES deputies and MBC investigators attended joint meetings to discuss the implementation of the pilot. The content of SB 231 was discussed, and all attendees were encouraged to be flexible to adapt to necessary changes as the pilot unfolded. New MBC policies, impacted by this new relationship, and which had been vetted by MBC and HQES, were distributed to all participants. HQES deputies were assigned to specific MBC offices and the new teams were introduced. Questions were raised regarding the handling of the pending caseload, which was created under the former DIDO model. There was general agreement that a phasing-in process would be necessary to resolve these cases.

Implementation

On January 1, 2006, the Medical Board of California (MBC) and Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) implemented the vertical prosecution model, as mandated by section 12529.6 of the Government Code. This model, a two-year pilot program, is a new concept never before implemented by another state agency. Implementation of this unique model, where members of the team are from two different governmental agencies with separate hiring authorities, communications systems, and chains-of-command, has presented significant challenges. To meet those challenges, MBC and HQES have taken significant steps, both individually and jointly to successfully implement the program.

HQES and MBC met throughout calendar years 2005 and 2006 to discuss issues, such as: how to handle the large volume of pending pre-VE cases, protocols the agencies would utilize, how communication by the VE teams would be undertaken, and how success of the pilot would be measured. Senior management from both agencies discussed the global issues impacting the pilot, while task forces were established to examine pre-VE policies, create new procedures and select reporting formats.

Both agencies agreed the VE pilot included three basic elements. First, each complaint of alleged misconduct by a physician and surgeon referred to an MBC office for investigation must be simultaneously and jointly assigned to an MBC investigator and HQES deputy attorney general. Second, that joint assignment must exist for the duration of the case. Third, under the direction of a deputy attorney general, the assigned MBC investigator is responsible for obtaining the evidence required to permit the Attorney General to advise the MBC on legal matters such as whether a formal accusation should be filed, dismiss the complaint, or take other appropriate legal action. (Gov. Code, § 12529.6.)

The MBC's Enforcement Operations Manual, a compilation of Enforcement Program policies and procedures, required modifications to comport with SB 231. After the revisions were made, they were carefully reviewed by both the MBC and HQES to ensure consistency and agreement.
Because the Enforcement Monitor highlighted MBC's inability to meet the 180-day legislative goal for non-complex investigations and the one-year goal for complex investigations (Bus. & Prof. Code, § 2319), efforts were undertaken to assess the MBC's policies. Consequently, new policies were developed to address delays encountered when seeking to obtain medical records and conducting physician interviews.

MBC staff also defined the criteria for a "complex" investigation[6] After applying this criteria to the current caseload, 40% of the caseload met the definition of "complex."

SB 231 stated that investigations were under the "direction" of HQES, however, the statute did not define "direction" or provide guidance on how to implement the VE model. While initially unable to reach agreement on a joint manual, in January 2006, HQES published its "Vertical Prosecution Manual for Investigations Conducted by Medical Board Investigators (First Edition, January 2006)," and both HQES and MBC published their "Joint HQE/MBC Vertical Prosecution Protocol (First Edition, January 2006)." HQES and MBC renewed their efforts to develop a joint manual and, in November 2006 successfully and jointly published their "Vertical Prosecution Manual (Second Edition, November 2006)." ***(Refer to Appendix C.)***

The DOJ has also made significant modification to its ProLaw computer software used to track investigations and prosecutions. In an effort to overcome co-location barriers, HQES also installed upgraded computers in each MBC district office for use by the deputy attorneys general.

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[6]On December 31, 2005, there were 140 allied health investigations in the MBC workload. This is also part of the MBC investigator workload from other DCA licensing boards and committees, in addition to the physician and surgeon cases which were the focus of the VE pilot.

A new investigation report format was instituted at the beginning of the VE model to enable investigators to advise DAGs of case progress on an ongoing basis. Minimally, the investigator and the assigned DAG will confer at three stages of an investigation: 1) upon initial case assignment; 2) prior to the interview with the subject physician and 3) prior to the submission of case documents for an expert review.

Generally, new governmental programs are rarely implemented in a vacuum and the VE model was no exception to this rule. All new complaints received in MBC offices after January1, 2006, have been investigated under the new VE model. However, as of December 31, 2005, there were 1,014 pending physician and surgeon cases under investigation. Thus, while HQES and MBC were in the process of implementing the VE model, they continued to handle this large volume of cases primarily under the "DIDO" model, where, upon completion, the investigation was transmitted to HQES for prosecution. At the present time, the majority of these pre-VE cases have been resolved.

APPENDIX B

Government Code Section

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California including all committees under the jurisdiction of the board or a division of the board, including the Board of Podiatric Medicine, and the Board of Psychology. (b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions. (c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the division or board. (d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, and the committees under the jurisdiction of the Medical Board of California or a division of the board, and the Board of Psychology, with the intent that the expenses be proportionally shared as to services rendered. (e) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed. **12529**. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California including all committees under the jurisdiction of the board or a division of the board, including the Board of Podiatric Medicine, and the Board of Psychology, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision (b) of Section **12529**.5. (b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the

Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions. (c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the division or board. (d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, and the committees under the jurisdiction of the Medical Board of California or a division of the board, and the Board of Psychology, with the intent that the expenses be proportionally shared as to services rendered. (e) This section shall become operative July 1, 2008. **12529**.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California or the Board of Psychology shall be made available to the Health Quality Enforcement Section. (b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section **12529** to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints. (c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or allied health committees, including the Board of Podiatric Medicine, in designing and providing initial and in-service training programs for staff of the division, boards, or allied health committees, including, but not limited to, information collection and investigation. (d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology, as appropriate in consultation with the senior assistant. (e) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed. **12529**.5. (a) All complaints or relevant information concerning

licensees that are within the jurisdiction of the Medical Board of California or the Board of Psychology shall be made available to the Health Quality Enforcement Section. (b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to assist the division and the boards in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations. A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases. (c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or allied health committees, including the Board of Podiatric Medicine, in designing and providing initial and in-service training programs for staff of the division, boards, or allied health committees, including, but not limited to, information collection and investigation. (d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology, as appropriate in consultation with the senior assistant. (e) This section shall become operative July 1, 2008. **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 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 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) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed. **12529**.7. By July 1, 2007, the Medical Board of California, in consultation with the Department of Justice, the Department of Consumer Affairs, the Department of Finance, and the Department of Personnel Administration, shall report and make recommendations to the Governor and the Legislature on the vertical prosecution model created under Section **12529.6**.

APPENDIX C

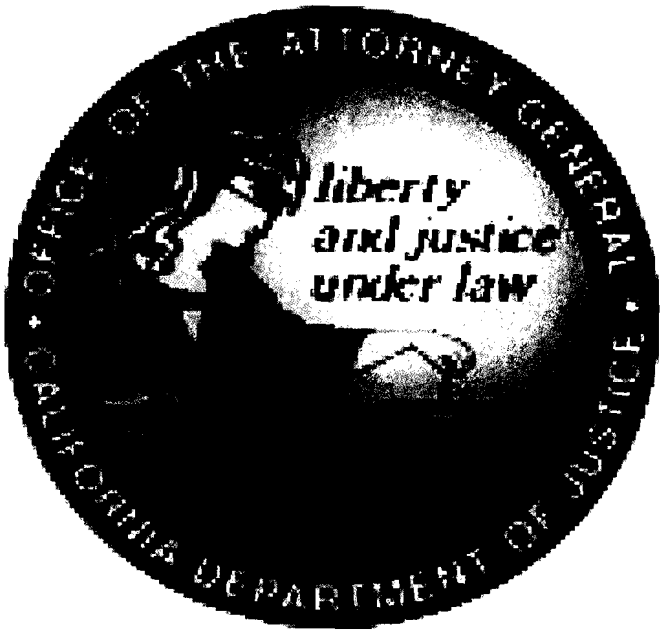
Vertical Prosecution Manual (Second Edition, November 2006)

Vertical Prosecution Manual

(Second Edition, November 2006)

Health Quality Enforcement Section
Office of the Attorney General
of the State of California

Medical Board of California
Department of Consumer Affairs



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11-20-06

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Preface

November 20, 2006

On January 1, 2006, Senate Bill 231 (Figueroa) became effective, bringing with it a new level of cooperation and teamwork in the joint mission of the Medical Board of California (MBC) and Health Quality Enforcement Section (HQE) to protect the public health, safety and welfare of all Californians. While the bill itself contained a number of significant changes to both the investigation and prosecution of cases involving physicians, the most significant change was the Legislature's adoption of the "Vertical Prosecution Model" which, for the first time, brought investigators and deputy attorneys general together from the very start of the investigation through to its closure or, if warranted by the evidence, prosecution of the case.

Since January 1, 2006 the MBC and HQE have made great strides in implementing the Vertical Prosecution Model. New policies and procedures have been adopted by both agencies. Investigators and attorneys have begun working together from the very start of the investigations, additional deputies have been and continue to be hired so they can be readily available to investigators, new DOJ computers are being installed in the MBC District Offices to facilitate the use of ProLaw and efforts continue toward creating a shared database.

Vertical Prosecution is a pilot program. As such, it represents an opportunity for both HQE and the MBC to demonstrate the public protection benefits so that, at the end of the pilot program, the goal of transferring MBC investigators to the Department of Justice can be achieved. The realization of this important goal will require that HQE deputies and MBC investigators continue to work together as a single unit notwithstanding the fact that, during this pilot program, they remain employed by two separate agencies.

We have learned a great deal about how both agencies can further improve their level of cooperation and teamwork. The provisions of this Second Edition will govern the handling of vertical prosecution investigations and prosecutions by MBC investigators and HQE deputies. Our thanks to everyone for your hard work and dedication, and commitment to public protection.

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Medical Board of California

I. The Vertical Prosecution Team:

Vertical prosecution is based on the team concept with each member working together with other members to achieve the common goal of greater public protection for the people of California. The development of a cohesive and positive team based on respect for the vital roles played by each team member is critical to the success of this pilot program. The following is a description of the duties, responsibilities and vital roles of each member of the vertical prosecution team.

- Investigators develop and update investigative plans, conduct fair, impartial ande thorough investigations and participate in the administrative hearing process, alle under the supervision of their Supervising Investigators I and II, Deputy Chiefs,e and Chief of Enforcement, and direction of the assigned Primary Deputy Attorneye General.e

- District Medical Consultants provide medical input and assistance through reviewe of medical records, participation in subject interviews, selection of experte reviewers and evaluation of expert opinions, all under the supervision of theire Supervising Investigators I and II, Deputy Chiefs, and Chief of Enforcement, ande direction of the assigned Primary Deputy Attorney General.e

- Supervising Investigators I supervise a staff of assigned investigators, medicale consultants, investigator assistants and clerical staff to ensure the forwarde progression of the caseloads for which they are responsible. Supervisinge Investigators I are responsible for ensuring that cases are investigated in a timelye and efficient manner and in conjunction with directions from the Primary Deputye Attorney General and that investigator support continues through the prosecutione of the case when disciplinary charges are filed. Supervising Investigators I alsoe complete monthly reports, monitor case progress through quarterly case reviewse and handle personnel matters as necessary.e

- Supervising Investigators II supervise a staff of Supervising Investigators Ie assigned to a geographical area and oversee the general operation of that area.e Supervising Investigators II develop and implement board policy, are the first-linee resolution attempt at the citation and fine informal conference, sign subpoenase duces tecum, develop, coordinate and implement training, handle complexe personnel matters and act as a liaison with other government entities.e

- Deputy Chiefs directly manage a staff of Supervising Investigators II, as well ase the overall enforcement operations program, including training, internal affairs,e background investigations and probation.e

- The Chief of Enforcement supervises the Deputy Chiefs and manages the overalle enforcement program to facilitate its efficient operation.e

- Primary Deputy Attorneys General work closely with other team members and, ins conjunction with Supervising Investigators I, direct investigators in the obtainings of evidence. Primary Deputy Attorneys General provide legal advice to the clients and prosecute the case when disciplinary charges are filed.s

- Lead prosecutors are assigned to specific Board district offices, act as thes principal liaison to that office, are jointly assigned with another deputy on eachs case, act as the Primary Deputy Attorney General when so assigned and, when nots so assigned, continue to monitor the progress of the investigation ands appropriateness of directions from the Primary Deputy Attorneys General.s

- Supervising Deputy Attorneys General supervise and provide support for theirs Deputy Attorneys General, oversee and monitor investigations within theirs respective geographical areas, and supervise the prosecution of cases whens disciplinary charges are filed.s

- Senior Assistant Attorney General, HQE, in conjunction with the Executives Director of the Medical Board, oversees and bears responsibility for alls investigations and prosecutions within the jurisdiction of the Board's Enforcements Program.s

II. Vertical Prosecution Under Senate Bill 231:

The three principle elements of the "vertical prosecution model" can be briefly summarized as follows:

1.s Each physician and surgeon complaint referred to a district offices sof the board for investigation shall be simultaneously and jointly assigned to ans investigator and to the deputy attorney general in the Health Quality Enforcements Section responsible for prosecuting the case if the investigation results in thes filing of an accusation.s

2. The joint assignment of the investigator and the deputy attorneys general shall exist for the duration of the disciplinary matter.[1S]

3.s During the assignment, the investigator so assigned shall, under thes direction of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action. (Gov. Code, § 12529.6.)

While the Legislature has expressly limited the mandatory use of the "vertical prosecution model" to cases involving physicians and surgeons (Gov. Code, § 12529.6, subd. (a)), HQE and the Medical Board have determined that it shall be used in cases involving all licensees and applicants within the jurisdiction of the Board, except criminal cases.

III. Cooperation and Consultation in Direction and Supervision:

The fundamental purpose underlying the vertical prosecution pilot program is to bring investigators and deputy attorneys general together from the beginning of an investigation in order to improve coordination and teamwork, increase efficiency, and reduce investigation completion delays, all with the overall goal of increasing public protection. At the same time, however, it is important to recognize that the authority and responsibility to supervise investigators remains vested in Supervising Investigators I and II who continue to play an essential and vital role in both the Medical Board's Enforcement Program, as well as the success of this pilot program.

It is vitally important that Supervising Investigators I and II and deputy attorneys general cooperate and consult with each other in order to provide consistent, clear instructions to investigators. By doing so, Supervising Investigators I and II and deputy attorneys general will not only help achieve the legislative goals underlying this vertical prosecution pilot program but, at the same time, help reduce instances where an investigator is unsure whom he/she works for or feels torn between two sets of inconsistent instructions.

In exercising the statutory authority of direction under Government Code section 12529.6, deputies should be careful not to do so in a manner that undermines the supervision authority of Supervising Investigators I and II. Likewise, Supervising Investigators I and II should be careful not to exercise their supervision authority in an manner that undermines the direction authority of deputy attorneys general. Cooperation and consultation are the keys to ensuring these expectations are met.

IV. Direction of Investigation:

Teamwork is an essential component of the Legislature's new "Vertical Prosecution Model" which brings investigators and deputy attorneys general together from the very beginning of an investigation through closure or completion of the prosecution. The shared goal of both the Board and HQE in implementing the Legislature's new "Vertical Prosecution Model" is to improve the quality of both investigations and prosecutions of cases involving alleged misconduct by licensees.

Variations of vertical prosecution are employed by many law enforcement agencies. Such models generally rely on a team concept that typically involves the joint assignment of an investigator and prosecuting attorney, the latter with responsibility and authority to direct the investigator in the accumulation of evidence necessary to evaluate and, if violations of law are discovered, prosecute the case. The "Vertical Prosecution Model" enacted by the Legislature in Senate Bill 231 is such a model with the single notable exception that, here, the investigators are employed by the Board and the attorneys by the California Department of Justice. Prior to the enactment of Senate Bill 231, investigators worked at the direction of their Supervising Investigators I and II, Deputy Chiefs, and the Chief of Enforcement, when conducting an investigation. However, effective January 1, 2006, Senate Bill 231 requires that investigators work at the direction of their jointly assigned deputy attorney general. (Gov. Code, § 12529.6, subd. (b).)

"Direction," as that term is used in section 12529.6, includes, but is not limited to, the authority and responsibility to direct the assigned investigator to complete investigative tasks, obtain required testimonial and documentary evidence, make periodic reports regarding the progress of the investigation, and complete additional tasks necessary to prepare and present the case for hearing.[2] Such authority and responsibility also includes setting investigative priorities in conjunction with the Supervising Investigator I, monitoring the progress of the investigation to ensure its completion in a timely and efficient manner, determining when an investigation should be closed as well as when an investigation is completed such that the case is appropriate for acceptance by HQE for prosecution.

Investigators continue to work under the supervision of the Supervising Investigator I of the District Office.[3] It is anticipated that Supervising Investigators I and II, Deputy Chiefs, and the Chief of Enforcement will assist in ensuring that investigators complete investigative assignments, as directed by the assigned deputy attorney general, in a timely and efficient manner.

While the passage of Senate Bill 231 represents a significant change with regard to who makes the ultimate determination regarding the manner, extent and duration of each investigation, as a practical matter, deputy attorneys general and Board investigators will continue to work as a strong team with each member contributing his or her own unique talents to the investigation and prosecution of physician disciplinary matters.

V. Lead Prosecutor:

As part of the implementation of Senate Bill 231, the new position of Lead Prosecutor has been created. One Lead Prosecutor shall be assigned to each of the Board's District Offices.[4] The Lead Prosecutor shall be physically present at the assigned District Office to the extent that it is necessary to fully discharge his or her responsibilities, as described herein.

The Lead Prosecutor shall be assigned to, and shall review, each complaint referred to the District Office for investigation. In addition to the Lead Prosecutor, a second deputy attorney general shall be assigned by the Supervising Deputy Attorney General to each complaint as well. The Lead Prosecutor shall act as the primary deputy attorney general on the case for all purposes until and unless replaced by the second deputy attorney general, as described below.

An investigator shall be jointly assigned to the case by his or her Supervising Investigator, in consultation with the Lead Prosecutor. The investigator shall work with, and at the direction of, the Lead Prosecutor as the primary deputy attorney general on the case.

The Lead Prosecutor shall determine whether the complaint warrants further investigation or whether it should be closed without further investigation. If the Lead Prosecutor determines an investigation should be closed without further investigation, he or she should consult with the Supervising Investigator I. Disputes regarding whether a complaint merits further investigation should be handled in accordance with Section XXII, below.

If the Lead Prosecutor determines that the complaint warrants further investigation, he or she will so inform the assigned investigator who, in turn, shall prepare a plan of investigation. (See Section VII, below.) Except as noted below, the Lead Prosecutor shall review and approve, with or without modifications, the original plan of investigation submitted by the assigned investigator.

In some cases, the Lead Prosecutor will function as the primary deputy attorney general throughout the investigation and prosecution of the case. Whenever the Lead Prosecutor determines, either upon review of the original complaint or as the investigation progresses, that it is a likely a violation of law may be found, the second deputy attorney general shall replace the Lead Prosecutor as the primary deputy attorney general on the case for all purposes. The Lead Prosecutor will promptly notify the assigned investigator and his or her Supervising Investigator I, in writing, of any such transfer of primary responsibility. Copies of this new assignment shall be sent to the Supervising Deputy Attorney General, Supervising Investigator II, Deputy Chiefs and Chief of Enforcement. Following transfer of responsibility, the Lead Prosecutor shall continue to monitor the progress of the investigation and appropriateness of directions from the primary deputy attorney general.

It is anticipated that the second deputy attorney general shall immediately become the primary deputy attorney general in all cases involving allegations of sexual abuse or misconduct, mental or physical illness affecting competency to practice medicine, and complex criminal conviction cases.

VI. Receipt of Complaint and Assignment of Staff:

Upon receipt of a complaint from the Central Complaint Unit, the Supervising Investigator I will review and assign the complaint. The supervisor will enter the assigned investigator name into the CAS system. The Supervising Investigator I will notify the Lead Prosecutor of the assignment and provide the Lead Prosecutor with a hard or electronic copy of the complaint.

The Lead Prosecutor will enter the case into ProLaw and assign him or herself as the primary deputy attorney general, except for complaints involving sexual abuse or misconduct, mental or physical illness affecting competency to practice medicine, and complex criminal conviction cases. The Lead Prosecutor will insert in the Prolaw "Notes" tab (second tab in the Matters module), under the SYNOPSIS, the following additional information regarding the case: (a)the name of the investigator assigned to the case; (2) whether the case is appropriate for an ISO or other pre-accusation relief; and (3) any other information the Lead Prosecutor determines is significant. The Lead Prosecutor will then send an e-mail which includes all of thee information in the Notes Tab to the Supervising Deputy Attorney General and Supervisinge Investigator I.e

The Supervising Deputy Attorney General will assign a second deputy attorney general to the case. Even though a second deputy is assigned, the Lead Prosecutor will remain as the "primary" on the case, i.e., the deputy responsible at any given time for the direction of the investigation. However, when it appears likely that the investigation will result in the filing of an accusation, a petition for pre-accusation relief or a civil action, or when the investigation

involves allegations of sexual abuse or misconduct, mental or physical illness affecting competency to practice medicine or criminal conviction cases in a complex matter, the second deputy will be made the "primary." While the Lead Prosecutor will remain assigned to the case and will continue to monitor the case, only the primary deputy attorney general will direct the investigation.

The Supervising Deputy Attorney General will send an e-mail to the Lead Prosecutor, second DAG, and Supervising Investigator I notifying them that the case has been assigned and identifying who shall be the primary deputy on the case. If and when the primary deputy changes from the Lead Prosecutor to the second deputy, the Supervising Deputy Attorney General will send an e-mail to the investigator notifying him or her of the change and copy the Lead Prosecutor and the Supervising Investigator I.

The Supervising Deputy Attorney General will send an e-mail to his or her secretary with instructions to open the physical investigative file and to deliver that file to the primary deputy on the case. The secretary will deliver the physical investigative file to the primary deputy.

The Supervising Investigator I will enter the primary deputy attorney general assignment into the CAS Supervisor Notebook.

VII. Investigation Plan and Progress Report:

Each investigation shall begin with the development and approval of a plan of investigation. The plan shall be updated as significant events occur, as tasks are completed, and as the plan is changed. While it is expected that the primary deputy attorney general and investigator will regularly discuss all aspects of the case, all updates and changes to the plan are to be documented as provided below.

Within five (5) business days of an initial assignment of an investigation, the assigned investigator shall prepare, and submit to the primary deputy attorney general for review and approval, a proposed plan of investigation.[5e]

In preparing the initial IPPR, the assigned investigator, should discuss the proposed investigative plan with his/her Supervising Investigator I, as necessary. The initial IPPR should contain the steps the investigator believes are most appropriate for the timely and efficient investigation of the case. Upon completion, the initial IPPR should be submitted by the assigned investigator to the primary deputy attorney general electronically as an e-mail attachment, with a copy sent to the Lead Prosecutor and Supervising Investigator I.

eWithin five (5) business days of receipt of the initial IPPR, the primary deputye attorney general shall review and approve the plan, with or without required changes or modifications, by way of a reply e-mail sent to the assigned investigator and copied to the Supervising Investigator I, Lead Prosecutor (if not the primary) and Supervising Deputy Attorney General. The primary deputy attorney general shall insure that a copy of the initial approved IPPR is placed in the Attorney General's ProLaw program.

The investigation is to be conducted pursuant to the IPPR. The assigned investigator and primary deputy attorney general should discuss proposed changes or modifications to the initial IPPR, as necessary and, if approved by the primary deputy attorney general, such changes or modifications should be confirmed in writing by e-mail.

The assigned investigator and primary deputy attorney general shall maintain a running e-mail thread, replying and communicating to each other by adding information to the e-mail thread as the investigation progresses which will then serve as ongoing documentation of the progress of the investigation. The primary deputy attorney general is charged with the responsibility of maintaining a copy of that running e-mail thread in the Attorney General's ProLaw program.[6]

As the investigation progresses, significant events occur and investigative tasks are completed, the assigned investigator shall keep the primary deputy attorney general informed by way of the running e-mail thread.

The assigned investigator shall inform the primary deputy attorney general in writing, by way of the running e-mail thread, of the dates of significant witness interviews, including the initial physician interview. The primary deputy attorney general shall notify the investigator if he or she will be participating in an interview. If so, the primary deputy attorney general, assigned investigator and District Medical Consultant (if he or she will be present for interview) should discuss the topics each will cover during the interview.

Finally, primary deputy attorneys general and investigators are reminded of the importance of sending copies of the initial IPPR and subsequent IPPR e-mails to both the Lead Prosecutor and Supervising Investigator I. This is essential since they are charged with insuring the overall efficient operation and timely completion of the investigation.

VIII. Documentation of Significant Communications:

All significant communications between the primary deputy attorney general and assigned investigator shall be reduced to writing by the originator of the communication. In addition to the initial IPPR and subsequent IPPR e-mails, it is recommended that these communications be documented by e-mail. Copies of all such e-mails shall be maintained by the primary deputy attorney general in the investigation case file. Documenting such significant communications will help avoid misunderstandings and allow Lead Prosecutors, Supervising Investigators and Supervising Deputy Attorneys General to monitor the progress of investigations.

IX. Investigation Reports:

Investigation reports are to be kept current. The investigator should keep the report of investigation current and record all events as soon as possible, and preferably no more than five (5) business days following the event.

X. Periodic Review of Ongoing Investigations:

The primary deputy attorney general and assigned investigator, and the Supervising Investigator I as necessary, should participate in the periodic review of ongoing investigations. While it is preferable that such reviews take place in person, participation electronically is permitted where necessary.

A case review, including the District Medical Consultant whenever possible, shall take place prior to referral of the matter to an expert. This review should, whenever possible, be conducted in person and include a review by the primary deputy attorney general of the investigation report and attachments. The primary attorney shall also insure the chosen expert is an appropriate expert to review the case, taking into consideration the expert's board certification and area of current active practice. Documents provided to the expert shall comply with the relevant provisions of the Board's Enforcement Operations Manual. Prior to submitting a case to an expert reviewer, the investigator should reference the Standards for Case Submission to Expert Reviewer (EOM section 7.4).

The assigned investigator should promptly provide a copy of the initial expert report to the primary deputy attorney general and District Medical Consultant. The primary deputy attorney general, District Medical Consultant and assigned investigator should determine whether all relevant matters have been reviewed and addressed by the expert, whether clarification of the expert's initial opinions and conclusions is needed, and whether additional further investigation (e.g., a second physician's interview) is required. After receipt of the initial expert report, the primary deputy attorney general is also strongly encouraged to consult with the District Medical Consultant to make this determination. If additional further investigation is required, the primary deputy attorney general shall inform the assigned investigator in writing, preferably by e-mail, with copies of that e-mail being sent to the investigator's Supervising Investigator I, Lead Prosecutor and Supervising Deputy Attorney General.

XI. Witness Interviews:

Throughout the course of the investigation, the primary deputy attorney general may elect to participate in witness interviews including the physician's interview. The primary deputy attorney general shall advise the assigned investigator if he or she will be participating in any witness interview. In such cases, prior to the commencement of the interview, the primary deputy attorney general should discuss the topics each will cover during the interview. If the District Medical Consultant will be present for the interview, he or she should be included in the pre-interview discussion as well.

XII. Pagination of the Investigation Material Before Transmittal to Expert:

Prior to transmittal of the investigation material to an expert for review, the assigned investigator, or his or her designee, shall paginate the investigation material. Page numbers shall be affixed to the investigation material in such a fashion as not to obscure any of the written information contained thereon. When referring to particular documents in the investigation material, the expert reviewer shall refer to specific page numbers in his or her expert report.

As of the date of the publication of this Second Edition of Vertical Prosecution Manual, the Medical Board does not presently have sufficient investigation support staff to paginate the investigation material as provided in this section. It is anticipated that, once sufficient investigation support staff have been retained by the Medical Board, the pagination of investigation material described in this section will be done prior to transmittal to an expert for review.

XIII. Acceptance of Cases for Prosecution:

Within five (5) business days of submission of the completed investigation, the primary deputy attorney general shall determine whether the case will be closed or accepted. If accepted for prosecution, the primary deputy attorney general shall communicate his or her acceptance of the case in writing by way of running e-mail thread which shall be sent to the assigned investigator, the Supervising Investigator I, the Lead Prosecutor and the Supervising Deputy Attorney General. The acceptance of the case by the primary deputy attorney general does not preclude the possibility that further investigation may be required.

XIV. Content of Investigation File:

Upon acceptance of the case by the primary deputy attorney general, the assigned investigator should deliver a copy of the entire investigation file, along with a memorandum documenting acceptance, to the Lead Prosecutor for delivery to the appropriate Supervising Deputy Attorney General. The entire investigation file shall consist of all documents related to the case, regardless of relevancy and regardless of the place where they are maintained (e.g., master file, investigator's copy of the file, or any other file, formal or not) beginning with and including the original complaint and related documents initially received by the District Office from the Board's Central Complaint Unit.

XV. Approval of Proposed Closure of Investigation:

In cases in which the report of investigation recommends closure, the primary deputy attorney general shall, within ten (10) business days, review the proposed closure and indicate either approval or disapproval. Any failure to comply with this time limitation shall be brought to the attention of the Supervising Deputy Attorney General.

If, at any stage in the investigation, the primary deputy attorney general concludes the investigation should be closed, he or she shall submit a proposal to close the investigation to the Lead Prosecutor by e-mail, with a copy of that e-mail being simultaneously sent to the assigned investigator, the Supervising Investigator I, and Supervising Deputy Attorney General. Within ten (10) business days, the Lead Prosecutor shall review the proposed closure and indicate in writing either approval or disapproval of the proposal. Any failure to comply with this time limitation shall be brought to the attention of the Supervising Deputy Attorney General. If approved, the Lead Prosecutor shall send notification of the case closure to the primary deputy attorney general, assigned investigator, and Supervising Investigator I. If disapproved, the Lead Prosecutor shall indicate in writing any additional investigative tasks that shall be completed.

If the Lead Prosecutor is the primary deputy attorney general at the time of the proposed closure, he or she shall close the case and notify, by e-mail, the assigned investigator, Supervising Investigator I, and Supervising Deputy Attorney General, of the closure. Disagreements regarding proposed closures of investigations shall be resolved as described in Section XXII, below.

XVI. Submission of Proposed Accusations for Filing:

The primary deputy attorney general should submit a proposed Accusation for filing to the Executive Director of the Board within thirty (30) calendar days of acceptance of the case for prosecution.

XVII. Filing of Requests to Set with the Office of Administrative Hearings:

Within fifteen (15) calendar days of receipt of the Notice of Defense, the primary deputy attorney general shall submit a request to set to the Office of Administrative Hearings.

XVIII. Subpoena Review and Enforcement:

Prior to issuance, all subpoenas requesting document production shall be supported by declarations which demonstrate that the particular records sought are relevant and material to the investigation. The declaration should be factually sufficient to permit a reviewing court to independently make a finding of good cause to order the documents disclosed. Within ten (10) business days after the determination that a subpoena will be necessary to compel document production, the assigned investigator shall submit the subpoena and supporting declaration for review and approval by the primary deputy attorney general. Preparation of the subpoena and supporting declaration shall be the responsibility of the assigned investigator. Subpoena enforcement actions shall be the responsibility of the primary deputy attorney general and shall be filed in the appropriate court within thirty (30) business days of acceptance of the subpoena enforcement request.

XIX. Interim Orders of Suspension and Penal Code Section 23 Appearances:

The Lead Prosecutor shall identify those cases in which an Interim Order of Suspension ("ISO") or Penal Code section 23 ("PC 23") appearance is necessary and shall so notify the Supervising Deputy Attorney General. In such cases, the Supervising Deputy Attorney General shall designate the second deputy attorney general as the primary deputy attorney general who shall be responsible for obtaining any necessary ISO or making any necessary PC 23 appearance. The Supervising Deputy Attorney General shall notify the assigned investigator, Lead Prosecutor, and Supervising Investigator I of such designations.

XX. Petitions for Competency, Physical and Mental Examinations:

The primary deputy attorney general shall be responsible for preparing and filing petitions for competency, physical and mental examinations.

XXI. Administrative Hearings:

After the filing of an Accusation, there are often additional investigative tasks that must be completed in order to prepare a case for an upcoming administrative hearing. When additional investigation is required post-accusation to prepare for, or present the case at, the administrative hearing, the primary DAG will notify the assigned investigator of the required additional investigation by e-mail, with a copy to the Supervising Investigator I, Lead Prosecutor (if not the primary) and Supervising Deputy Attorney General.

The assigned investigator is expected to attend the administrative hearing unless the primary deputy attorney general, in consultation with the Supervising Investigator I and Supervising Deputy Attorney General, releases the investigator. While such attendance necessarily takes time away from the investigator's other cases, the investigator's attendance and participation at the administrative hearing will ultimately benefit the prosecution of the case and the investigations and prosecutions of future cases.

XXII. Disagreements:

Occasionally, a disagreement may arise between an assigned investigator and primary deputy attorney general regarding an investigation. Whenever this occurs, the assigned investigator should first discuss his or her concerns directly with the primary deputy attorney general in an effort to resolve the disagreement. If the disagreement remains unresolved, the assigned investigator and primary deputy attorney general should discuss the matter with the Lead Prosecutor, Supervising Investigator I and/or Supervising Investigator II. If the disagreement remains unresolved, the matter shall be submitted to the Supervising Deputy Attorney General who, after consultation with the Chief of Enforcement, shall issue a determination.

It is the expectation of both the Senior Assistant Attorney General and the Executive Director of the Medical Board that, in the vast majority of cases, the determination of the Supervising Deputy Attorney General will resolve the disagreement. If, however, the disagreement remains unresolved, it shall be submitted to the Senior Assistant Attorney General who, after consultation with the Chief of Enforcement and the Executive Director of the Medical Board, shall issue a final determination.

XXIII. Statistical Measure of Efficiency of the Vertical Prosecution Model:

In addition to any other statistical measure that may be later identified, one statistical measure that shall be used to assess the efficiency of the vertical prosecution model, as described in Senate Bill 231, shall be the length of time from receipt by the Board's District Office of the original complaint from the Board's Central Complaint Unit to the date that the investigation is closed or a Request to Set is submitted to the Office of Administrative Hearings. Both Board investigators and HQE deputy attorneys general are jointly responsible for this statistical measure of efficiency. In its early stages, it is anticipated that use of the "vertical prosecution model" may extend the time it takes to complete some investigations.

XXIV. Implementation of the "Vertical Prosecution Model" with Existing Staff:

It is important to recognize that both the Board and HQE are presently in the process of recruiting, hiring and training additional personnel to fully implement the Vertical Prosecution Model contained in Senate Bill 231. This is a continuing process and, as the Board and HQE become fully staffed, there will be a far greater likelihood that the legislative goals of efficiency and enhanced public protection which underlie Senate Bill 231 will be achieved.

XXV. Future Revisions to this Manual:

It is anticipated that this "Vertical Prosecution Manual (Second Edition, November 2006)" will undergo future revisions and refinements as HQE and the Board continue on their joint mission to protect the public health, safety and welfare.

Endnotes:

1.eCase reassignments, which are a routine occurrence in any law enforcement agency, including HQE, aree necessitated for any number of reasons. For example, a case may be reassigned as a result of the illness or death of a deputy, the transfer of a deputy to another section or his/her termination of employment with the Attorney General's Office, the hiring of a new HQE deputy, a maternity leave, conflict of interest, and also for purposes of managing the case load of both individual deputies and the HQE section statewide. Likewise, an investigation may be reassigned from one investigator to another for similar reasons as well. While the presumption is that an original joint assignment will be maintained throughout the duration of a disciplinary matter, appropriate case reassignments will be made when necessary to insure the efficient, thorough and timely investigation and prosecution of cases.

2.eThe word "direction" has been defined as "[t]he act of governing; management; superintendence" (Black'se Law Dictionary, 4th ed. (1968) atep. 547, col. 1) and "[t]hat which is imposed by directing; a guiding or authoritative instruction; order; command" (*Id.*). The word "superintend" means "[t]o have charge and direction of; to direct the course and oversee the details; to regulate with authority; to manage; to oversee with the power of direction; to take care of with authority." (*Id.*, at p. 1606, col. 1; cf. Gov. Code, § 12529.5, subd. (b) ["The Senior Assistant Attorney General and deputy attorneys general working at his or her direction . . ."].)

3.eThe word "supervise" has been defined as "[t]o have general oversight over, to superintend or to inspect."e (Black's Law Dictionary, 4th ed. (1968) at p. 1607, col. 1.) The word "superintend" means "[t]o have charge and direction of; to direct the course and oversee the details; to regulate with authority; to manage; to oversee with the power of direction; to take care of with authority." (*Id.*, at p. 1606, col. 1.)

4.eUntil such time as HQE is fully staffed with a sufficient number of attorneys, it may be necessary for ae Lead Prosecutor to be assigned to more than one of the Board's district offices.

5.eIn the vast majority of cases, the primary deputy attorney general shall be the Lead Prosecutor assigned toe the District Office where the assigned investigator works.

6.eThis can be accomplished either by dropping and dragging updated copies of the entire e-mail thread intoe the ProLaw matter or by cutting and pasting the entirety of the e-mail thread text into the Case Diary in the matter.