Exhibit Q

Medical Board of California

Program Evaluation

Volume I
Summary Report

August 31, 2010

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Ms. Linda Whitney, Executive Director
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2005 Evergreen Street, Suite 1200
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Program Evaluation
Volume I - Summary Report

Dear Ms. Whitney,

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

Preliminary Diagnostic Review

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

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

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Governing Board Structure and Composition

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

License Fees and Fund Condition

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

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

Licensing Program

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

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

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

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

Enforcement Program

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

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

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

Impacts on Investigations

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

Impact on Prosecution of Cases

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

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

Impact on Disciplinary Outcomes

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

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

Impacts on Overall Enforcement Process Performance

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

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

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

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

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

Organizational and Workforce Development Impacts

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

Fiscal Impacts

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

Enforcement Program Improvement Plan

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

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

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

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

Very truly yours,

BENJAMIN FRANK, LLC

Ben Frank

Benjamin Frank
Chief Executive Officer

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October 12, 2010

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

Dear Board Members:

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

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

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

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

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

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

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

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

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

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

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

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

Table of Contents

I. Flaws in the Frank Report;
II. Physician Discipline under the Vertical Enforcement Program; and
III. Important Steps HQE Has Taken to Improve its Own Performance, and HQE's Recommendations on How the Medical Board's Enforcement Program Can Be Further Improved.

I. Flaws in the Frank Report

1. The Statistical Basis of the Frank Report is Unreliable

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Travel By Office of the Attorney General

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Physician Discipline under the Vertical Enforcement Program

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

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

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

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

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

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

Calendar Year	2006	2007	2008	2009
Statewide	430.55	419.12	392.66	259.60

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Calendar Year	2006	2007	2008	2009
Statewide	906.57	795.47	586.65	327.38

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

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

Accusations Resulting in "Serious Discipline"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Increase Medical Consultant Availability in the District Offices

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

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

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

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

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

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

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

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

Sincerely,

CARLOS RAMIREZ
Senior Assistant Attorney General

For EDMUND G. BROWN JR.
Attorney General

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

Linda Whitney
Executive Director
Medical Board of California
Sacramento

Exhibit R

2335. (a) All proposed decisions and interim orders of the Medical Quality Hearing Panel designated in Section 11371 of the Government Code shall be transmitted to the executive director of the board, or the executive director of the California Board of Podiatric Medicine as to the licensees of that board, within 48 hours of filing.

(b) All interim orders shall be final when filed.

(c) A proposed decision shall be acted upon by the board or by any panel appointed pursuant to Section 2008 or by the California Board of Podiatric Medicine, as the case may be, in accordance with Section 11517 of the Government Code, except that all of the following shall apply to proceedings against licensees under this chapter:

(1) When considering a proposed decision, the board or panel and the California Board of Podiatric Medicine shall give great weight to the findings of fact of the administrative law judge, except to the extent those findings of fact are controverted by new evidence.

(2) The board's staff or the staff of the California Board of Podiatric Medicine shall poll the members of the board or panel or of the California Board of Podiatric Medicine by written mail ballot concerning the proposed decision. The mail ballot shall be sent within 10 calendar days of receipt of the proposed decision, and shall poll each member on whether the member votes to approve the decision, to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of additional evidence, to defer final decision pending discussion of the case by the panel or board as a whole, or to nonadopt the decision. No party to the proceeding, including employees of the agency that filed the accusation, and no person who has a direct or indirect interest in the outcome of the proceeding or who presided at a previous stage of the decision, may communicate directly or indirectly, upon the merits of a contested matter while the proceeding is pending, with any member of the panel or board, without notice and opportunity for all parties to participate in the communication. The votes of a majority of the board or of the panel, and a majority of the California Board of Podiatric Medicine, are required to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of further evidence, or to nonadopt the decision. **The votes of two members of the panel or board are required to defer final decision pending discussion of the case by the panel or board as a whole.** If there is a vote by the specified number to defer final decision pending discussion of the case by the panel or board as a whole, provision shall be made for that discussion before the 100-day period specified in paragraph (3) expires, but in no event shall that 100-day period be extended.

Exhibit S

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
Medical Board of California
BOARD OF PODIATRIC MEDICINE
2005 Evergreen Street, Suite 1300 Sacramento, CA 95815-3831
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KRISTINA M. DIXON, M.B.A.
NEIL B. MANSDORF, D.P.M., Vice *President*
ALEIDA GERENA-RIOS, M.B.A.
RAYMOND K. CHENG, A.I.A.
JAMES J. LONGOBARDI, D.P.M.

6. Legislative Committee

Ms. Dixon, *chair*
Dr. Longobardi, *vice*

a. Overview ..... **S**

BPM has not submitted any proposals to the Senate Business & Professions Committee for possible inclusion in its 2011 committee omnibus bill for non-controversial provisions. Committee Consultant G.V. Ayers comments: "I'm sure there will be an opportunity to add something later," should the Board wish to ask consideration for something.

b. **Sunset review** ..... **T**

Currently, B&P Code Section 2460 sunsets BPM January 1, 2013. As Mr. Ayers has explained, under current law, "In the event a board sunsets, the board itself is repealed, and the licensing law would remain in effect."

Mr. Ayers informs us:

"Our plan is to send the request . . . for the report and the questionnaire at the end of January or first part of February. This has not changed -- so it can be expected soon. We will send the questionnaire at the same time that we make the request. We will ask for the report in the early fall of 2011 -- likely October 1. So . . . you should hear from us soon."

- The Senate and Assembly B&P Committees likely will hold joint hearings in October or November 2011, following submission of reports by BPM and other boards
- The Committees will sponsor sunset extension legislation in 2012 taking effect January 1, 2013
- Our report and the legislation may address public policy advances

Exhibit T

California State Senate

Sub-Committees

Information

~*Standing Committees*~

Business, Professions and Economic Development

Business and Professions meets every Monday at 1:30 P.M. in Room 3191.

JURISDICTION: Bills relating to business and professional practices and regulations other than bills relating to horseracing, alcoholic beverages, oil, mining, geothermal, or forestry industries.

Members:
Senator Curren Price (Chair)
Senator Bill Emmerson (Vice Chair)
Senator Ellen Corbett
Senator Lou Correa
Senator Ed Hernandez
Senator Gloria Negrete McLeod
Senator Juan Vargas
Senator Mimi Walters
Senator Mark Wyland

Addresses & Staff:
Chief Consultant:
Bill Gage
Consultants:
G
V. Ayers
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Assistant:
Kathy Sullivan
Phone:
(916)651-4104
Room 2053

Jim Rathlesberger

From: Ayers, GV [GV.Ayers@sen.ca.gov]

Sent: Wednesday, January 26, 2011 4:06 PM

To: Richard Woonacott; Luis Portillo; Kimberly Kirchmeyer; Bev Augustine; Pam Wortman; Accountancy - Matthew Stanley; pbowers@cba.ca.gov; Janelle Wedge; Doug McCauley; Justin Sotelo; William Douglas; Sherry Mehl; BAR - Virgina Vu; Barbering & Cosmo - April Oakley; Kristy Underwood; Kim Madsen; Tracy Rhine; Rick Fong; Joanne Wenzel; Noreene Dekoning; Connie Trujillo; Lisa Moore; Lori Hubble; Yvonne Fenner; cchristenson@cslb.ca.gov; MBrown@cslb.ca.gov; ssands@cslb.ca.gov; DBC - Cathy Poncabare; Donna Kantner; Richard DeCuir; Paul Riches; Electronic & Appliance Repair - Sophia Azar; Brian Stiger; Joanne Arnold; Guidedogboard; LINDA_SHAW@DCA.CA.GOV; Landscape Architects Committee - Ethan Mathef; Jennifer Simoes; Linda.Whitney@mbc.ca.gov; Francine Davies; Alcidia Valim; Louise Bailey; Heather Martin; Margie McGavin; Mona Maggio; Donald Krpan; Rebecca Burton; eportman@mbc.ca.gov; Kelli Okuma; Ryan Vaughn; Gil DeLuna; Anne Sodergren; Virginia K. Herold; Sarah Conley; Steven Hartzell; Rebecca Marco; Jim Rathlesberger; Robert Kahane; Linda Kassis; Christine Molina; Stephanie Nunez; Annemarie DelMugnaio; Cynthia Alameda; Sherrie Moffet-Bell; Vet Board - Jennifer Thornburg; Susan Geranen; Marina Okimoto; Teresa Bello-Jones

Cc: Gage, Bill; Pulmano, Rosielyn; Mason, Sarah; Alexander, Amber; Smith, Taryn; Paul, Richard; Sullivan, Kathleen

Subject: 4 Year Sunset Review Schedule

Attachments: Schedule for Sunset Review 2010 to 2014 (4 years).doc

Here is the current copy of the 4-year Sunset Review Schedule. It has been updated to reflect the sunset date adjustments made last year in SB 294. Please review the code sections and the dates for your board or bureau, and if there are any errors or questions, don't hesitate to call or email me. The last page of the attached document gives the 4-year review cycle and lists the boards which are up for review each year.

2010/2011 Sunset Review – Hearing dates are listed below. We will send each board a letter/email with greater details in the near future.

Monday, March 14, 2011
Board of Registered Nursing
Board of Vocational Nurses and Psychiatric Technicians
Dental Board of California
State Athletic Commission

Monday, March 21, 2011
Board of Accountancy
Professional Fiduciaries Bureau
Contractors State License Board
Board for Professional Engineers, Land Surveyors and Geologists
Architects Board and Landscape Architects Technical Committee

2011/2012 Sunset Review – It is anticipated that boards subject to review in 2011/12 will receive a request from the Committee in the next few weeks requesting the submission of a sunset report by October 1, 2011. That request will include the current questionnaire from the Committee.

Some have asked whether the new Joint Sunset Committee, created by last year's AB 1659 and AB 2130 will now review DCA boards and bureaus. It is anticipated that the Joint Committee, Chaired by Assemblymember Huber, will focus on reviewing other agencies in the state and the policy Committees (i.e., the Business and Professions Committees in the Senate and Assembly) will review DCA boards and bureaus.

Feel free to forward this email as you see fit.

G. V. Ayers, Consultant
Senate Business, Professions & Economic Development Committee
State Capitol, Room 2053
Sacramento, CA 95814
916.651.4104 (office)
916.324.0917 (fax)

DCA Boards and Bureaus: Sunset Dates and Review Cycle

Board	(BPC Code Sections)*	Sunset Dates	Review Cycle	Last Reviewed
Accountancy, Board of	(5000, 5015.6)	1/1/12	2010/11	2003/04
Acupuncture Board	(4928, 4934)	1/1/13	2011/12	2004/05
Architects Board, California	(5510, 5517, 5552.5)	1/1/12	2010/11	2003/04
Landscape Architects Technical Committee	(5620, 5621, 5622)	1/1/12	2010/11	2003/04
Automotive Repair, Bureau of	(9882)	None	2013/14	2003/04 (2005/06 monitor report)
Athletic Commission	(18602, 18613)	1/1/12	2010/11	2003-04
Board of Barbering and Cosmetology	(7303)	1/1/14	2012/13	2005/06
Behavioral Sciences, Board of	(4990, 4990.4)	1/1/13	2011/12	2004/05
Cemetery and Funeral Bureau	(7602)	None	2013/14	2004/05
Chiropractic Board	(1000 & Chiropractic Act of 1922)	None	2011/12	2005/06
Common Interest Development Managers	(11506)	1/1/15	2013/14	Never reviewed (New)
Contractors State License Board	(7000.5, 7011)	1/1/12	2010/11	2001/02 (2002/03 monitor report)
Court Reporters Board	(8000, 8005)	1/1/13	2011/12	2004/05
Dental Hygiene Committee of California	(1901)		2013/14	2003/04
Dental Board of California	(1601.1, 1616.5)	1/1/12	2010/11	2003/04
Electronic and Appliance Repair, Home Furnishings and Thermal Insulation	(9810, 19030)	None	2013/14	Never reviewed
Engineers, Land Surveyors & Geologists	(6710, 6714, 8710)	1/1/12	2010/11	2003/04
Guide Dogs for the Blind, Board of	(7200)	1/1/12	2011/12	2000/01
Interior Design, Certification Organization	(5810)	1/1/14	2012/13	2002/03
Massage Therapists Organization	(4620)	1/1/15	2013/14	Never reviewed (New)
Medical Board of California	(2001, 2020)	1/1/14	2012/13	2004/05
Occupational Therapy, California Board of	(2570.19)	1/1/14	2012/13	2005/06

Updated: January 2011

Board	(BPC Code Sections)	Sunset Dates	Review Cycle	Last Reviewed
Optometry, Board of	(3010.5, 3014.6)	1/1/14	2012/13	2001/02
Osteopathic Medical Board of California	(2450 & Osteopathic Act)		2012/13	2004/05
Naturopathic Medicine Committee	(2450.3, 3685, 3686)	1/1/13, 1/1/14	2012/13	Never reviewed (New)
Pharmacy, Board of	(4001, 4003)	1/1/13	2011/12	2002/03
Physical Therapy Board of California	(2602, 2607.5)	7/1/13 & 1/1/14	2011/12	2005/06
Physician Assistant Committee	(3504, 3512)	7/1/13	2011/12	2001/02
Podiatric Medicine, Board of	(2460)	1/1/13	2011/12	2001/02
Private Postsecondary Education, Bureau of	(94874.1, 94950)	1/1/15, 1/1/16	2013/14	2005/06
Professional Fiduciaries Bureau	(6510)	1/1/12	2010/11	Never reviewed (New)
Psychology, Board of	(2920, 2933)	1/1/13	2011/12	2004/05
Registered Dispensing Opticians (with Med Board)	(2569)	1/1/14	2012/13	2004/05
Registered Nursing, Board of	(2701, 2708)	1/1/12	2010/11	2002/03
Respiratory Care Board	(3710, 3716)	1/1/14	2012/13	2001/02
Security and Investigative Services, Bureau of	(7501)	None	2013/14	Never reviewed
Speech-Language Pathology, Audiology & Hearing Aid Dispensers Board	(2531, 2531.75)	1/1/14	2012/13	1998
Structural Pest Control Board	(8520, 8528)	1/1/15	2013/14	2004/05
Tax Preparer Education Council	(22259)	1/1/15	2013/14	2003/04
Veterinary Medical Board	(4800, 4804.5)	1/1/14	2012/13	2003/04
Vocational Nursing and Psychiatric Technicians, Board of	(2841, 2847, 4501, 4503)	1/1/12	2010/11	2002/03

Red = 2010/11 sunset review (Sunset Date – January 1, 2012)
Blue = 2011/12 sunset review (Sunset Date – January 1, 2013)
Black = 2012/13 sunset review (Sunset Date – January 1 2014)
Green = 2013/14 sunset review (Sunset Date – January 1, 2015)

Updated: January 2011

DCA Boards and Bureaus Sunset Dates for Review

2010/2011	2011/2012	2012/2013	2013/14
Accountancy Board	Acupuncture Board	Barbering and Cosmetology Board	Automotive Repair, Bureau of
Architects Board and Landscape Architects Technical Committee	Behavioral Sciences Board	Interior Design Organization	Cemetery and Funeral Bureau
Athletic Commission	Chiropractic Board	Medical Board of California	Electronic, Appliance Repair, Home Furnishings and Thermal Insulation Bureau
Contractors State License Board	Common Interest Development Managers	Occupational Therapy Board	Private Postsecondary Education Bureau
Dental Board	Court Reporters Board	Optometry Board	Dental Hygiene Committee
Engineers, Land Surveyors and Geologists	Guide Dogs for the Blind	Osteopathic Medical Board Naturopathic Medicine Committee	Massage Therapist Organization
Registered Nursing Board	Pharmacy Board		Security and Investigative Services Bureau
Vocational Nursing and Psychiatric Technicians Board	Physical Therapy Board	Respiratory Care Board	Structural Pest Control Board
Professional Fiduciaries Bureau	Physician Assistant Committee	Speech-Language Pathology, Audiology, Hearing Aid Dispensers Board	Tax Preparer Education Council
	Podiatric Medicine Board	Veterinary Medical Board	
	Psychology Board		

Updated: January 2011

Exhibit U

You & Your Doctor of Podiatric Medicine
Highly trained specialists keep Americans on the move

Walking on two feet is distinctly human. Our mobility is so basic we take it for granted until we need help to retain or regain it. Whether we are athletic or just pursuing the joy of an active and independent life, we have podiatrists to help keep us able and agile.

Podiatric medicine is an elite specialty

In the early 1900s, a few physicians like Dr. William M. Scholl recognized that the lower extremity was being ignored and worked to establish a new profession of specialists. Podiatric medicine was born and has become an elite specialty, particularly in California. Once known as chiropodists and later podiatrists, these specialists are now known as doctors of podiatric medicine (DPMs). DPMs are licensed and regulated in California by the California Board of Podiatric Medicine. Here are some things you may not know about this medical specialty. DPMs:

- Graduate from four-year podiatric medical schools closely paralleling the general medical school curriculum, but with an emphasis on biomechanics and conditions affecting the lower extremity.
- Must complete the first two years of a three-year graduate medical education residency program before being licensed. Other doctor licensing boards only require one year.
- Must meet peer-reviewed continuing competence requirements every two years in order to renew their licenses. The California Board of Podiatric Medicine is still the only doctor-licensing board in the country to implement this long-recommended reform.
- Have embraced lifelong learning and prevention of patient harm more than any other medical specialty.
- Have seen public complaints drop 50 percent since the Board of Podiatric Medicine initiated continuing competence more than 10 years ago. This accomplishment is unique among licensed healthcare professionals.

The California Podiatric Medical Association and the State licensing board have done much more to promote good medicine including:

- Insisting on Primary Source Verification – the gold standard for ensuring applicants are qualified and meet all the requirements for becoming California doctors. The Board wrote Primary Source Verification into its law so that no one could consider it open to waiver.
- Emphasizing quality over quantity – there are fewer than 2,000 DPMs practicing in California, but they all adhere to rigid standards.
- Disclosing information on cases referred to the Attorney General for prosecution, instead of waiting until the Attorney General prepares a formal accusation. BPM is one of the few health licensing boards to do this.

Here are some other facts about DPMs:

- DPMs are independent practitioners treating conditions affecting the feet, ankles, and related parts of the legs.

- DPMs diagnose, prescribe, treat, and perform surgery within this scope, as provided in the State Medical Practice Act.
- DPMs will often specialize in areas such as surgery, conservative foot care with expert knowledge of ambulation and biomechanics, or the care and preservation of diabetics' feet (to prevent amputations and keep patients mobile).
- Whether generalists or specialists, DPMs often are the first to see patients or to recognize their general health problems and will refer to other physicians as appropriate.
- Due to their close doctor-patient relationships and surgical skills, DPMs are also in high demand as assistant surgeons in non-podiatric surgeries. Since 2004, the State Medical Practice Act has made it part of DPM's scope to assist other surgeons in any surgical procedure.

How to Choose a Doctor

The Board of Podiatric Medicine Web site is rich with advice and information on how to choose a doctor of podiatric medicine.
www.bpm.ca.gov

Your can verify the license of any DPM licensed in California by clicking on the Board's verifications link:

http://www2.dca.ca.gov/pls/wllpub/wllqryna$lcev2.startup?p_qte_code=POD&p_qte_pgm_code=7100

For more information, contact the California Board of Podiatric Medicine.

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Information about DPMs is also available from the California Podiatric Medical Association. You can search the association's Web site for members of the professional association who practice in your area. Doctors of podiatric medicine do not have to be members of the association, but membership is one of the things patients often look for when evaluating a doctor's credentials.

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DRAFT