INFORMATIONAL HEARING

CREATING A SEAMLESS ENFORCEMENT PROGRAM FOR CONSUMER BOARDS

Monday, August 17, 2009
9:00 A.M. – 12:00 P.M
Room 3191, State Capitol

BACKGROUND PAPER

Problems with the Board of Registered Nursing Enforcement and Diversion Programs

Since its inception in 1913 as the Bureau of Registration of Nurses, charged with administering nursing examinations, registering qualified registered nurses, accrediting nursing schools, and revoking licenses of nurses found to be unsafe to practice, the protection of the public has been the core function of the Board of Registered Nursing (BRN). The importance of this function is further emphasized in Business and Professions Code Section 2708.1 which states that whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. Lately, the public protection function of the BRN has been confronted by revelations of lengthy enforcement timeframes against problem nurses who continue to practice and provide care to the detriment of patients.

On July 11, 2009, the *Los Angeles Times*, in conjunction with *Pro-Publica*, a non-profit investigative news agency, published an article entitled "*When Caregivers Harm: Problem Nurses Stay on the Job as Patients Suffer*"[1] charging that the BRN, which oversees California's more than 350,000 nurses, often takes years to act on complaints of egregious misconduct. Nurses with histories of drug abuse, negligence, violence, and incomptenence continue to provide care, and the BRN often took more than three years, on average, to investigate and discipline errant nurses. The other findings and issues raised by the article include the following:

1) **Delays**. Complaints often take a circuitous route through several clogged bureaucracies: from the nursing board for initial assessment to the Department of Consumer Affairs (DCA) for investigation, to the California Attorney General's Office (AG's Office) for case filing and the state Office of Administrative Hearings (OAH) for trial. Lastly, the case goes back to the BRN for a final decision. The biggest bottleneck occurs at the investigation stage, as DCA staffers struggle to handle complaints against nurses as well as those against cosmetologists, acupuncturists and others. Another reason given for the delay is that the nursing

[1] *See* Charles Ornstein, Tracy Weber & Maloy Moore, *When Caregivers Harm: Problem Nurses Stay on the Job as Patients Suffer*, L.A. Times, July 11, 2009, *available at* http://www.latimes.com/news/local/la-me-nurse12-2009jul12,0,2185588.story.

board must share a pool of fewer than 40 field investigators with up to 25 other licensing boards and bureaus, and some investigators handle up to 100 cases at a time.

2) **Sanctions by Other Agencies or Boards**. The BRN failed to act against nurses whose misconduct already had been throughly documented and sanctioned by others. There were 120 nurses that were identified by the reporters who were suspended or fired by employers, disciplined by another California licensing baord or restricted from practice by other states, yet have blemish-free records with the BRN.

3) **Probation and Grounds for Revocation**. The BRN gave probation to hundreds of nurses, ordering monitoring and work restrictions, then failed to crack down as many landed in trouble again and again. One nurse given probation in 2005 missed 38 drug screens, tested positive for alcohol five times and was fired from a job before the BRN revoked his probation three years later. More than half the nurses who respond to allegations from the BRN are handed a second chance. Each year, California places at least 110 nurses on probation, warning that if they get in trouble again, their licensees may be yanked. In reality, such action seldom happens quickly, if at all, according to a review of hundreds of nurse disciplinary records. Just five board staff monitors 470 nurses on probation. Often nurses must undergo physical and mental exams, take drug tests, submit to workplace monitoring and attend rehabilitation or support groups. But when they don't meet some or any of those requirements, years often pass before the BRN tries to revoke their probation. At times, the punishment for violating probation is more probation.

4) **Emergency Suspensions**. The BRN failed to use its authority to immediately stop potentially dangerous nurses from practicing. It obtained emergency suspensions of nursing licenses just 29 times from 2002-2007. In contrast, Florida's nursing regulators, who oversee 40% fewer nurses, take such action more than 70 times each year.

5) **Funding**. Current and former state attorneys indicate that at times they have been asked to suspend work on nursing board cases to save money. The BRN has not raised its fees in 18 years.

6) **Statute of Limitations**. There is no legal pressure for the BRN to act faster. Unlike with disciplinary cases against doctors, there is no statute of limitations on nurses. The delays make the pursuit of cases more difficult: witnesses die, records are purged and former co-workers cannot be found.

7) **Hospital Reporting.** Most states require hospitals to report nurses who have been fired or suspended for harming a patient or other serious misconduct. The Board of Vocational Nursing and Psychiatric Technicians (BVNPT) also has this requirement.[2] However, the BRN does not have a similar requirement for

[2] *See* Business and Professions Code § 2878.1. Any employer of a licensed vocational nurse is required to report to the BVNPT the suspension or termination for cause of any licensed vocational nurse in its employ. This Section also defines suspension or termination for cause for purposes of reporting.

nurses.

8) **Disclosure and Tracking of Cases.** The BRN also largely shuts itself off from information about nurses licensed in California who get in trouble. It is not part of a national compact of 23 state nursing boards that share information about nurses who are under investigation or have been disciplined. And unlike 35 states, California does not put the names of all its registered nurses into an industry database. So if a California-licensed nurse gets in trouble in another state, the state may not know to notify California. Perhaps the most telling instances of dysfunction is when other states act against nurses for crimes and misdeeds committed in California before California's own board does.

9) **Fingerprinting and Criminal or Disciplinary Disclosure Requirements.** In a separate article published by the *LA Times*, and in collaboration with *ProPublica* on October 4, 2008,[3] it was revealed that nurses convicted of crimes, including sex offenses and attempted murder continue to be licensed by the BRN. As a result of these findings, emergency measures were adopted to require all nurses licensed by the BRN to be fingerprinted and to disclose in their license renewal forms criminal convictions or any discipline imposed by another jurisdiction. The fingerprinting and criminal or disciplinary disclosure requirements were later implemented for other consumer health-boards. SB 389, legislation introduced by Senator Gloria Negrete McLeod in this Session, would have codified and expanded the fingerprinting and criminal or disciplinary disclosure requirements. However, SB 389 initially failed passage in the Assembly Public Safety Committee because of concerns that requiring existing licensees to be fingerprinted might delay the license renewal process. SB 389 is now a two year bill.

In response to the *LA Times* revelations, Governor Schwarzenegger on July 16, 2009, replaced four current members of the BRN and appointed two long-time vacancies. In addition, the former Executive Director Officer of the BRN and the Chief of the Division of Investigation (DOI) at DCA also resigned.

On July 25, 2009, the *LA Times* published another article on the BRN,[4] this time on the failures of its drug diversion program. This article pointed out that participants in the program continue to practice while intoxicated, stole drugs from the bedridden and falsified records to cover their tracks. Moreover, more than half of those participating in drug diversion did not complete the program, and even those who were labeled as "public risk" or are considered dangerous to continue to treat patients did not trigger immediate action or public disclosure by the BRN. The article further pointed out that because the program is confidential, it is impossible to know how many enrollees relapse or harm patients. But the article points out that a review of court and regulatory records filed since 2002, as well as interviews with diversion participants, regulators and experts suggests that dozens of nurses have not upheld their end of the bargain and oversight is lacking.

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[3] *See* Charles Ornstein & Tracy Weber, *Criminal Past Is No Bar to Nursing in California*, L.A.Times, October 4, 2008, *available at* http://www.latimes.com/news/local/la-na-nursing5-2008oct05,0,3509040.story.

[4] *See* Tracy Weber & Charles Ornstein, *Loose Reins on Nurses in Drug Abuse Program*, L.A. Times, July 25, 2009, *available at* http://www.latimes.com/news/local/la-me-nurse-diversion25-2009jul25,0,128964.story.

On July 27, 2009, the DCA convened a meeting for the purpose of taking testimony and evidence relevant to the BRN enforcement program. This meeting included presentations by the DOI and the AG's Office. The BRN's discussion focused on its proposals that were contained in the "*Enforcement Report On the Board of Registered Nursing."* The report pointed out the following barriers to the enforcement process:

1) **Understaffing**. For a number of years, BRN's enforcement unit has been understaffed. For example, five case analysts are assigned 400 – 600 cases.

2) **Delays at DOI**. DOI investigators (who provide investigative services to BRN) carry a caseload of 100 cases per investigator.

3) **Delays at the AG's Office**. On average, it takes the AG's Office 7.5 months to prepare an accusation, petition to revoke probation or statement of issues. Moreover, AG staff often allows respondents to file a notice of defense long after the 15-day time limit, which lengthens the time a case is processed by the AG's Office. The practice of the AG of not requesting a hearing date when notice of defense is received is also contributing to the delays. The AG's Office often waits for settlement negotiations to break down before requesting a hearing date with OAH.

4) **Lack of Information Sharing**. Information sharing between the BRN and BVNPT could be improved. For example, BRN cannot access the licensing or disciplinary records of the BVNPT. In addition, there is no cross-reporting requirement for other agencies to report to the BRN nurses who violate the Nursing Practice Act.

5) **Tracking of cases**. BRN relies upon an outdated, limited and cumbersome tracking system that is managed by DCA. Due to limitations of the automated system, BRN has created duplicative systems that do not interact with the DCA's system, therefore staff are required to make multiple entries.

6) **Storage**. BRN does not have sufficient space to store case files on-site. Many files are stored off-site and must be transferred to the board office as needed.

7) **Waiting for Licensee Decision to Participate in a Diversion Program.** When a substance abuse case is referred to the diversion program, the investigation is placed on hold *while the licensee decides* if he/she wants to enter diversion. This practice allows the licensee to delay final disposition of the case.

8) **Lack of Communication in the Diversion Program.** There is limited communication between the diversion program and the enforcement program which can delay investigation of licensees who are unsuccessfully diverted and are terminated from the program.

9) **Procurement of Health Records**. Investigators often have difficulties acquiring health records because there is no penalty for a licensee or healthcare facility that does not provide health records that assist investigators in investigating complaints.

10) **Automatic Suspensions**. BRN lacks a number of enforcement tools, including the ability to automatically suspend licensees pending a hearing.

11) **Mandatory Reporting**. There is no mandatory reporting requirement for employers of potential violations of the Nursing Practice Act.

The Center for Public Interest Law submitted a list of suggestions to improve the enforcement programs of the BRN and other healthcare licensing boards of the DCA. Further discussion of those suggestions can be found later in this paper.

Problems with the Department's Division of Investigation

According to DCA's 2007- 2008 Annual Report, "The Division of Investigation (DOI) serves as DCA's law enforcement and investigative branch. Its mission is to protect the public health, safety and welfare of consumers. DOI does this by providing timely, objective, courteous, and cost-effective investigations of alleged misconduct by licensees of client agencies, which often involves illegal use and theft of drugs, sexual misconduct, quality of care issues, and unlicensed activity. DOI and collects and assemble the necessary information needed to file criminal, administrative and civil actions by or on behalf of these agencies . . . In addition, DOI's Special Operations Unit leads DCA programs and investigations on workplace violence prevention and threat assessments, criminal offender record information program and clearances, infraction citation program and clearances, and internal affairs investigations. The Unit also oversees DOI internal programs and investigations which involve firearms, defensive tactics, computer forensics, background investigations, and internal affairs investigations."

DOI employs sworn peace officers to provide the investigative services described above. The division has seven field offices throughout the state from which field staff investigate complaints for DOI client agencies. As indicated above, DOI handles investigations for BRN. However, DOI also serves as the investigative arm of 20 other regulatory boards/bureaus within DCA, including:

Healthcare Licensing Boards	**Non-Healthcare Licensing Boards**
Acupuncture Board	Architects Board
Board of Behavioral Sciences	Athletic Commission
Hearing Aid Dispensers Bureau	Barbering & Cosmetology Board
Board of Occupational Therapy	Cemetery & Funeral Bureau
Board of Optometry	Court Reporters Board
Physical Therapy Board	Bureau of Electronic & Appliance Repair
Respiratory Care Board	Board for Professional Engineers & Land Surveyors
Speech Language and Audiology Board	Board for Geologists & Geophysicists
Veterinary Medical Board	Bureau of Security & Investigative Services
BVNPT	Structural Pest Control Board

This diversity of clientele means that investigators must be familiar with at least 21 different sets of laws and regulations, and DOI investigators are given limited opportunity to specialize on cases.

The following are several critical problems which have been identified in the administration and management of DOI and in the investigation of cases.

1) **Lack of Investigators and Increased Caseloads.** According to testimony offered by the Acting DOI Chief at DCA's July 27, 2009 hearing, DOI staffing levels have decreased from 55 authorized investigator positions in 2000-2001 to 42 authorized in 2008-2009. He further testified that the division currently has 38 field investigator positions, with only 31 filled. DOI management reports that the staff turnover and loss of authorized positions has exacerbated the backlogs at DOI. However, in 2006-2007, DOI augmented its Special Operations Unit (SOU) with two additional investigators. SOU now has five investigators dedicated to internal investigations. Additionally, there are 12 supervising investigators at DOI. The workload in SOU is not documented in this report.

   DOI reports that, in addition to reduced staff, the DOI workload has increased by 27%. In December 2001, DOI had 1313 open investigations. As of December 2008, there were 1778 open cases at DOI.

   Recruiting, hiring and training new investigators are lengthy processes. According to DOI, it typically takes over seven months to hire a new investigator; approximately three months to conduct the mandatory background check and four months of peace officer training at a formal training academy. After the academy, it can take a year for a new investigator to have developed the knowledge and skills necessary to independently conduct investigations in the field.

   According to DOI, prior to January 2009, some investigators were assigned more than 100 cases. The average caseload per investigator fluctuated monthly as new cases were assigned and others closed. Since January 1, 2009, investigators are assigned no more than 25-30 cases at a time. The unassigned cases (approximately 500 at present) remain at the queue at each field office awaiting assignment.

   In contrast, the Medical Board of California (MBC), which oversees over 160,000 licensees, employs its own investigators. The table on the next page represents the difference in authorized investigative staff between DOI and MBC.

FY 2008-2009	Staff Classification	Authorized Positions[5]	Licensees Served
Medical Board Regional Offices	Investigator	19	160,000
	Sr. Investigator	47	
	Total	*66*	
DOI SOU and Field Offices	Investigator	8	Over 700,000 (health boards only)
	Sr. Investigator	36.5	
	Total	*44.5*	

[5] See 2009/10 Wages and Salaries

2) **Retention of DOI Staff.**

Retention of DOI staff is also long-standing problem, and staff turnover at DOI has affected its ability to provide timely services to its clients. In the past nine years, DOI has had three different division Chiefs. According to the current Acting Chief of DOI, 80% of DOI staff have left the division since 2000. This high turnover has been attributed to retirement, change in management, pay disparity, heavy caseloads, and the broad subject matter of investigations.

The disparity in pay for sworn peace officers working as investigators for state agencies has been cited as a reason it is difficult to recruit and retain DOI investigators. The chart below shows a sampling of investigator classifications employed at state agencies. As shown, the entry level salary for DCA investigators is $271 less than at least six other state departments. Similarly, DCA investigators top salary is $536 a month less than investigators working at three other departments.

Department	**Investigator Monthly Salary Range**
Consumer Affairs	3,631 - 5,631
Corporations	3,631- 5,631
Toxic Substances Control	3,902 - 5,631
Employment Development	3,902 - 5,631
Alcoholic Beverage Control	3,902 - 5,631
Motor Vehicles	3,902 - 6,194
Mental Health	3,902 - 6,194
Insurance	3,902 - 6,194

It should be noted that these salaries are based on scope and complexity of work performed by the investigator and they are set by the Department of Personnel Administration after negotiations with unions.

3) **No Uniformity in the Use of DOI to Investigate Cases.**

While all of the DCA boards and bureaus are mandated to follow the Administrative Procedures Act, there is no uniformity in the use of DOI to investigate cases. For example, the Dental, Medical and Pharmacy boards use their own staff to investigate complaints and monitor their probationers. The Psychology, Podiatric Medicine, Physician Assistants and Osteopathic Boards contract with the Medical Board for investigative services. In contrast, the Board of Behavioral Sciences employs non-sworn in-house investigative analysts, and uses DOI on a very limited basis, such as for undercover work and to obtain information that is only accessible to sworn peace officers.

4) **Lack of Management and Prioritization of Cases and Severe Delays in Investigating Cases.**

A survey of health boards highlighted in this report revealed that, regardless of who conducts the investigation, the average time it took to complete an investigation in the past three years was well over one year for health boards. The shortest average

time for DOI to investigate a complaint was 285 days for BVNPT in 2002/03. The longest average investigation time was 665 days for BRN in 2008/09.

Average Time to Investigate Complaints									
	Type of Investigator	**2001/ 02**	**2002/ 03**	**2003/ 04**	**2004/ 05**	**2005/ 06**	**2006/ 07**	**2007/ 08**	**2008/ 09**
BVNPT	In-house staff	314	130	183	122	119	334	154	176
	DOI	509	285	352	388	536	539	475	665
BRN	DOI	436	482	441	503	545	646	637	403
Behavioral Sciences*	DOI and In-house staff	214	308	305	324	223	313	396	547
Dental Board	In-house staff	No data	315	225	256	248	249	210	304
Podiatric Medicine	MBC	337	199	271	257	307	260	338	419
Medical Board	MBC	198	208	220	259	277	307	324	350
Pharmacy**	In-house staff	238	229	230	180	166	197	238	285
Chiropractic Examiners***	Private contractors and in-house staff	164	222	256	327	337	437	415	418

*Complaints were referred to DOI from 2000/01 – 2007/08. In 2008/09, investigations were completed by both in-house investigative analysts and DOI.

**Average days for both mediated cases (informal investigations) and cases referred to a board inspector for formal investigation.

*** The board contracted with private investigators and used internal board staff to conduct investigations through June 2008. Board staff currently conducts investigations.

In September 2006, DOI issued a memorandum to all DOI clients explaining that, due to DOI's high caseload and low staffing levels, the division was going to limit the types of cases it would accept. DOI asked clients to follow its new "Request for Services (RFS) Guidelines" when considering if the board should refer a case for investigation. DOI stated that criminal cases, sexual misconduct, drug diversion and serious injury should continue to be referred for investigation. However, the memorandum advised that the following types of cases should not be referred to DOI:

- Licensee probation checks
- Complaints filed by anonymous victims regarding unprofessional conduct and negligence/incompetence
- Complaints of unlicensed activity made by anonymous persons
- Cases in which the incident occurred a year or more prior to the current date (depending on the severity of the allegations).

The memo stated that DOI supervisors would review incoming RFS for compliance with the guidelines, and assess available resources to determine if the case should be assigned. DOI also instructed boards that prior to referring cases to DOI, boards should obtain patient records and have them reviewed by an expert to determine the need for further investigation. However, no formal training was offered to the boards on how to perform the document retrieval or probation monitoring.

According to DOI, this was the second attempt by DOI since 2000 to reduce the number of RFS sent to DOI that had the potential to be resolved through the clients' own resources. Both attempts were met with mixed reaction from its clients and, in many circumstances; concessions were made to accommodate the client's request on a case by case basis. DOI points out that there is no data to verify the number of RFS that were returned to clients or to verify how many RFS were not sent to DOI based upon the guidelines.

In January 2009, DOI announced the creation of a complaint intake unit, which was intended to provide faster closure of cases that do not require a formal investigation conducted by a peace officer. The complaint intake unit evaluates the RFS to see if non-sworn DOI staff can perform the requested service. If the intake unit is able to, it performs the service. Often, the services provided by the intake unit are the document collection that DOI previously instructed boards to do themselves.

According to the new procedures, once a case reaches the field office, a supervisor will evaluate it to determine if it is a high priority (see below for discussion of priority cases). High priority cases are assigned to investigators. If the case is not a high priority, it is not assigned to an investigator and placed in a queue. Investigators now are assigned 25–30 cases to work at any given time. Once a case is complete, the investigator is given another new case. DOI states that this new case management system allows supervisors to manage, monitor and prioritize cases in the queue and gives management the opportunity to hold the supervisors accountable. However, as stated above, the unassigned cases remain at the queue, awaiting referral. DOI estimates that only 50% of pending cases in the queue require work by its field investigators. It is assumed that these cases were assigned to the field offices prior to creation of the complaint intake unit.

Additionally, DOI points out that as of December 31, 2008, DOI had 1778 open cases with 693 of those cases over 365 days old. As of July 1, 2009, DOI had 1512 open cases with 670 of those cases being more than 365 days old. DOI indicated that this figure has dropped steadily since it peaked at 753 in March 2009.

In an effort to address the BRN cases that are over a year old, DOI initiated its "365 Project" in late 2008 in which DOI and BRN staff review cases that are one year or older to determine whether the case should go forward, and if so, what action should be taken. At that time, 470 BRN cases were over a year old, as of March 2009, 100 of those had been closed. DOI has proposed creating a similar intake task force which will consist of representatives from DOI and its clients for the purpose of setting criteria for review of cases that are over one year old.

There are no formal standards for prioritizing cases. Early in 2006, DOI created a working group to formulate guidelines for prioritizing complaints. The working group

included representatives from DOI clients, DCA legal counsel and DOI staff. A draft document was developed but was never formally adopted. However, the draft document was used to justify the return of cases to clients in November of 2006. Additionally, as noted above, DOI continues to work cases that do not meet DOI's own RFS guidelines.

It is the Committee's understanding that in the past DOI was given direction to give higher priority to cases involving the underground economy rather than those involving cases of consumer harm. In DCA's 2007/08 annual report, DCA made unlicensed activity a priority by creating a new Unlicensed Activity Unit to provide education and services to consumers, businesses, and students on the importance of licensure. As part of this priority, DCA created a toll-free number to report unlicensed activity, and conducted multiple statewide enforcement stings or sweeps to combat unlicensed activity. The level of involvement by DOI investigators during these stings is unclear. According to DCA data, in 2007/08, 259 cases alleging unlicensed activity that were investigated by sworn peace officers were closed, 103 of which were DOI client cases.

5) **Lack of Coordination and Communication with Client Board.**

DOI has also been criticized for lack of coordination and communication with the boards in its handling of cases. DOI's monthly case reports only show billable hours. The reports do not provide information on what type of work has been performed or the status of the case. Additionally, DOI does not hold regular meetings with clients regarding performance expectations and service. Some boards state that they do not receive regular communication regarding their cases from DOI. For example, when clients complete an RFS, the RFS contains instructions from the client to DOI. Clients are also given the option of requesting the case be expedited. Until recently, the Committee is advised that DOI did not typically confirm or deny the request to expedite. It is unclear when or how clients are notified that their case have been assigned or placed in the "queue." Prior to 2009, DOI did not provide formal training to its client agencies on how to complete the RFS or how to prepare a case for transmittal to DOI. Nor has DOI provided formal training on how boards should handle cases that DOI will not work.

6) **Lack of Accountability.**

If performance measures or expectation exists for DOI, clients are not advised of those expectations. In contrast, the boards and bureaus within DCA are required to publish an annual report that includes a myriad of licensing and enforcement statistics, including the length time it takes to complete investigations. Although DOI clients must report the length of investigations, DOI does not publicly report any performance data at all. This means that the clients are held responsible for the lengthy investigations, not the DOI.

Moreover, the budgeting mechanism for DOI services is very complicated and creates a lack of accountability. Clients' annual budgets are estimated based on anticipated usage of investigative hours. If the client goes under or over the estimated usage, the difference is "rolled forward" as a debit or a credit into the client's budget two years later. Furthermore, the annual "amount charged" for

service is often different from the "actual cost." Clients do not know how much they will be charged by the hour for investigative service until the end of the fiscal year when DCA budget staff calculates it by dividing the entire DOI operating expenses (which includes rent, weapons, vehicles, gas, training, and support staff and management salaries) among DOI clients based on usage of DOI service. The attached table shows how BRN budget for DOI has been calculated from Fiscal Year 2005/06 to 2010/11.

Additionally, there are multiple hourly rates within a fiscal year, such as 1) estimate for cost recovery charged to probationers, 2) actual cost recovery charged to probationers, and 3) hourly rate charged to DOI clients. For example, in the beginning of Fiscal Year 2008/09, clients were provided an estimated cost of $152 per hour. At the end of the Fiscal Year, the actual rate for cost recovery was $190 per hour.

In 2008, DOI began issuing client satisfaction surveys with every completed case file when it is returned to the client for review and possible action. The survey questions are divided into five categories: thoroughness, grammar/spelling, timeliness, effectiveness, and overall rating. The survey results are listed below:

Category	# Responses Received	Rating
Thoroughness	279	96% rated good or excellent
Grammar/Spelling	286	98% rated good or excellent
Timeliness	139	48% rated good or excellent
Effectiveness	179	62% rated very effective
Overall Rating	280	96% rated good or excellent

In 2007/08, DOI closed approximately, 1,100 cases but only 286 survey responses have been received to date and only 139 responded to the timeliness question. DOI reports that 48% of the responses rated timeliness as "good" or "excellent," which means 52% rated timeliness "fair" or "poor." Therefore, DOI clients have positive rating for timeliness for only 70 of approximately 1,100 cases.

AG and OAH Processes too Lengthy and Boards Not Kept Informed About Cases

Attorney General's Office

All of the regulatory boards and bureaus within DCA rely upon the AG's Office for prosecution of their cases. The AG's Office has two separate sections providing legal services to DCA clients: the Licensing Litigation Section and the Health Quality Enforcement (HQE) Section. Each section has its own leadership and process.

The Licensing Section represents state regulatory agencies created to protect Californians from physical or economic harm in their dealings with over a million licensed businesses and professionals. Licensing Section represents licensing boards, bureaus and commissions in both administrative and trial court proceedings to deny, revoke or suspend licenses in cases brought against state-licensed professionals such as contractors, accountants, dentists, chiropractors, nurses, engineers, physical

therapists, auto repair and pest control firms. The Licensing Section has 85 attorneys and its clients include the following DCA boards/bureaus:

1. **Board of Behavioral Sciences**
2. Board of Accountancy
3. Cemetery and Funeral Bureau
4. Board of Architects
5. **Dental Board of California**
6. **Dental Hygiene Committee**
7. Athletic Commission
8. Bureau of Automotive Repair
9. Board of Barbering and Cosmetology
10. Court Reporters Board
11. **Board of Optometry**
12. **Board of Chiropractic Examiners**
13. **Board of Pharmacy**
14. Bureau of Security and Investigative Services
15. Contractors State License Board
16. Board of Engineers and Land Surveyors
17. Board for Geologists and Geophysicists
18. Guide Dogs for the Blind
19. Landscape Architects Technical Committee
20. Bureau of Home Furnishings and Thermal Insulation
21. Bureau of Electronic and Appliance Repair
22. **Board of Registered Nursing**
23. Structural Pest Control Board
24. Professional Fiduciaries Bureau
25. **Veterinary Medical Board**

Note: Bold text indicates health care licensing boards.

In contrast, the HQE Section is primarily responsible for prosecuting disciplinary proceedings against physicians, psychologists, doctors of podiatric medicine, acupuncturists, physical therapists, and other healthcare licensees and applicants. According to the AG's Office, HQE Section was created in 1991 by the Legislature to represent and assist the Medical Board of California, Acupuncture Board, Board of Podiatric Medicine, Board of Psychology, Hearing Aid Dispensers Bureau, Physician Assistant Committee, Physical Therapy Board, Respiratory Care Board, and other boards and committees in the intake and investigation of consumer complaints, medical malpractice settlements and judgments, and other matters that could constitute unprofessional conduct. The HQE Section is involved in handling all phases of administrative litigation, including the prosecution of disciplinary proceedings and seeking interim suspensions or other injunctive relief when emergency relief is necessary to prevent imminent harm to the public. The section also handles the enforcement of subpoenas, writs and appeals, civil matters or lawsuits filed against its client agencies or their staff, and other types of civil litigation in state and federal courts.

HQE has 49 attorneys representing and assisting the following DCA boards/bureaus:

1. Medical Board of California
2. Osteopathic Medical Board
3. Acupuncture Board
4. Board of Podiatric Medicine
5. Board of Psychology
6. Hearing Aid Dispensers Bureau
7. Physical Therapy Board
8. Respiratory Care Board

The following are several critical problems which have been identified in the prosecution of cases by the AG's Office.

Once investigated, meritorious cases are referred to the AG's Office for prosecution, which can be an extremely lengthy process. In 2008/09, the average case referred to

the AG's Office by the boards highlighted in this report took over 400 days to complete. These delays can be attributed to inadequate case work prior to referral for prosecution, limitations of administrative proceedings, inadequate case tracking system that does not interface with clients, lack of communication with clients and investigators, and lack of specialization by prosecuting attorneys.

1. **Lengthy Delays in the Handling of Cases**. As indicated above, there are delays in the prosecution of cases at the AG's Office that is contributing to the lengthy enforcement and disciplinary process. According to statistics provided by the AG's Office at the July 27, 2009 DCA hearing, the average time for the AG to close BRN cases peaked at 502 days in 2006-2007. This timeline was reduced to 295 days in 2008-2009. In 2007-2008, Licensing Section was referred 2,289 cases by its client boards, 698 of which came from health boards. The chart below represents the average time for the Licensing and HQE Sections to process complaints for boards.

Average Time for to Process Complaints at Attorney General's Office										
	AG Section		**2001 /02**	**2002 /03**	**2003 /04**	**2004 /05**	**2005 /06**	**2006 /07**	**2007 /08**	**2008 /09**
BVNPT	Licensing	Pre-accusation	233	389	285	285	324	309	182	150
		Post-accusation	280	575	566	542	362	475	336	423
BRN	Licensing	Pre-accusation	223	249	189	239	183	335	224	159
		Post-accusation	355	310	277	334	267	247	273	265
Behavioral Sciences	Licensing	Pre-accusation	148	133	129	137	94	153	117	278
		Post-accusation	330	330	297	369	324	362	364	370
Dental Board	Licensing	Pre- and Post-accusation	No data	413	591	619	414	518	524	489
Podiatric Medicine	HQE	Pre-accusation	51	154	138	175	118	76	137	152
		Post-accusation	585	475	337	495	349	337	298	373
Medical Board	HQE	Pre-accusation	103	91	107	116	132	127	121	103
		Post-accusation	437	471	513	473	515	446	471	381
Board of Pharmacy	Licensing	Pre-accusation	373	240	269	228	199	252	200	291
		Post-accusation	462	288	332	327	266	284	285	411
Chiropractic Examiners	Licensing	Pre-accusation	413	358	207	445	294	568	560	232
		Post-accusation	483	565	559	652	508	566	823	191

It should be noted that the time specified above excludes the length of time between pleading and proposed default decision, the length of time between receipt of notice of defense to request to set a case, length of time between opening of matter and proposed settlement, and length of time between receipt of notice of defense and proposed settlement.

2. **Lack of Communication and Coordination with Clients**.

   It is unclear how the Licensing Section communicates with the boards to apprise them of developments in cases it is prosecuting on boards' behalf. For example, at the July 27, 2009 DCA hearing, the AG's Office indicated that the AG usually holds off requesting a hearing with the OAH because the request generates the opening of a case at OAH and billable activity to boards, and to prevent costs. The AG's Office points out that if boards prefer to not hold off on requesting hearing dates, the boards need to notify the AG of their intents. It is also unclear of what kind of updates boards get on cases handled by the AG's Office.

3. **Lack of Specialized AGs for Healthcare Licensing Boards**.

   As indicated above, the Licensing Section handles cases for a number of boards and bureaus. In contrast, the HQE Section is focused solely on healthcare licensing boards. Dedicating specific AGs to prosecute healthcare licensing boards' cases may reduce delays, as attorney become experts in their fields.

4. **Lack of a Training Program for DAGs and other Employees Handling Healthcare Licensing Boards**.

   It appears that there is no training program for DAGs in the Licensing Section to ensure that there is a common and consistent knowledge base, especially for prosecuting cases related to healthcare licensing boards. According to the Medical Board of California's July 2009 Report to the Legislature on the Vertical Enforcement Model,[6] one of the recommendations made was for a mandated joint statewide training for all DAGs and investigators, regardless of their level, experience or past training, to achieve a common foundation and understanding, as well as to foster team building between staffs.

   Moreover, at the July 27, 2009 DCA hearing, the AG's Office pointed out that Legal Assistant Teams (LAT) plead cases on behalf of the AG's Office. Additionally, it was pointed out that LATs spend an average of 8-12 hours for diversion cases, mostly to review medical records. Again, it is unclear what type of training exists for LATs in pleading healthcare board cases, and reviewing medical records.

[6] *See* Medical Board Of California, *Report To The Legislature Vertical Enforcement Model*, June 2009.

Office of Administrative Hearings (OAH)

The OAH is a quasi-judicial tribunal charged with hearing administrative law cases of over 150 State and 800 local government agencies, including all of the cases brought by the AG's Office on behalf of DCA boards and bureaus.

According to OAH, the following chart represents the average number of days a case is open for specified healthcare licensing boards:

Office of Administrative Hearings 1/1/06 to 7/21/2009		
Board Name	**# Cases Opened**	**Average # Days Case is Opened**
Behavioral Sciences	112	134
Dental Board	295	140
Medical Board	958	161
Board of Pharmacy	236	128
Podiatric Medicine	27	136
Registered Nursing	900	127
Vocational Nursing & Psychiatric Technicians	402	118

OAH assigns Administrative Law Judges (ALJs) to oversee proceedings that require formal administrative hearings. As noted above, OAH provides these services to over 950 different governmental agencies. DCA boards and bureaus have over 40 different laws and regulations with which the judges must be familiar. However, only ALJs assigned to work on cases referred by the allied health boards receive specialized medical training. The lack of specialization and training for the types of cases referred by the remaining boards and bureaus creates a situation in which judges may issue inconsistent decisions.

1) **Lack of Specialized ALJs for Healthcare Licensing Boards**.

   There is no specialized section within OAH to hear cases only for healthcare licensing boards. In contrast, Government Code Section 11371 establishes within the OAH a Medical Quality Hearing Panel, consisting of no fewer than five full-time administrative law judges. The Code requires the ALJs to have a medical training as recommended by the MBC and approved by the Director of OAH. Unlike the ALJs for the MBC, which hear cases specifically for physicians, surgeons and other allied health professionals that the MBC regulates, the ALJs for the other healthcare licensing boards also hear cases for non-healthcare boards.

2) **Lack of Training for ALJs Handling Healthcare Licensing Boards Cases**.

   As specified above, ALJs in the Medical Quality Hearing Panel are required to have a medical training, it is unclear if ALJs that hear other healthcare licensing boards' cases receive appropriate training.

Impact of Budgetary Cuts and Loans to General Fund

1) **Employee Furloughs.**

On December 19, 2008, the Governor issued Executive Order S-16-08 which ordered all represented and non-represented state employees under his authority to begin taking two furloughs day a month beginning February 1, 2009 through June 30, 2010. On July 1, 2009, the Governor issued Executive Order S-13-09 which ordered an additional furlough day for all represented and non-represented state employees. Both of the furlough orders applied to all state agencies regardless of funding source, but provided for "limited" exemptions.

The furlough orders only affect employees of the executive branch. The orders do not apply to about 15,000 people working for independently elected officers in constitutional offices. These offices include:

- Attorney General's Office
- Bureau of State Audits
- Insurance Commissioner
- Judicial system
- Legislative Counsel Bureau
- Legislative offices
- Lieutenant Governor's office
- Public Utilities Commission
- Secretary of State
- State Board of Equalization
- State Controller's Office
- State Treasurer's Office
- Superintendent of Public Instruction

Additionally, some workers within the executive branch are exempt from furloughs including:

- California Highway Patrol officers (but not other CHP staff)
- California Department of Forestry and Fire Protection workers (but only during fire season)
- 500 attorneys working for the State Compensation Insurance Fund (but not other state fund workers).

A survey of DCA boards reveals that the services provided to the public is dropping significantly. The BRN estimates they have lost over 3,100 staff hours through July 2009, and that in total it will loose over 11,040 staff hours. This is equivalent to more than five full time staff positions. The MBC has suffered a reduction of 15,800 enforcement hours through July 2009 and will loose 48,000 hours by June 2010, the equivalent of 25 full time personnel. Pharmacy Board reports that the number of pending cases has increased by almost 800 since the furloughs began. This loss of staff will lengthen the time it is taking to process and close complaints and investigations.

Boards report that attempts to work cases are frustrated by the furloughs. Staff is impeded from interacting with non-furloughed individuals and entities, thus delaying enforcement response times. Examples of non-furloughed constituents

include expert witnesses, case witnesses, licensees, health facilities, other non-furloughed state agencies, and the public in general. Also, the three day furlough slows down production in other program areas, like licensing, mail delivery, and cashiering. This slows down overall work flow throughout the office and has added a negative effect on enforcement programs which rely upon these other services.

On July 23, 2009, SR 25 was introduced by Senator Gloria Negrete McLeod to urge the Governor to exempt from the furloughs enforcement officers of the DCA and various healthcare licensing boards that are directly involved in pursuing consumer complaints. SR 25 states that requiring employee furloughs of special fund boards that oversee the health and safety of the public and requiring the closure of these regulatory boards inhibits the consumer protection activities of the boards and further slows the enforcement process down, and is completely unnecessary to resolving any of the state's budget problems.

2) **Loans to the General Fund.**

Recently, there have been multiple loans from DCA's special fund programs to augment the General Fund in order to balance the General Fund budget. For instance, in 2002-2003, $164.6 million was loaned, $41.4 million was loaned in 2003-2004 and $96.5 million was loaned in 2008-2009. Overall, $302.5 million was borrowed from DCA's special fund programs from 2003-2004 to 2008-2009. To date, $46.6 million has been repaid, leaving a balance of $237.8 million. BRN alone funded a $14 million loan to the General Fund. This money, which is paid by licensees for the specific purpose of funding the regulatory programs, could have been used to augment the enforcement programs.

3) **Denial of Budget Change Proposals (BCP's) for Enforcement Positions.**

Committee staff has learned that in the past, BCPs for additional positions, including positions for enforcement, have not been authorized for various boards. Although there is no estimate on the actual number of BCPs that were not authorized, the delays in the enforcement process could be attributed to the lack of additional enforcement positions.

Additionally, the Department of Finance's 2009-2010 Budget Preparation Guidelines include the following:

> **Requests for New Positions** – The Administration's policy is to continue to contain the growth in authorized positions. Requests for new positions generally will be limited to redirections of existing positions. When requesting new positions, departments are required to clearly establish the long and short-term benefits to be gained by increasing personnel as opposed to other possible alternatives (e.g., automation, workload readjustments). Other alternatives that have been considered must also

be identified and analyzed. BCPs requesting new positions must effectively justify why a redirection is not possible. If new positions are approved, positions will be budgeted at the mid-step, unless evidence is provided justifying a higher level for hard-to-fill classifications or based on the department's hiring practices. Finance must approve the establishment of any position above mid-step of the respective salary range.

The Administration has maintained a policy designed to contain the growth of state government and has encouraged state agencies to avoid requesting additional staff. The Administration suggests state agencies seek alternatives, such as redirection of existing positions or automation. These instructions do not take into account the fact that DCA programs are funded by fees collected for the sole purpose of funding the regulatory operations.

Recommended Changes

The following is an initial list of recommended changes and options for the boards, State and Consumer Services Agency (CSA), the DCA, the AG's Office, and the OAH to consider for reforming and improving the enforcement process not only for the BRN, but other consumer boards under the DCA. Also included are recommendations for changes and reforms to the diversion programs of the BRN and healthcare boards under the DCA. These recommendations have been provided by the Center for Public Interest Law (CPIL), the DCA's Division of Investigation (DOI), the AG's Office (AG), the BRN and pursuant to discussions which Committee staff has had with many of the boards. Committee staff has provided its own recommendations to be considered in this context. Consideration will also be given to other recommendations made during the August 17th hearing and will be implemented as deemed necessary.

Auditing of Enforcement and Diversion Programs

According to the CPIL, the DCA and the BRN should seek appointment of an "Enforcement Monitor" to thoroughly audit the BRN's enforcement and diversion programs. (In fact, an audit of the private vendor that administers the BRN's diversion program is already required by SB 1441 (Ridley-Thomas), passed in 2008.) In recent years, enforcement monitors have been appointed for several DCA agencies, including the Contractors State License Board, the Dental Board, and the Medical Board of California (the MBC's enforcement monitor statute, now-repealed Business and Professions Code section 2220.1, was enacted in SB 1950 (Figueroa) in 2002 and is attached as Exhibit A). The CPIL participated in both the CSLB (2001–2003) and the MBC (2003–2005) enforcement monitor projects; additionally, the CPIL's Executive Director was the State Bar Discipline Monitor in a much earlier enforcement monitor project during 1987–1992.

Ideally, the Monitor would study and evaluate both programs, gathering and analyzing data and interviewing board staff and stakeholders; and release a report including findings and recommendations on all aspects of both programs. Some recommendations will require legislation; the Monitor and the Board would draft that legislation and advocate its approval. Other recommendations may require rulemaking or policy decisions by the Board. The Monitor should remain in place to ensure that all recommendations are properly implemented.

Staff Recommends: *Legislation should be immediately pursued which would require the appointment of an "Enforcement Monitor" to thoroughly audit the BRN's enforcement and diversion programs.*

Increased Resources for Enforcement Programs

According to the CPIL, the BRN needs to secure and devote additional resources to support both its enforcement and diversion programs. Those resources must come from nurse licensing fees, specifically renewal fees. The current statutory ceiling on biennial renewal fees is $150 (Business and Professions Code Section 2815). The BRN regulation (Section 1417, Title 16 of the California Code of Regulations) sets actual biennial renewal fees at $80 — meaning nurses pay $40 per year in licensing fees. The BRN renewal fees have not increased in 18 years, while the number of licensed nurses has increased substantially during that time period.

By way of comparison, physicians, podiatrists, and attorneys pay approximately $400 per year in licensing fees. The CPIL is not saying nurses should pay $400 per year, but argues that they should clearly pay much more than they currently do to support a vigorous and aggressive program that protects patients from dangerous nurses.

The BRN recommends increasing enforcement staff by approximately 60 positions to augment existing operations in the complaint unit, enhance probation and diversion participant monitoring, and manage disciplinary cases.

Staff Comments: Another major resource which the BRN and other boards lack is an updated and integrated information/computer system for purposes of licensing and tracking enforcement cases. For over a decade the DCA has struggled to update its licensing and enforcement information system. The DCA's current Consumer Affairs System (CAS), which was created in the early 1980s, is the mainframe database used department-wide to track licensing and enforcement activities. CAS is typically used in conjunction with the Applicant Tracking System (ATS), a separate database of the same vintage, that electronically tracks licensing applicants, processes payments, tracks applicant examination eligibility, and examination scheduling. Together, these two outdated proprietary database applications, track and document the boards' and bureaus' regulatory operations.

In the mid-1990s, DCA began a process to replace CAS/ATS with a new proprietary computer system, Integrated Consumer Protection System (ICPS). This system was to

be developed by a contracted vendor to meet the specified terms and needs identified by the DCA's licensing agencies. A great deal of time, staffing and financial resources were dedicated to establishing the criteria and standards for ICPS; the cost of the project was shared by the DCA's licensing agencies relative to their projected fund conditions, and full development and implementation of the new system was expected to be in excess of $6 million. The costs and workability of the ICPS system was a crosscutting issue in its 1998 sunset review the Joint Committee. Ultimately, DCA later abandoned ICPS.

In 2001, DCA again began moving ahead with the possible purchase of another computer system to replace the existing licensing, enforcement and applicant tracking systems. It was called the Professional Licensing and Enforcement Management System (PLEMS) and implementation was targeted for 2003/2004.

In 2003, the Department of Finance suspended financing for the work on implementation of PLEMS. Finance was not convinced that the proposed project was an essential information technology activity and had other issues with implementation of the information system and required DCA to conduct additional research. The DCA consequently suspended work on the PLEMS system.

Over the years, the lack of a viable alternative to the CAS system has severely limited DCA's licensing agencies. Requests by the Structural Pest Control Board to allow the use of the ATS for tracking applicant fingerprints was denied citing the data base was too fragile to allow the board to use the system. However other agencies (Bureau of Automotive Repair, Hearing Aid Dispensers Bureau, Cemetery and Funeral Bureau) have been transitioned into using the ATS and CAS systems.

In 2004, in the *Initial Report of MBC Enforcement Program Monitor*, the Monitor noted that CAS is so antiquated that the Department is reluctant to support further upgrades to it. Because CAS fails to meet its needs, the MBC is forced to track some information manually or with additional small database programs.

In recent years DCA has established an iLicensing system, and the system is available to several licensing boards such as Barbering and Cosmetology, Dental Board, Nursing Board, Board of Psychology, and Bureau of Security and Investigative Services. iLicensing allows online license renewals and applications. ILicensing has been renamed BREEZE, and was anticipated to expand the licensing system to the entire department.

In recent developments, earlier this summer, the BREEZE request for proposal (RFP) was cancelled due to on-going bidder deficiencies. After consulting with Agency and the Department of General Services, the DCA has decided to prepare a new RPF for release. The project does <u>not</u> include an enforcement or disciplinary element, but rather includes the ability to receive applications, renewals, duplicate/replacement request, address changes and associated electronic fee payments using a credit card. It is now anticipated that the BREEZE vendor contract will be awarded in early 2010.

Staff Recommends: *Increasing the annual licensing fee for nurses to cover increased costs for the BRN's enforcement program and to also provide for the increase in staffing levels necessary for BRN's enforcement program.*

The DCA should immediately move forward with providing an information/ computer system that would allow for the BRN and other boards, DOI, DCA and DOJ to be more integrated in handling all aspects of licensing and enforcement; especially allowing for the tracking of complaints and disciplinary cases. This system should be fully integrated with DOI's Case Assignment Tracking System (CATS).

Authorization to Spend Licensing Fees on Enforcement

According to the CPIL, the BRN and other DCA occupational licensing agencies are "special fund" agencies in that they are funded not by the state's General Fund (the account that was $26 billion in deficit) but by their own "special funds" consisting of fees paid by licensees. These licensing fees flow steadily in to each board and are statutorily required to fund the regulatory programs of each board.

In recent years, when the General Fund has experienced problems, Governors (of both parties) have instituted hiring freezes, mandatory budget cuts, and — most recently — "furloughs" of state employees at all state agencies. While the application of these measures to programs and employees of General Fund agencies does in fact save the General Fund money, the application of these measures to "special fund" agencies like the BRN saves no money for the General Fund and simply deprives the BRN of the ability to spend money on hand for enforcement and other purposes. It is not fair to the BRN and other special fund agencies to excoriate them for slow case processing and demand that they improve their enforcement programs while depriving them of the ability to use money paid by their licensees for that very purpose. Indeed, at the Medical Board's July 24, 2009 meeting, its enforcement chief noted that the current "furlough" requirement is costing the MBC almost 4,300 investigative hours per month — the equivalent of losing 28 or 29 of the MBC's 70 investigative positions.

The Administration should consider exempting special fund agencies from furloughs and other requirements intended to save General Fund expenditures. At the very least, those requirements on law enforcement agencies that regulate healthcare professionals in order to protect the public should be significantly relaxed.

Staff Comments: Over the years, the Administration has subjected special-fund boards to the same hiring freezes, elimination of vacant positions, budget cuts and now furloughs that applies to general fund agencies in times of a budget crisis. This Administration has also taken the unique step of "borrowing" from several of the boards reserve funds to place into the general fund to be paid back at some unspecified date. This Committee along with the Assembly Business and Professions Committee has over the years reviewed all boards (through the process of sunset review) and any anticipated problems in the appropriate funding of their programs has been considered and efforts have been made to either reduce their budget or program requirements, or

increase their level of funding through license fee increases. The Legislature and the Administration have now placed boards in a position of not being able to spend the revenue which has been made available to them for purposes of properly running their enforcement programs. They have either been denied spending authority for their increased revenue by denial of BCPs or by other directives, which has had the effect of increasing their reserve funds, and then find that rather than having any chance of using these funds in the future to deal with increased enforcement costs, the money reverts back to the general fund by way of a "loan." Unless there is strong mandate that licensing fees should only be used for purposes of properly operating the boards this vicious cycle will continue.

One of the outcomes of budget changes and cutbacks to boards has been the slow down of cases or actual holding off on pursuing cases by DOI and the AG's Office because the board(s) ran out of money at some point later in the fiscal year. For example, it appears as if the BRN had to tell the AG to slow down or stop working on its cases for a certain amount of months for fiscal years 2003-2004, 2004-2005, 2006-2007, 2007-2008 and 2008-2009.

Staff Recommends: *Exempt from the furloughs enforcement officers of the DCA and various special-fund healthcare licensing boards who are directly involved in pursuing consumer complaints.* (The Chair of this Committee has introduced SR 25 urging the Governor to implement this recommendation.)

Rather than reserve funds being loaned to the general fund, all reserve funds should be placed in an "emergency reserve enforcement fund" to be used only for purposes related to the board's enforcement programs. These funds should be immediately available, without the need to receive spending authority, if for some reason enforcement costs exceed budgetary allocations. This will ensure that boards are not placed in the position of having to either "slow down" their cases or ask either DOI or the AG to stop work on their cases and that boards are sufficiently funded for other purposes related to enforcement.

Enhanced Detection and Reporting of Problem Licensees

According to the CPIL, over the past two decades, the Medical Board's enforcement program has been the subject of significant media attention and at least seven full-scale bills have been passed by the Legislature overhauling many aspects of its enforcement and diversion programs. Those bills have enacted several "mandatory reporting mechanisms" that have significantly enhanced the MBC's ability to detect problem physicians. Thus, the MBC is not solely dependent on patient complaints in detecting physicians who warrant investigative attention.

Regrettably, as the CPIL argues, very few of those detection provisions have been replicated at other healthcare licensing boards. The BRN [and other health related boards] should seek the following detection mechanisms:

1. When a hospital, health facility, or HMO revokes a physician's admitting privileges for "medical disciplinary cause or reason" (or suspends or restricts those privileges for more than 30 days in a 12-month period), Business and Professions Code section 805 requires that hospital, health facility, or HMO to file a report with the Medical Board, informing the Board of its action. This enables MBC to detect a potential problem and permits it to initiate, at its discretion, an investigation into the matter.

   Nurses who are fired or terminated by hospitals are not reported to the BRN under section 805. Nor does the BRN's statute contain any sort of employer reporting mandate. Other healthcare licensing boards have sought such a mandate, including the Respiratory Care Board (Business and Professions Code Sections 3758 and 3758.6) and the Board for Licensed Vocational Nurses and Psychiatric Technicians (BVNPT) (Business and Professions Code Sections 2878.1 and 4521.2). The BRN should seek an employer reporting mandate.

2. Business and Professions Code Section 802.1 requires physicians to self-report to their board(s), in writing, criminal indictments charging a felony and any criminal conviction (felony or misdemeanor). This section does not apply to nurses. It should be expanded to apply to them. A self-report on their license renewal form every two years is not soon enough for effective detection.

3. Business and Professions Code Section 803 requires courtroom clerks to notify some healthcare boards of the criminal convictions of their licensees. This provision has never required courtroom clerks to notify the BRN of the criminal convictions of nurses. Section 803.5 requires prosecutors to notify courtroom clerks when a defendant is a licensee of some healthcare boards — so as to prompt the Section 803 notice to the licensee's board if the licensee is convicted of a crime. Section 803.5 has never been applied to nurses. Both sections should be expanded to require notice to the BRN of criminal convictions of its licensees.

4. It is unclear whether any state law requires a state licensee to notify his/her regulator of a disciplinary action taken by another state (or even a different agency in California). State law should require a nurse who is cross-licensed by the BRN and the BVNPT to notify one board when he/she has been disciplined by the other board. Obviously, the BRN should notify the BVNPT when it disciplines a person who is licensed by the BVNPT (and vice versa), but apparently, neither board is promptly informing the other of its discipline of a cross-licensed individual, and the Consumer Affairs System (CAS) computer system utilized by the DCA boards does not automatically forward such a notice to all boards regarding persons licensed by more than one board.

5. For over a decade, Business and Professions Code Section 138 has required all the DCA boards to require their licensees to provide notice to patients, clients, and customers that they are licensed by the State of California, to inform

consumers that regulated people are licensed by the State (as opposed to federal or local authorities). Legislative analyses of the bill enacting Section 138 indicate that its purposes are to inform consumers where they may file a complaint against a state licensee, thereby enhancing each board's detection capabilities, and to enable consumers to avail themselves of board Web sites and the information posted thereon.

However, most the DCA healthcare boards, including the BRN, have never implemented Section 138. The Medical Board very recently (July 24, 2009) adopted a regulation requiring physicians to notify patients that "Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2232. www.mbc.ca.gov." The regulation offers a number of options that permit physicians in all sorts of practice settings to comply with the disclosure requirement. The BRN should adopt regulations in compliance with Section 138.

6. Business and Professions Code Section 2220.7 prohibits a physician from including, in an agreement that settles a civil malpractice lawsuit, a "regulatory gag clause" that prohibits the plaintiff/victim from filing a complaint with the Medical Board, and/or prevents the plaintiff/victim from cooperating with the Medical Board if it investigates the incident that led to the civil settlement, and/or requires the plaintiff/victim to withdraw a pending complaint that he/she has already filed with the Medical Board.

   Section 2220.7 is a critically important detection provision. It is patterned after a provision in the State Bar Act (Business and Professions Code Section 6090.5), a 20-year-old provision that prohibits lawyers who are being sued for legal malpractice from requiring their client, in a civil settlement agreement, from filing a complaint with the State Bar. Similarly, licensed healthcare providers should not be able to manipulate civil settlement agreements in order to conceal information of their own misconduct from their own state regulator. This important provision, which now applies to physicians, has not been extended to nurses and other healthcare professionals, and it should be.

Staff Recommends: *This Committee should conduct a hearing during the interim recess to determine which of the mandatory reporting requirements and notice provisions for physicians and surgeons should be applicable to nurses and other healthcare professionals. The prohibition on a "regulatory gag clause" in a civil malpractice lawsuit settlement involving other healthcare practitioners should be immediately implemented.*

Faster Screening of Complaints and Prioritization of Cases

CPIL states than an enforcement monitor should determine why it takes the BRN staff an average of 105 days to screen complaints in order to determine whether they should be referred for formal investigation, when it takes MBC an average of 61 days to accomplish the same task. Clearly, as CPIL argues, the BRN is not protecting the

public if a complaint about a substance-abusing nurse sits in its complaint screening unit for three months before it is referred for investigation. CPIL indicates that the possible reasons may be inadequate staffing of the BRN's complaint screening unit, inadequate training of those who staff the unit, and the lack of mandatory priorities that would require expedited handling of certain kinds of egregious complaints. MBC is subject to Business and Professions Code Section 2220.05, which sets forth certain kinds of cases for "priority" handling by MBC's complaint screening unit and its investigators and prosecutors.

Staff Recommends: *This Committee should work with the BRN to establish priorities for the handling of complaints and those which should be immediately sent for investigation and these priorities should be immediately implemented. The BRN should also utilize, similar to the MBC, nurse consultants to assist in the screening and prioritization of complaints for investigation or possible referral to the District Attorney's Office for criminal violations.*

Faster and More Efficient Investigations by DOI and Boards

According to the CPIL, when the BRN receives a complaint, screens it, and determines that it should be referred for formal investigation, the BRN uses sworn peace officer investigators from the DCA's DOI. While these individuals are professional investigators, they are generalists who do not specialize in any particular kind of complaint. They have extraordinarily high caseloads — estimated by the *LA Times* at 100 cases per investigator. They may not have experience or expertise in gathering medical records that are (a) privileged, and (b) needed in order to prove the elements of a quality of care violation by a nurse or other healthcare professional. Lack of experience in this area, and inadequate access to experts who can assist in the analysis or interpretation of medical records substantially slows the investigation of a quality of care case.

The CPIL recommends that the BRN should seek its own investigators — either a subset of DOI investigators who are devoted primarily to the BRN cases, or its own investigative employees. Alternatively, the BRN should contract with the MBC for the use of its peace officer investigators to work quality of care cases. The MBC investigators are stationed at approximately twelve district offices throughout the State. Their caseloads average fewer than 25 cases per investigator — and that includes 16 ongoing investigations plus 7 completed investigations which have been referred for the filing of an investigation and for which they remain responsible for investigative follow-up. The MBC investigators have substantial training and experience in obtaining medical records for use at administrative evidentiary hearings; additionally, they have access to medical consultants (physician employees) who are available at each district office and assist in the analysis and interpretation of medical records.

Staff Recommends: *The BRN and the DCA should consider either consolidating all sworn investigators under DOI and creating two sections similar to the AG's office, one which deals with health quality cases from the various healthcare boards and the other*

section which would deal with general licensing board cases, or as recommended by CPIL, allow the BRN to both seek and have its own investigators or use investigators of the MBC. (Another alternative is indicated below under discussion of the AG's Office and would either eliminate DOI and move all sworn investigators to the AG's Office or at least allow investigators who specialize in health related cases to be under the AG's Office.)

Other recommendations include:

1. *DOI should immediately prioritize existing cases and work with boards to assist them in prioritizing cases which could be handled by the individual boards or referred immediately to DOI.*

2. *Allow boards to hire non-sworn investigators to investigate cases which may or may not be referred to DOI and allow boards to continue with their own specialized investigators, but working more in conjunction with the AG's Office when necessary.*

3. *Assure that all sworn and non-sworn investigators receive appropriate training.*

4. *Create within DCA a position of Deputy Director of Enforcement with major oversight responsibility for DCA's enforcement programs and act as liaison with the boards, the DOI, the AG, the OAH and local law enforcement agencies to ensure timely filing of disciplinary actions and prosecution and hearing of cases. However, the day to day responsibilities of the DOI should continue to be the responsibility of the Chief of DOI.*

5. *Change the process of payment for DOI services to that more closely aligned with the AG's office.*

Faster and More Efficient Prosecution of Cases by the AG's Office

According to the CPIL, after a complaint has been investigated and the BRN staff determines that the investigatory file contains sufficient evidence to justify disciplinary action, the BRN uses an attorney from the Licensing Section of the Attorney General's Office to file and prosecute the disciplinary action against its licensee. Similar to the DOI investigators, the Licensing Section attorneys are generalists who do not usually specialize in any particular type of disciplinary action. They prosecute all sorts of the DCA licensees, from barbers to landscape architects to nurses. They have high caseloads and are not necessarily familiar with the Nursing Practice Act or the BRN's regulations.

In contrast, the MBC uses attorneys from the Health Quality Enforcement (HQE) Section of the Attorney General's Office to file and prosecute disciplinary actions against physicians. The HQE is created in Government Code Section 12529 *et seq*.; it handles the MBC cases against physicians and also cases against the licensees of

several “allied health licensing programs” such as the Board of Podiatric Medicine, the Board of Psychology and the Physician Assistant Committee.

Under Government Code section 12529.6, the HQE investigators and the MBC prosecutors work together from the time a complaint is referred for investigation in a format called “vertical enforcement” (VE). VE increases the efficiency of the MBC investigations, because the prosecutor is involved in the design of the investigation, reviews the evidence as it comes in, and is able to direct the closure of cases in which proof of a violation by clear and convincing evidence is not surfacing. This is beneficial for both the accused licensee and the public: nonmeritorious cases are closed more quickly (benefiting the licensee), thus allowing the investigator/prosecutor team to move on to attack meritorious cases more quickly (benefiting the public).

The DOI investigators do not work in VE format with HQE or the Licensing Section prosecutors. A generalist investigator completes an investigation with little or no legal guidance on the elements of the offense, and then hands off a “completed investigation” to a generalist prosecutor who has had no role in the design of the investigation and who thereafter has no investigative assistance. The CPIL argues that this creates enormous inefficiencies.

The CPIL further indicates that the MBC’s specialized investigators and prosecutors have had a positive effect on the MBC case cycle times vs. the BRN case cycle times. The average BRN investigation takes 634 days, while the average MBC investigation of a physician case takes 324 days. After an investigation is completed, it takes a Licensing prosecutor an average of 265 days to file the formal accusation (which turns a confidential investigation into a matter of public record), while it takes an HQE prosecutor 121 days to file an accusation. The CPIL is not implying that MBC’s case processing times are acceptable. However, they do indicate that they are much better than the BRN’s.

The CPIL argues that there is no good reason why the BRN should not use the HQE as opposed to the Licensing Section. The division of work between the HQE and Licensing was based on the structure of the Medical Board when the HQE was created in 1991. However, that structure has changed significantly since then, and a 2001 audit of the structure of the Attorney General’s Office by PricewaterhouseCoopers suggested a more efficient and subject-matter-based split of work between the HQE and the Licensing Section.

As further argued by the CPIL, the use of the HQE attorneys could substantially enhance the quality and speed of the BRN prosecutions – especially quality of care cases. The HQE attorneys are familiar with medical records, medical experts, and other issues inherent in quality of care disciplinary matters in which nurses may be involved. The CPIL believes that the HQE should be restructured so that it serves not only MBC and some of its former allied health programs but also the BRN, the Dental Board, the Board of Pharmacy, and perhaps the Board of Optometry.

The CPIL has long advocated (since 1989) that even greater efficiencies could be achieved if the MBC's investigators were removed from MBC and transferred to the Department of Justice to work in VE fashion with HQE prosecutors — under the same roof, employed by the same shop, and stationed in the same offices throughout the state. The CPIL recommends that this is clearly an option that should be considered now: A revamped HQE that serves all the major healthcare licensing boards, staffed with both specialist prosecutors and specialist investigators working together in VE teams.

The CPIL also recommends that the newly revamped HQE should also have a special "strike force" of investigators and prosecutors that can immediately handle: (a) those who fail diversion, (b) criminal convictions, (c) those that violate probation conditions, and (d) any other high-profile type cases that need immediate attention.

The Licensing Section of the AG's Office, Senior Assistant Attorney General Alfredo Terrazas, identified several areas in which improvements could be made for the BRN. They are as follows:

1. Streamline Conviction Cases. As indicated by Mr. Terrazas, the BRN could cut down its turn around time on conviction cases by obtaining only rap sheets or computer print outs of the convictions. It is not necessary for the BRN to seek certified court documents since the AG is already required to do so. Also, there is not need for boards to send any warning letters to licensees to explain their criminal conviction.

2. Triage Complaints with Liaison DAGs. As indicated earlier, the AG instituted a Liaison DAG at BRN on a once of month basis to initiate a screening function of cases. (This was called the DIDO program.) It is recommended that this program be reinstated. According to Mr. Terrazas, this recommendation involves much less entanglement and structural changes than a VE model and has proven to be an effective way tying together investigative/prosecutorial services.

3. Plead Statutory Violations without Expert Reports. For cases that involve factual allegations that, standing alone, themselves constitute gross negligence of incompetence, the AG should be allowed to plead and file the cases immediately, rather than waiting for expert reports. Since 70% to 80% of these cases end up settling, a substantial number of these matters could be filed quickly and could avoid the need for securing expert reports, which delay the process.

4. Delegate Authority to the Executive Officer (EO) Re Stipulated Settlements and Default Decisions. Mr. Terrazas indicates that a majority of filed cases settle and the receipt of a Notice of Defense can trigger either settlement discussions or the taking of a Default Decision. Stipulated settlements are a more expeditious and less costly method of case resolution. The EO can provide summary reports of all settlements to the Board and it can provide constant review and feedback to the EO so that policies can be established and adjusted as necessary. Also,

there have been instances of undue delays between when a fully-signed settlement has been forwarded to the Board's headquarters and when it has been placed on the Board's agenda for a vote. Delegating this authority to the EO, as asserted by Mr. Terrazas, will result in a final disposition of these matters much quicker. The fact that the BRN has reduced the number of its annual meetings has only increased the need for this.

5. Implement a "Real Time" Case Information System. Mr. Terrazas indicates that everyone would be better served if an accurate "real time" case management system were established to enable case managers to proactively track cases at any stage of the process rather than a reactive tracking. The system could also be designed to interact with whatever tracking mechanisms or case management systems exist at DOI and/or the AG's Office. In this way, everyone will be on the same page and comparing "apples with apples" so that when someone either at agency, the Governor's Office, a reporter, a public records act request, an Enforcement Monitor, whoever the requestor may be, the data can be retrieved quickly and accurately. (This issue and recommendation is addressed under the discussion of the need for a new information system for DCA and the boards under the need for additional "resources" in this paper.)

Staff Comments: Another issue that CPIL is concerned about, is the time it takes the AG to prepare a proposed default decision. The filing of a default decision is made once a licensee has failed to file a "notice of defense" when an accusation has been served on him or her. If the licensee fails to file a notice of defense within a specified timeframe, he or she is subject to a default judgment because of a failure to appear or make a defense of their disciplinary case. In 2004-2005 it was taking the AG almost 6 months to file a proposed default decision. In 2008-2009 it was down to about 2.5 months. As argued by CPIL, filing of a proposed default decision is "not rocket science," and should only take a matter of hours.

Staff Recommends: *If maintaining and reforming DOI is not considered as a viable option, or if it is decided that DOI should only be responsible for investigating non-health related cases, then the DCA, MBC and the AG should consider moving all of the MBC and DOI investigators involved with health-related cases to the AG's Office so they can work in teams with HQE prosecutors in a VE format, as recommended by the CPIL.*

The AG's Office attorneys should also be realigned into two units: (1) the HQE which would do all healthcare cases (MBC, BRN, Pharmacy, Dentists, etc.) and (2) the Licensing Section which would handle disciplinary matters for all other non-health DCA boards (e.g., Architects, Engineers, Accountants, etc.). More evidence of the success of the DIDO program as a proven effective model of investigative/prosecutorial services would need to be provided before consideration should be given to rejecting the implementation of the VE format for investigations and prosecution of cases. Initial reports seem to indicate some success of the VE format in both the investigation and prosecution of health-related disciplinary cases.

Except for the reinstatement of the DIDO program, all recommendations of the AG's Licensing Section should be given strong consideration, some of which could be implemented immediately.

Consideration should also be given to setting certain timeframes for the AG in the filing of accusations, proposed default decisions, the setting of a hearing date once a notice of defense is received, etc.

Use of Specialist Administrative Law Judges

In addition to specialist investigators and specialist prosecutors, the MBC uses administrative law judges (ALJs) from the Office of Administrative Hearings (OAH) who are appointed to a special panel called the "Medical Quality Hearing Panel" under Government Code Section 11371. These judges specialize in medical discipline cases and are trained in medical terminology and records issues. CPIL recommends that the DCA, the BRN, and the OAH should consider whether the BRN and the other major healthcare boards could utilize the Medical Quality Hearing Panel in order to achieve higher-quality ALJ decisions.

Staff Recommends: *The OAH should consider whether the BRN and other major healthcare boards could utilize the Medical Quality Hearing Panel so as to have more specialize ALJ's dealing with the more complicated healthcare quality cases.*

More Effective Probation Monitoring

According to the CPIL, in many of the BRN's disciplinary decisions, the BRN places a licensee on probation subject to multiple terms and conditions. In this situation, the BRN has expended an average of 3.5 years (and has spent a minimum of six figures) to take a formal, public disciplinary action against a licensee. That action has resulted in a license revocation but the revocation has been stayed, the licensee has possibly been required to take some time off on suspension, and then spends years on probation subject to terms and conditions. This entire process, as the CPIL argues, is meaningless unless the BRN vigorously monitors compliance with those terms and conditions of probation; noncompliance with any of them should prompt an immediate petition for revocation of probation and revocation of the license.

Regrettably, as the CPIL states, the *LA Times* series has exposed serious probation violations which have gone unaddressed by the BRN for years. This is inexcusable. The *Times* describes the BRN's probation unit as "five board monitors oversee[ing] about 470 nurses on probation." This is grossly inadequate. Probationers, by definition, are individuals who have violated the law but are being given a second chance. Probation orders often require compliance with 10-15 conditions each. Probation monitors are not meaningfully capable of monitoring more than 50-60 cases each. As the CPIL argues, probation violations should not be tolerated; in other words, they should be dealt with on a "zero tolerance" basis. One violation should yield an immediate petition to revoke probation and revoke the license. That does not happen at

the BRN. "That must happen at the BRN; that is the only action that is consistent with the Board's "paramount" public protection mandate."

The CPIL recommends that probation monitoring could occur either at the revamped HQE in the Department of Justice discussed above, or via staff at the BRN. However, those staff must not handle excessive caseloads and they must have easy access to peace officer investigators and prosecutors who will act in a "strike force" fashion to obtain evidence of any probation violation and file an immediate petition to revoke probation and to revoke the license. "Nothing less should be tolerated," as stated by the CPIL.

Staff Recommends: *There should be created within the revamped DOI or HQE a special "strike force" to handle cases involving failed diversion, criminal convictions, violations of probation, and other cases needing immediate attention such as an interim suspension order (ISO) or temporary restraining order (TRO). The BRN staff and other boards which lack sufficient staff should have staffing levels immediately increased to deal with probation monitoring of cases.*

Enhanced Disclosure of Information About Licensees

According to the CPIL, the *LA Times* series revealed that, in addition to patients, nurse employers rely heavily on the BRN's Web site for information about California-licensed nurses. However, the BRN is subject only to Business and Professions Code Section 27, which requires the BRN to disclose only its own disciplinary decisions concerning nurses. Although the BRN collects other information about its licensees, it is not required to post any of that information on its Web site.

For almost ten years, the MBC has been subject to Business and Professions Code Sections 803.1 and 2027. These sections require the MBC to disclose considerably more information about its physician licensees than the BRN must disclose about its nurse licensees. These provisions also require that disclosure to occur via the most efficient means possible: the Internet.

CPIL recommends that consistent with the MBC's public disclosure statutes, the BRN should be required to disclose, on its Internet Web site, the following information about its licensees and former licensees:

1. Information regarding any enforcement actions taken by the BRN or by another state or jurisdiction, including temporary restraining orders issued; interim suspension orders issued; revocations, suspensions, probations, or limitations on practice ordered by the board, including those made part of a probationary order or stipulated agreement; public letters of reprimand issued; and infractions, citations or fines imposed.

2. All current accusations filed by the AG, including those accusations that are on appeal.

3. Civil judgments or arbitration awards in any amount; and civil settlement agreements where there are three or more in the past ten years that are in excess of $10,000.

4. All felony convictions reported to the Board, and all misdemeanor criminal convictions that result in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed.

Staff Recommends: *This Committee should include as part of its hearing during the interim recess what public disclosure requirements for physicians and surgeons should be applicable to nurses and other healthcare professionals.*

Diversion Programs Should be Substantially Improved or be Abolished

According to the CPIL, diversion programs purport to monitor substance-abusing licensees, and most programs, including the BRN's, afford confidential participation to those licensees, such that patients are not able to know whether their provider is in such a program and/or is afflicted with substance abuse. As such, these programs operate in an area of significant sensitivity and grave public risk. A substance-abusing healthcare professional poses a strong risk of irreparable harm to the many patients that he/she may treat on any day that he she uses drugs/alcohol or suffers from the effects of long-term substance abuse.

The BRN's diversion program, created in 1985, is modeled after the state's first diversion program for physicians created at the Medical Board in 1981. The MBC's program was audited four times between 1982 and 2004; it failed all four audits miserably, the CPIL asserts. After the fourth failed audit (which was conducted by the Medical Board Enforcement Monitor in 2004), the Legislature enacted 2005 legislation imposing a June 30, 2008 sunset date on the diversion program, effectively giving the MBC two more years and one more chance to address all of the deficiencies identified by the Enforcement Monitor and other auditors. Despite the fact that the MBC pumped $500,000 in additional resources into the program between 2004 and 2006, the program failed a fifth audit in 2007, conducted by the Bureau of State Audits. Confronted with the BSA's audit results and with the testimony of patients who had been injured by physicians while they were participating in the diversion program, the MBC voted unanimously to abolish its program as of June 30, 2008.

The BRN's program operates somewhat differently from the MBC's program in at least two respects: (1) the BRN uses a private vendor to administer the program — a vendor that has never been audited, and (2) the BRN requires a "cease practice" period of all nurses entering the program — a period that may last from three to twelve months during which the nurse must agree not to work. During this time, the nurse has an opportunity to focus on recovery and demonstrate to the program that he/she is capable

of safe practice. However, as was documented in the July 25, 2009 *LA Times* article, the BRN has no way to enforce its "cease practice" mandate. It performs no investigations and has no way to know whether a nurse who has agreed to cease practice has in fact stopped practicing. Further, because the "cease practice" agreement is not public information or available in any way to nurse employers, nurses subject to a "cease practice" order can and do return to work (or find work with a different employer or employers), and can and do divert drugs from their workplace and use while on duty. "This is unacceptable," as stated by the CPIL.

As the CPIL notes above, the BRN's diversion program has never been audited in its 24-year existence. The private vendor of the BRN's diversion program is currently subject to audit by DCA pursuant to SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008); but that audit has not yet commenced. Clearly, as argued by CPIL, "that audit must be expedited and its results used to fashion comprehensive reforms to the BRN's diversion program."

As further argued by CPIL, the absence of an independent, external audit of the BRN's diversion program casts doubt on any of the Board's rosy claims about the program and the way the vendor runs it. For example, the BRN can argue that nurses in the diversion program are drug-tested X times per month, but the BRN has no idea whether the vendor is actually testing participants X times per month, and/or whether those tests are truly random or they are administered on days the participant anticipated (as happened at the MBC). The absence of an external audit renders the "success rate" claimed by the BRN moot. That rate is simply the number of nurses who enter the program and eventually complete it. If its monitoring mechanisms are so lax that anybody could complete it (including alcoholics and addicts who are manipulative and desirous of maintaining both their licenses and their addictions), a "success rate" is meaningless.

But the *LA Times* series focused not only on the program as run by the private vendor based on standards set by the BRN (which standards apparently allow five relapses while in the program before a nurse's participation is terminated), but also on the BRN's performance after a nurse has been kicked out of the diversion program. The findings according to the CPIL are inexcusable. As stated by the CPIL, it is incomprehensible that BRN could possibly take an average of 15 months after its own diversion program has terminated a nurse's participation because of repeated relapses and noncompliance and labeled that nurse a "public safety threat" just to file an accusation against that nurse. It is positively mind-boggling that it could take an additional ten months for the Board to take disciplinary action against that nurse.

The CPIL argues that these programs should operate on a zero tolerance basis. One relapse should result in public license suspension to protect patients and future employers. Terminations from the diversion program should march to the front of the complaint screening/investigation hierarchy and should be dealt with by a properly-resourced strike force of investigators and prosecutors.

In fact, as further pointed out by the CPIL, the MBC Enforcement Monitor recommended that the MBC consider a mechanism similar to that in Penal Code Section 1000, to ensure that those who do not and cannot comply with the terms and conditions of a diversion program are promptly removed from practice. As a condition of entering the diversion program, and especially for nurses who are on license probation, a nurse should be required to stipulate that he/she has violated the Nursing Practice Act and surrender his/her license. That stipulation would be deferred pending the nurse's entry into the program. If the nurse successfully completes the program, the stipulation is destroyed. If the nurse relapses while in the program, the stipulation is activated and the suspension takes effect immediately. This would ensure that a nurse who has been given one last chance, and who has blown that chance, is publicly removed from practice and cannot provide healthcare. (The BRN has also indicated that they want this "automatic suspension" provision for nurses who flunk out of their Diversion program.)

Staff Comments: SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) established within the Department of Consumer Affairs the Substance Abuse Coordination Committee (SACC) to formulate by January 1, 2010, uniform standards that will be used by healing arts boards in dealing with substance-abusing licensees, whether or not a healthcare board operates a diversion program. These standards, at a minimum, include: requirements for clinical diagnostic evaluation of licensees; requirements for the temporary removal of the licensee from practice for clinical diagnostic evaluation and any treatment, and criteria before being permitted to return to practice on a full-time or part-time basis; all aspects of drug testing; whether inpatient, outpatient, or other type of treatment is necessary; worksite monitoring requirements and standards; consequences for major and minor violations; and criteria for a licensee to return to practice and petition for reinstatement of a full and unrestricted license.

On March 3, 2009, the SACC conducted it first public hearing and the discussion included an overview of diversion programs, the importance of addressing substance abuse issues for healthcare professionals and the impact of allowing healthcare professionals who are impaired to continue to practice. During this meeting, the SACC members agreed to draft uniform guidelines for each of the standards. During subsequent meetings, roundtable discussions were held on the draft uniform standards, including public comments.

Staff Recommends: *As recommended earlier, the Enforcement Monitor appointed to the BRN should audit the diversion program and recommend either substantial changes to the program to assure that substance-abusing nurses are properly monitored or the elimination of the program operated by the BRN. In the meantime, a sunset date of January 1, 2011, should be placed immediately on this program and other diversion programs provided by the boards. The DCA shall also immediately proceed with the audit on the effectiveness, efficiency, and overall performance of the vendor chosen by the department to manage diversion programs for substance-abusing licensees of healthcare licensing boards. Based on this audit, the DCA shall immediately make recommendations to the Legislature regarding the continuation of these programs by*

the boards, and if continued, any changes or reforms necessary to ensure that individuals participating in these programs are properly monitored, and that the public is protected from healthcare practitioners who are impaired due to alcohol or drug abuse or mental or physical illness.

The DCA shall also immediately provide to the Legislature an update on the work of the Substance Abuse Coordination Committee and at what time the Committee will have completed its work and provide uniform standards that will be used by all health licensing boards which provide diversion programs.

As recommended by CPIL and the BRN, provide for the automatic suspension of a nurse's license similar to that in Penal Code Section 1000, to ensure that those who do not and cannot comply with the terms and conditions of a diversion program are promptly removed from practice.

Other Changes and Recommendations for the BRN and Other Health Related Boards

Staff Recommendations: The following are other changes and recommendations which should be made to the BRN and possibly other health related boards under the DCA:

1. *Immediately provide for the BRN a medical records request statute (similar to Business and Professions Code Section 2225 which applies to the MBC and its investigators) and a penalty on doctors/hospitals/facilities for failure to comply with a lawful request for medical records (similar to Business and Professions Code Section 2225.5).*

2. *Immediately require the BRN as well as other health related boards to provide an annual report (similar to the MBC under Business and Professions Code Section 2313) on its enforcement program statistics, including the timeframes for every step in the enforcement process.*