

Health Related Boards

November 2003

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John G. Morgan
Comptroller

November 12, 2003

The Honorable John S. Wilder
Speaker of the Senate
The Honorable Jimmy Naifeh
Speaker of the House of Representatives
The Honorable Thelma M. Harper, Chair
Senate Committee on Government Operations
The Honorable Mike Kernell, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of six Health Related Boards. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the six boards should be continued, restructured, or terminated.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/dww
02-017

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit
Health Related Boards
November 2003

AUDIT OBJECTIVES

The objectives of the audit were to determine the authority and responsibility mandated to the six boards by statute; to determine the extent to which the boards and the Division of Health Related Boards have fulfilled that mandate and complied with applicable laws and regulations; and to assess the efficiency and to make recommendations that might result in more efficient and effective operation of the boards.

FINDINGS

Despite improvements, the practitioner complaint resolution process continues to be lengthy and inconsistent*

Audit file reviews indicated that many open and closed cases took a long time to be processed. Although the division uses an information system to monitor the complaint process, there are problems obtaining the necessary reports for analysis. While the division has reduced the backlog of complaints, discipline still appears inconsistent in many cases. Serious disciplinary action was taken in few cases (page 9).

Most boards don't have disciplinary guidelines; some guidelines appear lenient*

The boards of Alcohol and Drug Abuse Counselors; Dispensing Opticians; Electrolysis Examiners; and Professional Counselors and Marital and Family Therapists, and Clinical Pastoral Therapists do not have disciplinary guidelines. The guidelines for the Board of Osteopathic Examination do not include specific actions for disciplinary violations. While the Board of Medical Examiners' disciplinary guidelines are comprehensive, the range of

penalties for major offenses appears to be too lenient for the frequency of occurrences (page 17).

Alternative Dispute Resolution case results are not always documented, and timeliness should be improved

With alternative dispute resolution (ADR), disciplinary cases are reviewed by a screening panel to determine whether a practitioner should be diverted from formal board action. Many of the ADR results for the Board of Medical Examiners were not recorded in the case files, and many of the cases exceeded timeliness benchmarks (page 19).

Access to accurate public information continues to be inconsistent among boards*

Anonymous calls by auditors to four boards about disciplinary actions taken against practitioners revealed that the amount of information and level of cooperation provided by the staff varied. Also, information on disciplinary actions on the Department of Health Web site was sometimes incomplete (page 23).

No background checks for licensure applicants

State law does not specifically require or authorize criminal background checks before granting licenses to practitioners. Practitioners are required to report any arrest and conviction information on their license application and practitioner profile (page 29).

Several boards have not met self-sufficiency requirements

Current-year revenues generated from license fees collected by some of the health-related boards have not covered current year operating costs incurred in regulating the professions for more than two consecutive fiscal years. Some boards experiencing annual deficits have had cumulative surpluses from prior years that are used to cover the annual deficits. While this may allow the boards to remain self-sufficient, the boards may still be in violation of statute by running consecutive year deficits. Several boards raised license fees to address these deficits (page 33).

Boards have not used their authority to assess disciplinary costs to practitioners

The Board of Medical Examiners and the Board of Osteopathic Examination have not always assessed costs to practitioners because of questions regarding the types of fees to assess

and how the Office of General Counsel would determine its costs per case. The Division of Health Related Boards needs to work with the General Counsel to determine the costs for legal work. Also, in 2003, the General Assembly passed legislation granting all boards the authority to assess costs to practitioners (page 38).

No internal audit function for the boards

The Department of Health has not conducted internal audits on the Division of Health Related Boards or on individual boards since 1998. Internal audits can be beneficial by addressing areas of efficiency and effectiveness, identifying potential areas of fraud and abuse, and assessing the complaint investigation process (page 40).

Weaknesses in the board nominating process

State law requires all boards to have a public member and encourages the Governor to appoint at least one senior and one minority member. All six boards have a public member, but the Board of Osteopathic Examination does not have any minority members. Also, the Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists does not have a senior member (page 42).

* Related issues were also discussed in the 1999 performance audit of 16 health related boards.

OBSERVATION AND COMMENT

The audit also discusses the following issue: optician licensure (page 7).

ISSUES FOR LEGISLATIVE CONSIDERATION

The General Assembly may wish to consider (1) amending *Tennessee Code Annotated* to require the boards to conduct criminal background checks for license applicants and (2) evaluating the boards that have not proven to be self-sufficient (page 46).

"Audit Highlights" is a summary of the audit report. To obtain the complete audit report, which contains all findings, recommendations, and management comments, please contact

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Performance Audit Health Related Boards

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**Performance Audit
Division of Health Related Boards**

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of six health-related boards was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-224, *Tennessee Code Annotated*, the six boards were scheduled to terminate June 30, 2003. As provided for in Section 4-29-115, however, the boards will continue through June 30, 2004, for review by the designated legislative committee. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the boards and to report to the Joint Government Operations Committee of the General Assembly. The audit is intended to aid the committee in determining whether the boards should be continued, restructured, or terminated. The following boards were reviewed:

1. Board of Alcohol and Drug Abuse Counselors
2. Board of Dispensing Opticians
3. Board of Electrolysis Examiners
4. Board of Medical Examiners
5. Board of Osteopathic Examination
6. Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to determine the authorities and responsibilities the General Assembly mandated to the Department of Health's Division of Health Related Boards and to the individual boards;
2. to determine the extent to which the boards and division have fulfilled their legislative mandates;
3. to evaluate the efficiency and effectiveness of the division and board; and

4. to develop recommendations, as needed, for administrative and legislative action which might result in more efficient and/or more effective operation of the division and boards.

SCOPE AND METHODOLOGY OF THE AUDIT

We reviewed the activities and procedures of the boards and the Division of Health Related Boards focusing on procedures in effect for fiscal years 2000 through 2003. The audit was conducted in accordance with the standards applicable to performance audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. The methods include

1. interviews with division staff, board members, and representatives of health associations;
2. a review of statutes and departmental rules and regulations;
3. a review of a random sample of open and closed complaint investigation files; and
4. interviews with officials from other states' health profession regulatory agencies and with Tennessee Bureau of Investigation officials.

ORGANIZATION AND STATUTORY DUTIES

Division of Health Related Boards

Under *Tennessee Code Annotated*, Section 63-1-101, the Department of Health's Division of Health Related Boards' purpose is to provide all administrative, fiscal, inspectional, clerical and secretarial functions to the 22 health-related boards. The division is charged with the responsibility of regulating health care professionals to help assure the quality of health care and protect the public's health, safety, and welfare. Under Section 63-1-115, the division is allowed to employ investigators, inspectors, or agents to carry out its administration and enforcement of laws regulating the health professions. The division, in conjunction with the boards, has the power and duty to enforce all laws regulating the healing arts. The division can petition circuit or chancery court to forbid persons practicing without a license from continuing to practice. The director of the division is appointed by the Commissioner of Health from a list of three nominees provided by a committee of board chairs.

The boards perform regulatory functions which include giving examinations, issuing licenses, making rules and regulations governing the standards of the professional practice, setting fees, approving continuing education requirements, and conducting disciplinary hearings.

All boards, following specific notice requirements and hearings, adopt rules that have the force of law and may be used in the regulation of professions. Administrative staffs support the

boards by issuing licenses to those who meet the requirements of the law and rules. All board members are appointed by the Governor, and all boards are required under Section 63-1-124, *Tennessee Code Annotated*, to have at least one citizen member. The cost of operating boards comes primarily from license fees collected from regulated practitioners. Under Section 4-29-121, all boards must be financially self-sufficient.

The following is a summary of the purpose and responsibilities of the boards included in the scope of this audit.

Board of Alcohol and Drug Abuse Counselors

The Alcohol and Drug Abuse Counselors Licensure Advisory Committee, created in 1996, was restructured effective January 1, 1998, as the Board of Alcohol and Drug Abuse Counselors per Sections 68-24-604 through 68-24-609, *Tennessee Code Annotated* (Alcohol and Drug Treatment). The board was created to license and regulate counselors who demonstrate competence based on the licensing process and examinations. The five-member board consists of four certified master alcohol and drug abuse counselors and one person who is not engaged in the alcohol and drug abuse profession. As of April 2003, there were 545 licensed counselors in Tennessee.

Board of Dispensing Opticians

The Board of Dispensing Opticians was created in 1955 by Section 63-14-101, *Tennessee Code Annotated*. The purpose of the board is to license individuals who prepare, adapt, and dispense lenses, spectacles, eye glasses, and optical devices based on the written prescription of a physician or optometrist, and the dispensing of frames. The six-member board consists of five licensed opticians who must each have five years of experience and one member who is a health care consumer. All members of the board are appointed by the Governor to serve four-year terms. There are 841 licensed dispensing opticians in the state.

Board of Electrolysis Examiners

The Board of Electrolysis Examiners was created in 1988 by Section 63-26-104, *Tennessee Code Annotated*, to safeguard the health, safety, and welfare of Tennesseans by requiring those licensed by the board to practice electrolysis within the state to be qualified. The five-member board consists of one nationally certified electrologist, one Tennessee licensed electrologist, one physician, one administrative educator certified in the state's education system, and one consumer. All members of the board are appointed by the Governor to serve three-year terms. There are 62 licensed electrologists in Tennessee.

Board of Medical Examiners

The Board of Medical Examiners was created in 1901 by Section 63-6-101, *Tennessee Code Annotated*. The board awards licenses to qualified candidates who have graduated from approved medical schools and who have completed appropriate postgraduate work. There are 17,741 licensed medical doctors as of April 2003. The board is also vested with the

responsibility of ratifying all licenses or certificates for athletic trainers, physicians' assistants, acupuncturists, clinical perfusionists, and x-ray operators in medical doctors' offices.

Athletic Trainers—Under Section 63-24-103, the Board of Medical Examiners has certified athletic trainers in this state since 1983, under Section 63-24-103. An athletic trainer is a person with specific qualifications who, upon the advice, consent, and oral or written prescriptions of a physician, carries out the practice of prevention, recognition, evaluation, management, disposition, treatment, or rehabilitation of athletic injuries. There are 465 certified athletic trainers in Tennessee.

Committee on Physician Assistants—The Committee on Physician Assistants was created in 1985 by Sections 63-1 (Division of Health Related Boards) and 63-19 (Physician Assistants). The committee, working with the Board of Medical Examiners, is responsible for safeguarding the health, safety, and welfare of Tennesseans by requiring that all physician assistants are qualified and licensed. Licenses are awarded to both Physician Assistants and Orthopedic Physician Assistants. The seven-member committee consists of five physician assistants, one orthopedic physician assistant, and one health care consumer. All members are appointed by the Governor and serve four-year terms. There are 596 licensed physician assistants as of April 2003.

Advisory Committee for Acupuncture—Under Section 63-6-1003, the Advisory Committee for Acupuncture operates under the auspices of the Board of Medical Examiners to assist the board in the performance of its duties and certify qualified acupuncturists. The committee consists of five members appointed by the Governor, three of whom are certified acupuncturists; one ADS (Acupuncture Detoxification Specialist) practicing in Tennessee; and one consumer member who is not employed in a health care profession. The three acupuncturists initially appointed need not be certified at the time of their appointments but must meet all the qualifications for certification. No person may serve more than two consecutive full terms as a member of the committee. Each member serves on the committee until a successor is appointed. (The committee was given a termination date of 2005 by Public Acts of 2003, Chapter 125.)

The Acupuncture committee held its initial meeting in May 2002 and met again in July 2002, when rules were adopted. Rules have since been sent to the Attorney General's office for approval, and as of April 2003, 14 certifications have been issued.

Committee for Clinical Perfusionists—Under Section 63-28-104, the Committee for Clinical Perfusionists, under the guidance of the Board of Medical Examiners, licenses qualified clinical perfusionists in this state. Perfusion means the functions necessary for the support, treatment, measurement or supplementation of the cardiovascular, circulatory, or respiratory systems, or other organs, or a combination of these activities, and to ensure the safe management of physiologic functions by monitoring and analyzing the parameters of the systems under an order and under the supervision of a licensed physician. The committee has four perfusionist members, one hospital administrator from a health care facility where cardiac surgery is performed, one physician, and one public member.

The Clinical Perfusionist committee held its first meeting in November 2001, and the Attorney General's office approved committee rules in July of 2002. As of April 2003, 80 licenses have been issued. (The committee was given a termination date of 2005 by Public Acts of 2003, Chapter 269.)

X-Ray Operators—Under Section 63-6-224, the board has the authority to issue certifications to qualified individuals as X-ray operators. As of April 2003, there were 2,268 certified medical X-ray operators in Tennessee.

Board of Osteopathic Examination

The Board of Osteopathic Examination was created in 1905 by Section 63-9-101, *Tennessee Code Annotated*, Osteopathic physicians may be licensed by examination, by endorsement from other states, or by certification by the National Board of Examiners for Osteopathic Physicians and Surgeons. The board also licenses X-ray operators in osteopathic physician offices. The six board members are appointed by the Governor to serve five-year terms—five are osteopathic physicians and one is a citizen member. The board also certifies osteopathic X-ray operators and has the responsibility for ratifying certifications issued by the Council of Certified Professional Midwifery. As of April 2003, there were 619 licensed osteopathic physicians and 14 certified osteopathic X-ray examiners.

Council of Certified Professional Midwifery—The Council of Certified Professional Midwifery of Tennessee was created in Chapter 576 of the Public Acts of 2000. The council, working with the Board of Osteopathic Examination, is responsible for safeguarding the health, safety, and welfare of Tennesseans by requiring those who practice as a midwife to be qualified. The council is authorized to issue licenses to qualified candidates who have completed appropriate education and successfully completed required examinations. The nine-member council consists of four certified professional midwives, one consumer, one certified nurse midwife, one obstetrician, one family physician, and one pediatrician. All members are appointed by the Commissioner of Health and serve four-year terms.

The Midwifery committee first met in January 2002, and licensure fees have been set at \$750. As of April 2003, there were 22 licenses issued.

Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists

The Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists was created in 1984 by Section 63-22-101, *Tennessee Code Annotated*, and expanded in January 1, 1998, to include clinical pastoral therapy. The board is responsible for safeguarding the health, safety, and welfare of Tennesseans by requiring that all who practice professional counseling, marital and family therapy, and clinical pastoral therapy within this state to be qualified. The board consists of five members appointed by the Governor to serve five-year terms. The Tennessee Association for Counseling and Development, the Tennessee Association for Marriage and Family Therapy, and the Tennessee Association of Pastoral Therapists each may provide the Governor with a list of four candidates from which to fill vacant

positions. One position is a consumer member. As of April 2003, there were 917 licensed professional counselors, 136 certified professional counselors, 246 licensed marital and family therapists, 29 certified marital and family therapists, and 26 certified clinical pastoral therapists in Tennessee.

The table below documents the numbers of active licenses and certifications for the boards in this audit as of April 30, 2003.

Active Licenses as of April 30, 2003

Profession	Active Licenses 4/30/03
Alcohol & Drug Abuse Counselor	545
Dispensing Opticians	841
Electrologist	62
Medical Doctor	17,741
Medical Doctor Special Training	68
Medical X-Ray	2,268
Athletic Trainer	465
Physician Assistant	596
Clinical Perfusionist	80
Acupuncture	14
Osteopathic Physician	619
Osteopathic X-Ray	14
Marriage & Family Therapist-Certified	29
Marriage & Family Therapist-Licensed	246
Professional Counselor-Certified	136
Professional Counselor-Licensed	917
Pastoral Therapist	26
Midwife	22

OBSERVATION AND COMMENT

The issue discussed below did not warrant a finding but is included in this report because of its effect on the operations of the Division of Health Related Boards and the Board of Dispensing Opticians.

OPTICIAN LICENSURE

The Board of Dispensing Opticians was created in 1955. In recent years, there have been questions concerning the need to license opticians. Some have argued that the work is not so complex as to require regulation and that the licensure may increase costs to consumers. A letter the board sent requesting support for its continued existence has also been questioned.

Tennesseans may get eyeglasses from optometrists or opticians. Contact lens may be obtained from ophthalmologists or optometrists. Opticians in Tennessee can only fit contact lens in the direct presence of an ophthalmologist or optometrist.

Twenty-two states license opticians, including the southeastern states of Arkansas, Florida, Georgia, Kentucky, North Carolina, South Carolina, and Virginia. No states have chosen to start licensing since 1982; however, no states have repealed their licensing laws according to the president of the Opticians Association of America. There are 841 opticians with active licenses in Tennessee. The Division of Health Related Boards receives about two to three complaints per year about dispensing opticians. They are generally licensure- or advertising-related.

Nature of Optician Work and Skills Required

According to a job description in the U.S. Department of Labor's *Occupational Outlook Handbook*, dispensing opticians have a wide variety of complex responsibilities. They fit eyeglasses and contact lenses, following prescriptions by ophthalmologists or optometrists. Also, they examine written prescriptions to determine lens specifications, recommend eyeglass frames, lenses, and lens coatings. They measure clients' eyes, including the distance between the centers of the pupils and the distance between the eye surface and the lens. Knowledge of physics, basic anatomy, algebra, geometry, and mechanical drawing is particularly valuable, according to the handbook. According to the Tennessee Dispensing Opticians Association, "the work of the optician occurs when the optician translates the doctor's prescription, consistent with anatomical features of the face and eyes, assists in selecting appropriate eyewear consistent with the patient's needs. Once ground, the optician checks the lenses against the prescription before fitting the eyewear onto the patient. Without a trained optician, a laboratory mistake would not be caught and the customer could receive eyewear that could cause problems for the individual."

Licensing

Generally there are two ways in which to meet license qualifications in the states that require licensure: an educational requirement or an apprenticeship program under the direction of an ophthalmologist or an optometrist. In Tennessee, both are options. The board requires two years of approved course work or a three-year apprenticeship. License applicants are required to pass the National Opticianry Competency Examination and National Contact Lens Registry Examination. The board requires eight hours of continuing education a year.

Cost of Regulation

Some have argued that consumers pay higher prices for glasses in Tennessee because opticians are regulated. However, consumers also purchase eye glasses from optometrists who are regulated. Also, if opticians were not regulated, consumers would have no assurance that the person had the knowledge and skills required to ensure that the eyeglasses matched the prescription and fit appropriately. If consumers choose to go to a licensed optometrist instead of an unlicensed optician, prices might increase. Price can also be affected by the type of seller: private medical office vs. a chain store.

Letter about the Sunset Process

The board sent a memorandum in February 2003 to all licensed opticians, optometrists, and ophthalmologists seeking support for the board (and put a similar letter on its Web site). The appropriateness and cost of this letter have been questioned. The memo briefly explained the sunset process and stated that the board would expire “unless the Senators and Representatives are convinced that opticians need to be licensed and regulated by the state of Tennessee.” The letter was discussed in board meetings open to the public. The board’s attorneys had no objections to issuing the memo. Producing and mailing the letters cost about \$740 according to the staff of the Division of Health Related Boards. This money was paid out of licensee fees which are collected by the board to cover the cost of regulating the profession.

FINDINGS AND RECOMMENDATIONS

1. Despite improvements, the practitioner complaint resolution process continues to be lengthy and inconsistent

Finding

Despite efforts by the Division of Health Related Boards, the timeliness of the complaint resolution process remains lengthy. Although the division utilizes the Regulatory Board System (RBS) to monitor the complaint process, there are problems obtaining the necessary reports for analysis. While the division has reduced the backlog of complaints being investigated and adjudicated, discipline still appears inconsistent in many cases.

As in the prior audit, auditors identified several examples of complaint cases that either took excessive times to resolve or where disciplinary action, if any was administered, appeared inconsistent with the facts of the case. We are restricted by confidentiality requirements from discussing the details of the complaints and cases we reviewed. However, in the process of reviewing complaints, we identified serious weaknesses in the complaint resolution process that may jeopardize the health and safety of the citizens of Tennessee. The types of complaints include unprofessional conduct, overprescribing, substance abuse, and failure to disclose disciplinary actions in another state. Some cases involved multiple complaints and practitioners with prior disciplinary action. The boards administered serious disciplinary action in only 2 of 77 cases reviewed, with only one revocation. Not revoking licenses in a timely manner can allow practitioners to apply for a license in another state.

Departmental Actions Reduce Case Backlog

The 1999 performance audit identified major weaknesses in processing complaints against practitioners in a timely and consistent manner. Since that time, the division has taken positive steps to address this concern. In 2000, a committee composed of Health Related Boards' management and staff, Office of General Counsel (OGC) management, board directors, the director of the Department of Health's Bureau of Investigation (BIV), and the Board of Medical Examiners consultant met to discuss the problems with untimely investigations. The original focus of the committee was problems with the Medical Examiners board, but all boards were included in the discussion. The committee established a goal of completing investigations within 4 months and presenting all complaint cases to the boards within 12 months of receipt of complaint.

In 1999, the Department of Health and the Division of Health Related Boards made major organizational changes to address the complaint issue. The division's Investigations section was moved from the department's Office of Internal Audit to be directly under the direction of the management of the Bureau of Health Licensure and Regulation, which oversees the operations of the HRB division. In December 2000, the newly hired Investigations director

established a policy for all investigators to complete an average of seven complaints per month. According to the Investigations director, most investigators met this mandate.

To improve the timeliness of the initial complaint review, the Investigations director assumed responsibility for scheduling and assigning complaints to board consultants assigned to each board to assist in reviewing complaints and assigning priority. Consultants are licensed practitioners of the boards they represent and must meet the same criteria as board members. New policy required that Medical board reviews be conducted twice a week. Reviews were previously completed every two to three months.

Another change involved removing OGC from the initial P1 review and changing the manner in which they conducted the follow-up P2 review. Investigations management felt these moves would streamline the process, improve the timeliness of reviews, and allow OGC attorneys to focus on reducing their own backlog of cases. Board consultants along with the board directors or staff conduct P1 reviews of complaints after they are received to determine if they warrant investigation and to assign a priority. Consultants, board directors/staff, and OGC attorneys conduct the P2 review, after the investigation is complete, to determine whether the allegations have been substantiated and, if so, the level of discipline to seek (informal with letter of concern or warning or closure to OGC for possible formal disciplinary action).

The new policies led to a dramatic turnaround in the resolution of backlogged cases. On December 31, 2000, there were 1,037 open complaints being investigated. This number was reduced to 645 by March 1, 2001; to 330 by June 1, 2001; and to 338 on September 1, 2001. At the time the numbers were decreasing, the division continued to receive approximately 100 new complaints each month. As of May 9, 2003, however, the number of open complaints with investigations had increased to 737. Health Related Boards' management attributes the increase to a steady increase in complaints, the opening and logging of all Medical Malpractice Payment reports as a complaint to create a history for the practitioner, and the overlapping of files in the field, due to new requirements for both quantity and quality. (Incomplete or inaccurate investigations were returned to the field for correction.)

Timeliness of Complaint Resolution Remains Lengthy

While the division significantly reduced the numbers of backlogged complaints, based on an auditor review of complaint files, the average lengths of time to resolve complaints is still excessive. Auditors reviewed files for the health-related boards as a whole, and for the boards included in the scope of this audit. Auditors reviewed a random sample of complaints that were closed during calendar years 2000 and 2001, and also complaints that were open as of May 9, 2002.

To better understand the complaint handling process, following is an explanation of the terminology. While in BIV, the file is termed a complaint. Once the complaint is resolved in BIV, it is closed. Closure in BIV can indicate closing the complaint for lack of merit, or closing the complaint and transferring it to OGC for prosecution. Once transferred to OGC, the complaint is then termed a case for OGC tracking purposes. One OGC case could involve more than one BIV complaint as multiple complaints can be combined.

Open Files

As of May 2002, there were 204 open files for the boards in this audit's scope. Auditors reviewed a total of 26 files (12.7 %). The average age of a complaint for all 26 files reviewed was 627 days, while the average for the 15 Medical Examiner board files was 719 days. (See Exhibit 1.) Averages for other individual boards were excessive including 975 days for Physician Assistants and 631 days for Osteopathic Examination. Twelve of the 26 files were open longer than 400 days; 9, over 600 days; 5, over 1,000 days; and 2, over 2,800 days (over seven and a half years). Three of the 12 files open over 400 days had been assigned a high priority, including an overprescribing complaint that had been open almost eight years (2,897 days), while for 6 of the 12 files, there was no indication in the file as to the priority.

Closed Files

For the boards included in this audit's scope, auditors reviewed 46 of 1,054 files closed during calendar year 2000 (4.4%), and 41 of 1,002 files closed during calendar year 2001 (4.1%).

While the division's efforts have improved the timeliness of complaint processing, the amount of time still appears excessive. The average number of days to close a complaint decreased from 817 days in calendar year 2000 to 482 days in 2001. (See Exhibits 2 and 3.) By comparison, the averages from prior years as determined from the previous audit were 457 days in 1996, 546 days in 1997, and 545 days in 1998.

The average time for processing Medical Examiner board complaints improved from 425 days in 2000 to 384 days in 2001. It appears this can partly be attributed to quickness in conducting the initial P1 review, as this average decreased from 34 days in 2000 to 13 days in 2001. Also, the time to complete investigations was reduced from 268 days in 2000 to 78 days in 2001. In general, however, because information in the files was incomplete and missing in many cases, it is difficult to make overall assessments based on the file reviews alone regarding some of the steps within the complaint process.

The reviews identified numerous examples of cases taking lengthy amounts of time to complete. For cases closed in 2000, 21 of the 46 cases reviewed took over 400 days to close, with 15 of the 36 Medical Examiner cases taking over 400 days. Twelve of 46 cases took over 600 days to close, (9 of these were Medical Examiner cases) and 6 took over 1,000 days to close (four of these were Medical Examiner cases). Five cases took over three years to close (three Medical Examiner cases), with three taking over four years to close. One Medical Examiner case took 1,688 days to resolve.

For cases closed in 2001, 14 of the 41 cases took over 400 days to close, with 8 of the 29 Medical Examiner cases taking over 400 days. Ten of the 41 cases took over 600 days (four of these were Medical Examiner cases), and 6 took over 1,000 days to close (four of these were Medical Examiner cases). Three cases took over three years to close (one of these was a Medical Examiner case), with two taking over four years to close. One Medical Examiner case took four and a half years (1,637 days) to close, and one Professional Counselor, Marital and Family Therapist, and Clinical Pastoral Therapists case took over five years (1,938 days) to close.

While the average times to process Medical Examiner board complaints improved, a high percentage of cases are being closed either at the initial P1 or P2 review stage with no disciplinary actions taken. For example, for 2000, 29 of 46 files reviewed (63%) were closed without disciplinary action at either the P1 or P2 review stage (six at P1 and 23 at P2), 3 were closed with either a warning letter or letter of concern, and 12 were referred to OGC for further action (for 2 files reviewed, auditors were unable to determine the exact resolution due to incomplete data in the files). For the Medical Examiners board in 2000, 26 of 36 files (72.2%) were closed at either P1 or P2. No serious disciplinary action (i.e., suspension or revocation) was issued in any of the cases. According to the department, files that are closed with no action at these stages represent those cases for which there is no violation of the practice act, or the allegations could not be substantiated by witness or documentary evidence.

This trend continues for 2001 closed files, as 29 of 41 files reviewed (70.7%) were closed at either P1 or P2. Of this total, 22 of 29 of Medical Examiners files (75.9%) were closed at P1 or P2, with no disciplinary action taken. For all 2001 cases, only 5 of 41 cases (12.2%) resulted in any form of disciplinary actions (including letters of concern and warning), with only 2 of 41 (4.9%) resulting in serious disciplinary action (one agreed order with probation and one revocation).

Exhibit 1
Complaint Files Open as of May 9, 2002
Averages in Number of Days

Board (number of files reviewed)	Received as of May 9, 2002
Alcohol & Drug Abuse Counselors (2)	195.5
Dispensing Opticians (2)	419.0
Electrolysis (1)	257.0
Medical Examiners (15)	719.0
Physician's Assistants (2)	975.0
Osteopathic Examination(2)	631.0
Professional Counselors, Marital and Family Therapists, & Clinical Pastoral Therapists (2)	415.0
Averages (26)	627.0

Exhibit 2
Complaint Files Closed in 2000
Average Number of Days for Case Processing*

Board (number of files reviewed)	Received to First Review	First Review to Investigator	Investigator to Complete	Investigation Complete to OGC	OGC to Boards	Boards to Resolution	Received to Resolution
Alcohol & Drug Abuse Counselors (0)							
Dispensing Opticians (2)	1		931	332			791
Electrolysis (1)		9	103	340			454
Medical (36)	34		154	44	696	14	425
Physicians Assistants (2)	11	36	170	32			418
Osteopathic (3)	1		95	652			467
Professional Counselors, Marital and Family Therapists, & Clinical Pastoral Therapists (2)	182		156	103			2,346
Averages (46)	46	23	268	250	696	14	817

*Note: The numbers in each column are the averages of the cases for which the number of days in that phase could be calculated. Not all cases went through each phase. Also, some dates were missing from the files so the number of days for some phases could not be determined. All cases are reflected in the Received to Resolution column.

**Exhibit 3
Complaint Files Closed in 2001
Average Number of Days for Case Processing***

Board (number of files reviewed)	Received to First Review	First Review to Investigator	Investigator to Complete	Investigation Complete to OGC	OGC to Boards	Boards to Resolution	Received to Resolution
Alcohol & Drug Counselors (1)	9		129	186			324
Dispensing Opticians (2)							587
Electrolysis (1)	444	312	216	2			1,132
Medical (29)	13	70	173	148			384
Physicians Assistants (1)	240	311	26	94			671
Osteopathic (4)	44	26	58	124			310
Professional Counselors, Marital and Family Therapists, & Clinical Pastoral Therapists (3)	66	134	163	491			934
Averages (41)	102	122	78	131			482

*Note: The numbers in each column are the averages of the cases for which the number of days in that phase could be calculated. Not all cases went through each phase. Also, some dates were missing from the files so the number of days for some phases could not be determined. All cases are reflected in the Received to Resolution column.

The division has the ability to track and monitor complaints through the RBS system. As stated earlier, however, the system does not generate the type of reports necessary for adequate analysis. For example, the reports do not provide adequate information to determine the timeliness of specific phases within the complaint resolution process, such as the time it takes to conduct the P1 review after the complaint is received. Investigations has established a benchmark of completing an investigation within 120 days and randomly sampled cases investigated during 2002. Based on this review, Investigations determined that it took on average 130 days to complete an investigation in 2002, exceeding the standard by 10 days.

Medical Examiners Board Ranked 48th in Disciplining Doctors

Public Citizen's Health Research Group, a national nonprofit public interest organization, ranked Tennessee 48th nationally in 2002 for disciplining its medical doctors. Public Citizen released a report dated April 9, 2001, regarding Public Citizen's new edition of questionable doctors. The document includes 20,125 doctors nationwide who have been disciplined by state medical boards and other agencies for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses, and other offenses.

The report includes a state ranking to help citizens determine which states are doing the best job of regulating the medical profession. The ranking was based on data obtained from the Federation of State Medical Boards (FSMB) on the number of disciplinary actions taken against doctors in 2000. This report has been updated to account for data in 2001 and 2002, with the most recent report released March in 2003 (2002 data). Public Citizen calculated the rate of serious disciplinary actions (revocations, surrenders, suspensions and probation/restrictions) per 1,000 doctors in each state and compiled a national report ranking state boards by the number of serious disciplinary actions taken against doctors in 2001. For 2002, Tennessee ranked 48th nationally (rankings include 50 states and the District of Columbia), with 1.47 serious actions per 1,000 doctors (14,954 doctors and only 22 serious actions). This represents a significant drop in rankings from the 2001 ranking of 33rd, when Tennessee had 2.34 serious actions per 1,000 doctors (14,954 doctors and only 35 serous actions taken). Tennessee has ranked in the bottom third nationally for the last 11 years, ranking as follows: 2001-33rd, 2000-35th, 1999-49th, 1998-51st, 1997-48th, 1996-48th, 1995-31st, 1994-38th, 1993-44th, 1992-49th, and 1991-38th.

Recommendation

The department, the Division of Health Related Boards, and individual boards should continue efforts to improve the timeliness of complaint resolution processing. They should improve the monitoring of each stage of the complaint process. In resolving complaints, boards should use disciplinary guidelines to ensure that practitioners who are problematic and may endanger the public welfare are adequately disciplined and prohibited from practicing when necessary.

Management's Comment

Division of Health Related Boards

We concur with the finding. The division will form a work group to meet on a bi-monthly basis to review and evaluate data to identify areas in the complaint/case process for improvement. The work group will consist of the Director of Investigations, the Director of Health Related Boards, the General Counsel, and others as deemed necessary. Each unit will continue to process available reports internally and identify those stages where improvements can be made. Policies will be developed to place the work group's recommendations into effect.

The department is in the process of upgrading the Regulatory Board System (RBS) to allow for a significant improvement in the monitoring of the stages in the complaint/case process. This upgrade will be much more user friendly than the current DOS-based RBS system. The reports that will be generated will provide management the data that will allow complaint/case tracking in a unified approach.

We do not concur with all of the recommendation. The division does not concur that the use of disciplinary guidelines will result in consistent resolutions. Guidelines cannot be written to address most of the fact situations that the division investigates. Very few complaints contain a violation of only one section of board law or rule. Most boards have chosen not to develop guidelines, as each case must stand on its own particular fact situation.

Chair of the Board of Alcohol and Drug Abuse Counselors

The Board of Alcohol and Drug Abuse Counselors will work with Health Related Boards to improve its processing, timeliness and resolution of all complaints. A system to monitor each stage and the overall length of the complaint process will be developed. The Board of Alcohol and Drug Abuse Counselors will utilize disciplinary guidelines to ensure that practitioners who are problematic and could be an endangerment to public welfare are adequately disciplined and if necessary prohibited from practicing.

Chair of the Board of Dispensing Opticians

I concur with the response of the Division of Health Related Boards.

Chair of the Board of Electrolysis Examiners

I concur.

Director of the Board of Medical Examiners

The Chairman of the Board of Medical Examiners has received a copy of the findings and recommendations of the audit of the Division of Health Related Boards, and the board will discuss the audit at a future board meeting.

Chair of the Board of Osteopathic Examination

I concur.

President of the Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists

I have read and concur with the division's responses.

2. Most boards don't have disciplinary guidelines; some guidelines appear lenient

Finding

Only two of the six boards reviewed in this audit have disciplinary guidelines—the boards of Medical Examiners and Osteopathic Examination. The remaining four boards—Alcohol and Drug Abuse Counselors; Dispensing Opticians; Electrolysis Examiners; and Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists—do not have guidelines. While boards are not statutorily required to develop and implement disciplinary guidelines, as a result of their absence, Health Related Boards' efforts to achieve greater consistency in disciplinary actions may be limited.

The Federation of State Medical Boards (FSMB), a not-for-profit entity composed of 70 licensing and disciplinary boards throughout the United States, supports the use of disciplinary guidelines by health-related boards. FSMB has created *A Model for the Preparation of a Guidebook on Medical Discipline*, a document to guide health-related boards in the development of their own guidelines. Section 63-1-120, *Tennessee Code Annotated*, provides all boards the statutory authority to discipline practitioners for unprofessional, unethical, or dishonorable conduct and to define actions constituting unprofessional, unethical, or dishonorable conduct. Division management believes that the consistency and appropriateness of disciplinary actions taken in hearings should improve when formalized disciplinary guidelines are being used. As a result, situations in which the disciplinary actions appear too excessive or too lenient for a particular offense should be minimized.

The guidelines for the Osteopathic board are documented in the board rules but are much more general in nature than the Medical Examiners board guidelines and do not include specific actions for associated disciplinary actions. The Medical Examiners board has developed more specific guidelines that include specific ranges of disciplinary actions for associated offense categories, including overprescribing, fraud, malpractice, sexual misconduct, and impairment. The severity of the disciplinary action recommended is dependent on either the frequency of occurrence or the numbers of points accumulated (see Appendix 1). For example, the recommended disciplinary action for a doctor found to have engaged in overprescribing to one to five patients is a warning letter or informal settlement up to one year of probation, plus an optional 10 hours of continuing education. The board is not required to follow the guidelines;

rather, the recommendations are to be used when possible “to expeditiously and justly conclude disciplinary matter.”

While the Board of Medical Examiners’ disciplinary guidelines appear to be comprehensive, the range of penalties for major offenses where the safety of the public is at risk appears to be too lenient for the frequency of occurrences. For example, for a major offense of “overprescribing,” a doctor can be found to have overprescribed medications to up to 10 patients before the guidelines call for a suspension of license, and up to 20 patients before a revocation is recommended. A doctor who overprescribes to that large a number of patients could be considered a threat to the safety and welfare of the citizens of the state, and the board may need to take action to stop further interaction with patients. For serious offenses, public safety could be protected by discontinuing the practice privileges of violators. Therefore, suspension or revocation might be a more appropriate disciplinary action.

A suspension of license may not necessarily be warranted for first or subsequent offenses. The boards need the flexibility that is built into the Medical Examiners’ disciplinary guidelines to consider the facts and circumstances of each individual case before taking such serious action. A practitioner’s license should be removed only when absolutely necessary and when the public’s safety is at risk. However, a doctor shouldn’t be allowed to overprescribe to 10 patients before a suspension is recommended. It does not appear consistent with the division’s mission of protecting the public from harmful and/or careless practitioners.

Recommendation

All boards should develop and implement disciplinary guidelines that detail specific actions to take for certain offenses. Also, within the guidelines, the boards should ensure that each sanction is consistent with the severity of the offense.

Management’s Comment

Division of Health Related Boards

We concur in part with the finding and the recommendation. The Board of Medical Examiners and the Board of Osteopathic Examination are the only boards of this audit having disciplinary guidelines. Since other boards handle very few disciplinary cases, these boards have spent very little time discussing the development and utilization of disciplinary guidelines. The subject will be brought before each of the boards for discussion at their next meeting.

The Board of Medical Examiners and the Board of Osteopathic Examination have repeatedly stated that they should not be bound by those guidelines in determining the nature and extent of whatever disciplinary action might be appropriate to the offenses charged and proven and consider each case individually on a case by case basis. The guidelines are currently under review to be amended after due consideration.

Chair of the Board of Alcohol and Drug Abuse Counselors

The Board of Alcohol and Drug Abuse Counselors will work with the Division of Health Related Boards in developing and implementing disciplinary guidelines that detail specific actions to render for certain offenses. The Board will ensure that within the guidelines each sanction is consistent with the severity of the offense.

Chair of the Board of Dispensing Opticians

I concur with the response of the Division of Health Related Boards.

Chair of the Board of Electrolysis Examiners

I concur.

Director of the Board of Medical Examiners

The Chairman of the Board of Medical Examiners has received a copy of the findings and recommendations of the audit of the Division of Health Related Boards, and the board will discuss the audit at a future board meeting.

Chair of the Board of Osteopathic Examination

I concur in part. Our board, along with the Board of Medical Examiners, does have established disciplinary guidelines. Our board will review the current disciplinary guidelines to insure that each sanction is consistent with the severity of the offense. I also suggest that since our two boards deal with the two professional entities licensed as physicians in our state that this be a joint review to insure common guidelines for similar offenses.

President of the Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists

I have read and concur with the division's responses.

3. Alternative Dispute Resolution case results are not always documented, and timeliness should be improved

Finding

Alternative Dispute Resolution (ADR) represents an informal mediation or hearing concept that makes use of screening panels. Of the boards included in this audit, only the Board of Medical Examiners and the Board of Osteopathic Examination have the authority to use it, and the Medical board is the only one using it. The division introduced legislation in 2001 to grant authority for all boards, but approval was given to only five boards (including Osteopathic Examination) on a pilot basis. By design, any board opting to use ADR would create its own

screening panel. Per Section 63-6-214 (i) (1), *Tennessee Code Annotated*, the Medical Examiners board “may utilize screening panels in its investigative and disciplinary process to assure that complaints filed and investigated are meritorious, and to act as a mechanism for diversion, to professional peer review organizations and/or impaired professionals associations or foundations, those cases which the board, through established guidelines, deems appropriate.”

With the exception of the Medical Examiners board, ADR screening panels generally have three members—two professional members and one public member. The board members select the screening panel membership. Mediators on the panels should reflect the boards; for example, they should be individuals who would qualify as a board member. Thus, many are former board members. The Medical Examiners board has chosen to have a board panel hear ADR cases. ADR actions include a letter of warning or concern, a dismissal, or an agreed order of probation, suspension, or revocation of license. The practitioner has the option of either accepting the results of the ADR, or the case is referred to the General Counsel for prosecution before the board. Results of the ADR hearings are non-binding until the board ratifies them.

The Bureau of Health Licensure and Regulation developed policies and procedures effective April 2002 to provide guidelines for using ADR. These policies were based on general guidelines adopted by the Board of Medical Examiners in July 1999. The policies and procedures include both the process for using ADR and the criteria for determining if cases are appropriate for ADR. For example, cases are appropriate if they are non-contested, fully investigated, low risk (the facts are not egregious enough to warrant immediate discipline), and are a clear violation of the respective entity’s practice act. Appropriate examples would include practice act violations; drug-related, first-time offenders; and malpractice/negligence cases, all of which include an admission by the respondent. Examples could also include conviction of a crime, discipline in another state, and unethical conduct.

Department policy states that ADR cases should be fully investigated and prosecutable should the respondent choose not to participate or if the screening panel yields no results. The General Counsel has stated that an ADR case should be used exclusively for first offense cases when the practitioner admits guilt. However, the Board of Medical Examiner ADR panel took action in only one of 14 cases of files reviewed for 2001 and only one of ten cases in 2002. In addition, one practitioner in 2001 came before an ADR panel twice for the same offense (drug-related allegations). In both instances, the cases were closed with no action taken. The Division of Health Related Boards does not have a written policy addressing repeat visits to ADR Panel sessions by practitioners, especially for the same offense. A formal ADR policy addressing repeat complaints could help to ensure that public safety is protected.

ADR Consultant Did Not Document Panel Decisions

The Investigations Section is required by division policy to notify complainants of the Alternative Dispute Resolution results. If this information is not recorded and placed in the case file, the section does not have the information it needs, and the results are not available for future complaint cases. The division does not have a formal written policy indicating what practitioner materials should be included in all complaint files (e.g., copy of license, copies of closure memorandums forwarded to respondents and complainants).

Investigations Section staff identified at least seven items that generally should be included in all folders: (1) an activity sheet, containing a receipt date of the complaint, a file number, a respondent license number, a profession code number, a complaint number, and the last name of the complainant; (2) a Health Related Boards sheet, with respondent personal data; (3) a board review form; (4) a complainant information sheet; (5) a copy of either a warning or concern letter; (6) a copy of the ADR closure memorandum forwarded to the respondent outlining concerns; and (7) a copy of the Investigations closure memorandum sent to the complainant explaining the panel's concerns about the respondent (if any were raised by the panel). A file review of 14 complaint files revealed that only one had a copy of a respondent closure memorandum letter. According to Investigations Section management, copies of closure memorandums should appear in the complaint file folders. The consultant of the Medical Examiners board has not made it a practice to include resolution results into practitioner folders or to have copies of such documents forwarded to respondents. These results should be included in the folder, especially since the consultant stated that he always verbalized concerns in the actual panel hearings.

In 2002, ten cases were scheduled for hearing in ADR for the Medical board. Of the ten scheduled cases, five were dismissed, three were continued, one license was retired, and one was returned to the Office of General Counsel.

ADR Case Closure Times Do Not Meet Benchmarks

The Alternative Dispute Resolution timeliness benchmark for case closure, with no Office of General Counsel involvement, is 180 days (developed in 2002). A file review of all ADR closed cases in 2001 and 2002 (six for 2001 and eight for January through May 2002) indicated that five cases in 2001 and four cases in 2002 exceeded the benchmark. The average time per ADR/Board of Medical Examiners closure for 2001 was 453 days and, for 2002, was 341 days. For 2001, the actual figure exceeded the benchmark by 273 days or 152%. For 2002, the actual figure exceeded benchmark by 161 days or 89%. See table below.

Average Days to Complete Board of Medical Examiner ADR Cases

Year	Complaint Received to 1st Review	1st Review to Begin Investigation	Begin Investigation to 2nd Review	2nd Review to Complaint Closed	Complaint Received to Closed
2001	47	227	69	109	453
2002	9	173	18	141	341

In 2001, the average time needed to complete the first phase was 47 days or approximately 10% of the total average time to complete the process. This appears to be an excessive number of days to begin the initial review. Completion of phase two required an average of 227 days, also an excessively high average compared to the time needed for phase three completion (investigative time) of only 69 days. For 2002, the distribution of days dropped to 9 days for phase one, 173 days for phase two, 18 days for phase three, and 141 days for phase

four. In other words, processing improvements should be achievable in the first and second phases (in the Bureau of Investigation) and in phase four when the respondent file is closed and forwarded to ADR.

Legislation has provided the Health Related Boards with the authority to expand ADR to other boards on a trial basis. Section 63-1-138, *Tennessee Code Annotated*, effective May 30, 2001, authorizes the boards of Psychology, Osteopathic Examination, Veterinary Medical Examiners, Occupational and Physical Therapy Examiners, and the Tennessee Emergency Medical Services Board to use screening panels in their investigative and disciplinary process. The division should ensure that it has all needed policies in effect before any of these boards begin using ADR.

Recommendation

The Division of Health Related Boards should establish a written policy indicating what licensed practitioner materials (e.g., copy of license, copies of closure memorandums forwarded to respondents and complainants) must be included in all complaint files.

The Division of Health Related Boards and the Bureau of Investigation should identify areas where case processing time can be decreased, and strategies should be implemented to reduce processing delays.

Management's Comment

Division of Health Related Boards

We concur with the finding and the recommendation. The division admits there were problems with documentation in the screening panel process. Additionally, the confidential nature of the screening panels has led to poor documentation of results. Internal practices have been developed to insure better documentation of results. The ADR policy (Policy 201) has been amended to incorporate documentation requirements.

In October 2003, the Boards of Medical Examiners and of Osteopathic Examination and their administrative staffs received training on the ADR processes and procedures from staff in the Secretary of State's Office.

The issue of timeliness in the ADR process is and will continue to be included in the division's continuous quality improvement program. Timeliness is monitored on a monthly basis. The department believes that the benchmark timeframes will be met now that the older cases that were identified as appropriate for ADR have been resolved. Only new complaints will be referred from this time forward.

The division agrees that a policy should be developed to indicate documents that should be contained in all complaint files and has amended the current policy regarding investigative reports (Policy 301) to include this provision.

Director of the Board of Medical Examiners

The Chairman of the Board of Medical Examiners has received a copy of the findings and recommendations of the audit of the Division of Health Related Boards, and the board will discuss the audit at a future board meeting.

Chair of the Board of Osteopathic Examination

I concur. However, our board has not utilized this process, but we will examine the utilization of the Alternative Dispute Resolution (ADR), and concur with your recommendations made pertaining to the Division of Health Related Boards establishing written policies on utilization of ADRs.

4. Access to accurate public information continues to be inconsistent among boards

Finding

Despite positive efforts made by the Health Related Boards Division, problems still exist with the public's ability to access information related to disciplined practitioners. The boards have eliminated the use of informal settlements, the results of which were not open to the public, and in compliance with legislation, have enhanced the division's Internet site that provides the public with information regarding disciplinary actions taken against practitioners. However, an auditor review of this database identified incomplete and inconsistent information. Also, despite efforts to encourage all boards to consistently provide information to members of the public, the manner in which the information is communicated remains inconsistent across boards (as noted in the prior audit). Full public access to information is essential to protecting the health and safety of citizens, and allowing consumers to make informed decisions regarding health-care providers.

Elimination of Informal Settlements

The Health Related Boards division's policies regarding public access to information have improved. The division has made efforts to enhance public access to practitioner disciplinary actions. The boards have stopped issuing informal settlements because of what division management says is the public's lack of access to the information. The division is still issuing letters of concern and warning, and if a settlement is made, agreed orders. While the public has access to information regarding an agreed order, confidentiality provisions in statute preclude any disclosure of information during the investigative process.

Right-to-Know Legislation

The Health Care Consumer Right-to-Know Act of 1998 (Section 63-51, *Tennessee Code Annotated*) was enacted to help health care consumers make informed decisions. License applicants, both new and renewals, must complete a practitioner profile before a license is issued. Individual boards are responsible for collecting background information on applicants, including prior criminal convictions, board disciplinary actions (both in Tennessee and other states), revocation or involuntary restriction of hospital privileges, medical malpractice judgements and awards, education, experience, and participating managed care plans including TennCare. The boards are required to document any disciplinary information on the division's Internet license verification site.

The public's access to reliable disciplinary information is not as problematic for in-state disciplinary actions. The division's discipline coordinator is responsible for entering disciplinary information on the Health Related Boards' Internet licensure verification site. Included on the site are the practitioner profiles that all applicants must complete as a licensure requirement. Division policy 406.01-R001 requires the Health Related Boards' discipline coordinator, upon receipt of a signed order from the Office of General Counsel, to post the following information on the Department of Health Web site:

- (a) profession code,
- (b) file number,
- (c) license number,
- (d) date of action,
- (e) licensee's name,
- (f) action taken, and
- (g) reason for action taken.

The division is also responsible for reporting disciplinary actions to the U.S. Department of Health and Human Services, which maintains the Health Integrity Protection Data Bank and the National Practitioner Data Bank. These information systems document disciplined practitioners in the country who have been involved in fraud and abuse and have paid out malpractice claims. State regulatory agencies, like the Division of Health Related Boards, are required to submit information to the U.S. Department of Health and Human Services. The purpose of the databases is to improve the quality of medical care and to restrict the ability of incompetent doctors to move from state to state without disclosure of prior incompetent performance. While state entities like Health Related Boards have access to this information, the general public does not. Public Citizen, a national nonprofit public interest organization, believes the public should have access to these data systems. Public Citizen believes that "there are no excuses for allowing this data to be viewed by HMOs and the insurance companies but not by the people who must put their lives in the hands of these practitioners."

All practitioner profiles and disciplinary actions are to be maintained on the department's Internet site. By policy, a member of the public can review the information on the Internet or come into the division offices and review files. While division and individual board compliance rates for submission of practitioner profiles is high, the information contained in the profiles is not necessarily verifiable because background checks are not always conducted and in addition, based on auditor review, the information is not always comprehensive or consistent. According to division management, the information contained in the practitioner profiles is supplied by the practitioner, and cannot be changed by the division.

Incomplete and/or Inconsistent Web Site Information

When a citizen calls a board office for information regarding a disciplined practitioner, by policy, staff inform the caller that there has been a disciplinary action. The caller is referred to the Health Related Boards' Internet site for more detailed information. By informal policy, however, staff may decide to help someone by looking on the Web site if the caller does not have access to the Internet. Based on anonymous phone calls to boards for information, the ability to obtain accurate information is inconsistent. In several instances, staff refused to provide information when informed the caller did not have Internet access. This policy and practice may effectively prevent citizens from obtaining information, especially the elderly who may not have access to the Web site.

Auditors anonymously contacted four boards included in the scope of this audit—Dispensing Opticians; Electrolysis; Medical Examiners; and Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists—to determine how boards respond to public requests for information. Auditors requested information about four practitioners, and all four had received some form of disciplinary action as identified in the practitioner file reviews (see finding 1). The information provided and the level of cooperation provided by staff varied among boards.

Staff from three of the four boards provided auditors with practitioner licensure information, but only two of those three boards were cooperative in providing information regarding disciplinary action. Staff from the Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists told the caller that the practitioner had received disciplinary action in the form of an agreed order of one year's probation. The caller was told it was necessary to go to the division's Web site for more detailed information, including the offense charge. Staff refused to look up the information on a follow-up request and did not offer the caller the Web address. Medical board staff would not even provide acknowledgement that a complaint was filed and told the caller to go to the Web site for any information, again even upon a follow-up request. Dispensing Optician staff was cooperative, informing the caller that the license was inactive and that the practitioner had received a letter of warning, but offered no details of the complaint. The one board that did not provide any information, Electrolysis Examiners, referred auditors to the division's Investigation section instead. Electrolysis Examiners staff told auditors that the boards do not provide information regarding disciplinary actions. Upon calling Investigations' staff, auditors were informed that the division's policy is for boards to provide this information. Auditors made a second phone

call to the Electrolysis board with the same results; staff again informed the caller that the boards do not provide information regarding disciplinary action. Staff made no mention of accessing the division's Web site for further information.

Auditors accessed the Health Related Boards' license verification section on the Department of Health's Web site to compare information contained on the site with what was contained in the complaint/investigation files. The site contains data profiles for all licensed practitioners as discussed above. Auditors were able to find profiles for all four practitioners. The Web site provided more information than provided by staff, and while the information was more detailed, there were several discrepancies noted. For the Licensed Practitioner and Marital and Family Therapist case, for example, the profile section and the disciplinary action section each listed a different disciplinary action, one in 1996 and one in 2001. However, neither action was listed in the other section. For the Medical Examiners case, the disciplinary action section listed three actions, none of which were found in the practitioner profile section.

Public Citizen Reports Improvement in Access

An April 2002 report issued by Public Citizen indicates that the Division of Health Related Boards' efforts to enhance access have improved since 1999, at which time the organization's Health Research Group gave the division's Web site only a passing grade on its providing medical board information to the public. The study was conducted to assess states' Internet sites, focusing on their content and user-friendliness scores. In addition, Public Citizen determined whether other information was present, including the date of a disciplinary action and the address, telephone number, license number, license issue date, license expiration date, specialty of the physician, and whether 10 years of data was present. Tennessee's grade on content improved from a C in the 1999 study to a B in 2002. In addition, Tennessee was one of 20 states receiving a grade of A for user-friendliness. However, it was noted that "neither the content score nor the user-friendliness score was associated with the state's disciplinary rate."

A report released by Public Citizen in 2000, *The Survey of Doctor Disciplinary Information on State Medical Board Web Sites*, surveyed state boards in the United States (50 states and the District of Columbia) that regulate medical doctors to determine the current state of Internet-accessible disciplinary information. The survey sought to answer the following questions: What types of information are available on the Internet? In what format is the information presented? How complete and current is the information? How does it compare to the disciplinary information a consumer can get by calling the board? Before contacting the boards/states, their Web sites were reviewed directly and assessed.

The report stated that in general, Internet use by regulating boards is on the rise. Boards receiving fewer time-consuming phone and mail queries from patients might be able to devote more time and resources to enforcement duties. However, many boards "have not assumed an active role in disseminating adequate information about these disciplinary actions to the patients, preferring all-too-often to shield physicians from adverse publicity. For years, patients have had to call or write the boards to learn whether their physician has been disciplined and, if so, why, how, and when."

The survey found that all 41 boards that provide disciplinary information on the Internet also furnish hard copies of board orders to the public upon request. The survey used a grading scale to assess the content of disciplinary information each Web site provides. Furthermore, the survey established five criteria that comprise an “adequate amount of information.” This includes:

- (1) the doctor’s name,
- (2) the disciplinary action taken by the board,
- (3) the offense committed by the doctor,
- (4) a concise summary narrative of the physician’s misconduct, and
- (5) the full text of the actual board order.

Specifically, Public Citizen made the following recommendations:

- 1) Each board should have a Web site that links to a database of physician information. For each physician disciplined, the information should include the action taken by the board, the offense committed, and a summary narrative of the misconduct. The database should also feature links to the full text of board orders and other public documents related to the action.
- 2) Information should be provided for all disciplinary action taken in the last 10 years.
- 3) Public access to disciplinary data should be preserved even when a physician’s license is suspended, revoked, or expired.
- 4) Patients should be able to retrieve data by entering a physician’s name and/or license number in a search engine.
- 5) Disciplinary action information should be updated as frequently as the boards meet to consider actions (usually once a month).
- 6) Information should be removed from the database when a court overrules or vacates a board action, and such change should be made within two weeks of the ruling.

Summary

Through its Internet site and policy changes, the division has made improvements in providing the public with more comprehensive information. However, the information provided on the division’s database is not always comprehensive and consistent. Also, the individual boards’ actions in communicating this information, even when it’s comprehensive, remain a problem that needs immediate action. In no instance should members of the public be denied access to information that can be essential to their health, welfare, and safety.

Recommendation

The division should continue to improve its efforts to enhance public access to information. Efforts should be made to maximize the consistency and accuracy of information included on practitioner databases and the Internet site.

The division should improve its efforts to communicate to staff its policy regarding public access to disciplinary information. Management should ensure that all citizens have full and complete access to disciplinary information, including those who may not have Internet access.

Management's Comment

Division of Health Related Boards

We concur with the finding and the recommendation. The division has made progress in providing full and accurate information to the public. The division maintains two distinct databases for public information: the department licensure verification website and the practitioner profile. The department's website contains information on all licensed practitioners. There is a notation whether any disciplinary history exists for the licensee and a link to that information. The information will include any formal disciplinary action resulting from a complaint.

In November 2002, the department instituted a process to cross check reports of malpractice payments by insurance companies with the practitioner profile information and to insure practitioners updated information as required by law.

The department's website provides all the information suggested by the Public Citizen report. Actual copies of orders, entered on or after July 1, 2002, were added to the site in July 2003. Orders entered prior to July 1, 2002 can be obtained from the Secretary of State's office and the public is given the address for that office. In addition, a listing of disciplinary actions taken by month was added to the website January 1, 2003.

The division has scheduled training with all staff on the policy to address the problem identified with obtaining information via the telephone. The behaviors identified in the audit report are unacceptable and will be addressed. Compliance with the policy will be monitored by using the same method of anonymous calling as used by the auditors. An initial survey has already been conducted.

Chair of the Board of Dispensing Opticians

I concur with the response of the Division of Health Related Boards.

Chair of the Board of Electrolysis Examiners

I concur.

Director of the Board of Medical Examiners

The Chairman of the Board of Medical Examiners has received a copy of the findings and recommendations of the audit of the Division of Health Related Boards, and the board will discuss the audit at a future board meeting.

Chair of the Board of Osteopathic Examination

I concur.

President of the Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists

I have read and concur with the division's responses.

5. No background checks conducted for licensure applicants

Finding

The Division of Health Related Boards does not check for a criminal background before granting licenses to practitioners. Statute does not specifically require or authorize criminal background checks for health related board applicants. The current practice is to require practitioners to report any arrest and conviction information voluntarily on the license application. Failure to conduct background checks limits the division's ability to identify applicants with prior disciplinary problems and limits its ability to safeguard the citizens of the state from problem practitioners.

Individual boards do not check license applicants' names with either national crime databases (NCIC) or state databases like the Tennessee Bureau of Investigation (TBI). The division does not have access to the NCIC database. Although the division provides information to two national professional databases it does not have access to verify applicant information. HRB does not run names against the TBI database because, according to management, there is no statutory requirement that this be done.

According to management, the only means of determining if an applicant has had a prior disciplinary problem or conviction in another state is the information provided in the practitioner profile completed as part of the application process. The boards rely solely on the information in the practitioner profile to identify prior problems. Thus, the only means of discovering a problem is if the applicant provides that information.

According to management of the Medical Examiners Board, the boards have not discussed the issue of whether to conduct criminal record checks for applicants. However, management believes that such a policy would be a good idea and that members of the board would support criminal history checks. Given statutory support, management believes that

boards should require criminal history checks due to the growing number of out-of-state applicants. There is also a high potential for abuse of citizens who may be in a vulnerable state due to illness, including children and the elderly. In addition, board management suggests that international criminal history background checks would also be of great interest given the number of applicants and licensees from other countries.

Management of the Nursing Board believes that the process of background checks would take too long—up to six months—and that the information available from the TBI would cover only offenses within the State of Tennessee.

Health Related Boards division management stated that an arrangement could be worked out with TBI but that TBI probably does not have time to check the large number of new and renewal applications that come before the division and boards annually. Management believes that the TBI or national databank checks would probably be more essential and important for new applicants, primarily those who move in from another state.

In the interest of public health and safety, it seems prudent to promote the quality assurance of the health-related professions by obtaining the most complete background information possible.

Feasibility

Auditors asked the TBI about the feasibility of having background checks performed for selected boards' licensees. According to TBI's fiscal director, TBI currently has the capability through the Automated Fingerprint Identification System (AFIS) to quickly process criminal histories for certain licensed professions. According to management of TBI's Information Systems, they no longer use the Tennessee Crime Information System (TCIS).

According to TBI management, TBI could use the National Instant Check System (NICS) as well as the National Crime Information Center (NCIC). The NICS database, used for background checks in retail gun sales, checks criminal background by the individual's name and processes in seconds.

Because processing paper fingerprint cards through the AFIS system might take as long as six weeks, TBI installed a new TAPS fingerprinting system. The new system uses electronic fingerprint scanners that are set up in every county with a population greater than 100,000. The applicant(s), or group of applicants, can call an 800 number to set up appointments for their fingerprints to be scanned. Their personal identification will be checked at the site, and the system submits fingerprints electronically to AFIS. Processing takes three days and costs only \$8.00 more than a paper submission (approximately \$56.00 instead of \$48.00).

TBI performs more than 65,000 criminal background checks each year. This includes criminal histories on daycare workers, eldercare workers, teachers, school bus drivers, and others as required by statute. With their upgraded system, TBI management believes that, for example, processing the criminal histories of 100,000 licensed nurse practitioners in a timely manner is

currently feasible. In 2002, the Medical Examiners board processed 3,202 new license applications, and the Nursing board processed 5,355 registered nurse applications.

Precedent in Statute

Current Tennessee statute allows criminal history background checks for the following job classifications, professions, or licenses:

- county and municipal employees (*Tennessee Code Annotated* 5-1-126 and 6-54-129);
- operators and employees of Child Care Agencies (*Tennessee Code Annotated* 37-5-502[g] and [i] and *Tennessee Code Annotated* 71-3-507[2][A]);
- employees and volunteers for Child Care Centers (*Tennessee Code Annotated* 68-11-234);
- operators, employees, and volunteers of home health care and hospice organizations (*Tennessee Code Annotated* 68-11-233);
- owners and directors of postsecondary educational institutions (*Tennessee Code Annotated* 49-7-2005); and
- private investigators (*Tennessee Code Annotated* 62-26-208[a][3]).

An Internet search identified other states, including contiguous states, which have similar statutes in place:

- Mississippi requires criminal background checks on principals, teachers (*Mississippi Code* 37-9-17), and child care and child placement agencies (*Mississippi Code* 43-15-6).
- *Arkansas Code* 17-87-3 and *Kentucky Statutes* 314.103 require criminal background checks for nursing licenses.
- Illinois, New Mexico, and Wyoming also have statutes requiring criminal history checks for licensing nurses.
- *Florida Statute* Title 32, Chapter 456.039(4), requires applicants for a physician's license to submit fingerprints to the Florida Department of Health for the Florida Department of Law Enforcement to perform criminal history checks.

Based on Internet research, 18 states have statutes that require criminal background checks for physicians, and seven of those states require fingerprint checks. Eleven of the states that require criminal background checks for nurses also require fingerprint checks. In addition, the Federation of State Medical Boards recommends that all state boards conduct criminal record checks as a part of the initial licensure application process.

Approximate Cost

TBI fiscal management estimates the cost to process a criminal history check at \$48, or \$56 for electronic submissions. About half of the cost of this processing charge goes to the federal government. The Division of Health Related Boards could pass on the remaining half of the cost to the licensee. The estimated fee seems economically reasonable for the medical and nursing professions when compared to the average income for daycare workers. The current license application fee for medical doctors is \$400; a \$24 increase in fee (one-half of the \$48 criminal history check) would represent a 5.7 percent increase. In 2002, there were 3,202 license applications processed by the Medical Examiners board. The current examination and endorsement fees for registered nurses are \$195; a \$24 increase in fees would represent an 11 percent increase. In 2002, the Nursing board processed 5,355 license applications.

These costs would probably be a one-time fee beginning with new and out-of-state licensees. TBI fiscal management added that the system's data retrieval capability may have program options that would filter out minor offenses and focus the background search on specific types of records, such as drug-related offenses as opposed to traffic tickets.

The primary responsibility of the Health Related Boards is protecting the health and safety of the public by regulating new applicants and existing licensees. Criminal history checks have become technologically and economically feasible. The Federation of State Medical Boards has adopted criminal record checks for licensees as part of its policy and has encouraged adoption of this policy in all states. This policy is operational in other states and should be in Tennessee as well.

Recommendation

We recommend that the division develop and implement a policy to require the boards to conduct criminal background checks for their new applicants. The one-time fee should be incorporated into the license fee and passed along to the licensee. If necessary, the General Assembly may wish to consider legislation that would require the boards to conduct criminal background checks.

Management's Comment

Division of Health Related Boards

We concur with the finding and the recommendation. The division is of the opinion that legislation to require criminal background checks is needed to allow access to appropriate data systems and to authorize the use of the Automated Fingerprint Identification System (AFIS) so

that TBI may quickly process criminal histories for licensed professionals. After discussions with the TBI, the division believes this system would provide the most complete background information available and would allow the information to be processed electronically and thus, not overly increase the time needed to obtain a license. Cost of this background check is not prohibitive and could be added to the initial licensure fee.

Chair of the Board of Dispensing Opticians

I concur with the response of the Division of Health Related Boards.

Chair of the Board of Electrolysis Examiners

I concur.

Director of the Board of Medical Examiners

The Chairman of the Board of Medical Examiners has received a copy of the findings and recommendations of the audit of the Division of Health Related Boards, and the board will discuss the audit at a future board meeting.

Chair of the Board of Osteopathic Examination

I concur. Our board will explore the feasibility of requiring criminal background history checks for licensure applicants.

President of the Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists

I have read and concur with the division's responses.

6. Several boards have not met self-sufficiency requirements

Finding

Current-year revenues generated from the license fees collected by a number of the health-related boards have not covered current year operating costs incurred in regulating the related professions and their practitioners for more than two consecutive fiscal years. Some boards experiencing annual deficits have had cumulative surpluses from prior years that are used to cover the annual deficits. While this may allow the boards to remain self-sufficient, the boards may still be in violation of statute by running consecutive year deficits. Several boards have raised license fees to address these deficits.

Section 4-29-121, *Tennessee Code Annotated*, requires that all regulatory boards be self-supporting; each board's current-year operating expenses should not exceed the current-year

revenues for more than two consecutive fiscal years. Four of the six boards included in the scope of this audit have operated at a deficit for the last two or more consecutive fiscal years. These are the Board of Alcohol and Drug Abuse Counselors, the Board of Electrolysis Examiners, the Board of Medical Examiners, and the Board of Osteopathic Examination, and also the Athletic Trainers Committee within the Medical Examiners board. While the Board of Alcohol and Drug Abuse Counselors had annual deficits for 2001 and 2002, cumulative carryover balances from the prior years were sufficient to compensate for the deficits, and the net result was a cumulative surplus for both years. The Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists was insufficient for Fiscal Years 1999, 2000, and 2001 but had a positive balance in 2002. The Medical Examiners and the Osteopathic Examiners boards have had a negative ending balance for all four years. The Dispensing Opticians board has been self-sufficient all four years. The table below documents the deficit amounts for these boards for fiscal years ended June 30, 2001, 2000, and 1999.

Current Net Income at Fiscal Year End

Board	2002	2001	2000	1999
Alcohol & Drug Abuse Counselors	\$(42,966)	\$(34,787)	\$52,054	\$14,574
Electrolysis Examiners	(6585)	(6,533)	(8,724)	1,881
Medical Examiners	(208,520)	(185,309)	(347,441)	(390,832)
Osteopathic Examiners	(3,008)	(4,195)	(3,226)	86
Professional Counselors, Marital and Family Therapists, & Clinical Pastoral Therapists	(2,541)	(31,346)	(4,510)	(23,743)

Source: Division of Health Related Boards Fiscal Director

As a whole, the combined year-end balance for all boards for fiscal year 2002 was \$329,214. This represented an improvement over the prior two years, both of which ended with negative balances. As a whole, the combined deficit of all health-related boards was \$626,041 for fiscal year ended June 30, 2001, and \$323,050 for fiscal year ended June 30, 2000. See Appendix 2 for net income for all boards.

Based on their Revenue and Expense Reports, this was the third consecutive year that the Board of Medical Examiners had a deficit of more than \$100,000, and the second consecutive year for the Board of Dentistry. Ending fiscal year 2001, both the Board for Medical Laboratories and the Board of Nursing each had deficits of more than \$100,000. However, both of these boards have become self-sufficient as of fiscal year 2002. The Board of Nursing and the Medical Laboratory boards made the biggest gains over the last two fiscal years. The Board of Nursing improved from a deficit of \$275,636 in fiscal year 2001 to a positive balance of \$508,960 in fiscal year 2002, an increase of \$775,596. The Medical Laboratory board improved from a deficit of \$165,757 in fiscal year 2001 to a positive balance of \$128,942 in fiscal year 2002, an increase of \$294,699.

In addition to the boards, two of the three committees that have been in operation three years or less were not self-supporting for the past two years—the committees for Acupuncture and Clinical Perfusion. According to bureau fiscal management, however, new boards or committees begin incurring expenses long before they begin taking in revenue. It takes the board administrator, management, and OGC time to get a new board up and running before the first license can be issued and the first dollar of revenue collected. According to fiscal management, both Acupuncture and Clinical Perfusion are expected to close with an annual as well as a cumulative surplus balance in FY 2003.

It is the practice of the Department of Finance and Administration (F&A) to cover the deficits of some boards with the surpluses from other boards. While the boards as a whole had deficits the prior two fiscal years, the division's surpluses from prior years covered these deficits. Thus, in effect, boards with surpluses are subsidizing those boards with deficits. The Bureau of Health Licensure and Regulation's Fiscal division provides each health related board and committee two financial projection reports and one close-out financial status report annually. The boards use these reports to determine if changes in licensure fees are necessary. In addition, Fiscal staff will meet with board management periodically to discuss such financial issues.

Overall, 16 boards and committees have either had license fees increases approved or have had rules sent to the state Attorney General's (AG) office for approval since February 2001. For the boards included in this audit's scope, the boards for Alcohol and Drug Abuse Counselors (effective 11/02/02); Medical Examiners (10/31/02); Osteopathic Examination (12/01/02); and Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists (10/30/02) have had license fees increases. The Electrolysis Examiners board has had rules sent to the AG's office and is awaiting fee increase approval.

According to Section 4-29-121(b), *Tennessee Code Annotated*, the Commissioner of the Department of Finance and Administration should have notified a joint evaluation committee of government operations and the code commission of each board and entity that was not self-sufficient. For fiscal year 2002, this would have included the following boards and committees: Acupuncture, Alcohol and Drug Abuse Counselors, Athletic Trainers, Chiropractic Examiners, Clinical Perfusion, Communication Disorders and Sciences, Dentistry, Electrolysis, Hearing Instrument Specialists, Medical Examiners, Optometry, Osteopathic Examination, Physician Assistants, Podiatry, Psychology, Social Workers, and Veterinary.

In addition, Section 4-29-121(b), *Tennessee Code Annotated*, requires that the joint evaluation committee review all boards and entities that are not self-sufficient for two consecutive fiscal years. These entities may be subject to a revised termination date of June 30 of the fiscal year immediately following the second consecutive year during which such board or commission operated at a deficit. These evaluations were not performed. For fiscal year 2002, the following boards and entities met this criteria and should have been reviewed: Acupuncture, Alcohol and Drug Abuse, Athletic Trainers (not self-sufficient for the last three years), Clinical Perfusion (three years), Communication Disorders and Sciences, Dentistry, Electrolysis (three years), Hearing Instrument Specialists (four years), Medical Examiners (four years), Osteopathic Examination (four years), Podiatry (four years), Psychology, Social Workers (four years), and Veterinary (four years).

According to management of the bureau's fiscal division, these same committees review rule changes, and the majority of the boards cited here have had rule changes concerning fees in progress. Thus, fiscal management believes that the evaluation committees should have been aware of their efforts to comply with self-sufficiency requirements. In addition, the committees would have been aware of the Acupuncture and Clinical Perfusion committees' situation as they had recently reviewed rules as the committees were established.

Section 4-3-1011, *Tennessee Code Annotated*, requires the Department of Finance and Administration (F&A) to certify to the Division of Health Related Boards each year the amount of fees required by each board for the subsequent fiscal year. This amount should be based on the general appropriations act for that year. Within 60 days after the certification, the division should provide F&A with an estimate of fees for each individual board. Section 4-3-1011(c)(2), *Tennessee Code Annotated*, directs F&A to reduce the budget of any board whose estimate of fees was determined to be less than the certified amount by the amount of the deficiency. None of the budgets for the boards that failed to meet self-sufficiency requirements were reduced.

Under Section 4-3-1011(c)(3), *Tennessee Code Annotated*, the General Assembly may supplement any board's appropriation from fees with an appropriation from tax revenue by making specific appropriations in the general appropriations acts.

Recommendation

The division should continue to periodically analyze each board's financial condition and either increase or decrease fees accordingly so that the boards meet the requirements for self-sufficiency.

The General Assembly may wish to consider evaluating the boards that have not proven to be self-supporting. Under Section 4-29-121(b), *Tennessee Code Annotated*, the General Assembly may wish to consider the option to move the termination dates of the boards that are not self-sufficient to the following June 30th.

The Commissioner of the Department of Finance and Administration should reduce the budget of the boards that have not proven to be self-supporting in compliance with Section 4-3-1011(c)(2), *Tennessee Code Annotated*.

Management's Comment

Division of Health Related Boards

We concur with the finding and concur, in part, with the recommendation. The division will continue to meet with boards to discuss their fiscal condition and to provide financial reports three (3) times a year. The latest financial report is given to the board and discussed at each board meeting. The Boards are kept apprised of any costs that may be charged against the board,

for example, the cost of the RBS upgrade has been discussed with each board as a cost that is coming at some point in the near future. The Bureau administrative staff is always available to discuss the details of the report either at the meeting or individually.

Regarding review by the General Assembly, the rulemaking process requires rules be brought before the joint evaluation committee for review. Rules regarding fees have been brought regularly before this committee. Additionally, the Committees of Acupuncture and of Clinical Perfusion have been before the joint evaluation committee for start up review. The fiscal condition of those boards has been discussed during those hearings.

We concur, in part, with the recommendation. The department does not concur that any board budget should be reduced. Each board remains responsible for any deficit incurred. Reducing their budget does not eliminate or diminish that responsibility.

Chair of the Board of Alcohol and Drug Abuse Counselors

The Board of Alcohol and Drug Abuse Counselors will work with the Division of Health Related Boards to establish best practices to assure that the Board of Alcohol and Drug Abuse Counselors ascertain and maintain self-sufficiency.

Chair of the Board of Dispensing Opticians

I concur with the response of the Division of Health Related Boards.

Chair of the Board of Electrolysis Examiners

I concur.

Director of the Board of Medical Examiners

The Chairman of the Board of Medical Examiners has received a copy of the findings and recommendations of the audit of the Division of Health Related Boards, and the board will discuss the audit at a future board meeting.

Chair of the Board of Osteopathic Examination

I concur. Our board should work with the Division of Health Related Boards to determine the best way to become self-sufficient. Recent efforts to include licensure fee increases have been implemented within the last year and have had positive impact towards reaching self-sufficiency.

President of the Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists

I have read and concur with the division's responses.

We concur.

7. Boards have not used their authority to assess disciplinary costs to practitioners

Finding

None of the 15 boards and committees who have had statutory authority to assess investigative and/or legal disciplinary costs to practitioners have used this authority. In the past, the obstacles to this practice have been the inability of the department's Office of General Counsel (OGC) to accurately document a per-case rate to charge and the question concerning whether OGC legal fees may be assessed. As a result, boards, some of which have experienced financial difficulties, have not taken advantage of a reliable revenue source for cases that can be very expensive. Also, assessing costs may be an effective deterrent to problem practitioners. In 2003, legislation was passed granting all boards the authority to assess both investigation and legal costs to practitioners.

Prior to 2003, among the boards and committees included in this audit, only the Board of Medical Examiners, the Board of Osteopathic Examination, and the Committee on Physician Assistants had the statutory authority to assess the legal and investigative costs directly related to a disciplinary action against the disciplined practitioner.

While many boards possessed the authority to assess disciplinary costs prior to 2003, the practice was not being used because questions regarding the types of fees to assess and how OGC would bill for its hours had yet to be settled.

The primary obstacle to assessing disciplinary costs has been the inability of OGC to provide accurate data on attorney fees by case. Currently, investigative costs can be broken down by board and by individual case. However, OGC can break down costs by board but not by case.

OGC management agrees with the assessment that it currently lacks a method to track and document attorney hourly costs per case. OGC tracks on an hourly basis for each board but does not track billable hours on a case-by-case basis. OGC management believes that OGC can and should be able to track on a per-case basis.

The issue of disciplinary costs was a finding in the prior audit released in 1999. At that time, division management believed the authority would not be used until the question of who would receive the recouped costs was resolved—whether the collected monies would go to the division or to the state's general fund. From the 1999 audit, the department's management's comment agreed that "all boards should have the authority to recoup disciplinary costs from disciplined practitioners. The department will defer to the will of the General Assembly on legislation that would assess the investigation and prosecution expenses to the respondent."

Recommendation

The Division of Health Related Boards should work with OGC in assessing both investigative and legal costs. Also, the division should work with OGC to establish policy and guidelines for billing legal fee hours to individual cases. In the meantime, boards should assess investigative costs, which can be identified to individual cases.

Management's Comment

Division of Health Related Boards

We concur in part with the finding and with the recommendation. The Board of Medical Examiners has assessed costs on a limited basis. Costs were assessed as follows: 2001- 2 cases; 2002 - 9 cases; 2003 to date - 26 cases.

Public Chapter 102 of the Public Acts 2003 was enacted to allow all boards to assess disciplinary costs and specifically included costs of the Office of General Counsel. This legislation has been discussed with all boards and all boards have agreed to begin assessing costs. Costs are being requested in all cases brought before the boards. A policy is being drafted to set out the process used to calculate those costs that can be identified.

Currently, the Department is interviewing information systems' specialists for a contract to develop a system to capture prosecution costs. It is anticipated that a system will be in place within the next fiscal year.

Chair of the Board of Dispensing Opticians

I concur with the response of the Division of Health Related Boards.

Chair of the Board of Electrolysis Examiners

I concur.

Director of the Board of Medical Examiners

The Chairman of the Board of Medical Examiners has received a copy of the findings and recommendations of the audit of the Division of Health Related Boards, and the board will discuss the audit at a future board meeting.

Chair of the Board of Osteopathic Examination

I concur in part. Our board should take advantage of its authority to assess investigational costs which can be identified to individual cases.

President of the Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists

I have read and concur with the division's responses.

8. No internal audit function for the boards

Finding

No internal audits have been conducted for the Division of Health Related Boards, or for individual boards since 1998. The division does not have an in-house internal audit section that could perform these audits. Internal audits could be beneficial to the boards by addressing areas of efficiency and effectiveness, identifying potential areas of fraud and abuse, and assessing the complaint investigation process.

Prior to 1999, the division's internal audit function was limited and sporadic at best. The division did not have staff that was specifically responsible for internal audits. Rather, the division's Investigations section performed this function conducting approximately three audits per year of individual boards. Since 1999, however, the division has had no internal audit function, and no audits of individual boards have been conducted.

The absence of any internal audit function for the division is apparently the result of an attempt in 1999 to consolidate the Departments of Health and Mental Health and Mental Retardation (renamed Mental Health and Developmental Disabilities as of July 2000) into one department. While that effort never materialized, one result was consolidating the internal audit functions of four health areas (Health, Mental Health, Mental Retardation, and TennCare) into the Office of Health Services, which reports directly to the Commissioner of the Department of Finance and Administration. The move to have all internal audit functions under the guidance of F&A was made effective July 1, 1999.

The Office of Health of Services has not conducted an audit of a health-related board since the reorganization, nor does it have one scheduled for future audit plans. Office of Health Services management believes a Health Related Boards internal audit should be conducted sometime in the near future. Also, since the consolidation, the Division of Health Related Boards has not notified the Office of Health Services of any significant issues, nor has it requested an internal audit be conducted on any of its boards.

According to Office of Health Services management, staff size has limited its ability to conduct internal audits of the health-related boards. The office currently has a staff of 30 auditors, 4 short of being fully staffed. Per office management, it has not been allowed to hire and fill those four positions. According to Health Related Boards personnel management, no investigative positions were lost as a result of the consolidation. Division management states that while the personnel in those positions physically moved under the Office of Health Services, all positions remained under the division's budget codes and technically still performed work for

the boards. By the beginning of 2000, the investigation responsibility and corresponding positions have been returned to the Investigations section. However, the auditing function remained with the Office of Health Services.

While neither statute nor division policy requires internal audits to be conducted, these audits are important to protect the integrity of the division and its boards. An effective internal audit process is essential to ensure that an entity's management controls are functioning properly and to help management identify potential areas of concern.

Recommendation

The division should work with the Office of Health Services to see that periodic internal audits of selected boards are conducted. Division management should notify the Office of Health Services whenever they identify any issues that might require audit inquiry.

Management's Comment

Division of Health Related Boards

We concur with the finding and the recommendation. The division will begin to work with the Office of Health Services and identify selected boards for audit. While the division has not had an internal audit, a continuous quality improvement (CQI) program has been utilized to measure the performance of the division in meeting the needs and expectations of licensees and citizens. This program has established performance measures to monitor application process, rule process, and the ADR process. In using this system, the division has been able to identify areas where improvement is needed, and make changes to the process to improve customer service.

Chair of the Board of Dispensing Opticians

I concur with the response of the Division of Health Related Boards.

Chair of the Board of Electrolysis Examiners

I concur.

Director of the Board of Medical Examiners

The Chairman of the Board of Medical Examiners has received a copy of the findings and recommendations of the audit of the Division of Health Related Boards, and the board will discuss the audit at a future board meeting.

Chair of the Board of Osteopathic Examination

I concur.

President of the Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists

I have read and concur with the division's responses.

9. Weaknesses in the board nominating process

Finding

Because of weaknesses in the nomination process for board membership, board staff is often unable to determine whether board composition meets statutory requirements. Neither board staff nor Division of Health Related Boards management knows whether some boards include a senior member. Also, based on a review of the current composition of boards, many boards do not have a minority member as suggested by statute.

By statute, all health-related boards are required to appoint a public member. In addition, the law states that the Governor should strive to ensure the boards have at least one senior and one minority member. Some boards have more than one public member. The Medical Examiners board, for example, has three.

Auditors reviewed the current composition of the six boards and committees included in this audit, and also of the 27 boards and committees as a whole. The review included identifying those boards and committees that have vacancies and/or fail to have the required citizen, minority, and senior members.

Based on the review, none of the boards selected for this audit currently have any vacancies. The Board of Osteopathic Examination, the Committee for Clinical Perfusionists, the Acupuncture Advisory Committee, and the Committee for Physician Assistants do not have minority members. The Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists does not have a senior member. For three newly formed committees—the Council for Certified Professional Midwifery, Clinical Perfusionists, and Acupuncture—board management could not say whether any board members meet the senior qualifications because they do not ask board members their age and also because the responsibility for board nominations resides with the Governor's office.

Per our review of 27 boards and committees as a whole, vacancies existed for 2 of the 27 boards and committees (7.4 percent). Citizen members were needed on only one board—Social Workers. Minority members, however, were needed for 11 of the 27 boards (40.7 percent). Noncompliance for senior members was 4 of 27 (14.8 percent), and for another 4 boards (14.8 percent), the status was unknown.

Seniors may not be chosen to serve on boards because the division does not note potential nominees' ages when it submits lists to the Governor. The Health Related Boards' liaison, who notifies the nominating associations of upcoming vacancies, maintains member rosters for all boards. The rosters are used to track member names, addresses, dates appointed, expiration dates, and whether the member fills the citizen or practitioner qualification. The board liaison also maintains a separate file that indicates whether the boards' members included a female, minority, or senior member.

As the expiration of a board member's term approaches, the liaison sends a memo to the nominating association requesting nominations and biographical information. Although the form letter requests that the board include minorities and women among its nominees, the form does not mention seniors.

Auditors contacted seven representatives from professional organizations responsible for submitting nominations for board membership. All seven organizations have made recommendations for nominees to their licensing boards. All seven representatives agreed that they had been notified of upcoming vacancies by the division. However, one respondent stated that they had been notified late. Three of the seven respondents did not believe that vacancies are filled in a timely manner.

In addition to notifying the nominating associations, the board liaison also notifies the Secretary of State's office, which enters the information for publication in the *Open Appointments Annual Report* and the *Monthly Vacancy Reports*. These can be accessed on the Secretary of State Web site along with the Notice of Vacancy or Notice of Appointment forms. Because neither the Notice of Vacancy nor the Notice of Appointment form includes a board member's age, the senior member status cannot be included in the report or on the Web site.

A space for age or date of birth could be added to the Notice of Vacancy and Notice of Appointment forms as published on the Secretary of State's Web site and elsewhere. In addition, the Notice of Vacancy does not include questions about race, sex, or age. Because the answers to these questions can aid the Governor in including persons who represent these attributes, these questions need to be asked.

After the appointment, the new member attends a Division of Health Related Boards orientation meeting. At the meeting, the board liaison notes the date of birth on the person's identification to verify the senior member qualification. However, this is done after the appointment, when it is been confirmed and it's too late to ensure the appointee is a senior member.

Based on the audit review, it appears that board vacancies are being filled. The success of the division's and administration's efforts to meet statutory requirements with regard to age and race when filling board seats, however, may be limited due to the lack of readily available qualifying information.

Recommendation

The Division of Health Related Boards should take actions to ensure that statutory requirements regarding race, age, and public membership are met when board vacancies arise. These can include providing nominating associations with relevant information regarding qualification for any open seats. In addition, the boards should require that the nominating associations include information regarding a nominee's race, sex, and age.

The division should compile and maintain a complete contact list of nominating associations, whether authorized by *Tennessee Code Annotated* or used in practice, for all of the boards.

Management's Comment

Division of Health Related Boards

We concur with the finding and with the recommendation to the extent compliance is within the division's control. The division works closely with the Governor's office to insure that statutory requirements regarding race, age and public membership are met. Equal geographic representation is also sought.

Many of the weaknesses in the process are outside the control of the division. The division must rely upon the various professional associations to submit properly qualified licensees for appointment and to submit those nominations in a timely manner. Nominations are also accepted from other sources.

The division has developed a list of associations and has revised the format of the letter sent to the associations requesting nominations to include the make up of the board so that the nominations may include properly qualified nominees that will satisfy the statutory requirements for board membership.

Chair of the Board of Dispensing Opticians

I concur with the response of the Division of Health Related Boards.

Chair of the Board of Electrolysis Examiners

I concur.

Director of the Board of Medical Examiners

The Chairman of the Board of Medical Examiners has received a copy of the findings and recommendations of the audit of the Division of Health Related Boards, and the board will discuss the audit at a future board meeting.

Chair of the Board of Osteopathic Examination

I concur in part. Nominations for our boards have always been made in a timely manner. When requests for nominations are made, however, there is no guidance given for specific parameters to be met, e.g., need for nominees to be either a senior member or minority member. Suggest such guidance be forthcoming and to include definition of such requirements. Further suggest the selection process be completed prior to the time of vacancy on the board.

President of the Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists

I have read and concur with the division's responses.

RECOMMENDATIONS

LEGISLATIVE

This performance audit identified the following areas in which the General Assembly may wish to consider statutory changes to improve the efficiency and effectiveness of the Department of Health's and the boards' operations.

1. The General Assembly may wish to consider legislation that would require the boards to conduct criminal background checks for license applicants.
2. The General Assembly may wish to consider evaluating the boards that have not proven to be self-supporting. Under Section 4-29-121(b), *Tennessee Code Annotated*, the General Assembly may wish to consider the option to move the termination dates of the boards that are not self-sufficient to the following June 30th.

ADMINISTRATIVE

The following areas should be addressed to improve the efficiency and effectiveness of the Department of Health's and the boards' operations.

1. The department, the Division of Health Related Boards, and individual boards should continue efforts to improve the timeliness of complaint resolution processing. They should improve the monitoring of each stage of the complaint process. In resolving complaints, boards should use disciplinary guidelines to ensure that practitioners who are problematic and may endanger the public welfare are adequately disciplined and prohibited from practicing when necessary.
2. All boards should develop and implement disciplinary guidelines that detail specific actions to take for certain offenses. Also, within the guidelines, the boards should ensure that each sanction is consistent with the severity of the offense.
3. The Division of Health Related Boards should establish a written policy indicating what licensed practitioner materials (e.g., copy of license, copies of closure memorandums forwarded to respondents and complainants) must be included in Alternative Dispute Resolution complaint files.
4. The Division of Health Related Boards and the Bureau of Investigation should identify areas where Alternative Dispute Resolution case processing time can be decreased, and strategies should be implemented to reduce processing delays.

5. The division should continue to improve its efforts to enhance public access to information. Efforts should be made to maximize the consistency and accuracy of information included on practitioner databases and the Internet site.
6. The division should improve its efforts to communicate to staff its policy regarding public access to disciplinary information. Management should ensure that all citizens have full and complete access to disciplinary information, including those who may not have Internet access.
7. The division should develop and implement a policy to require the boards to conduct criminal background checks for their new applicants. The one-time fee should be incorporated into the license fee and passed along to the licensee.
8. The division should continue to periodically analyze each board's financial condition and either increase or decrease fees accordingly so that the boards meet the requirements for self-sufficiency.
9. The Division of Health Related Boards should work with Office of General Counsel in assessing both investigative and legal costs. Also, the division should work with the Office of General Counsel to establish policy and guidelines for billing legal fee hours to individual cases. In the meantime, boards should assess investigative costs, which can be identified to individual cases.
10. The Division of Health Related Boards should work with the Office of Health Services to see that periodic internal audits of selected boards are conducted. Division management should notify the Office of Health Services whenever they identify any issues that might require audit inquiry.
11. The Division of Health Related Boards should take actions to ensure that statutory requirements regarding race, age, and public membership are met when board vacancies arise. These can include providing nominating associations with relevant information regarding qualification for any open seats. In addition, the boards should require that the nominating associations include information regarding a nominee's race, sex, and age.
12. The division should compile and maintain a complete contact list of nominating associations, whether authorized by Tennessee Code Annotated or used in practice, for all of the boards.
13. The Commissioner of the Department of Finance and Administration should reduce the budget of the boards that have not proven to be self-supporting in compliance with Section 4-3-1011(c)(2), *Tennessee Code Annotated*.

**Appendix 1
Board of Medical Examiners Disciplinary Guidelines**

Overprescribing Cases

If found by contested hearing or agreed order to have engaged in overprescribing as to:	Disciplinary Action Guidelines would be:
1 to 5 patients	Warning Letter or Informal Settlement up to one year of Probation; plus (Option) 10 hours CE
6 to 10 patients	Probation (up to 3 years) up to Suspension (3 months); plus Civil Penalty up to \$1,000; plus 20 hours CE; plus (Option) Limitation on DEA
11 to 19 patients	Suspension (3 months) up to Revocation; plus Civil Penalty \$500 to \$5,000; plus 30 hours CE; plus (Option) Limitation on DEA
20 or more patients	Revocation plus Civil Penalty of \$1,000 minimum

Fraud Cases

If found by contested hearing or agreed order to have engaged in fraud as to:	Disciplinary Action Guidelines would be:
1 instance	Warning Letter or Informal Settlement up to one year of Probation; plus (Option) Civil Penalty up to \$1,000
2 to 5 instances	Probation (up to 3 years) up to Suspension (3 months); plus Civil Penalty \$1,000 to \$2,500
6 to 10 instances	Suspension (3 months) up to Revocation; plus Civil Penalty \$3,000 to \$10,000
11 to 24 instances	Suspension (6 months) up to Revocation; plus Civil Penalty \$5,500 to \$24,000
25 or more instances	Revocation plus Civil Penalty \$25,000 minimum

Malpractice Cases: Incidents of malpractice will be assigned a point value. Each incident of malpractice in which death of a patient occurs will either be assigned three or four points depending upon the facts of each case. Each incident of malpractice in which permanent disability of a patient occurs will either be assigned two or three points depending upon the facts of each case. Each incident of malpractice in which other injury to patient occurs will either be assigned one or two points depending upon the facts of each case.

If found by contested hearing or agreed order to have engaged in malpractice in which the total accumulated points are:	Disciplinary Action Guidelines would be:
1 to 2 points	Warning Letter or Informal Settlement up to one year Probation; plus (Option) CE up to 20 hours
3 to 4 points	Probation (up to 3 years) up to Suspension (3 months); plus Civil Penalty up to \$1,000; plus (Option) CE up to 30 hours
5 points	Probation (up to 3 years) up to Suspension (3 months); plus Civil Penalty \$1,000 to \$2,500; plus (Option) Proctorship or Fellowship
6 points	Suspension (3 months) up to Revocation; plus Civil Penalty \$2,500 to \$5,000; plus (Option) Mini-residency

7 or more points

Revocation plus Civil Penalty \$5,000 minimum

Sexual Misconduct Cases: Incidents of sexual misconduct will be assigned a point value. Each incident of sexual misconduct in which penetration occurs will be assigned 10 points. Each incident of sexual misconduct in which fondling occurs will be assigned 3 points. Each incident of sexual misconduct in which a verbal offense occurs will be assigned one point.

If found by contested hearing or agreed order to have engaged in sexual misconduct in which the total accumulated points are:

Disciplinary Action Guidelines would be:

1 point

Warning Letter or Informal Settlement up to one year Probation; plus (Option) \$500 Civil Penalty

2 points

Probation (up to 3 years) up to Suspension (3 months); plus Civil Penalty \$500 minimum

3 points

Suspension (3 months) up to Revocation; plus Civil Penalty \$1,000 minimum

4 to 9 points

Suspension (6 months) up to Revocation; plus Civil Penalty \$2,500 minimum

10 or more points

Revocation plus Civil Penalty \$5,000 minimum

Impairment Cases: Incidents of impairment will be assigned a point value. Each incident of impairment in which injury to a patient occurs will either be assigned 4 or 5 points depending upon the facts of each case. Each incident of impairment in which danger to patients occurs will either be assigned 2 or 3 points depending upon the facts of each case. Each incident of impairment in which no patient injury or danger to patient occurs will be assigned one point.

If found by contested hearing or agreed order to have been impaired in which the total accumulated points are:

Disciplinary Action Guidelines would be:

1 to 3 points

Informal Settlement up to one year Probation; plus (Option) \$500 Civil Penalty

4 to 6 points

Probation (up to 3 years) up to Suspension (3 months); plus Civil Penalty \$500 minimum; plus Treatment

7 to 15 points

Suspension (3 months) up to Suspension (6 months); plus Civil Penalty \$1,000 minimum; plus Treatment

16 or more points

Suspension (6 months) up to Revocation; plus Civil Penalty \$2,500 minimum; plus Treatment

**Appendix 2
Health-Related Boards
Current Net Income at Fiscal Year End**

<u>Board/Committee</u>	<u>2002</u>	<u>2001</u>	<u>2000</u>	<u>1999</u>
Alcohol & Drug Abuse Counselors	\$			\$
	(42,966)	\$ (34,787)	\$ 52,054	14,574
Chiropractic	(39,868)	38,456	(20,963)	(28,299)
Communication Disorders & Sciences	(3,253)	(2,984)	3,407	(5,554)
Dentistry	(134,429)	(155,876)	56,038	81,228
Dieticians & Nutritionists	2,785	8,007	11,378	9,566
Dispensing Opticians	18,607	11,272	24,164	38,695
Electrolysis Examiners	(6,585)	(6,533)	(8,724)	1,881
Hearing Instrument Specialist	(9,996)	(18,136)	(4,810)	(1,322)
Massage	240,871	212,568	224,214	163,866
Medical Examiners	(208,520)	(185,309)	(347,441)	(398,032)
Acupuncture	(12,052)	(4,556)	*	*
Athletic Trainers	(3,008)	(4,195)	(3,226)	86
Clinical Perfusionists	(3,119)	(8,952)	(1,997)	*
Physician Assistants	(10,039)	7,036	1,551	17,117
Medical Laboratory	128,942	(165,757)	(136,378)	(1,921)
Nursing	508,960	(275,636)	(395,848)	70,047
Nursing Home Administrators	15,935	28,408	22,058	33,138
Occupational Therapy	54,738	33,269	26,425	9,245
Optometry	(63,050)	30,005	46,064	41,706
Osteopathic Examination	(2,541)	(31,346)	(4,519)	(23,743)
Midwifery	758	(8,383)	*	*
Physical Therapy	97,309	125,771	171,697	63,978
Podiatry	(12,882)	(20,241)	(3,518)	(2,106)
Professional Counselors, Marital & Family Therapists, & Clinical Pastoral Therapists	14,018	(36,880)	(6,246)	(27,377)
Psychology	(19,690)	(38,038)	28,457	(5,704)
Respiratory Care	17,215	7,073	1,098	3,829
Social Workers	(22,865)	(38,394)	(7,963)	(14,769)
Veterinary	<u>(113,061)</u>	<u>(91,903)</u>	<u>(50,022)</u>	<u>(34,019)</u>
Year End Totals	<u>\$ 392,214</u>	<u>\$ (626,041)</u>	<u>\$ (323,050)</u>	<u>\$ 6,110</u>

*Board/Committee Not Yet in Operation

Source: Division of Health Related Boards Fiscal Director