STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

MEDICAL BOARD OF CALIFORNIA – Executive Office
1434 Howe Avenue, Suite 92, Sacramento, CA 95825
(916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

MEMBERS OF THE DIVISION

Cesar A. Aristeiguieta, M.D., President
Barbara Yaroslavsky, Vice President
Steve Alexander
John Chin, M.D.
Shelton Duruisseau, Ph.D.
Reginald Low, M.D.
Mary L. Moran, M.D.
Janet Salomonson, M.D.
Ronald H. Wender, M.D.
Frank V. Zerunyan, J.D.

DIVISION OF MEDICAL QUALITY QUARTERLY MEETING

November 1 - 2, 2007

Hilton San Diego Mission Valley
901 Camino del Rio South
San Diego, CA 92108
(619) 543-3000

Action may be taken on any items listed on the agenda

AGENDA

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

PANEL A: Dr. Aristeiguieta (Chair), Mr. Alexander, Dr. Chin, Dr. Duruisseau, Ph.D. & Dr. Moran

CARMEL 3 ROOM

Thursday, November 1, 2007

8:00 a.m. OPEN SESSION

CALL TO ORDER; ROLL CALL

Oral Argument on Nonadopted Proposed Decision

1. FOXLEY, William Noall, M.D.

8:45 p.m. *CLOSED SESSION – Nonadopted Proposed Decision

FOXLEY, William Noall, M.D.

9:00 a.m. OPEN SESSION

Oral Argument on Petition for Reconsideration

2. GRANT-ANDERSON, Betty Sue, M.D.

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

9:45 a.m. *CLOSED SESSION – Petition for Reconsideration

GRANT-ANDERSON, Betty Sue, M.D.

3. Deliberation on disciplinary matters, including decisions and stipulations.

OPEN SESSION

Adjournment

PANEL B: Ms. Yaroslavsky (Chair), Dr. Low, Dr. Salomonson, Dr. Wender & Mr. Zerunyan

NEWPORT BALLROOM

Thursday, November 1, 2007

8:00 a.m. OPEN SESSION

CALL TO ORDER; ROLL CALL

***CLOSED SESSION**

4. Deliberation on disciplinary matters, including decisions and stipulations.

OPEN SESSION

Adjournment

The Division and/or Panel of the Division will convene in Closed Session, as authorized by Government Code Section 11126(c)(3), to deliberate on disciplinary decisions and stipulations.
****
For additional information, call A. Renee Threadgill, Chief of Enforcement, at (916) 263-2389.
Listed times are approximate and may be changed at the discretion of the President/Chair.

CARMEL 3 ROOM

Friday, November 2, 2007

8:00 a.m. – 10:00 a.m. OPEN SESSION

1. CALL TO ORDER; ROLL CALL

2. Approval of Orders Restoring License Following Successful Completion of Probation, Orders Issuing Public Letter of Reprimand, and Orders for License Surrender During Probation

3. Approval of the July 27, 2007 Minutes

4. Legislation and Regulation Update (For Items A, B, and C, refer to legislative packet and regulation matrix.)
   A. 2007 Legislation
   B. Status of Regulatory Action
   C. 2008 Proposed Legislation

5. Diversion Program Report (Valine)
   A. Program Status

6. Division Chief's Report (Threadgill)
   A. Medical Expert Program Survey
   B. Expert Utilization Report
   C. Expert Review Program Reports

7. Vertical Enforcement Update/Progress Report (Ramirez)

9:00 a.m.

8. REGULATIONS – PUBLIC HEARING – Ms. Kirchmeyer, Dr. Aristeiguieta, and Mr. Zerunyan
   A. Oral and Written Arguments – Amend Section 1364.30 in Article 8 of Chapter 2, Division 13; Adopt Section 1364.32 in Article 8 of Chapter 2, Division 13. This proposal will: 1) allow an administrative law judge or panel member to ask the parties to cite the record (Sec. 1364(c)); 2) require written arguments to cite the record, and authority, if applicable, for each point addressed (Sec. 1364.32); and 3) require respondents to be placed under oath, if the respondent elects to address the panel (Sec. 1364.30(e)).

9. Public Comment on Items Not on the Agenda

10. Adjournment

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak.

****

For additional information call (916) 263-2389.

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Teresa Schaeffer at (916) 263-2389 or sending a written request to Ms. Schaeffer at the Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825. Requests for further information should be directed to the same address and telephone number.

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DIVISION OF MEDICAL QUALITY Agenda Item 3

Embassy Suites
South San Francisco, CA

July 27, 2007

MINUTES

Agenda Item 1

A quorum was present and due notice having been mailed to all interested parties, the meeting was called to order at 8:05 a.m. Members present included:

Members Present:
Barbara Yaroslavsky, Vice President
Steve Alexander
Stephen R. Corday, M.D., Secretary
John Chin, M.D.
Dorene Dominguez
Shelton Duruisseau, Ph.D.
Reginald Low, M.D.
Mary L. Moran, M.D.
Janet Salmonson, M.D.
Ronald H. Wender, M.D.
Frank V. Zerunyan

Members Absent:
Cesar A. Aristeiguieta, M.D., President
Ronald L. Moy, M.D.

Staff and Guests Present:
David T. Thornton, Executive Director
Barbara Johnston, Executive Director (appointment effective August 1, 2007)
Kimberly Kirchmeyer, Deputy Director
Renee Threadgill, Chief of Enforcement
Kurt Heppler, DCA Legal Counsel
Carlos Ramirez, Senior Assistant Attorney General
Jose Guerrero, Supervising Deputy Attorney General
Lawrence Mercer, Deputy Attorney General

Thomas Reilly, Deputy Attorney General
Jane Zack Simon, Deputy Attorney General
Candis Cohen, Public Information Officer
Linda Whitney, Chief of Legislation
Kevin Schunke, Regulation Coordinator
Kelly Nelson, Legislative Analyst
Paulette Romero, Associate Analyst
Janie Cordray, Research Program Manager
Frank Valine, Diversion Program Manager
Rhonda Baldo, Associate Analyst
Richard Prouty, Staff Services Manager
Teresa Schaeffer, Associate Analyst
Valerie Moore, Associate Analyst
Lynda Swenson, Area Supervisor - North California
William A. Norcross, M.D., Director, Physician Assessment and Clinical Education Program
Julie D'Angelo Fellmeth, Center for Public Interest Law
Sandra Bressler, California Medical Association
Brett Michelin, California Medical Association
James Hay, M.D., California Medical Association
Zennie Coughlin, Kaiser Permanente Medical Group
Antonette Sorrick, Deputy Director, Department of Consumer Affairs, Board Relations
Frank Lucido, M.D.
Tara Kittle

Agenda Item 2 Approval of Orders

Approval of Orders Restoring License Following Completion of Probation
The Division reviewed and approved 8 Orders. Vote: 11-0

Approval of Orders Issuing Public Letters of Reprimand
The Division reviewed and approved 9 Orders. Vote 11-0

Approval of Orders for License Surrender During Probation/Administrative Action
The Division reviewed and approved 3 Orders. Vote 11-0

Agenda Item 3 Approval of Minutes

It was M/S (Corday/Moran) to approve the Open Session minutes of the April 27, 2007 Division Meeting. Motion carried (11-0).

Agenda Item 4 Legislation and Regulation Updates

No report was given.

Agenda Item 5 Consideration of Proposal to Amend Oral Argument Regulations

Kimberly Kirchmeyer, Deputy Director, reported Dr. Aristeiguieta and Mr. Zerunyan met with an administrative law judge and board staff to discuss the process for oral argument. The committee determined amendments to the regulations were needed and suggested the following:

- Amending California Code of Regulations (CCR) section 1364.30(c) to authorize the administrative law judge and any panel member to request a party support the party's oral argument on the matter with a specific citation to the record;
- Amending CCR section 1364.30(e) to require the respondent to be placed under oath if they address the panel;
- Creation of CCR section 1364.32 to place specific requirements on written argument submitted in response to an order of nonadoption or reconsideration.

Mr. Zerunyan added the amendments to the regulations will help streamline the process and ensure information is not added to the record.

It was M/S (Duruisseau/Wender) to approve the proposed language to amend CCR section 1364.30 and creation of CCR section 1364.32 and hold a regulatory hearing on this matter at the November 2007 meeting. Motion carried unanimously.

Agenda Item 6 Division Chief's Report

Renee Threadgill, Chief of Enforcement, provided an update on the reorganization of the probation unit. The transfer of the cases from the investigators to inspectors/investigator assistants is in the training phase, and the transition is expected to be completed by the end of the year.

Ms. Threadgill stated the development of a computer medium which will allow the DAGs in the district offices the ability to access information from CAS in a user-friendly environment is underway.

Ms. Threadgill announced the promotion of Laura Sweet, Los Angeles Area Supervising Investigator II, to Deputy Chief with Board. Lynda Swenson, Probation Supervisor II has been promoted to the Chief position of the Division of Investigation.

Agenda Item 6A Medical Expert Program – Survey

Ms. Threadgill stated in response to continued feedback from expert reviewer surveys, the DMQ members asked board staff to explore the feasibility of increasing the expert reviewers' pay. Upon preliminary research, it was found the Board could increase the expert reviewers' hourly rate of pay without a significant impact to the Board's current budget and without having to submit a BCP to DCA. Ms. Threadgill recommended the DMQ approve a $50 per hour increase

to the expert reviewers' pay, which would raise the pay from $100 to $150 per hour.

Mr. Alexander requested board staff conduct a comprehensive budget analysis to determine the maximum pay the Board could budgetarily accommodate for the expert reviewers. Discussion ensued on the expert reviewer program including current recruitment and retention efforts.

It was M/S (Wender/Moran) to approve a $50 per hour increase of expert reviewers' pay. Motion carried unanimously. The DMQ further directed Ms. Threadgill to provide a comprehensive budget analysis of the expert reviewers' pay and a comprehensive report on the Board's recruitment and retention efforts to the DMQ at the November 2007 meeting.

Agenda Item 6B Expert Utilization Report

Ms. Threadgill directed the DMQ members' attention to the expert utilization report. There were no questions asked or comments made.

Agenda Item 7 Vertical Enforcement Update/Progress Report

Carlos Ramirez, Senior Assistant Attorney General, reported the information technology staff from the AG's office and the Board are actively working on a method of integrating information from CAS into a system the DAGs and investigators can use. He stated a progress report will be provided to the DMQ at the November 2007 meeting.

Mr. Ramirez stated he is in the process of hiring three new deputies in HQES, as two senior deputies in San Diego and one senior deputy in Los Angeles have retired. He stated 75 to 80 applications were received for those three positions.

Discussion ensued on the information to be integrated into the new system, the accessibility of the information by both deputies and investigators, the amendment of SB731 to include a directive that both deputies and investigators use ProLaw, and the projected time to implementation of the new process. The DMQ directed Mr. Ramirez and Ms. Threadgill to provide a comprehensive report regarding vertical enforcement at the November 2007 meeting, which should include every detail of the full integration of the program under the current law, the challeges to full integration, Board policy to be established to assist with integration, and budgetary authority needed to implement full integration.

Agenda Item 8 Discussion of Federal and California Appellate Decisions Pertaining to Medical Marijuana

Jane Zack Simon and Lawrence Mercer, Deputys Attorney General, reported the recent court cases involving medical marijuana, e.g., the Ninth Circuit's decision in Conant v. Walters and United States Supreme Court decision in Gonzales v. Raich, have had no impact on the policy statements previously adopted by the Board with respect to a physician's role when recommending and approving patient use of medical marijuana. The Board's existing policy is

physicians who recommend marijuana to patients should do so in accordance with the generally accepted standard of practice including a good faith examination, treatment plans, evaluation of the patient, having a bonified physician-patient relationship, maintenance of medical records, etc. Ms. Simon stated there is no reason for the Board to make any changes to the policy at this time.

Frank Lucido, M.D., stated the recent federal decisions also had no impact on the California Compassionate Use Act of 1996, which entitles physicians to make recommendations of medical marijuana in a safe and appropriate manner as long as they do not aid and abet a patient in obtaining the cannabis.

Agenda Item 9 Proposed Designation of Precedential Decisions pursuant to Government Code §11425.60

Kurt Heppeler, DCA Legal Counsel, provided a history of the Board's authority to designate decisions as precedential. He presented the procedural backgrounds and Facts/Findings of two decisions, i.e., Joseph J. Basile, M.D. and Tod H. Mikuriya, M.D., to the DMQ for such designation.

It was M/S (Alexander/Wender) to designate a portion of the decision in the matter of the accusation against Joseph J. Basile, M.D., as precedential, more specifically, Factual Findings 1 and 2; the first sentence of Factual Finding 3; Factual Findings 4 and 5; Factual Finding 6 except for the last two sentences; and Legal Conclusions 1 through 5. The motion carried unanimously.

It was M/S (Wender/Alexander) to designate the decision in the matter of the accusation against Tod H. Mikuriya, M.D., as precedential with emphasis on the standard of care for conducting a medical marijuana evaluation being identical to that followed by physicians in recommending any other treatment or medication and further that the Compassionate Use Act does not immunize a physician from disciplinary action in those cases where the physician's care falls below the accepted standard. The motion carried unanimously.

Dr. Lucido asked the DMQ to further clarify whether the entire Mikuriya decision was designated as precedential or only a portion of it. After much discussion, and a caution from Thomas Reilly, Deputy Attorney General, against limiting the precedent in any way, it was M/S (Alexander/Wender) to designate the entire text of the Mikuriya decision as precedential. The motion carried unanimously.

Agenda Item 10 Report Regarding Practice Monitoring Conditions

Lynda Swenson, Area Supervising Investigator II, reported detailed information on the practice monitors is being gathered in order to develop some consistent standards for the practice monitors to follow. She stated as part of the PACE PEP Program, Dr. Norcross and his staff developed an educational CME course to be used as a training tool for practice monitors.

William A. Norcross, M.D., Director of the PACE Program, stated since the April 2007 DMQ meeting, the PACE Program held two CME conferences. The practice monitors in attendance

provided good feedback to the PACE Program and were provided information concerning educational and behaviorial skills in how to be an effective mentor for physicians, e.g., what to do at the first meeting with the physician; how to examine the physician's continuing personal development in an objective way which can be sustained over time; how to do chart audits; how to give feedback to the physician in a meaningful way to help the physician with improved record keeping. In a related subject, Dr. Norcross stated USCD has received an $8 million grant which will enable them to build an infrastructure for the TeleHealth Network and be very useful in the mentoring program.

Agenda Item 11 Report on Surgical or Procedural Deficiencies

Dr. Norcross reported the review of surgical and procedural competency continues to be a challenge. UCSD has been looking at ways to explore these types of competencies for a number of years. There are issues with liability on the part of the physician, the mentoring physician, the hospital, and performance outcomes. He stated he continues to contact programs throughout the world to obtain useful information.

Dr. Wender suggested the Board consider taking a strong stand for appropriate peer review in hospital settings. Mr. Heppeler pointed out the Board has a contract in place to study peer review. Discussion ensued. Ms. Yaroslavsky stated she would consider forming a review committee to monitor this study.

Tara Kittle stated there needs to be a better system of physician accountability available to the public. She stated physician error records should be placed in a computer system, which is accessible throughout the state and made available to the public when evaluating physicians in regard to patient care.

Agenda Item 12 Diversion Program Report

Frank Valine, Diversion Program Administrator, provided a brief overview of the Diversion Committe's meeting held on July 26, 2007. In light of the full Board's recommendation to abolish the Diversion Program, a transition team will be created to oversee the process and ensure the Program meets its current operational mandate. The Diversion Committee approved the insertion of the language of the clinical competency examination regulation into Part II of the Agreement for Participants in the Diversion Program.

It was M/S (Duruisseau/Alexander) to approve the reappointment of Shannon Chavez, M.D. as a DEC member. Motion carried unanimously.

Agenda Item 13 Agenda Items for November 2007 Division Meeting

- Regulation Hearing on Amendment to Oral Argument Language
- Comprehensive Report on the Status of the Integration of the Vertical Enforcement Probation

- Comprehensive Report on Recruitment and Retention of Expert Reviewers Including a Study and/or Recommendation for Appropriate Compensation

Agenda Item 14 Public Comment

No public comment given.

Agenda Item 15 Adjournment

There being no further business, the meeting was adjourned at 9:45 a.m.

Barbara Yaroslavsky
Vice President

Draft

REFER TO YOUR

LEGISLATIVE PACKET

FOR DISCUSSION OF

2007 LEGISLATION

Sent under separate cover.

MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations

Subject	Current Status	Date Approved by Division	Date Notice Published by OAL	Date of Public Hearing	Date of Final Adoption	Date to DCA for Review *	Date to OAL for Review **	Date to Sec. of State
Licensing Special Programs for Foreign Trained Physicians	Filed with Secretary of State 9/3/07; effective 30 days thereafter	Text modified at hearing 2/2/07; no adverse comments received by close of public comment period (3/15/07), so adopted	12/8/06	2/2/07	2/2/07	4/6/07	7/17/07	9/3/07
Licensing Special Programs for Foreign Trained Physicians-FEES	Filed with Secretary of State 9/3/07; effective 30 days thereafter	No comments at public hearing 2/2/07, so adopted	12/8/06	2/2/07	2/2/07	4/6/07	7/17/07	9/3/07
Physician Assistant Comm. (Section 100 changes)	Filed with Secretary of State 8/3/07; effective 30 days thereafter	Since non-substantive changes, Divisions will not need to approve	publication not required	hearing not required	adoption not required	review by DCA not required	5/26/07	8/3/07
Oral and Written Arguments	Public comment period closes 10/23/07; set for hearing 11/2/07	7/28/07	9/7/07	11/2/07				
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations pending Fall 2007							

* - DCA is allowed 30 calendar days for review
** - OAL is allowed 30 working days for review

Prepared by Kevin A. Schunke
Updated September 24, 2007
For questions, call (916) 263-2368

REFER TO YOUR

LEGISLATIVE PACKET

FOR DISCUSSION OF

2008 PROPOSED LEGISLATION

Sent under separate cover.

State of California

Department of Consumer Affairs

Memorandum

To: Renée Threadgill, Chief of Enforcement
Medical Board of California

Date: October 1, 2007

Agenda Item 6-A

From: Susan Goetzinger
Expert Reviewer Program

Subject: Results of the Expert Survey Questionnaires

Questionnaires Sent this quarter (July 1-Sep 30, 2007)	42
Feedback Received from the questionnaires sent this quarter	27 (64%)
Total Feedback Received for this quarter's report	31

Questions 1-8, *positive response*: Yes
Question 9, *positive response*: No
Questions 10-13, *positive response*: Yes

1	Were you provided sufficient information/evidence to allow you to render a medical opinion?	100 percent YES
2	Were you encouraged to render an unbiased opinion?	96 percent responded YES 4 percent responded N/A
3	Was the case directly related to your field of expertise?	96 percent YES 4 percent responded NO
4	Were you given sufficient time to review the case?	100 percent YES
5	Did the training material provided to you (the Expert Reviewer Guidelines and videotape/DVD) give you adequate information to perform your case review?	90 percent YES 10 percent N/A
6	Were you given clear, concise, and easy to follow instructions throughout the process?	100 percent YES
7	Was the investigator and/or MBC staff readily available to answer questions or concerns about the case?	96 percent YES 4 percent responded N/A
8	Is the required written report adequate to cover all aspects of your opinion?	100 percent YES
9	Do you feel the MBC has requested your services more frequently than you would prefer?	100 percent NO
10	Would you be willing to accept more MBC cases for review?	100 percent YES
11	If you were required to testify, was the Deputy Attorney General readily available to answer questions and provide direction?	20 percent YES 80 percent N/A

12	**Do you feel the reimbursement amount for case review is appropriate for the work you are required to perform?**	45 percent YES 51 percent NO 4 percent did not respond
13	**Do you think that more physicians would be willing to become experts if the Board offered CME in addition to monetary compensation?**	64 percent YES 28 percent NO 4 percent responded N/A 4 percent did not respond
Level of satisfaction with overall experience performing case reviews for MBC		83 percent HIGH 17 percent AVERAGE

SUGGESTIONS FOR IMPROVEMENT TO THE PROGRAM

The MBC staff has been excellent. My only concern is some of these cases are very intense. The process of reviewing peers is intense especially when below the standard of practice. I have always felt one should be rewarded for difficulty. $100/hr is below that level.
Better reimbursement rates in keeping with community standards.
Increase review time from 4 weeks to 6 weeks.
Follow-up regarding any actions taken by the Board against the practitioner being investigated.
A hard copy of CD Rom of Laws relating to the Medical Board of California, most recent edition would be helpful as a reference for review.

COMMENTS REGARDING REIMBURSEMENTS/CME

I think the compensation is low for what we are required to review and write up. It is less than ½ of what defense and plaintiff attorneys pay for similar services.
$100 per hour - on the low side of compensation.
Reimbursement for med legal consultations is in the $300-350/hr range.
Increased compensation. The reviews and opinions take much time and effort. The compensation is not commensurate with this.
CME (for me) is so widely available, useful and cheap- it is no incentive (hospital based & a pathologist - pathologists constantly read, etc.)
The reimbursement of $100 per hour is too low. I do the reviews as a civic duty! Please increase the reimbursement for physicians especially the specialists!
Defense experts generally obtain $300-500/hr of review. Most experts have sufficient CMEs.
The level of compensation has been flat for many years.
Reimbursement could be improved a bit if possible.

Additional reimbursement would be nice but I am more than willing to review more cases and would be willing to testify if necessary. Thank you for all your efforts to improve the quality of medicine.
Pay is low, but not that important to me. I'm willing to do more. I enjoy this kind of work.

GENERAL COMMENTS

I would like to continue to serve if requested. It is still difficult to distinguish between simple and gross negligence. Do repeated instance of simple negligence = gross negligence?
It is a good program. MBC has not requested my services more than I would prefer. I now only work as a part-time volunteer ob-gyn for the So. Bay free clinics, thus I have time to review cases as needed or requested. I told a couple of doctors to call you if interested (to participate in the program).
I was pleasantly surprised by the professionalism of Ms. Veverka so I'd be happy to work with her. Only 1 case ever in a few years.
Available for more referrals.
Request for review are appropriate. I would be willing to accept more.
The fees are low compared to private practice but it is both an honor and a duty to serve. I take my responsibilities very seriously and feel it is important to provide the best consultations and opinions for my physician colleagues. My interaction with the staff and investigators have always been superlative, helpful, cordial and professional. The Board does an excellent job overall with this program.
I have not been used more than decided. Reimbursement is a little lower than it should be. I doubt CME would attract more physician reviewers. The investigators with whom I have worked are Terrific!
I would be more than happy to review more cases for the MBC. I have been very impressed by the quality of work and integrity of every investigator I have worked with so far.
Great working with the MBC. I am available to perform new reviews.
I've only done 1 case. Happy to review more.

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
CALENDAR YEAR 2007 (JAN - SEP)

Agenda Item 6-B

SPECIALTY	**Number of cases reviewed/sent to Experts**	**Number of Experts used and how often utilized**	**Active List Experts (TOTAL=1,085 ↑)**
ADDICTION	1	1	11 ↓
AEROSPACE MEDICINE	0	0	1
ALLERGY & IMMUNOLOGY	2	1 expert reviewed 2 cases	10 ↓
ANESTHESIOLOGY	12	12	85 ↑
COMPLEMENTARY/ALTERNATIVE	5	4	13
CORRECTIONAL HEALTHCARE	1	1	5
DERMATOLOGY	6	5	11 ↑
EMERGENCY	13	9 (1expert reviewed 2 cases; 1 expert reviewed 3 cases)	62 ↑
FAMILY	35	29	93 ↑
HOSPICE & PALLIATIVE CARE	0	0	7
HYPERBARIC MEDICINE	0	0	1
INTERNAL GENERAL INTERNAL/other sub-specialties (not listed below)	35	29 (1 expert reviewed 4 cases; 1 expert reviewed 3 cases; 2 experts reviewed 2 cases)	218
INTERNAL - CARDIOLOGY	11	4 (2 experts reviewed 4 cases)	26 ↑
INTERNAL - ENDOCRINOLOGY			9
INTERNAL - GASTROENTEROLOGY	6	4 (1 outside expert used also)	14
INTERNAL -INFECTIOUS DISEASES	1	1	8
INTERNAL - NEPHROLOGY			7
INTERNAL - ONCOLOGY	5	4	9
MEDICAL GENETICS	0	0	1
MIDWIFE REVIEWER	1	1	12
NEUROLOGICAL SURGERY	3	3	13 ↑
NEUROLOGY	8	5 (3 experts reviewed 2 cases)	20 ↓
NEUROLOGY (CHILD)	1	1	2

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
CALENDAR YEAR 2007 (JAN - SEP)

OBSTETRICS & GYNECOLOGY	40	27 List Experts 1 Outside Expert ---------- 1 expert reviewed 8 cases 2 experts reviewed 2 cases 1 expert reviewed 3 cases 1 expert reviewed 4 cases	78 ↑
REPRODUCTIVE ENDOCRINOLOGY	2	1 List expert 1 Outside expert	3
OCCUPATIONAL MEDICINE	0	0	8
OPHTHALMOLOGY	5	5	48 ↑
ORAL & MAXILLOFACIAL SURGERY	0	0	1
ORTHOPAEDIC SURGERY	11	10	43 ↓
OTOLARYNGOLOGY	7	5	35 ↑
PAIN MEDICINE	5	4	24 (12ABMS,12 ABPM)
PATHOLOGY	1	1	14
PEDIATRICS	3	3	57
PEDIATRIC CARDIOLOGY	1	1	4
PEDIATRIC HEMATOLOGY/ONCOLOGY	0	0	3
PEDIATRIC SURGERY	0	0	3
PHYSICAL MEDICINE & REHABILITATION	1	1	8 ↑
FACIAL PLASTIC & RECONSTRUCTIVE SURGERY			8
PLASTIC SURGERY	23	15 List Experts 2 Outside experts 2 Experts reviewed 3 cases 2 Experts reviewed 2 cases	36
PSYCHIATRY	36	22 List Experts 1 Outside Expert 2 experts reviewed 5 cases 1 expert reviewed 3 cases 3 experts reviewed 2 cases	112 ↑
PUBLIC HEALTH & GENERAL PREVENTIVE MEDICINE	0	0	6
DIAGNOSTIC RADIOLOGY/ RADIOLOGY/NUCLEAR MEDICINE	5	3	37

RADIATION ONCOLOGY/ THERAPEUTIC RADIOLOGY	1	1	6
SLEEP MEDICINE	0	0	5
SPINE SURGERY (ABSS-MBC APPROVED)			1
SURGERY	11	9	58
COLON & RECTAL SURGERY	0	0	6
THORACIC SURGERY	4	4	17
VASCULAR SURGERY	1	1	5
UROLOGY	6	2 List Experts (1 reviewed 3cases) 1 Outside Expert (reviewed 2 cases)	16

/susan (10/3/07)

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	October 15, 2007
ATTENTION:	Division of Medical Quality
DEPARTMENT:	Enforcement Program
SUBJECT:	MBC Expert Reviewer Program
STAFF CONTACT:	Renee Threadgill

REQUESTED ACTION: Board considers establishing some means to publicly acknowledge the public service contributions of the physician expert reviewers.

STAFF RECOMMENDATION:
Staff recommends that the Board consider establishing some means to publicly acknowledge the public service contributions of the physician experts. One suggestion could be an acrylic plaque recognizing their contribution that the experts can display in their offices.

EXECUTIVE SUMMARY:
At the July meeting of the Division of Medical Quality, Members asked staff for information about the recruitment and retention of the physicians for the medical expert reviewer program. Medical expert reviewers provide the opinions upon which a determination is made whether to close an investigation or seek disciplinary action against the licensee. The Board's stated goal in developing the current program was to "create a systematic, objective and efficient approach to the qualifications, appointment, training, oversight, evaluation and functions of the physicians who constitute the Board's medical resources." The program is accessible to all staff through the Board's Intranet. Investigators can search by name or specialty and have immediate access to the expert's CV, all of the cases the expert has reviewed, and all of the evaluations.

Most experts only review one case a year, with a rare few performing more than three and policy recommends that no expert should review more than three cases a year, except in extraordinary circumstances. Once an expert reviews their third case in one year, their profile on the database is flagged. Investigators must then justify and seek approval from the Deputy Enforcement Chief in order to utilize that expert again

Recruitment strategies include Advertisement in MBC quarterly newsletter and on MBC website, advertisement in CMA Newsletter, current experts and MBC Members recruit, MBC Staff outreach to hospital staffs and administrators, specialty societies and medical associations and also speaking engagements at medical facilities, associations and specialty society meetings.

FISCAL CONSIDERATIONS:
The costs for the first year to provide an individual plaque for each of the 1066 current expert reviewers is estimated to be $106,600 as each plaque costs approximately $100. The average number of new reviewers each year is about 100 and the ongoing costs would be related to the actual number of new participants times the costs of each plaque.

PREVIOUS MBC AND/OR COMMITTEE ACTION:
At the last MBC meeting in July 2007, the Members approved an increase in compensation for expert reviewers form $100/hour to $150/hour.

ATTACHMENT A

Medical Expert Reviewer Program

BACKGROUND AND DISCUSSION

Medical expert reviewers provide the opinions upon which a determination is made whether to close an investigation or seek disciplinary action against the licensee. Prior to 1995, district medical consultants who were employed in each district office recruited local physicians to render opinions and testify at disciplinary hearings. There was no centralized, formal system for investigators or deputy attorneys general to access experts. In addition, there were no formally adopted standards for the qualifications of the experts or their utilization.

In 1993, then-Governor Pete Wilson convened a summit to address a number of criticisms directed toward the Medical Board of California (hereinafter referred to as Board) and its disciplinary system. Consequently, a great number of improvements were made in both the handling of complaints and the disciplinary process. Senator Robert Presley authored SB 916 (Chap. 1267; Stats. of 1993), which added Business & Professions Code Section 2332(a) and authorized the Board to establish a panel of experts. This was the genesis what is now the Board's medical expert reviewer program. On July 29, 1994, the medical expert reviewer program was implemented. The Board's stated goal in developing the program was to "create a systematic, objective and efficient approach to the qualifications, appointment, training, oversight, evaluation and functions of the physicians who constitute the Board's medical resources." The program addressed the minimum qualifications of experts, their appointment, training, evaluations, and how they would be assigned.

Minimum qualifications:

- Board certification by an ABMS Board or an "emerging" specialty, sub-specialty or equivalent qualifications under special circumstances;
- License in good standing, with no prior discipline, no current accusation pending, no complaints "closed with merit";
- Minimum of 5 years of practice in the area of specialty;
- Active practice, defined as at least 80 hours a month in direct patient care or clinical activity or teaching, with at least 40 hours in direct patient care (under special circumstances, this requirement could be waived); and
- Peer review experience recommended, but not required.

Appointment:

- Appointed by the Division of Medical Quality to a 2-year term, after meeting qualifications, successfully completing training and signing a written agreement to serve and testify as needed in any case in which a written opinion was provided (under special circumstances, this requirement could be waived);

- May be reappointed to subsequent terms after positive evaluation if they continue to meet minimum qualifications; and
- Appointment agreement included the obligation to testify or complete testimony on cases pending at the time of term expiration.

Training:

- Minimum 8 hours of training;
- Training faculty: Supervising Investigator, Deputy Attorney General (DAG), and District Medical Consultant;
- Training to utilize statewide, standardized course outline and;
- Retraining required every 4 years.

Oversight and Evaluation:

- Written standards established by DMQ to address performance, including completeness of reports, clarity, objectivity, timeliness, capability as a witness, among other factors;
- Statewide database of all appointed experts maintained by Board enforcement staff; and
- Oversight Committee: two members of the DMQ (minimum 1 physician) and representatives from the AG's Health Quality Enforcement Section, District Medical Consultant, and Enforcement management staff that performs initial and reappointment evaluations.

Assignment to Cases:

- Made by district medical consultant from the statewide panel of appointed experts;
- Board certification or area of practice to match that of respondent's specialty or area of practice under review;
- One expert per case in non-quality of care cases, except when necessary;
- Expert must not have, or appear to have, any conflict of interest which could be construed as economically competitive or have any professional, personal or financial association which could be construed as undue influence on independent judgment; and
- Quality of care cases to be reviewed at a meeting with the investigator, supervising DAG or DAG assigned to the case, and the district medical consultant prior to referral to the AG for the filing of an Accusation. Expert must be available to participate in the meeting after the written opinion is filed, and must also be available for meetings to conduct a retrospective analysis of cases that are unsuccessful.

The Current Program:

The program, since its inception, has undergone a number of improvements and changes. After the first notice was published in the *Action Report* in January 1995, over 400 physicians applied, with over 300 qualifying for appointment. The

program has grown to its current size and composition of 1,066 experts in 48 specialties and sub-specialties.

Improvements, Changes and Challenges of the Program:

As with most programs, adjustments are continually being made as a result of problems or challenges experienced. The following are some examples: Database of Experts:

When the program began, headquarters analytical staff prepared a database which was periodically printed and distributed to investigative staff. When investigators wanted to hire an expert, they would ask headquarters about previous cases reviewed and asked to see the evaluations of their work. Often, databases were outdated and contained names of persons who were no longer available. All of this took time and was not user-friendly.

In 2000 a database was specifically designed for the program that is accessible to all staff through the Board's Intranet. Investigators can search by name or specialty and have immediate access to CVs of the experts, all of the cases the expert has reviewed, and all of the evaluations.

Background checks:

In 2004, the Board utilized an expert reviewer who had an action pending at a hospital, which brought into question the validity of his expertise. The Board was unaware of the pending action at the time the expert was selected. To prevent future problems, Case Review and Professional Competency Examination Checklists were revised to ensure that experts were asked about any pending actions, or any other matter that, in the future, could be used to challenge their expertise.

Evaluations:

Evaluations of the experts are vital to enforcement and AG staff. While the investigators and DAGs have always evaluated experts' work, now there is an organized electronic repository for information about each expert's performance. Evaluations are completed by district medical consultants, investigators and DAGs. The evaluations are maintained in a database that is accessible to users on the Board's Intranet. Additionally, via the Intranet, investigators have immediate access to previously assigned cases, enabling investigators and their supervisors to evaluate what cases are best suited for an expert.

Training:

At the very beginning of the program, the Board required physicians to attend a training class taught by in-person faculty consisting of a medical consultant, an investigator or supervisor, and a Deputy Attorney General. As all practicing physicians are busy, scheduling training for more than one physician was extremely problematic. As no expert could be assigned a case for review until the training class requirement was fulfilled, the Board had willing experts unable to work. For

that reason, a training video was developed, and experts are now given a tape or DVD, and published guidelines to review. While this certainly has expedited the use of experts, the lack of interpersonal contact has its faults. To address this, investigators or district medical consultants, whenever possible, hand-deliver the first case assigned to the expert so that a relationship can be established and questions can be addressed. Staff is also in the process of drafting a Budget Change Proposal (BCP) to establish a full-time position devoted to training.

Utilization Report to the Division:

Prior to the implementation of the medical expert reviewer program, the Board heard concerns from various physician groups that the Board utilized only a few experts who provided only adverse opinions. While there was never any evidence to support those concerns, in order to demonstrate the fairness of the system, a report was developed that summarizes the use of experts. The report is provided to Board members and the data reveals that most experts only review one case a year, with a rare few performing more than three.
Moreover, staff adopted a policy that no expert should review more than three cases a year, except in extraordinary circumstances. Once an expert reviews their third case in one year, their profile on the database is flagged. Investigators must then justify and seek approval from the Deputy Enforcement Chief in order to utilize that expert again.

Surveys of Experts:

In order to maintain good working relations with the experts, staff sends a survey to every expert following the completion of a review. The survey poses 13 specific questions and asks for suggestions for program improvement. The results of these surveys, including all comments, are incorporated in a quarterly report to the DMQ members.

As members see in the quarterly report, most physicians are positive about their experience. The vast majority indicate that they are willing to accept more cases for review. Given that past reimbursement rate was only $75 an hour and raised to $100, which is not remotely competitive with expert compensation in the private sector, one can infer that most experts see their work for the Board as a form of public service. If physicians indicate that they are unwilling to review any more cases for the Board, the overwhelming reason cited is that they are too busy to take on any additional work.

Recruitment & Retention:

The Board has been proactive in efforts to recruit medical experts. Recruitment outreach is ongoing, especially to obtain experts in under-represented specialties. Our efforts include:

- Advertising in the *Medical Board of California Newsletter* and Website;
- Placing notices in medical and specialty association newsletters;
- Writing to and personally speaking with hospital staffs, including department

chairs, medical training program directors, specialty societies and other medical associations;

- Speaking engagements at medical facilities, associations, and specialty society meetings.

The majority of our most qualified experts are referred to us by other experts.

Future Improvements:

According to the Experts:
While the current system functions well, recommendations from the expert reviewers included:

- Raise the reimbursement rates;
- Pay reimbursement more quickly (it takes 4-6 weeks);
- Provide a form of recognition for reviewers

According to the Users:

In January 2007, staff established a working group of medical consultants, investigators, supervisors, and deputy attorneys general to brainstorm, review the effectiveness of past efforts, and make recommendations for improvements. Here are some of their observations and ideas:

- CMA published a "call for experts" in their newsletter, which resulted in 50 inquiries. Half were qualified. This should be continued periodically.
- The American Board of Neurosurgery reported in their newsletter that the Board needed experts. As a result, there were 3 inquiries, although none of them met the minimum requirements. Perhaps more notices would yield some qualified experts.
- The *Medical Board of California Newsletter* provides a steady stream of inquiries, some of which meet the requirements. It's recommended that the *Newsletter* have a notice in every issue.
- Letters were sent to selective faculty members in different specialties in teaching hospitals. There was a 15% response rate, and this effort should be continued.
- Letters were sent to individuals from directories of medical societies representing specialties for which there is a specific need. Although very time consuming, it has yielded some modest results. More staff would be needed if this were to be an ongoing effort.
- Raise the reimbursement rate.
- Provide some formal recognition (plaque/certificate) for their service.
- Pay experts for training time and reviewing the training materials (training is done by watching video and reading written materials). In addition, provide CME hours for the training program.
- Require experts to take a refresher course every four years, followed by a brief exam, and pay them for it.

- If there is reason to question an expert's objectivity, send them a "test" case to perform to determine if they have certain biases before sending them a real case.
- District medical consultants and assigned DAGs should prepare a list of questions for experts to answer in their report.
- Materials must be presented to experts in a binder, not rubber-banded or boxed, and should include a sample report.
- A short document outlining various legal definitions and other important information needed for the report to ensure that the major elements of the report are not overlooked.
- Provide feedback to the experts involved with the case, i.e. inform when accusations are filed, settlement, or a decision is rendered.
- Both positive and constructive feedback should be given.

Actions Taken:

Many of the above recommendations have already been implemented. Compensation has been raised, staff continues with outreach efforts, and greater communication is being pursued.

In order to improve the training of the experts, staff is requesting an additional position and resources to be dedicated solely to this function. Investigators and district medical consultants, whenever possible, are hand-delivering cases to first-time experts to establish a better working relationship with better communication. District medical consultants are being utilized to speak with experts when constructive feedback is necessary, and more flexibility, when possible, is given to experts in preparing their reports. Investigators are making every effort to inform experts of the outcome of cases they review. Additional materials are being developed to further explain the process and assist experts in preparing their reviews.

Other ideas were explored but are not possible to implement. As an example, providing CME credit for training was explored in 2006, and found to be impractical, as either legislation or accreditation would be required. The Board and its staff has no power or jurisdiction over the speed at which the experts are paid. The idea of providing public recognition or appreciation of expert reviewers should be more fully explored.

CONCLUSION

The medical expert reviewer program is one of the more critical and effective programs within the enforcement program. It is successful in providing investigative staff with qualified witnesses and has established a system to promote varied, objective and fair opinions. While it is always a challenge found in the healthcare system in general. Some specialties are under-represented on our panel, but no greater than that in the medical provider system.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	November 2, 2007
ATTENTION:	Division of Medical Quality Members
DEPARTMENT:	Medical Board of California (MBC)
SUBJECT:	Increase in Payment to Expert Reviewers
STAFF CONTACT:	Renee Threadgill

REQUESTED ACTION:
Division members approve justification provided in this document for staff's previous recommendation made at the July 2007 Division of Medical Quality meeting to increase the medical expert's hourly rate for case reviews from $100 to $150.

STAFF RECOMMENDATION:
Staff recommends that, based upon the figures that have been developed below in the Fiscal Considerations section, the Division continue to support an increase of $50 per hour at this time, rather than an increase of $100 or more.

EXECUTIVE SUMMARY:
In the past years there has been discussion regarding increasing the hourly rate for the expert reviewers used by the Board's Enforcement Unit. These experts review cases during an investigation and determine if the physician has departed from the standard of care. In addition, if the case proceeds to hearing, this expert also provides testimony. It has been a concern that the hourly rate for case review, set at $100, is too low based upon the significant work of the experts.

The Board's budget line item entitled "Evidence/Witness" has a set amount to be spent for the usage of expert reviewers (used during investigation and prosecution of the case) and the usage of the medical consultants that the Central Complaint Unit (CCU) uses for complaint triage. The Division Members, based upon comments made by the experts and staff, requested that staff review the hourly rate for experts in conjunction with the Board's budget, and determine if an increase could be made.

FISCAL CONSIDERATIONS:
In fiscal year (FY) 2006/2007, the Board's budget for "Evidence/Witness" was set at $1,557,983 and the Board spent $1,214,680. This left a balance of $343,303. To determine if an increase was possible and the amount of the increase, Board staff needed to determine how many hours were billed in that FY only for expert case review. Please see the attached report. Based upon this report, there were 6,736 hours billed for expert reviewers in FY 06/07 and 6,983 hours billed in FY 05/06. Board staff believed that in order to accurately determine the amount of an increase, it needed to average the hours used in the last two fiscal years and use that average for projections for FY 07/08. The average was 6,860 hours billed for expert case reviews for the last two fiscal years.

The Board's budget for "Evidence/Witness" for FY 07/08 is currently set at $1,676,318. (Board staff has made an assumption that all other spending for experts, e.g. travel, etc. and medical consultants in CCU will remain the same or similar. Therefore, the following shows that an increase of $50 per hour is the logical increase at this time:

FY 07/08 budget:	$1,676,318
FY 06/07 spending:	$1,214,680
FY 07/08 projected increase based upon $50 increase ($50 X 6860):	$343,000
FY 07/08 projected increase based upon $100 increase ($100 X 6860)	$686,000
Projected total spent in FY/07/08 w/ $50 dollar increase:	$1,557,680 (under budget)
Projected total spent in FY/07/08 w/ $100 dollar increase:	$1,900,680 (over budget by $224,362)

PREVIOUS MBC AND/OR COMMITTEE ACTION:
Board staff previously reviewed usage by experts in the past two fiscal years and determined the Board's budget could support an increase of $50 per hour for a total of $150 per hour for expert reviewers without requesting additional funding. At the last Division meeting in July 2007, the Members approved an increase of $50 per hour, but also requested additional information be provided to them to substantiate the increase of only $50.

PAYMENT TO EXPERT REVIEWERS

FISCAL YEAR **2005/2006**		
TOTAL HOURS	*RATE/HR*	*COMMENTS*
122	$75	Travel Time
6,983	$100	Case reviews; Conference w/ DAG, MC, Inv;Oral competency
223	$200	Testimony
372	$100 - $500	Mental/Physical Evaluations - usual/customary fee Total Expense = $89,895 (an average rate of $250/hr)
Other Expenses: $10,108 (experts' transcription/typing expenses, mileage, lodging, per diem, parking, transportation)		
FISCAL YEAR **2006/2007**		
TOTAL HOURS	RATE	COMMENTS
127	$75	Travel Time
6,736	$100	Case reviews; Conference w/ DAG, MC, Inv; Oral competency
296	$200	Testimony
308	$100 - $500	Mental/Physical Evaluations - usual/customary fee Total Expense = $80,164 (an average rate of $250/hr)
Other Expenses: $9,122. (experts' transcription/typing expenses, mileage, lodging, per diem, parking, transportation)		

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October 15, 2007

Agenda Item 7

Members, Division of Medical Quality
Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

RE: Vertical Prosecution Program Update

Dear Board Members:

At the request of the Division of Medical Quality (DMQ), the following is a report regarding significant steps taken by the Health Quality Enforcement Section (HQE) in the implementation of the vertical prosecution (VP) program which went into effect on January 1, 2006. Statistics gathered by the Medical Board of California (MBC) over the first sixteen (16) months of the program are favorable, demonstrating an overall decrease in the length of time it takes to complete investigations, along with additional improvements in other areas as well. While much progress has been made, there is still much to do. Establishing a common limited data base to permit HQE and the MBC to share case information remains a high priority. Establishing and implementing a plan to co-locate HQE deputy attorneys general and MBC investigators in the same offices, as appropriate, is also an important objective to further enhance the VP program. While these and other important steps lay ahead, the single most significant obstacle that must be overcome is the continuing loss of experienced investigators who, for a variety of reported reasons, are leaving employment with the MBC. The inability of the MBC to provide investigative services resulting from the loss of experienced investigators would seriously jeopardize the continued success of the VP program and, ultimately, undermine the public protection of healthcare consumers statewide.

I. Introduction:

During the 2004-2005 legislative session, Senate Bill 231 was passed by the Legislature and later signed into law by the Governor on October 7, 2005. Effective January 1, 2006, Senate Bill 231 made numerous changes to laws relating to the MBC and HQE. The most significant change effectuated by Senate Bill 231 was the legislative transfer of primary responsibility for investigations from the MBC to HQE, together with the legislative mandate that the "vertical prosecution model" be implemented for cases involving alleged unprofessional conduct by physicians and surgeons.

In order to provide HQE with the statutory authority necessary to discharge its new responsibility to investigate cases, the Legislature added section 12529.6 to the Government Code which defines the "vertical prosecution model" as including the following three elements: (1) each physician and surgeon complaint referred to an MBC district office for investigation shall be simultaneously and jointly assigned to an investigator and HQE deputy attorney general responsible for prosecuting the case if the investigation results in the filing of an accusation; (2) the joint assignment shall exist for the duration of the disciplinary matter; and (3) during the joint assignment, the assigned investigator shall, under the direction of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.

In its Report to the Legislature, the MBC has correctly observed that "[w]hile the MBC investigative process is essentially unchanged under the [VP] model, the changes within [HQE], both structurally and procedurally, have been more dramatic." (Medical Board of California, Report to the Legislature, Vertical Enforcement (July 19, 2007) p. 6.)[1] For example, according to the MBC, HQE has been required to: (1) "[d]evelop a database for all cases referred for investigation, not just those that are prosecuted"; (2) "[d]evelop familiarity with all MBC policies pertaining to investigations"; (3) "[b]ecome responsible for all elements of the investigative process on cases resulting in closure or prosecution"; (4) "[p]rovide case direction from the investigative stage through the prosecutorial stage"; and (5) "[p]rioritize a new workload, which included investigative and prosecutorial tasks." (*Id.*, at pp. 6-7.) The examples cited by the MBC are just a few of the significant steps that HQE has taken to successfully implement the VP program.

II. Successful Publication of the Joint HQE/MBC Vertical Prosecution Manual:

With the passage of Senate Bill 231, it became immediately clear that HQE needed to establish policies and procedures to implement the VP program statewide and include them in a manual for use by both investigators and deputy attorneys general. Accordingly, in January of 2006, HQE published its "Vertical Prosecution Manual for Investigations Conducted by Medical Board Investigators" (First Edition, January 2006) addressing the statutory construction of Government Code section 12529.6, as well as the policies and procedures, including dispute resolution, that governed the initial implementation of the VP program. In addition, HQE also participated in the drafting and publication of a "Joint HQE/MBC Vertical Prosecution Protocol." These two documents provided the structural context for the VP program and guided both its initial implementation and day-to-day operations from January to November 2006.

After several months of experience working with the program, in November of 2006, HQE and the MBC staff consolidated the previously published manual and protocol into a single joint HQE/MBC "Vertical Prosecution Manual (Second Edition, November 2006)." This new joint manual incorporated various changes and improvements to the program and strongly emphasized that vertical prosecution is based on a team concept where each member of the VP team makes his/her own valuable contribution toward the ultimate goal of public protection. As of the date of this memorandum, the joint HQE/MBC Vertical Prosecution Manual (Second Edition, November 2006) continues to govern the day-to-day operation of the VP program.

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1. This report has not been filed with the Legislature.

III. Development of the Investigation Plan and Progress Report:

Under the former Deputy-In-the-District-Office ("DIDO") program which existed prior to the enactment of Senate Bill 231, a deputy attorney general was required to "frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff." (Former Gov. Code, § 12529.5, subd. (b).) In essence, DIDO deputies provided only consultation to investigators, medical advisors and executive staff in the investigation and prosecution of disciplinary cases. Thus, under the DIDO program, there was no need for investigators to regularly communicate with, or provide periodic updates to, deputies regarding ongoing investigations.

The enactment of the VP program, however, fundamentally changed the relationship between investigators and deputies. In order to create a vehicle for investigators and deputies to establish and maintain communication regarding ongoing investigations, and permit deputies to provide the statutorily required direction to investigators, HQE developed the "Investigation Plan and Progress Report," otherwise known as the "IPPR." The IPPR was designed to permit the investigator, in the first instance, to exercise his/her professional judgment to identify the steps he/she believes are most appropriate for the timely and efficient investigation of the case. The IPPR is then electronically transmitted by e-mail to the assigned deputy who then reviews and approves it, without or without modifications. Thereafter, the investigator and deputy maintain a "running e-mail thread," communicating and replying to each other by adding information to the e-mail thread as the investigation progresses. The IPPR running e-mail thread also serves as ongoing documentation of the progress of the investigation.

In the initial phase of the VP program, the IPPR format used by investigators varied and was not uniform statewide. However, in June of 2007, an "IPPR Working Group" consisting of personnel from both the MBC and HQE was created and, in July of 2007, the group met and agreed on a uniform IPPR format to be used statewide. The IPPR has become one of the cornerstones of the VP program and its use is now required by both the Joint HQE/MBC Vertical Prosecution Manual (November 2006, Second Edition) and the MBC's own Enforcement Operations Manual.

IV. Technological Achievements and Future Challenges:

The legislative transfer of primary responsibility for investigations from the MBC to HQE also created the immediate need for significant technological improvements in order to satisfy the dramatically increased data inventory, tracking, retention and reporting demands of the program.

In late 2005, HQE proposed the creation of a common limited data base which would receive case information from both the Department of Justice "ProLaw" case management program and the Department of Consumer Affairs' "Consumer Affairs System" (CAS) system. This new common limited data base would have permitted the sharing of case information between HQE and MBC, reduced the time spent by both agencies inputting case specific information into separate data bases, and eliminated the need to reconcile case information and statistics. However, due the technical challenges required to maintain this project and the limited nature of the pilot program this project was not pursued at that time.

This project required that the Department of Justice make substantial modifications to the ProLaw program. HQE worked closely with the Case Management Section (CMS) and, in particular, with Angelo Whitfield, the Department of Justice's information and technology consultant, to develop the Vertical Prosecution Initiative Flow Chart which identified each significant step in a typical investigation and prosecution of a case. The Flow Chart, in turn, permitted the identification of the various data tracking markers which, in turn, permitted HQE to create two sets of Mandatory Docket Events, one for VP investigations and one for administrative prosecutions. HQE deputies then enter the appropriate Mandatory Docket Event in the ProLaw matter for each of their assigned cases, thus permitting CMS to run reports documenting case progress. As of the date of this memorandum, the lists of Mandatory Docket Events is currently under review to determine what, if any modifications, should be made to them.

HQE also worked with CMS to create various Rule Sets for the different types of matters handled by the section. These Rule Sets were developed to permit deputies to quickly and easily enter the Mandatory Docket Events in each of their cases. As of the date of this memorandum, CMS is in the process of refining the available Rule Set to ensure they are all-inclusive and to eliminate unnecessary or redundant rule sets. The completion of this project has been temporarily delayed because the Department of Justice is currently upgrading its Pro Law program to a newer version. This upgrade is anticipated to be completed by October 31, 2007.

In order to provide HQE deputy attorneys general with continuing access to the Department's case tracking and e-mail computer programs, the Department installed computers in each of the MBC's district offices. Additional resources were later expended to successfully resolve significant connectivity and computer security issues and, ultimately, it became necessary for the Department to install new upgraded computers in each of the MBC's district offices. More recently, the MBC developed a "read only" limited data base that it has made available to HQE. At the present time, HQE is studying whether information from this data base can be effectively migrated to the ProLaw case management program.

While HQE continues to work to improve its own data tracking and reporting capabilities, the creation and maintenance of a common limited data base to permit the sharing of case information between HQE and the MBC is a top priority for both agencies in order to further enhance the VP program. The Board's Executive Director, the Board's Deputy Director, Mr. Whitfield and I have met on several occasions and are currently working to accomplish this objective. However, at this time, the completion of this project has temporarily delayed due to the upgrade of its Pro Law program, mentioned above. Mr. Whitfield is expected to attend the next Board meeting and be available to answer questions you may have on the technical aspects of this project.

V. <u>VP Training for HQE Deputies and Legal Support Staff Statewide</u>:

The implementation of the VP program, like any new governmental program, required extensive training for both HQE deputies and the Department's legal support personnel to permit them to assume their new duties and responsibilities under the program. In order to meet this challenge, in October of 2006, HQE conducted statewide training in San Diego for all Lead Prosecutors and Supervising Deputy Attorneys General. Supervising Deputy Attorneys General have also continued to provide on-the-job training on the VP program for all deputies in their respective sections. In addition, the Department's legal support personnel have received necessary training on a variety of subjects including, for example, the opening and closing of VP investigations within the ProLaw program.

VI. The Results of the VP Program from January 2006 to April 2007:

The MBC statistical data collected during the first sixteen (16) months of the VP program show, when modified to exclude cases prior to implementation of the program, an overall decrease of ten (10) days in the average time to complete an investigation. (Medical Board of California, Report to the Legislature, Vertical Enforcement (July 19, 2007) p. 1.) Statistical data gathered by the MBC also reflects improvement in several other important areas as well. (*Id.*, at p. 2.) These improvements are not, however, the only measure of the program's overall success.

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

VII. The Continued Success of the VP Program Depends on the MBC's Ability to Recruit, Hire, Train and Maintain a Staff of Experienced Investigators:

In order for the VP program to remain successful, the MBC must maintain a sufficient staff of experienced investigators to investigate the often complex cases of alleged unprofessional conduct by physicians and surgeons.

According to its Report to the Legislature, on January 1, 2006, the MBC had ninety-two (92) sworn staff positions comprised of seventy-one (71) investigators and twenty-one (21) supervisors. (Medical Board of California, Report to the Legislature, Vertical Enforcement (July 19, 2007) p. 25.) Between January 2006 and July 19, 2007, there have been a total of nineteen (19) separations (six retired, two resigned and eleven transferred). (*Id.*, at p. 26.) Low salaries and a more complex workload than other agencies were some of the reasons cited by investigators who left employment with the MBC. (*Id.*)

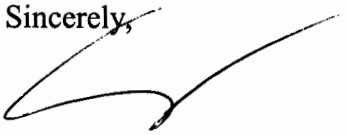
It cannot be overstated that the continued success of the VP program depends, in large part, on the ability of the MBC to provide investigative services on cases of alleged misconduct by physicians and surgeons.

IX. Conclusion:

As the MBC has correctly observed, implementation of the VP program has required HQE to make significant structural and procedural changes in order to successfully carry out its new and expanded duties and responsibilities under the program. While much has been accomplished and early statistical data demonstrates its benefits, further improvements can and should be made to the VP program. Establishing a common limited data base to share case information, and implementing a plan to co-locate HQE deputy attorneys general and MBC investigators in the same offices, as appropriate, remain top priorities. Most importantly, efforts must be made to stem the continuing loss of experienced investigators who, for a variety of reported reasons, are leaving employment with the MBC. Continued loss of experienced investigators would seriously jeopardize the overall success of the VP program and, ultimately, would undermine the public protection of healthcare consumers statewide.

I hope the foregoing has been of some assistance to you. Please let me know if you have any questions regarding the foregoing or if I can be of any further assistance.

Sincerely,



CARLOS RAMIREZ
Senior Assistant Attorney General

For EDMUND G. BROWN JR.
Attorney General

TITLE 16. Medical Board of California

NOTICE IS HEREBY GIVEN that the Medical Board of California is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held at Hilton San Diego Mission Valley, 901 Camino del Rio South, San Diego, California, at **9:00 a.m.**, on **November 2, 2007**. Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 p.m. **on October 22, 2007** or must be received by the Board at the hearing. The Division of Medical Quality, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Sections 2018 and 2336 of the Business and Professions Code, and to implement, interpret or make specific Sections 2336 of said Code, the Medical Board of California is considering changes to Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Amend Section 1364.30 in Article 8 of Chapter 2, Division 13; Adopt Section 1364.32 in Article 8, of Chapter 2, Division 13, relating to oral and written arguments.

In 2003, as a result of legislation (SB 1950, Ch. 1085, stats. of 2002), the Medical Board of California was assigned an Enforcement Monitor to review its enforcement operations and processes. Part of that two-year review was to examine the disciplinary process, including the process used by the Division of Medical Quality (DMQ) to hear oral arguments. In summary, in the "Final Report: Medical Board of California Enforcement Monitor," the Monitor was concerned with two elements of the oral argument process:

1) The current oral argument process legally prohibits the introduction of evidence beyond the record. In practice, however, the process often allows the introduction of evidence outside of the record.
2) Respondents are allowed to address the DMQ panel without being placed under oath.

The proposed regulation addresses the above two concerns raised by the MBC's Enforcement Monitor. The proposal will:

1) Allow an administrative law judge or panel member to ask the parties to cite the record (Sec. 1364.30(c)),
2) Require written arguments to cite the record, and authority, if applicable, for each point addressed (Sec. 1364.32), and
3) Require respondents to be placed under oath, if the respondent elects to address the panel (Section 1364.30(e)).

FISCAL IMPACT ESTIMATES

Fiscal Impact on Public Agencies Including Costs or Savings to State Agencies or Costs/Savings in Federal Funding to the State: None

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

Cost to Any Local Agency or School District for Which Government Code Section 17561 Requires Reimbursement: None

Business Impact:

___x_ The board has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

AND

_____ The following studies/relevant data were relied upon in making the above determination:

There are no costs associated with the proposed regulatory action. The proposed only relates to the presentation of oral arguments and written arguments and the swearing-in of respondents in disciplinary matters.

Impact on Jobs/New Businesses:

The Medical Board of California has determined that this regulatory proposal will not have

_____ a significant

_____x____ any

impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

Cost Impact on Representative Private Person or Business:

The Medical Board of California is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

Effect on Housing Costs: None

EFFECT ON SMALL BUSINESS

The Medical Board of California has determined that the proposed regulations would not affect small businesses.

The proposed regulations only make procedural changes to the oral and written argument process of disciplinary actions. The parties will be asked to cite the record for points made in the written and oral arguments to prevent the introduction of evidence beyond the record. The proposal will require respondent to be placed under oath if the respondent elects to address the panel.

CONSIDERATION OF ALTERNATIVES

No reasonable alternative to the regulation would be either more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed regulation.

Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

INITIAL STATEMENT OF REASONS AND INFORMATION

The Medical Board of California has prepared an initial statement of the reasons for the proposed action and has available all the information upon which the proposal is based.

TEXT OF PROPOSAL

Copies of the exact language of the proposed regulations and of the initial statement of reasons, and all of the information upon which the proposal is based, may be obtained at the hearing or prior to the hearing upon request from the Medical Board of California at 1426 Howe Avenue, Suite 92, Sacramento, California 95825.

AVAILABILITY AND LOCATION OF THE FINAL STATEMENT OF REASONS AND RULEMAKING FILE

All the information upon which the proposed regulations are based is contained in the rulemaking file which is available for public inspection by contacting the person named below.

You may obtain a copy of the final statement of reasons once it has been prepared, by making a written request to the contact person named below or by accessing the website listed below.

CONTACT PERSON

Inquiries or comments concerning the proposed rulemaking action may be addressed to:

Name:	Janie Cordray Medical Board of California
Address:	1426 Howe Avenue, Suite 92 Sacramento, CA 95825
Telephone No.:	(916) 263-2389
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

The backup contact person is:

Name:	Kelly Nelson Medical Board of California
Address:	1426 Howe Avenue, Suite 92 Sacramento, CA 95825
Telephone No.:	(916) 263-2389
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

Website Access: Materials regarding this proposal can be found at www.mbc.ca.gov.

Specific Language of Proposed Changes
Division of Medical Quality
Medical Board of California
Oral and Written Arguments

1364.30 Procedures for the Conduct of Oral Argument

(a) A party who wishes to present oral argument to the panel of the division that issued an order of nonadoption or reconsideration shall make a written request for oral argument not later than twenty (20) calendar days after the date of the notice of nonadoption or the order granting reconsideration.

(b) An administrative law judge will preside at oral argument. The administrative law judge may sit with and assist the panel members with their closed session deliberations.

(c) The arguments shall be based only on the existing record and shall not exceed the scope of the record of duly admitted evidence. No new evidence will be heard. The panel members may ask questions of the parties to clarify the arguments, but may not ask questions that would elicit new evidence. The administrative law judge and any panel member may ask a party to support the party's oral argument on a matter with a specific citation to the record.

(d) The administrative law judge shall stop an attorney, a party, or a panel member if the line of questioning or argument is beyond the record or is otherwise out of order.

(e) The administrative law judge shall offer the respondent an opportunity to address the panel regarding the penalty. If the respondent elects to address the panel, the administrative law judge shall place the respondent under oath.

(f) The sequence of, and time limitations on, oral argument are as follows:

(1) First -the respondent licensee and/or his or her legal counsel, who shall be limited to fifteen minutes.

(2) Second -the deputy attorney general, who shall be limited to fifteen minutes.

(3) Third -the respondent licensee's rebuttal or that of his or her legal counsel, which shall be limited to five minutes.

(4) Fourth -the deputy attorney general, who shall be limited to five minutes.

NOTE: Authority cited: Sections 2018 and 2336, Business and Professions Code. Reference: Section 2336, Business and Professions Code.

1364.32 Written Argument Submitted in Response to an Order of Nonadoption or Reconsideration

(a) Written argument submitted in response to an order of nonadoption or reconsideration shall:

(1) State each point under a separate heading or subheading summarizing the point and support each point by argument, and citation of authority if applicable; and

(2) Support any reference to a matter in the record by a citation to the volume and page number of the record or exhibit number where the matter appears.

NOTE: Authority cited: Sections 2018 and 2336, Business and Professions Code. Reference: Section 2336, Business and Professions Code.

MEDICAL BOARD OF CALIFORNIA

INITIAL STATEMENT OF REASONS

Hearing Date: November 2, 2007

Subject Matter of Proposed Regulations: Oral and Written Arguments

1) Procedure for the Conduct of Oral Argument
2) Written Argument Submitted in Response to an Order of Nonadoption or Reconsideration

Section(s) Affected: 1) Amend Section 1364.30 in Article 8 of Chap. 2, Div.13
2) Adopt Section 1364.32 in Article 8 of Chap. 2, Div. 13

Specific Purpose of each adoption, amendment, or repeal:

This rulemaking addresses deficiencies in the current oral argument process.

In 2003, as a result of legislation (SB 1950, Ch. 1085, stats. Of 2002), the Medical Board of California was assigned an Enforcement Monitor to review its enforcement operations and processes. Part of that two-year review was to examine the disciplinary process, including the process used by the Division of Medical Quality (DMQ) to hear oral arguments. In summary, in the "Final Report: Medical Board of California Enforcement Monitor," the Monitor was concerned with two elements of the oral argument process:

1) The current oral argument process legally prohibits the introduction of evidence beyond the record. In practice, however, the process often allows the introduction of evidence outside of the record.

2) Respondents are allowed to address the DMQ panel without being placed under oath.

Factual Basis/Rationale

The proposed regulation addresses the above two concerns raised by the MBC's Enforcement Monitor.

1) Refining the process to prevent the entering into evidence beyond the record (Secs. 1364.30(d) and 1364.32):

Administrative law judge or panel member may ask parties to cite to the record (Sec. 1364.30 (c)):
Oral arguments are heard by a DMQ panel and presided over by an Administrative Law Judge. The judge presiding over the oral arguments is not the same judge that presided over the hearing. Requiring the parties to cite to

the record to support their arguments will assist the presiding judge and panel members in ensuring new evidence is not introduced.

Written Arguments must cite the record, and authority, if applicable, for each point addressed (Sec. 1364.32):
Before the parties present oral arguments before a panel, written arguments are submitted. Panel members read the written arguments before hearing the oral arguments. For that reason, requiring citation to the record in written arguments will assist the panel members in ensuring new evidence is not introduced.

2) Requiring respondents to be placed under oath, if they elect to address the panel (Sec 1364.30(e)):

To address the Enforcement Monitor's concern that respondents addressing the panel are not under oath, the proposed regulation will require the judge to place the respondent under oath.

Underlying Data

As referenced above, in the "Final Report: Medical Board of California Enforcement Program Monitor" (published November 1, 2005), two major concerns regarding the oral argument process were raised. The following portions of the report are relevant to the proposed regulations:

> "Procedurally, the respondent is usually permitted to argue first. The HQE DAG is given equal time to respond, and each side is afforded a brief rebuttal. In making oral argument, the lawyers are required to confine themselves to evidence that is "in the record" — that is, evidence that has been presented at the evidentiary hearing and admitted by the ALJ. The DMQ members have all of this evidence, because in nonadoption cases the entire transcript and record of the evidentiary hearing are ordered and delivered to all panel members, and by law all of them are required to read the entire record and personally hear any additional oral argument and evidence presented to the panel before voting on the nonadoption. However, counsels do not always confine themselves to the record, and an objection to the argument may be voiced — requiring a legal ruling on the objection." (Page 137)

> ".....1995's SB 609 (Rosenthal) required MBC to adopt regulations governing the procedure at oral arguments, and those regulations now require an ALJ to preside at oral argument. Of course, this cannot be the same ALJ who presided over the hearing and whose decision was nonadopted in the matter at issue, so the ALJ presiding at oral argument necessarily has little or no knowledge of the sometimes voluminous record in the underlying matter. As opposed to the panel chair, this judge might be somewhat more successful in controlling the proceeding, ruling on objections, and requiring counsel to cite to the record when there is a question as to whether argument is based on the record. However, the required presence of the ALJ adds more expense to this process, and interrupts the hearing schedule of that MQHP ALJ." (Page 138)

> "..... in what is by far the most unusual aspect of the proceeding, the respondent himself must be given an opportunity to personally address the panel, and members of the DMQ panel are permitted to question either counsel or the respondent. Neither the statute nor the regulation requires that the respondent be put under oath when he makes this statement or answers questions. Respondents sometimes stray from the record and/or the topic at hand, and are subject to objections. Well-meaning DMQ panel members often ask questions outside the record, and are subject to more objections." (Page 138)

The full report may be accessed at: http://www.cpil.org/MBC_Final_Report.htm. The full section on the oral argument process begins on page 137.

Business Impact

___x__ This regulation will not have a significant adverse economic impact on businesses. This initial determination is based on the following facts or evidence/documents/testimony:

This proposed regulation only addresses the oral and written argument process. It requires that counsels providing written and oral arguments include the citation of the official record in their arguments, and that respondents be placed under oath. There are no costs associated with either of these requirements.

_____ Description of alternatives which would lessen any significant adverse impact on business:

Not applicable, as the proposed regulation has no business or economic impact.

Specific Technologies or Equipment

__x___ This regulation does not mandate the use of specific technologies or equipment.

_____ This regulation mandates the use of specific technologies or equipment. Such mandates or prescriptive standards are required for the following reasons:

Consideration of Alternatives

No reasonable alternative to the regulation would be either more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed regulation.

Title 16. MEDICAL BOARD OF CALIFORNIA NAME

NOTICE OF EXTENSION OF PUBLIC COMMENT PERIOD

NOTICE IS HEREBY GIVEN that the Medical Board of California is extending the public comment period concerning Oral and Written Arguments (Title 16, California Code of Regulations, Sections 1364.30 and 1364.32) until October 23, 2007. Attached is a copy of the proposed regulations for your reference. These proposed regulations are also available in the board's website: www.mbc.ca.gov/Regulations_Proposed.htm

Any interested person, or his or her authorized representative, may submit written comments no later than 5:00 p.m. on October 23, 2007 to:

Name:	Janie Cordray Medical Board of California
Address:	1426 Howe Avenue, Suite 92 Sacramento, CA 95825
Telephone No.:	(916) 263-2389
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

DATED: _____

_____
Kevin A. Schunke
Regulations Manager
Medical Board of California