

Department of Health

October 2003

Arthur A. Hayes, Jr., CPA, JD, CFE
Director

Deborah V. Loveless, CPA, CGFM
Assistant Director

Diana L. Jones, CGFM
Audit Manager

Catherine B. Balthrop, CPA
In-Charge Auditor

Lisa Williams, CGFM
Julie Maguire Vallejo
Temecha Jones, CFE
Staff Auditors

Amy Brack
Editor

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-0264
(615) 401-7897

Performance audits are available on-line at www.comptroller.state.tn.us/sa/reports/index.html.
For more information about the Comptroller of the Treasury, please visit our Web site at
www.comptroller.state.tn.us.



**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

State Capitol
Nashville, Tennessee 37243-0260
(615) 741-2501

John G. Morgan
Comptroller

October 30, 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 the Department of Health. 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 department should be continued, restructured, or terminated.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/dlj
02-081

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit
Department of Health
October 2003

AUDIT OBJECTIVES

The objectives of the audit were to determine the department's legislative mandate and the extent to which it has carried out that mandate efficiently and effectively and to make recommendations that might result in more efficient and effective operation of the department.

FINDINGS

State Law and Departmental Rules Do Not Sufficiently Safeguard Access to Vital Records, Specifically Birth Certificates

In 1993, the Tennessee General Assembly passed legislation (codified as Section 68-3-205[d][2][A], *Tennessee Code Annotated*) opening vital records and making them public. Since that time, access to vital records has become an issue because of national security concerns and the increase in identity theft crimes. According to Department of Health management, both the department and the U.S. Department of State were opposed to opening the state's vital records in 1993. In addition, the National Association of Public Health Statistics and Information Systems (NAPHSIS), an association of state vital records and public health statistics offices, does not support open access to vital records. According to NAPHSIS, as of 2000, only 14 states had open access on either a state and/or local level to the birth certificates they archive. Open access means that virtually anyone can review birth records or purchase a copy of any birth certificate from issuing entities as long as they know the name and birth date of the person listed on the birth certificate (page 16).

The Bureau of Alcohol and Drug Abuse Services Is Paying Some Agencies With Grant-Based Contracts Full Contract Amounts Even When the Agencies Do Not Meet Utilization Requirements

The February 1998 performance audit of the Department of Health found that the Bureau of Alcohol and Drug Abuse Services had no standard rate of payment for alcohol and drug treatment and prevention services, and that the rates paid for those services varied widely depending on when the department first funded the bed or other services. Since that time, the bureau has taken steps to equalize reimbursement rates for services. However, weaknesses in the bureau's service reimbursement process remain, and as a result, some agencies that have not met service expectations have essentially been overpaid (relative to other agencies that did meet service expectations) (page 19).

Medical and Pharmaceutical Supply Information in the Department's Computer System Is Often Incomplete and/or Inaccurate

The Department of Health's Bureau of Health Services uses a computer system called PTBMIS (Patient Tracking and Billing Management Information System) to coordinate with local health departments. PTBMIS compiles some

medical information, generates bills, tracks drug and vaccine supplies, and provides information for reports to the state and federal government. During our audit work, we observed the department's on-site quality management reviews of 113 encounters in five counties. The types of PTBMIS-related problems reviewers identified included a service/procedure coded in PTBMIS to the wrong program, a procedure coded in PTBMIS but not documented in the paper file, a service/procedure documented in the paper file but not coded in PTBMIS, the wrong diagnosis or procedure code in PTBMIS, test results not entered into PTBMIS, and financial information that was wrong or out-of-date. Because the billing system and pharmacy inventories are controlled through PTBMIS, it is a problem when the paper medical file and PTBMIS do not agree. If procedures performed are not coded into PTBMIS, they will not be billed for. If procedures are coded into PTBMIS and there is no written evidence they were performed, patients could be paying for

services not rendered. If medications are not properly entered, billing may be affected, and supplies may not be properly tracked. Also, because management uses PTBMIS data to assess various aspects of health service, erroneous or incomplete information limits the usefulness of PTBMIS data as a management tool (page 21).

The Division of General Environmental Health Should Perform Quality Assessments of the Field Offices and Contract County Offices More Frequently

Although the Department of Health's Division of General Environmental Health has a policy and process to perform quality assessments of field offices and contract county offices, the policy does not dictate the timing of the assessments, and the division has not performed those assessments as scheduled. Information obtained from such assessments could be beneficial in identifying problems and making improvements in the inspection process (page 23).

OBSERVATIONS AND COMMENTS

The audit also provides follow-up information regarding program monitoring in the AIDS Support Services and Maternal and Child Health Divisions and the Bureau of Alcohol and Drug Abuse Services. In addition, the audit discusses the following issues: bioterrorism response plans, the status of public health in Tennessee, and the Office of Minority Health (page 4).

ISSUES FOR LEGISLATIVE CONSIDERATION

The General Assembly may wish to consider amending Section 68-3-205, *Tennessee Code Annotated*, to restrict access to vital records and specifically require department personnel to request some type of documentation of identity (page 26).

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

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-0264
615-401-7897

Performance audits are available on-line at www.comptroller.state.tn.us/sa/reports/index.html.
For more information about the Comptroller of the Treasury, please visit our Web site at
www.comptroller.state.tn.us.

**Performance Audit
Department of Health**

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
Purpose and Authority for the Audit	1
Objectives	1
Scope and Methodology	1
Organization and Responsibilities	2
Revenues and Expenditures	4
OBSERVATIONS AND COMMENTS	4
Follow-up on the Department’s Program Monitoring of the AIDS Support Services and Maternal and Child Health Divisions	4
Follow-up on Alcohol and Drug Abuse Services’ Program Monitoring and Data Collection	8
Bioterrorism Response Plans	9
Status of Public Health in Tennessee	12
Office of Minority Health	14
FINDINGS AND RECOMMENDATIONS	16
1. State law and departmental rules do not sufficiently safeguard access to vital records, specifically birth certificates	16
2. The Bureau of Alcohol and Drug Abuse Services is paying some agencies with grant-based contracts full contract amounts even when the agencies do not meet utilization requirements	19
3. Medical and pharmaceutical supply information in the department’s computer system is often incomplete and/or inaccurate	21
4. The Division of General Environmental Health should perform Quality Assessments of the field offices and contract county offices more frequently	23
RECOMMENDATIONS	26
Legislative	26
Administrative	26
APPENDIXES	28
Appendix 1 - Title VI Information	28
Appendix 2 - Healthy People 2010 – Identified Focus Areas and Leading Health Indicators	37

Performance Audit Department of Health

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Tennessee Department of Health was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-225, the Tennessee Department of Health is scheduled to terminate June 30, 2004. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the department 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 agency should be continued, restructured, or terminated.

OBJECTIVES

The objectives of the audit were

1. to determine the authority and responsibility mandated to the department by the General Assembly;
2. to determine the extent to which the department has fulfilled its legislative mandate and complied with applicable laws and regulations; and
3. to recommend possible alternatives for legislative or administrative actions that might result in more efficient and effective operation of the department.

SCOPE AND METHODOLOGY

The activities and procedures of the Tennessee Department of Health were reviewed with a focus on procedures in effect during fieldwork (May 2002 to February 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. review of applicable statutes and rules and regulations;
2. examination of the department's documents, policies, and procedures;

3. review of prior performance audits, financial and compliance audit reports, and audit reports from other states; and
4. interviews with department staff and site visits to local health departments.

ORGANIZATION AND RESPONSIBILITIES

The Tennessee Department of Health is responsible for protecting and improving the health of Tennesseans. The department is organized into offices and bureaus that report directly to the Commissioner of Health.

The Commissioner's Office provides overall direction, supervision, and coordination for health services and regulatory activities, and coordinates legislative and public relations activities. The Office of Human Resources is responsible for personnel functions, and the Office of General Counsel represents the department in legal matters. The Office of Internal Audit and Investigations audits and evaluates the performance of the department and investigates allegations of fraud, waste, and abuse.

Laboratory Services offers microbiological and environmental laboratory services for intra- and interdepartmental programs. Reference and limited microbiological support is provided to hospitals, private physicians, and private laboratories. The lab also provides analytical support to the department's prevention and treatment programs and to environmental regulatory programs.

The Office of Minority Health is responsible for improving overall minority health and minorities' access to health care. The office provides state-funded grants to prevention programs that focus on children and youth, develops policy, evaluates strategic plans, develops programs, and disseminates information to assist in advancing minority health issues.

The Office of Patient Care Advocacy answers questions from and provides assistance to the general public regarding health and mental health services, nursing home services, and other health-related needs.

The Bureau of Alcohol and Drug Abuse Services administers federal block grant funding for prevention and treatment programs related to alcohol and drug abuse.

The Bureau of Health Services coordinates health service delivery for the state by administering programs and services, regional health offices, and local health departments. The bureau contains the following major sections:

Health Services Administration. This section provides administrative and fiscal coordination and support, along with medical/nursing support, to the bureau's programs and the regional and local health departments.

General Environmental Health. Through a system of permits and field inspections, this section enforces laws and regulations relating to sanitation and safety in hotels, food service establishments, bed and breakfast facilities, organized camps, public swimming pools, schools, and child care facilities. The section is also responsible for rabies and West Nile Virus control activities.

Maternal and Child Health. This section provides services to women of childbearing age and to children in low-income populations in an effort to reduce maternal and infant mortality and morbidity.

Communicable and Environmental Disease Services. This division is responsible for detecting, preventing, and controlling communicable diseases through disease surveillance and investigation and for educating the public about protecting themselves from illnesses.

Population-Based Services. This section's mission is to reduce premature death, disease, and disability through a combination of preventive programs and wellness initiatives. Prevention efforts consist of public information programs to promote the adoption of healthy lifestyles.

WIC Supplemental Foods. This section provides screening, counseling, and food supplements to needy women, infants, and children. Other activities include breastfeeding promotion and support and a variety of preventive and therapeutic community nutrition services through local health departments.

General Local Health Services. An array of health programs and services are provided to Tennesseans through the bureau and a network of 89 county and 6 metropolitan health departments.

The Bureau of Administrative Services is responsible for administrative support (including accounting, budgeting, contracting, facilities management, and procurement) to program areas of the department.

The Bureau of Health Informatics collects and analyzes public health data and assesses health trends. Bureau staff administer the Division of Vital Records and provide information systems support to the various programs within the Department of Health.

The Bureau of Health Licensure and Regulation is not included in this audit. A review of that bureau's activities is included as part of the audits of the Health Related Boards and the Board for Licensing Health Care Facilities.

REVENUES AND EXPENDITURES

During fiscal year 2003, the Department of Health had expenditures and revenues of approximately \$401.6 million, of which approximately \$194.9 million was from the federal government. The major types of expenditures include Local Health Services (\$135.6 million), WIC Supplemental Foods (\$105.6 million), and Alcohol and Drug Abuse Services (\$44.5 million).

The department had 2,456 filled positions and 491 vacant positions as of June 2003.

OBSERVATIONS AND COMMENTS

The issues discussed below did not warrant a finding but are included in this report because of their potential effect on the operations of the department and on the citizens of Tennessee.

FOLLOW-UP ON THE DEPARTMENT'S PROGRAM MONITORING OF THE AIDS SUPPORT SERVICES AND MATERNAL AND CHILD HEALTH DIVISIONS

The February 1998 performance audit of the Department of Health found that the AIDS Support Services and the Maternal and Child Health divisions of the Bureau of Health Services had weaknesses in program monitoring. In a follow-up report to that audit, dated March 1999, we found that AIDS Support Services had implemented a monitoring system to evaluate the operations of HIV Consortia. Four agency reviews had been completed at that time. The Maternal and Child Health division had implemented a monitoring system to evaluate its programs on a three-year cycle and had completed evaluations of four programs. The changes made in the monitoring programs since that time are detailed below.

Program Accountability Review (PAR)

The Tennessee Department of Health contracted with the Tennessee Department of Finance and Administration's Office of Program Accountability Review (PAR) for monitoring services in fiscal years 2001, 2002, and 2003. The contracts included the AIDS Support Services and the Maternal and Child Health divisions' programs and subrecipients.

PAR, established July 1, 1999, provides coordinated monitoring services to state agencies and departments for purposes of determining subrecipient compliance with the requirements of state and/or federal programs. PAR's objective is to increase the level of monitoring and encourage uniformity of monitoring. According to PAR management, because PAR monitoring is performed during the course of the contract, problems found can be corrected prior to any post-audit work. For each subrecipient, PAR monitors the following 14 core areas:

- Activities Allowed and Unallowed
- Davis-Bacon Act
- Civil Rights
- Equipment and Real Property Management
- Allowable Cost and Cost Principles
- Period of Availability of Funds
- Eligibility
- Procurement, Suspension and Debarment
- Matching, Level of Effort, Earmarking
- Real Estate Acquisition and Relocation Assistance
- Program Income
- Reporting
- Cash Management
- Special Tests

In its 2002 annual report, PAR states that it performed monitoring for 16 agencies during 2002 and monitored 1,726 contracts in fiscal year 2002 for a total of more than \$550 million in contracts reviewed. The report contains a table of findings by core area reviewed. According to the table, the Department of Health had findings in 3 of 14 core areas: Activities Allowed or Unallowed, Allowable Costs, and Reporting.

According to that report, for the fiscal year 2002, PAR monitored all Department of Health subrecipients with the exception of three medium-risk contracts monitored by the Bureau of Alcohol & Drug Abuse Services and 75 high-risk Community Prevention Initiative contracts monitored by the Bureau of Health Services Administration.

TDOH Annual Monitoring Plan and Risk Analysis

Under the terms of the contracts, the Department of Health provides PAR with all program and fiscal policies and procedures. Department staff train the PAR monitoring staff. Annually, the department provides PAR a monitoring plan that lists all subrecipients and, based on previous experience with the subrecipient and knowledge of program requirements, assigns each a risk factor (high, medium, or low). High-risk subrecipients are monitored annually, medium-risk subrecipients are monitored every two years, and low-risk subrecipients are monitored every three years. PAR bills the department monthly for monitoring costs and applicable administrative expenses.

Coordination Between PAR and the Department of Health

Prior to performing a monitoring visit, PAR notifies department and division management of the scheduled review. Program staff and department management are encouraged to inform PAR of any areas needing review or any problems.

PAR submits copies of all reviews to the department's staff person who coordinates the monitoring plan and contract. If a report contains findings, the subrecipient is required to submit a Corrective Action Plan to the department within 30 days. Program staff review the plan and work with the subrecipient to correct the findings. The department notifies the subrecipient when the plan has been accepted.

Annually, the department completes a PAR grantor survey. Department of Health management indicated that there is an open-door policy of communication between the department and PAR. Any problems are communicated and resolved by contacting PAR staff. According to department management, PAR monitoring was enhanced as compared to the prior monitoring by the individual program staff because PAR includes financial monitoring with the program monitoring.

PAR Report Reviews

For the contract year ending June 30, 2001, we reviewed 92 PAR reports for the department's Bureau of Health Services subrecipients. Examples of findings were

- no written procurement procedures,
- not complying with non-discrimination requirements for contract,
- not meeting financial reporting requirements,
- unallowable costs charged to grants,
- not filing quarterly reports, and
- not meeting program objectives.

For the contract period ending September 30, 2002, we reviewed 61 PAR reports. Examples of findings included

- not meeting financial reporting requirements,
- not maintaining proper documentation and financial records,
- no cost allocation plans, and
- not filing quarterly reports.

As noted above, in PAR's 2002 annual report, the department had three core areas in which findings were most prevalent: Activities Allowed and Unallowed, Allowable Costs, and

Reporting. These core areas are consistent with the findings listed in the reports we reviewed for that year.

Contract Amounts

Details of the Department of Health’s contract with PAR for monitoring services were

Contract Period	July 1, 2000, to June 30, 2001	July 1, 2001, to September 30, 2002	October 1, 2002, to September 30, 2003 (tentative)
Cost of Monitoring	\$537,325	\$424,101	\$300,000
Number of Contracts Monitored	154	94	75
Dollar Amount of Contracts Monitored	\$32,565,273	\$24,744,563	\$21,567,048

These amounts include the three bureaus in the department with subrecipient contracts: the Bureau of Alcohol and Drug Abuse Services, the Bureau of Health Services, and the Bureau of Health Licensure and Regulation.

Summary

Based on our review of documentation and interviews with Department of Health staff and management, it appears that, overall, the contract with PAR provides appropriate monitoring of subrecipients of the AIDS Support Services and the Maternal and Child Health divisions. The various divisions and bureaus in the Department of Health contribute to the monitoring process by providing guidance and program-related monitoring tools and by informing PAR of any problems. Over the three years the contract has been in place, the cost has decreased annually.

Some concerns regarding PAR’s monitoring were raised, however, during an August 2002 Financial Management Review by the U.S. Department of Agriculture’s Division of Food and Nutrition Service. The resulting report, which focused on the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) administered by the Tennessee Department of Health, contained five observations. Regarding the PAR reviews of the WIC program, the federal report noted that the PAR reviewers sampled one month per health district reviewed and, according to the report, a minimum sample should include three months. (Department management said PAR had indicated that a three-month sample would be used in future reviews.) In addition, the federal reviewers recommended that the fiscal oversight function be transferred back to the WIC program in the Department of Health. (According to management, the department does not intend to take over fiscal oversight from PAR.)

Department management should work with PAR and the federal reviewers to address federal concerns and ensure that the state’s fiscal oversight of programs like WIC meets federal requirements.

FOLLOW-UP ON ALCOHOL AND DRUG ABUSE SERVICES' PROGRAM MONITORING AND DATA COLLECTION

The February 1998 performance audit of the Department of Health found that the Bureau of Alcohol and Drug Abuse Services needed to improve its monitoring of quality of care that contract agencies provide. In addition, the audit recommended that the bureau eliminate its client data backlog and use outcome information to develop methods of payment for contract agencies. The March 1999 audit followed up on these findings and determined that, although improvements had been made, additional improvement was needed. Changes made by the department since those audits were completed are detailed below.

Monitoring

As part of the department's contract with the Office of Program Accountability Review (PAR), the bureau's contract agencies have been monitored by PAR since fiscal year 2001. A review of PAR reports for the contract agencies found the following findings:

- missing documentation regarding treatment and family history,
- incomplete policy and procedures manuals,
- no Quality Assurance plan,
- service not provided as billed, and
- referrals not done timely.

Because PAR is serving as the contract monitor for the bureau, bureau staff act as program consultants to contract agencies. Bureau staff review the annually submitted program plans and budgets and monitor the monthly data submitted by agencies to see if they are on target with utilization rates. According to bureau staff, 90 days after a corrective action plan has been submitted in response to PAR-cited deficiencies, the bureau follows up to see if the problems have been solved. If deficiencies are not resolved, the follow-up report is sent to the assistant commissioner, who meets with the agency and arranges a date for deficiencies to be resolved. If the agency does not meet this deadline, the department can take action, including the withholding of funding and canceling the program and/or contract.

Client Data

The Bureau of Alcohol and Drug Abuse Services has a new client data collection system called ADMIS-PC (Alcohol & Drug Management Information System). The ADMIS-PC client data collection system was developed to increase the efficiency and effectiveness of data collection for 238 statewide programs supported with federal funding. The ADMIS-PC data system allows contracted service providers to confidentially report each client receiving contracted services. These data are received each month from providers, loaded into the database, and processed daily to produce management and financial reports. These reports are used to determine payments to providers and monitor contract compliance. Agency staff review encounter data submitted by the contract agencies, offer technical assistance, occasionally visit

on-site, and do research. Data are received monthly, and reports are run and reviewed for trends and to see if agencies are meeting their contract utilization requirements.

Summary

Based on our review of the monitoring and client data systems now in place, it appears that the issues identified in the prior performance audits have been resolved. Bureau staff did express some concerns regarding PAR staff's knowledge of the programs/contractors they were monitoring. However, a reasonable process appears to be in place, and department management expressed satisfaction with PAR's performance.

Bureau staff should ensure that agencies resolve PAR-cited deficiencies in a timely and appropriate manner. If deficiencies are not corrected within stated deadlines, bureau management should take appropriate action, including the withholding of funding and evaluating whether the bureau should renew its contract(s) with the agency.

BIOTERRORISM RESPONSE PLANS

In response to September 11, 2001, and subsequent events, the Tennessee Department of Health began to plan and prepare the state's public health infrastructure for the possibility of bioterrorism. According to the national Centers for Disease Control and Prevention (CDC), bioterrorism is a significant public health threat facing the United States. Response to a bioterrorism event will require rapid deployment of scarce public resources, and the nation's public health infrastructure needs to be prepared to respond.

The department prepared a Bioterrorism Funding Application in April 2002. This is a document submitted to the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention specifying plans along with benchmarks to be met by the department in order to receive federal funds. Semi-annual updates that report benchmarks that have been met and ongoing activities were submitted in November 2002 and April 2003. The next update is due in October 2003.

In June 2002, the department received a \$20 million federal grant from the U.S. Health Resources and Services Administration (HRSA) to enhance the state's bioterrorism preparedness. The department applied the grant funds to local health services, laboratory services, and communicable and environmental disease surveillance.

Local Health Services

Hospital Preparedness

In August 2002, the department contracted with General Physics Corporation of Maryland for an evaluation of the bioterrorism preparedness of the state's hospitals. (The total contract cost was \$188,470—\$137,800 for completion of the Web-based needs assessment tool and \$50,670 for completion of the final needs-assessment results report.) General Physics'

report, issued in January 2003, states that although Tennessee hospitals achieved preparedness scores slightly higher than average, there are significant opportunities for improvement.

The report analyzed 17 areas of preparedness. The areas in which hospitals are best prepared are

- general emergency preparedness,
- surge capacity, and
- hospital management and security.

Areas in which the report found a need for improvements are

- medical treatment procedures,
- access to care,
- personal protective equipment,
- pharmacy,
- evidence collection,
- psychiatric services and crisis counseling, and
- bioterrorism incident detection and recognition.

The study recommended that hospitals be resurveyed at a future date in order to determine improvements made and to ensure that needs are kept up-to-date. The department has used the survey as a tool in the development of the Statewide Hospital Bioterrorism Preparedness Plan and is conducting exercises (to test the plan) in each of the hospital regions. The department is also using the survey to plan for the distribution of HRSA funds to help hospitals prepare to respond to a bioterrorism attack.

Smallpox Vaccination Program

The department developed its smallpox vaccination program in December 2002, using guidance from the national Centers for Disease Control and Prevention. The plan has two phases: pre-event and post-event.

Pre-Event – vaccinate designated public health care personnel who will be responsible for treating smallpox cases and vaccinating exposed persons. The Pre-Event Smallpox Vaccination Program has three phases:

- Phase 1 – voluntary vaccination of public health investigation teams, public health vaccinators, and hospital smallpox health care teams;
- Phase 2 – opportunity provided for all health care workers and first responders to be vaccinated; and

- Phase 3 – vaccination opportunity opened to the general public.

Phase 1 began in February 2003 and was completed in March 2003, with the vaccination of 2,429 persons. Vaccination activities are currently suspended because of the increased rate of side effects and the decreased threat of disease. The federal government is responsible for the initiation of Phases 2 and 3.

Post-Event – vaccinate the entire state population. The Post-Event Smallpox Vaccination Program will provide for the vaccination of Tennesseans at 117 clinics across the state. The CDC has instructed states to plan so that they will be able to vaccinate their entire populations within 10 days. For Tennessee, this will mean each of the 117 clinics must vaccinate approximately 5,000 persons a day and would require 25,000 to 30,000 persons to staff the clinics. Currently, the Tennessee Department of Health has only 4,500 public health staff statewide. The department's regional offices are asking physicians and nurses to volunteer and are recruiting volunteers from community organizations, companies, civic groups, and schools. In addition, the department's Internet site allows volunteers to register.

Laboratory Services

The department's Nashville laboratory performed approximately 1,600 anthrax tests in 2001. Those events also required interaction with law enforcement and emergency personnel. From those experiences, laboratory staff and department management have identified ways to improve the laboratory's ability to respond to bioterrorism events.

The department has four laboratories in Tennessee: Knoxville, Nashville, Jackson, and Memphis. The Memphis laboratory is part of the Memphis-Shelby County Health Department, and the department contracts with Memphis for communicable disease and bioterrorism testing. The department has purchased equipment to upgrade the laboratories' capabilities with regard to bioterrorism-related procedures and testing.

Communicable and Environmental Disease Surveillance

The department's Surveillance Program collects and maintains reports of notifiable conditions in Tennessee. Physicians, hospitals, and laboratories providing care to individuals diagnosed with notifiable diseases/conditions are required by Section 68-5-102, *Tennessee Code Annotated*, to report these conditions to their local health department. Communicable diseases and/or those dangerous to the public are considered notifiable (reportable). Access to information about what diseases are required to be reported and the process for reporting is available via the department's Internet site, www2.state.tn.us/health/Ceds, under *Notifiable Disease Data*. The reports on diseases/conditions identified are entered into the National Electronic Telecommunication System for Surveillance and transmitted to the Communicable and Environmental Disease Services Division (CEDS) weekly. CEDS then provides this information to the Centers for Disease Control and Prevention.

After September 11, 2001, the department contacted hospital emergency rooms, local health departments, and other health care providers to be on alert for unusual illnesses or clusters

of disease. The department's Bioterrorism Funding Application noted that the state was not adequately prepared to rapidly detect and obtain additional information about bioterrorism, other infectious disease outbreaks, or other public health threats. However, the department is developing new surveillance systems and has plans to receive electronic data from hospitals and laboratories, using federal funding for hospital preparedness.

Summary

The department is continuing its efforts to prepare and enhance its ability to respond to a biological or chemical attack. These include

- determining the level of hospital preparedness;
- preparing and implementing a smallpox vaccination program;
- enhancing laboratory capacity to detect and diagnose biological agents that could be used in a bioterrorism event;
- using electronic communications to enable state, local, and federal health officials to communicate quickly and securely regarding diagnoses; and
- providing conferences, seminars, and training exercises on bioterrorism topics for public health workers, physicians, hospital personnel, and others. Bioterrorism information is also available to the public and the health care industry on the department's Internet site, www.state.tn.us/health.

STATUS OF PUBLIC HEALTH IN TENNESSEE

Tennessee's Progress Toward Meeting Selected Healthy People 2000 Objectives

The U.S. Department of Health and Human Services released the Healthy People 2000 objectives in 1990, as national standards to help states achieve improved health status. As part of the Healthy People 2000 initiative, the Tennessee Department of Health agreed to seek attainment of targets for various health status indicators. We reviewed the health status indicators relating to mortality, teenage pregnancy and births, and adult behavioral risk factors to determine Tennessee's progress toward meeting the national objectives. Based on our review of the most recent data available, Tennessee did not meet the year 2000 objectives (see Table 1) for 13 of 14 health status indicators published in the Department of Health and Human Services' *Healthy People 2000 Review*:

Coronary heart disease deaths	Suicide	Cases of syphilis
Stroke deaths	Infant deaths	Low birthweight
Cancer deaths	Adolescent birth rates	First trimester prenatal care
Motor vehicle injury deaths	Cases of tuberculosis	
Homicide	Cases of measles	

Tennessee did meet the year 2000 objective for one health status indicator—reported cases of AIDS—and was, in fact, substantially below the target rate.

Of the 14 health status indicators reviewed for this audit, 11 were also reviewed in the prior performance audit. Of those 11 indicators, Tennessee’s rates showed improvement in nine areas: coronary heart disease deaths, stroke deaths, motor vehicle injury deaths, homicide, infant deaths, and reported cases of AIDS, tuberculosis, measles, and syphilis. (See Table 1.)

Table 1
Comparison of Tennessee, U.S., and Year 2000 Target Rates
Per 100,000 Population (a)

Health Status Indicators	Tennessee Rates		1998 U.S. Rate	Target Rate
	1996	1998		
Coronary Heart Disease Deaths	125.8	123.2	96.8	100.0
Stroke Deaths	34.7	32.6	25.1	20.0
Cancer Deaths	(b)	138.9	123.5	130.0
Motor Vehicle Injury Deaths	24.3	22.0	(c)	14.2
Homicide	11.1	9.5	7.1	7.2
Suicide	12.1	12.6	10.4	10.5
Infant Deaths	8.9	8.2	7.2	7.0
Adolescent Birth Rates (d)	(e)	37.7	30.4	23.3
Reported Cases of AIDS	17.8	13.7	(c)	43.0
Reported Cases of Tuberculosis	9.5	8.1	(c)	3.5
Reported Cases of Measles	2	1	100	0
Reported Cases of Primary and Secondary Syphilis	16.2	10.4	2.6	4.0
<i>Numbers below are reported as percentages:</i>				
Low Birthweight	8.8	9.1	7.6	5.0
1 st Trimester Prenatal Care	(f)	84.1	82.8	90.0

Notes:

- a. Unless otherwise indicated, all rates age-adjusted per 100,000 population.
- b. Prior audit reported only female breast cancer deaths and lung cancer deaths.
- c. No U.S. rate reported.
- d. Live birth rates per 1,000 females ages 15-17.
- e. Adolescent birth rate listed in prior audit used different measurement method.
- f. Prior audit reported late or no prenatal care.

Healthy People 2010

Building on the foundations of the *Healthy People 2000* initiative, the U.S. Department of Health and Human Services’ *Healthy People 2010* is a comprehensive set of disease prevention and health promotion objectives. It identifies a wide range of public health priorities and specific, measurable objectives. The two overarching goals of this initiative are to increase the quality and years of a healthy life and eliminate health disparities between racial and ethnic groups and between regions of the country. For a listing of national focus areas and leading health indicators, see Appendix 2. The following exhibit provides examples of strategies and objectives the department has included in its strategic plan.

Healthy People Initiative

Strategic Plan	Offer Every Child a Safe, Healthy Start
GOAL 2:	
	<ul style="list-style-type: none">◆ Increase the percentage of infants born to pregnant women seeking prenatal care in the first trimester from 81.4% (1986) to 89% by FY 2003.◆ Improve infant mortality rates to no more than 8 per 1,000 annually by FY 2003.◆ Decrease the number of births to teens ages 15-17 to 30 per 1,000 births by 2003.◆ Annually conduct at least one educational activity targeted toward primary care providers on a topic related to preconception care and/or early infancy care.◆ Increase age-appropriate immunizations and screening to achieve Healthy People 2010 objectives.◆ During 2003, the TB Elimination Program will collaborate with the EPSDT providers to test, and if need be appropriately treat, 100% of children identified as having risk for TB infection.

OFFICE OF MINORITY HEALTH

Overview

Minority health issues have received a great deal of attention recently, both at the state and federal levels. Issues concerning minority health continue to be a focus of national health policy. The Federal Office of Minority Health was created by the U.S. Department of Health and Human Services to improve the health of racial and ethnic populations by developing effective health policies and programs to help eliminate disparities in health care and health-care access. The Office of Minority Health works closely with established state offices of minority health and provides technical assistance, as requested, to minority community groups.

Enormous disparities in health status and disease outcomes continue to exist between various population groups in the United States. In response to this, the U.S. Department of Health and Human Services' Office of Minority Health implemented the *Initiative to Eliminate Racial and Ethnic Disparities in Health*. As part of this initiative, the federal Office of Minority Health provides overall public health guidance to the U.S. Department of Health and Human Services (DHHS) on issues affecting African Americans, Hispanic Americans, Asian Americans/Pacific Islanders, and American Indians/Alaska Natives. In addition, in April 2002, DHHS launched a new prevention initiative—a comprehensive strategy to reduce the nation's burden of death, illness, and disease through methods that greatly improve individual health and wellness, particularly for racial and ethnic minorities. The following chart lists several DHHS programs developed to address minority health issues.

Prevention Initiatives Sponsored by the U.S. Department of Health and Human Services

Closing the Gap

A health education and information campaign for communities of color.

Racial and Ethnic Adult Disparities
in Immunizations Initiative

An adult immunization initiative to reduce racial and ethnic disparities in influenza and pneumococcal vaccination coverage for adults 65 years of age or older, focusing on African-American and Hispanic communities.

Healthy People 2010

A comprehensive set of health objectives for the nation; includes two overarching goals of increasing the quality and years of a healthy life, and eliminating racial and ethnic disparities in health.

Healthy Communities Innovation
Initiative

The President's fiscal year 2003 budget includes \$20 million for a new interdisciplinary services demonstration program that will focus on preventing diabetes, asthma, and obesity through community systems of services, with special attention to eliminating racial and ethnic disparities in health.

National Diabetes Education
Campaign

Cosponsored by DHHS's National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health and the Centers for Disease Control and Prevention and is a leading source of information about diabetes care and prevention.

Tennessee Office of Minority Health

Tennessee's Office of Minority Health is the state's contact for the National Office of Minority Health. The office was established in 1994 to serve as a central point for the Department of Health's minority health issues. According to information provided by the office, Tennessee's racial and ethnic minorities consist primarily of African-Americans, American Indians, Hispanics, and Asians/Pacific Islanders. Information provided by the Tennessee Department of Health indicates that minority populations often experience poor health due to unhealthy lifestyles, limited prevention measures, and inadequate access to health care. Health issues that result in inordinate mortality rates in minority communities include alcohol and drug abuse, cardiovascular disease, cancer, violence and injury, infant mortality, HIV/AIDS and other sexually transmitted diseases, and ethnic-specific diseases (e.g., sickle cell anemia).

Activities of Tennessee's Office of Minority Health include providing leadership and technical consultation to various state agencies, community organizations, and health-care professionals; providing funding (on a limited basis) to community programs that target at-risk youth; and working with both public- and private-sector organizations to establish networks for improved health access. (See page 16 for a listing of the office's strategies.) The office also publishes educational materials and reports like the Tennessee Department of Health's annual *Title VI Report* and *Narrowing the Gap*, which focuses on the health status of minorities in Tennessee. The information provided in *Narrowing the Gap* is intended to support DHHS's efforts to achieve the goals of Healthy People 2010 by identifying ways to eliminate racial and ethnic health disparities.

Strategies of the Office of Minority Health

- ◆ Facilitate coalitions directed toward healthy communities.
- ◆ Support recruitment and retention of minority healthy professionals.
- ◆ Promote policies that improve minority health.
- ◆ Emphasize improvement and focus of minority health research data.
- ◆ Develop and allocate resources for health programs.
- ◆ Encourage recognition of health issues of special populations not traditionally considered (i.e., elderly, women, poor).
- ◆ Monitor legislative activity on issues with direct impact on minority health.
- ◆ Collaborate with established associations to enhance minority health initiatives for diabetes, cancer, family issues, and rural health.

In addition, the Tennessee Department of Health has a strategic planning process intended to identify the challenges facing public health and then develop actions that can be taken to meet those challenges. The June 2002 strategic plan identified several objectives related to the Office of Minority Health.

FINDINGS AND RECOMMENDATIONS

1. State law and departmental rules do not sufficiently safeguard access to vital records, specifically birth certificates

Finding

In 1993, the Tennessee General Assembly passed legislation (codified as Section 68-3-205(d)(2)(A), *Tennessee Code Annotated*) opening vital records and making them public. Since that time, access to vital records has become an issue because of national security concerns and the increase in identity theft crimes.

According to Department of Health management, both the department and the U.S. Department of State were opposed to opening the state's vital records in 1993. In addition, the National Association of Public Health Statistics and Information Systems (NAPHSIS), an association of state vital records and public health statistics offices, does not support open access to vital records. According to NAPHSIS, as of 2000, only 14 states had open access on either a state and/or local level to the birth certificates they archive. Open access means that virtually

anyone can review birth records or purchase a copy of any birth certificate from issuing entities as long as they know the name and birth date of the person listed on the birth certificate. Nineteen states have open death records, although four (including Tennessee) do restrict access to cause of death. According to the department's Director of Vital Records, many of the states with open records are now trying to close them.

In the United States, there has been an increase in the fraudulent use of vital records (e.g., birth and death certificates). In September 2000, the Office of the Inspector General prepared a report on "Birth Certificate Fraud" for the U.S. Department of Health and Human Services. This report addresses birth certificate fraud and encourages changes in access to birth certificates, on both local and state levels. According to NAPHSIS, fraudulent use of vital records is directly linked to identity theft, which is the fastest growing white-collar crime in the United States. Numerous studies have been conducted over the years and have found that birth certificates are used as "breeder documents" to create new identities. While originally intended for the sole purpose of birth registration, birth certificates are now used extensively for employment purposes and to obtain benefits or other documents used for identification. The birth certificate in some cases is a key to obtaining a social security card, driver's license, and credit cards for use in committing crimes. The perpetrator knows this and uses the system to his or her advantage.

NAPHSIS believes that the ability to obtain birth certificates for illegal purposes is aided when access to those birth certificates is not questioned or even challenged. Certified copies of original birth certificates are used in most birth certificate fraud cases. According to NAPHSIS, 85 to 90 percent of the Passport Office's and Immigration and Naturalization Services' fraud cases involve *bona fide* birth certificates.

Copies of birth certificates can be obtained through a variety of methods. In Tennessee, birth certificates can be obtained in person or by mail from the Department of Health's central office, some local health departments, and via the Internet. Neither Tennessee state statutes nor Department of Health rules and regulations require applicants requesting certified copies of vital records to provide proof of their identity. Departmental rules only state, "The State Registrar or Local Registrar shall not issue a certified copy of a record until the applicant has provided sufficient information so that the record can be located. Whenever it shall be deemed necessary to establish an applicant's right to a certified copy of a vital record, the State Registrar or Local Registrar may also require identification of the applicant or a sworn statement as to the identity of the applicant and the applicant's relationship to the registrant." According to the State Registrar, in everyday practice, staff do not ask for formal identification but have the option to do so if a question arises. Requests for certified copies of death certificates are scrutinized a bit more closely because the cause of death is not public record. However, even then, for example, an attorney who is the executor of someone's estate and needs a copy of the death certificate only has to show a letter on his or her office's letterhead in order to receive the copy.

Establishing the proper identity of those requesting birth certificates is also important because of delays in many states in matching death and birth records. Such a delay makes the identities of deceased persons easy to assume between the time the person dies and the time death and birth records are matched. According to the State Registrar, in Tennessee it usually

takes over a week from the date of death for a death certificate to be received by the local health department. The local health departments send in death certificates to the central office in Nashville once a week. It then can take up to two weeks before the central office of Vital Records has coded, entered, and stored paper and electronic copies of the death certificate. If a person born in Tennessee dies outside the state, the process could take even longer, from 2 to 15 months, depending on how quickly the other state sends Tennessee the information.

Recommendation

The department should adopt policies and procedures restricting access to vital records, particularly birth certificates, to only the person listed on the birth certificate or a parent, child, sibling, grandparent, or other person who demonstrates a direct and tangible interest and connection. Department staff should always request some form of identification that connects the applicant with the record requested and should denote on the application the type of documentation presented and accepted by staff processing the application. In addition, the General Assembly may wish to consider amending Section 68-3-205, *Tennessee Code Annotated*, to restrict access to vital records and specifically require department personnel to request some type of documentation of identity.

Management's Comment

We concur. The department understands and agrees with the auditors concerning the possibility of identity theft occurring by access to vital records. However, we believe the intent of the statute (Section 68-3-205, *Tennessee Code Annotated*) was to provide open access, with certain exceptions, to the vital records and the use of rules, policies, or procedures with the intent to restrict access to these records could be seen as contrary to the statute.

Nonetheless, the department will review its existing policies and procedures and enforce those to the extent possible without impeding the intent of Section 68-3-205. The review will take into consideration the fact that the majority of requests received by the department come through the mail, the Internet, or by phone, and verifying the validity of an original ID becomes problematic in those instances. We also note that requiring ID will deter some, but not all, fraudulent efforts to obtain a record.

It should also be noted that the department does not maintain a permanent record of applications for copies of vital records except for applications for copies of death certificates that include cause of death. Those applications are retained for six years to comply with federal HIPAA requirements. Maintaining copies of the approximately 500,000 applications received by the department and the local health departments each year will create a personnel, financial, and space burden on the department.

While it appears a legislative change may be required to provide more protection of information contained in vital records, the department believes any changes should be pursued

only after internal study and observance of this issue from a national perspective. For instance, the department would prefer that legislation not specify the steps that must be followed to verify the identity of a requester because many technological changes are occurring in this field and the department should be allowed the flexibility to adopt new methods of verifying identity as those methods become available.

2. The Bureau of Alcohol and Drug Abuse Services is paying some agencies with grant-based contracts full contract amounts even when the agencies do not meet utilization requirements

Finding

The February 1998 performance audit of the Department of Health found that the Bureau of Alcohol and Drug Abuse Services had no standard rate of payment for alcohol and drug treatment and prevention services, and that the rates paid for those services varied widely depending on when the department first funded the bed or other services. Since that time, the bureau has taken steps to equalize reimbursement rates for services. However, weaknesses in the bureau's service reimbursement process remain, and as a result, some agencies that have not met service expectations have essentially been overpaid (relative to other agencies that did meet service expectations).

Effective January 1, 1999, the bureau implemented a unit-rate reimbursement system for approximately 47% of its contracts (including most contracts for ambulatory, residential, and detoxification services) with about 60 agencies. Contractors paid on a unit-rate basis are paid so much per unit of service, depending on the type of service. The bureau established the rates following a 1998 cost information survey of area states and member agencies of the Tennessee Alcohol and Drug Association and the Tennessee Association of Mental Health Organizations. When we reviewed data for agencies with unit-rate-based contracts in fiscal years 2001 and 2002, we found that the agencies were being paid according to the bureau's fee schedule.

For the remaining 53% of the bureau's contracts (which are termed "grant-based"), the contract agencies bill for services in advance and are reimbursed for allowable costs up to the contract amount. The grant contracts include regional training programs, prevention programs, and adolescent and women's treatment programs. According to bureau staff, the services delivered under these grant programs include wrap-around and related services that do not easily convert to unit rates. Additionally, the women's treatment programs have remained grant based to ensure that the bureau meets the spending levels required by the federal Substance Abuse Prevention and Treatment block grant. For the adolescent and women's treatment programs, bureau management has set certain utilization goals based on the type of service provided. These utilization levels were determined by a combination of the type of service offered and the corresponding unit rate for that service, as well as allowing 25% for wrap-around and related services.

Several of the grant-based contract agencies have had difficulty meeting the utilization goals, however. For example, all of the five agencies providing services under the Family Intervention Referral program had problems providing services to the number of clients required by contract during fiscal years 2001 and/or 2002. Although agencies are supposed to reach at least 80% of their utilization goals, two agencies had utilization percentages ranging from 6.8% to 30.9% for both years. Three of the seven agencies providing women's intensive outpatient services failed to meet their utilization goals for both 2001 and 2002, with utilization percentages ranging from 23.7% to 69%. In ten cases, agencies that did not meet (and sometimes fell significantly below) the required 80% utilization rate, were paid the contract maximum for 2001 or 2002 because their allowable costs met or exceeded the contract maximum. In nine cases, even though allowable costs did not exceed the contract maximum, agencies were paid disproportionately more than some other agencies to treat fewer clients because their allowable costs were within contract limits.

According to bureau staff, if agencies have trouble meeting their utilization goals, staff will work with them for about two years to attempt to solve the problems. If the problems are not solved, the bureau will no longer allow that agency to provide the service, or the agency may voluntarily drop that program. (Because the process is new, we could not confirm that the process works as described. According to bureau staff, however, the Family Intervention Referral contractor with the lowest utilization percentages dropped that program for fiscal year 2003.) Sometimes a problem may not be confined to one agency but may be program-wide (e.g., the Family Intervention Referral program). In that instance, the bureau will try and resolve the problem, or it may even consider doing away with the program altogether.

Recommendation

Bureau management should reevaluate the provisions of the bureau's grant-based contracts to ensure that payment provisions are in the state's best interest. It appears reasonable that contract agencies are assured some minimum level of payment to cover their costs. However, since contract amounts are tied to expected utilizations (resulting in an expected set cost per utilization within programs), it does not seem appropriate that agencies that have not met the required utilization levels are paid the contract maximum. Furthermore, if bureau staff have made reasonable efforts to assist an agency but utilization problems have not been resolved, the bureau should no longer contract with that agency to provide that service.

Management's Comment

We concur. The Grant-Based Under-Utilization Corrective Action Plan has been developed that requires agencies with less than 80% utilization to meet the requirement within one year. The policy states that "if resolution is not achieved, the program contract for services will be amended or cancelled."

3. Medical and pharmaceutical supply information in the department's computer system is often incomplete and/or inaccurate.

Finding

The Department of Health's Bureau of Health Services uses a computer system called PTBMIS (Patient Tracking and Billing Management Information System) to coordinate with local health departments. PTBMIS compiles some medical information, generates bills, tracks drug and vaccine supplies, and provides information for reports to the state and federal government. As part of the department's internal quality management system, regional staff conduct quality management reviews of county health department operations, including reviewing the accuracy and completeness of patient files and PTBMIS information. During our audit work, we observed the department's on-site quality management reviews of 113 encounters in five counties. The types of PTBMIS-related problems reviewers identified included (listed from most prevalent to least)

- service/procedure coded in PTBMIS to the wrong program, 16 instances;
- procedure coded in PTBMIS but not documented in paper file, 8 instances;
- service/procedure documented in paper file but not coded in PTBMIS, 7 instances;
- wrong diagnosis or procedure code in PTBMIS, 4 instances;
- test results not entered into PTBMIS, 4 instances;
- financial information wrong or out-of-date, 4 instances; and
- medication entered into PTBMIS twice, one instance.

These review results represent PTBMIS-error rates of 30% (9 of 30 files) for Wilson County; 14% (4 of 28 files) for Sumner County; 25% (5 of 20 files) for Hardin County; 24% (4 of 17 files) for Knox County; and 67% (12 of 18 files) for Blount County.

Since medical records are allowed to be kept in a paper, electronic, or combination format, it is not absolutely necessary for all medical information that can be entered into PTBMIS to be entered into PTBMIS. However, because the billing system and pharmacy inventories are controlled through PTBMIS, it is a problem when the paper medical file and PTBMIS do not agree. If procedures performed are not coded into PTBMIS, they will not be billed for. If procedures are coded into PTBMIS and there is no written evidence they were performed, patients could be paying for services not rendered. If medications are not properly entered, billing may be affected, and supplies may not be properly tracked. Also, because management uses PTBMIS data to assess various aspects of health service, erroneous or incomplete information limits the usefulness of PTBMIS data as a management tool.

Department policy requires drug inventory audits at least every six months. There appears to be an across-the-board problem with obtaining accurate drug inventories through PTBMIS, whether from drugs being in transit between regional offices and local health departments or from local health departments not entering drug dispensations accurately (or occasionally not entering drug dispensations into PTBMIS at all). Although local health departments are required to notify regional pharmacists monthly of drug transfers, expired drugs, wasted drugs, etc., the regional pharmacists are not requiring local health departments to account for discrepancies between PTBMIS and the shelf count, as directed in departmental policies and procedures.

Recommendation

Department management should place increased emphasis on training both medical and administrative staff on proper documentation (paper and electronic) of services, medications, and other materials provided to patients.

Management's Comment

We concur. Proper coding and documentation of medical procedures and pharmaceuticals are very complex tasks. Within the regional and local health departments, staff strive for precise and accurate information. However, medical coding is not a precise science. One of the purposes of having health professionals conduct quality management (QM) reviews of coding and documentation is to provide for continuous improvement in clinic practices. When the regional QM coordinator identifies a potential problem, the problem is communicated to the appropriate local health department personnel. A plan of correction is filed with the QM coordinator. Generally, a follow-up review is conducted within six months to identify improvement in the problem areas.

The bureau has a Codes Committee that maintains a *Codes Manual* that is standard for all 89 rural health departments. If a problem-coding trend is identified, this committee provides clarification through updates to the *Codes Manual*. Training for local health department nurses and office staff often includes emphasis on proper coding. The bureau will continue to monitor and stress the importance of appropriate coding and documentation in the PTBMIS system. The bureau director will stress the importance of appropriate coding and documentation at the next nursing directors' meeting and regional directors' meeting.

A bureau committee, chaired by the bureau medical director, met and analyzed the pharmacy inventory issues and problems. Their analysis, despite the fact that staff in the county health departments often use this as an excuse for physical inventory counts not agreeing with PTBMIS counts, did not indicate that the inventory problems were related to "in transit" pharmacy shipments. The main problems identified were inaccurate and inconsistent posting of drugs dispensed and inconsistent inventory methods.

A policy for pharmacy inventory has been drafted and is currently being circulated for review. The bureau believes the new policy will improve the accuracy of regional and local office pharmacy inventories. Management is committed to continue the current focus to assure that the pharmacy inventory problems are addressed. The bureau director will stress the importance of maintaining an accurate pharmacy inventory at the next nursing directors' meeting and regional directors' meeting.

4. The Division of General Environmental Health should perform Quality Assessments of the field offices and contract county offices more frequently

Finding

Although the Department of Health's Division of General Environmental Health has a policy and process to perform quality assessments of field offices and contract county offices, the policy does not dictate the timing of the assessments, and the division has not performed those assessments as scheduled. Information obtained from such assessments could be beneficial in identifying problems and making improvements in the inspection process. In addition, the U.S. Food and Drug Administration encouraged such assessments in its August 2000 publication *Report of the FDA Retail Food Program Database of Foodborne Illness Risk Factors*.

In its six-month response to the February 1998 performance audit of the Department of Health, management of the Division of General Environmental Health said the division had scheduled (for fiscal year 1999) quality program assessments for all eight field offices and five contract counties. By the time our follow-up audit was released in March 1999, the division had only completed an assessment of Metro Nashville-Davidson County. Since that time, the division has completed the Quality Assessments detailed in Table 2. During fiscal year 1999, the division only completed 3 of 13 scheduled assessments, and from July 1999 through December 2002, had only completed an additional 4 assessments, leaving five field offices and two contract counties not reviewed.

Table 2
Division of General Environmental Health
Quality Assessments Completed or In Progress
December 31, 2002

Field Office/Contract County	Assessment Report Date
East Tennessee Field Office	April 1999
Northwest Tennessee Field Office	May 1999
South Central Tennessee Office	June 2000
Metro Nashville-Davidson County	October 2001
Memphis and Shelby County	December 2001
Knox County	Report in progress

Assessment Authorization, Purpose, and Procedures

According to division staff, the Quality Assessments are authorized under Section 68-14-303(7)(C), *Tennessee Code Annotated*, which states, “The commissioner shall retain the right to exercise oversight and evaluation of performance of the county health department or departments and terminate the agreement or contract for cause immediately.” The current method used is patterned after a federal Food and Drug Administration program started in 1985 that provided recommended evaluation procedures and sampling techniques.

According to the division’s documentation, the purpose of quality assessment is (1) to identify strengths and weaknesses and recommend changes, and (2) to maintain the consistency and integrity of the program. The techniques used in the assessments include file reviews, joint inspections, and interviews with staff and managers. The Quality Assessment team includes central office staff and supervisors or environmentalists from the county field offices. The county field office team members vary so that they are not assessing their own county. The team travels to the field office/county office and reviews files and observes the local environmentalists. The review team performs inspections in establishments right after the local environmentalists to determine if the central office team scores the establishment the same as the local staff.

Results of Quality Assessments

Examples of conclusions in the 1999 and 2000 Quality Assessments include the following:

- All establishments did not have appropriate permits.
- Enforcement procedures are not followed.
- Supervision needs improvement.
- Environmentalists are not citing all violations.

Specifically, the 1999 Quality Assessment report for the East Tennessee Field Office found that all violations in the Food, Hotel, and Public Swimming Pool programs were not being marked. The assessment found a ten-point difference between the survey scores and the environmentalists’ scores. The 2000 Quality Assessment report for the South Central Tennessee Field Office also found that all violations in the Food, Hotel, and Public Swimming Pool programs were not being marked. The assessment found a 14-point difference between the survey scores and the environmentalists’ scores. The 2001 Quality Assessment report for Memphis/Shelby County found significant differences between the review team’s survey scores and the environmentalists’ scores for critical items. The report states that environmentalists were citing 5 of 13 critical violations at less than 50% of the frequency that they were occurring. According to division management, these differences indicated that the inspectors (environmentalists) were not finding violations as often as the Quality Assessment team thought they should. In addition, 379 Shelby County establishments that prepared potentially hazardous food had not been inspected between July 1, 2001, and December 31, 2001. A total of 2,914 establishments are subject to inspection by Memphis/Shelby County.

Follow-ups to the assessments are performed to determine how problems have been addressed. The follow-up for Shelby County, which was conducted in February 2003, found the following:

- Hard copies of inspection forms with scores had not been filed for hotel establishments or public swimming pools in a year.
- The computer database indicated that 73 hotel follow-up inspections were not performed and 53 follow-ups were performed late.
- The computer database indicated that swimming pool follow-up inspections were not performed in calendar year 2002. Critical violations that should have been corrected were marked as critical again on the next complete inspection.

The assessment follow-up did not address the finding regarding environmentalists citing critical violations less frequently than they occur.

Division management stated that the division now has a goal of assessing either one field office or one contracted county office each quarter. This would result in each office being reviewed once every three years.

Recommendation

The Division of General Environmental Health needs to improve the timeliness of its Quality Assessment program to ensure that the public's health is adequately protected and that the division is meeting the FDA's suggestions regarding program assessment. Upper management should determine why the division did not complete the Quality Assessments as scheduled and identify actions that might be needed (e.g., reallocation of staff, reassignment of staff priorities) to ensure assessments are conducted timely. Information obtained from the assessments should be used to identify problems and formulate improvements in the inspection process. Follow-ups to the assessments should be timely in order to evaluate the progress of improvements to the inspection process.

Management's Comment

We concur. By reallocating some staff and reassigning staff priorities, the division can meet the goal of performing four Quality Assessments per year.

Changes have been made in the format of the Quality Assessment report in an effort to simplify the compilation of the final document. Management will work with the program manager responsible for the Quality Assessments and develop a schedule that will require a minimum of four Quality Assessments a year and will allow for the completion of an assessment in each field office and contract county every three years. Further, management will meet with the program manager biweekly to monitor the progress of the assessments.

RECOMMENDATIONS

LEGISLATIVE

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

1. The General Assembly may wish to consider amending Section 68-3-205, *Tennessee Code Annotated*, to restrict access to vital records and specifically require department personnel to request some type of documentation of identity.

ADMINISTRATIVE

The department should address the following areas to improve the efficiency and effectiveness of its operations.

1. The department should adopt policies and procedures restricting access to vital records, particularly birth certificates, to only the person listed on the birth certificate or a parent, child, sibling, grandparent, or other person who demonstrates a direct and tangible interest and connection. Department staff should always request some form of identification that connects the applicant with the record requested and should denote on the application the type of documentation presented and accepted by staff processing the application.
2. Bureau management should reevaluate the provisions of the bureau's grant-based contracts to ensure that payment provisions are in the state's best interest. It appears reasonable that contract agencies are assured some minimum level of payment to cover their costs. However, since contract amounts are tied to expected utilizations (resulting in an expected set cost per utilization within programs), it does not seem appropriate that agencies that have not met the required utilization levels are paid the contract maximum. Furthermore, if bureau staff have made reasonable efforts to assist an agency but utilization problems have not been resolved, the bureau should no longer contract with that agency to provide that service.
3. Department management should place increased emphasis on training both medical and administrative staff on proper documentation (paper and electronic) of services, medications, and other materials provided to patients.
4. The Division of General Environmental Health needs to improve the timeliness of its Quality Assessment program to ensure that the public's health is adequately protected and that the division is meeting the FDA's suggestions regarding program assessment.

Upper management should determine why the division did not complete the Quality Assessments as scheduled and identify actions that might be needed (e.g., reallocation of staff, reassignment of staff priorities) to ensure assessments are conducted timely. Information obtained from the assessments should be used to identify problems and formulate improvements in the inspection process. Follow-ups to the assessments should be timely in order to evaluate the progress of improvements to the inspection process.

**APPENDIX 1
TITLE VI INFORMATION**

All programs or activities receiving federal financial assistance are prohibited by Title VI of the Civil Rights Act of 1964 from discriminating against participants or clients on the basis of race, color, or national origin. In response to a request from members of the Government Operations Committee, we compiled information concerning federal financial assistance received by the Tennessee Department of Health, and the department's efforts to comply with Title VI requirements. The results of the information gathered are summarized below.

According to the Tennessee Department of Health Budget by Program FY 2003-2004, the department was to receive \$247,455,500 in federal assistance, broken down as follows:

Program	Amount
Executive Administration	\$850,300
Administrative Services	\$1,061,700
Information Systems	\$54,600
Office of Health Licensure & Regulation	\$6,194,900
Emergency Medical Services	\$632,500
Laboratory Services	\$3,278,800
Policy Planning & Assessment	\$1,542,400
Alcohol and Drug Services	\$34,043,500
Health Services Administration	\$1,247,300
Maternal and Child Health	\$8,267,100
Communicable Disease Control	\$42,076,400
Population-Based Services	\$6,165,200
WIC Supplemental Foods	\$80,711,300
Local Health Services	\$61,329,500

The Tennessee Department of Health submitted its FY 2003-2004 Title VI Compliance Plan and Implementation Manual to the Office of the Comptroller of the Treasury, Division of State Audit, as required by Section 4-21-901, *Tennessee Code Annotated*.

The department's Title VI coordinator is responsible for helping to regulate compliance and implementation programs for Title VI by working closely with the Title VI Coordinating Committee. The committee is responsible for coordination, implementation, and compliance for the Tennessee Department of Health Title VI programs. The committee is composed of three community representatives and department representatives from the following program areas: the Bureau of Health Licensure and Regulation, the Bureau of Alcohol and Drug Abuse Services, the Bureau of Health Services, the Office of Minority Health, the Office of the General Counsel, the Office of Human Resources, and the Bureau of Health Informatics. According to information in the department's Title VI plan, the committee has nine minority members. Title VI coordinators have also been appointed at each Department of Health regional office.

Department staff are made aware of Title VI requirements through periodic training and dissemination of Title VI literature. According to the department's Title VI plan, staff of the Tennessee Title VI Compliance Commission will provide civil rights training for all department staff during workshops held in the summer and fall of 2003. Title VI-related information is posted at all department facilities and is provided to contractors, vendors, clients, and other community agencies (who might refer clients). The department established the Minority Health Advisory Council to help ensure that community participation is included in the overall process of Title VI enforcement.

All department recipients/contractors receive information about the Title VI Act in the contract language when contracts are signed. Annually, the Title VI assurance and compliance form and the subrecipient compliance plan form are mailed to contractors for completion and signature. Internal Audit and program staff provide orientation conferences for contractors, detailing grant requirements including those related to Title VI.

Regional staff in Health Services perform Quality Assurance audits, which include reviews of Title VI compliance. Each region has a Title VI coordinator to monitor health department sites for Title VI compliance and record any problems found. Internal Audit is responsible for auditing health department sites and contractors for compliance with Title VI requirements. The Department of Finance and Administration's Office of Program Accountability Review monitors department contractors for compliance with Title VI requirements. The department has contracted to provide monitoring of Tennessee's nursing homes to assure compliance with admission requirements. Any problems found in these areas are reported to the department's Title VI coordinator along with corrective actions or plans for correction of compliance problems. The Title VI Coordinating Committee meets quarterly to review the data, analyze it, and make recommendations to the Commissioner.

The department's complaint form states that complaints alleging violations of Title VI may be filed with the department's central office, one of the regional offices, or one of the local county health departments, or even with the U.S. Department of Health and Human Services. According to the plan, Title VI complaints may also be received through the Comptroller's Hot Line. Such complaints would be forwarded to the Department of Health for investigation. A written report of the investigation would then be sent back to the Comptroller's Office, noting the outcome of the investigation. According to information obtained from the Title VI Coordinator and from recent Title VI Plans, the department received no Title VI complaints during fiscal years 2001 through 2003.

The department contracts for the delivery of alcohol and drug abuse services; HIV/AIDS prevention and support services; and community prevention programs related to health issues, local health services, nutrition programs for infants, etc. Regarding the ethnicity of contractors during fiscal year 2003, the department provided the following summary information:

Bureau	Total Number of Contracts	Number of Minority-Led Contracts	Percentage of Minority-Led Contracts
Alcohol and Drug Services	65	14	22%
Office of the Commissioner	3	0	0%
Health Services Administration	592	36	6%
Health Licensure and Regulation	81	25	31%
Laboratory Services	1	0	0%
Total	742	75	10%

A summary of the department employees' gender and ethnicity is included below. As of October 2003, the department had 2,461 staff, of whom 80% were female and 20% were male. Minorities constitute 14% of the department's staff—12% were Black and the remaining 2% were Asian, Hispanic, Other, or Indian.

**Staff of the Department of Health by Title, Gender, and Ethnicity
As of October 2003**

<i>Title</i>	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Account Clerk	0	10	0	3	0	0	7	0
Accounting Manager	1	1	0	0	0	0	2	0
Accounting Tech 1	1	7	0	0	0	0	7	1
Accounting Tech 2	1	3	1	0	0	0	3	0
Accountant Auditor 1	2	1	0	0	0	0	3	0
Accountant 2	1	4	0	1	0	0	4	0
Accountant 3	7	10	0	1	1	0	13	2
Assistant Commissioner 2	0	2	0	1	0	0	1	0
Administrative Director Regulatory Board 1	0	3	0	0	0	0	3	0
Administrative Manager Regulatory Board	0	2	0	0	0	0	2	0
Administrative Assistant Regulatory Board 1	0	5	0	3	0	0	2	0
Administrative Assistant Regulatory Board 2	0	13	0	5	0	0	8	0
Administrative Assistant Regulatory Board 3	0	1	0	0	0	0	1	0
Administrative Assistant 1	0	39	0	6	0	0	33	0
Administrative Services Assistant 1	0	8	0	3	0	0	5	0
Administrative Services Assistant 2	1	36	0	10	0	0	27	0
Administrative Services Assistant 3	5	45	0	8	0	0	42	0
Administrative Services Assistant 4	6	28	0	6	0	0	28	0
Administrative Services Assistant 5	9	11	0	2	0	0	18	0
Administrative Services Manager	3	4	0	0	0	0	7	0
Administrative Secretary	0	26	0	4	0	0	22	0
Attorney 2	1	1	0	1	0	0	1	0

<i>Title</i>	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Attorney 3	4	3	0	0	0	0	7	0
Attorney 4	2	2	0	1	0	0	3	0
Audiologist 2	0	1	0	0	0	0	1	0
Audit Director 3	1	0	0	0	0	0	1	0
Auditor 2	2	0	0	0	0	0	2	0
Auditor 3	5	1	0	0	0	0	6	0
Auditor 4	3	0	0	0	0	0	3	0
Budget Analysis Director 1	1	0	0	1	0	0	0	0
Biologist 3	2	3	0	1	0	0	4	0
Biologist 4	1	0	0	0	0	0	1	0
Cancer Registrar	1	4	0	1	0	0	4	0
Chemist 2	9	8	3	3	0	0	11	0
Chemist 3	3	3	0	0	0	0	5	1
Chemist 4	2	2	0	0	0	0	4	0
Clerk 2	5	30	0	13	0	0	22	0
Clerk 3	5	30	0	11	0	0	24	0
Clerk Typist	0	1	0	0	0	0	1	0
Computer Operations Manager 3	0	1	0	0	0	0	1	0
Community Health Council Coordinator 1	1	10	0	4	0	0	7	0
Community Health Council Coordinator 2	2	6	0	0	0	0	8	0
Commissioner 3	1	0	0	1	0	0	0	0
Counseling Assistant	0	14	0	0	0	0	14	0
Custodial Worker 1	3	1	0	1	0	0	3	0
Data Entry Operator	2	10	0	6	0	0	6	0
Data Base Administrator 2	2	2	1	0	0	0	3	0
Dental Assistant 1	0	1	0	0	0	0	1	0
Dental Assistant 2	0	11	0	1	0	0	10	0
Dentist	11	6	0	2	0	0	15	0
Dental Board Director	1	0	0	0	0	0	1	0
Dental Hygienist – Health Services	1	32	0	0	0	1	32	0
Deputy Commissioner 2	0	1	0	0	0	0	1	0
Dietetics Consultant	0	3	0	0	0	0	3	0
Data Processing Operator 1	0	1	0	0	0	0	1	0
Data Processing Operator 2	0	3	0	3	0	0	0	0
Data Processing Operator 3	0	1	0	1	0	0	0	0
Data Processing Operator Supervisor	0	1	0	1	0	0	0	0
Distributed Computer Operator 2	0	3	1	1	0	0	1	0
Distributed Computer Operator 3	1	1	0	0	0	0	2	0
Distributed Program Analyst 2	1	1	0	0	0	0	2	0
Distributed Program Analyst 3	4	0	1	0	0	0	3	0

<i>Title</i>	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Distributed Program Analyst 4	3	0	0	2	0	0	1	0
Emergency Medical Services Consultant 1	5	1	0	0	0	0	6	0
Emergency Medical Services Consultant 2	3	1	0	0	0	0	4	0
Emergency Medical Services Director	1	0	0	0	0	0	1	0
Environmental Field Office Manager	3	0	0	0	0	0	3	0
Environmental Program Director	1	0	0	0	0	0	1	0
Environmental Program Manager 1	2	0	0	0	0	0	2	0
Environmental Program Manager 2	1	0	0	0	0	0	1	0
Environmental Specialist 1	2	2	0	1	0	1	2	0
Environmental Specialist 3	55	12	0	2	0	0	64	1
Environmental Specialist 4	23	1	0	1	0	0	23	0
Environmental Specialist 5	2	2	0	1	0	0	3	0
Environmental Specialist 6	6	0	0	0	0	0	6	0
Epidemiologist	10	14	2	0	0	0	22	0
Executive Administrative Assistant 1	0	1	0	0	0	0	1	0
Executive Administrative Assistant 2	1	1	0	2	0	0	0	0
Executive Administrative Assistant 3	2	2	0	1	0	0	3	0
Executive Secretary 1	0	3	0	0	0	0	3	0
Executive Secretary 2	0	1	0	0	0	0	1	0
Facilities Construction Director	1	0	0	0	0	0	1	0
Facilities Construction Specialist 3	4	0	1	0	0	0	3	0
Fire Safety Specialist 1	8	1	0	2	1	0	6	0
Fire Safety Specialist 2	2	1	0	0	0	0	3	0
Fire Safety Supervisor	1	0	0	1	0	0	0	0
Fiscal Director 1	3	0	0	0	0	0	3	0
Fiscal Director 2	2	0	0	0	0	0	2	0
Fiscal Director 3	0	1	0	0	0	0	1	0
General Counsel 4	1	0	0	0	0	0	1	0
Graphic Artist	1	0	0	1	0	0	0	0
Health Facilities Surveyor	3	0	0	0	0	0	3	0
Health Planner 3	1	2	0	0	0	0	3	0
Health Regional Emergency Response Coordinator	4	3	0	0	0	0	7	0
Health Statistics Manager	0	2	0	1	0	0	1	0
Health Facilities Survey Manager	2	1	0	1	0	0	2	0
Health Facilities Survey Director	0	1	0	0	0	0	1	0
Health Facilities Program Manager 1	1	3	0	1	0	0	3	0
Health Facilities Program Manager 2	0	2	0	1	0	0	1	0
Health Related Boards Director	0	1	0	0	0	0	1	0
Health Related Boards Investigations Director	0	1	0	0	0	0	1	0

<i>Title</i>	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Human Services Program Manager	1	1	0	0	0	0	2	0
Information Resource Specialist 2	6	4	0	4	0	0	6	0
Information Resource Specialist 3	18	13	0	2	1	0	28	0
Information Resource Specialist 4	9	7	0	1	0	0	15	0
Information Resource Specialist 5	10	1	0	0	0	0	11	0
Information Officer	0	1	0	0	0	0	1	0
Information Systems Analyst 2	0	1	0	0	0	0	1	0
Information Systems Analyst 3	2	3	1	1	0	0	3	0
Information Systems Analyst 4	3	2	0	2	0	0	3	0
Information Systems Analyst Supervisor	1	1	0	0	0	0	2	0
Information Systems Associate	1	1	0	1	0	0	1	0
Information Systems Consultant	1	0	0	0	0	0	1	0
Information Systems Manager 1	2	0	0	1	0	0	1	0
Information Systems Manager 2	1	0	0	0	0	0	1	0
Information Systems Manager 3	1	1	0	0	0	0	2	0
Laboratory Aide	0	1	0	0	0	0	0	1
Laboratory Supervisor 1	1	0	1	0	0	0	0	0
Laboratory Supervisor 1 Certified	0	1	0	1	0	0	0	0
Laboratory Supervisor 2 Certified	0	1	0	1	0	0	0	0
Laboratory Supervisor 3 Certified	2	0	0	0	0	0	2	0
Laboratory Technician 1	0	2	0	2	0	0	0	0
Laboratory Technician 2	2	13	0	5	0	0	10	0
Legal Assistant	2	5	0	3	0	0	4	0
Licensing Technician	3	17	0	12	0	0	8	0
Licensed Practical Nurse 2	0	8	0	0	0	0	8	0
Licensed Practical Nurse 3	0	11	0	1	0	0	10	0
Managed Care Specialist 3	0	1	0	0	0	0	1	0
Medical Board Director	0	1	0	0	0	0	1	0
Medical Records Assistant	1	3	0	0	0	0	3	1
Medical Social Worker 1	0	1	0	1	0	0	0	0
Medical Social Worker 2	1	3	0	0	0	0	4	0
Medical Technologist Consultant 1	1	3	0	1	0	0	3	0
Medical Technologist Consultant 2	0	3	0	0	0	0	3	0
Media Program Director	1	0	0	0	0	0	1	0
Mental Health Planning and Evaluation Specialist 3	0	1	0	0	0	0	1	0
Mental Health Program Specialist 3	1	4	0	1	0	0	4	0
Mental Health/Mental Retardation Program Director	4	0	0	2	0	0	2	0
Microbiologist 2 Certified	13	30	1	7	0	1	34	0
Microbiologist 3 Certified	3	7	1	1	0	0	8	0

<i>Title</i>	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Microbiologist 4 Certified	1	6	0	1	0	0	6	0
Mainframe Computer Operator 2	0	1	0	0	0	0	1	0
Network Technical Specialist 3	9	0	0	1	0	0	8	0
Nurse Assistant 1	0	2	0	0	0	0	2	0
Nurse Assistant 2	1	90	0	22	0	0	69	0
Nurse Practitioner	4	36	0	0	0	0	40	0
Nursing Board Director	0	1	0	0	0	0	1	0
Nutrition Educator	0	23	0	1	0	0	22	0
Nutritionist 1	0	4	0	0	0	0	4	0
Nutritionist 2	0	19	2	0	0	0	17	0
Nutritionist 3	0	10	0	0	0	0	10	0
Nutritionist 4	0	3	0	1	0	0	2	0
Office Automation Specialist	1	6	0	0	0	0	6	1
Office Supervisor 1	1	1	0	0	0	0	2	0
Office Supervisor 2	2	4	0	0	0	0	6	0
Office Supervisor 3	0	2	0	0	0	0	2	0
Personnel Analyst 2	0	7	0	1	0	0	6	0
Personnel Analyst 3	0	1	0	0	0	0	1	0
Personnel Manager 1	0	1	0	1	0	0	0	0
Personnel Manager 2	0	1	0	1	0	0	0	0
Personnel Technician 3	0	2	0	0	0	0	2	0
Personnel Training Supervisor	0	1	0	0	0	0	1	0
Public Health Administrator 1	0	1	0	0	0	0	1	0
Public Health Administrator 2	2	2	0	1	0	0	3	0
Public Health County Director 1	1	2	0	0	0	0	3	0
Public Health County Director 2	0	1	0	0	0	0	1	0
Public Health County Director 3	13	17	0	0	0	0	30	0
Public Health Educator 2	2	28	0	3	0	0	27	0
Public Health Educator 3	1	7	1	2	0	1	4	0
Public Health Laboratory Director	1	0	0	0	0	0	1	0
Public Health Office Assistant	1	233	1	16	2	0	215	0
Public Health Office Supervisor 1	0	42	0	1	0	0	41	0
Public Health Office Supervisor 2	0	24	0	2	0	0	22	0
Public Health Office Supervisor 3	0	7	0	0	0	0	7	0
Public Health Program Director 1	5	13	0	7	0	0	11	0
Public Health Program Director 2	5	10	0	0	0	0	15	0
Public Health Program Director 3	2	5	0	0	0	0	7	0
Public Health Regional Assistant Director	1	5	0	0	0	0	6	0
Public Health Regional Director	6	2	0	0	0	0	8	0
Public Health Regional Regulatory Program Manager	0	3	0	0	0	0	3	0

<i>Title</i>	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Public Health Representative 1	0	1	0	1	0	0	0	0
Public Health Representative 2	12	20	0	8	0	0	24	0
Public Health Representative 3	6	4	0	0	0	0	10	0
Public Health Representative 4	1	1	0	1	0	0	1	0
Pharmacy Technician	0	4	0	1	0	0	3	0
Pharmacist 2	4	2	0	0	0	0	6	0
Public Health Nurse 2	2	190	2	5	2	0	183	0
Public Health Nurse 3	0	93	1	2	1	0	89	0
Public Health Nurse 4	0	74	0	1	0	0	73	0
Public Health Nurse 5	0	10	0	0	0	0	10	0
Public Health Nursing Consultant 1	3	65	0	4	0	1	63	0
Public Health Nursing Consultant 2	0	33	1	3	0	0	29	0
Public Health Nursing Consultant Manager	1	0	0	0	0	0	1	0
Public Health Nursing Director	0	1	0	0	0	0	1	0
Physician	19	16	1	7	0	0	27	0
Planning Analyst 5	1	0	0	0	0	0	1	0
Procurement Officer 1	4	5	0	5	0	0	4	0
Procurement Officer 2	0	4	0	2	0	0	2	0
Regulatory Board Investigator	3	2	0	1	0	0	4	0
Regulatory Board Investigator Specialist	0	2	0	0	0	0	2	0
Registered Nurse – Expanded Skills	0	25	0	2	0	0	23	0
Registered Nurse 1	0	4	0	0	1	0	3	0
Secretary	0	44	0	8	0	0	36	0
Social Counselor 1	0	2	0	0	0	0	2	0
Social Counselor 2	1	15	0	0	1	0	15	0
Social Counselor Supervisor	0	1	0	0	0	0	1	0
Social Worker 1	0	1	0	1	0	0	0	0
Social Worker 2	0	12	0	5	0	1	6	0
Speech and Hearing Assistant 2	0	2	0	0	0	0	2	0
Statistical Analyst 3	1	0	0	1	0	0	0	0
Statistical Analyst 4	3	3	0	2	0	0	4	0
Statistical Analyst Supervisor	4	2	0	0	0	0	6	0
Statistical Clerk	0	1	0	0	0	0	1	0
Statistical Program Specialist 1	1	0	0	0	0	0	0	1
Statistical Program Specialist 2	4	2	0	0	0	0	6	0
Statistical Research Specialist	0	1	0	0	0	0	1	0
Statistician 2	0	2	0	0	0	0	2	0
Statistician 3	1	0	1	0	0	0	0	0
Storekeeper 1	1	1	0	2	0	0	0	0
Storekeeper 2	2	0	0	0	0	0	2	0

<i>Title</i>	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Telephone Operator 1	0	2	0	1	0	0	1	0
Vehicle Operator	1	0	0	0	0	0	1	0
Veterinary Board Director	0	1	0	0	0	0	1	0
Vital Records Field Representative	1	1	0	0	0	0	2	0
Vital Records Information Assistant	0	11	0	2	0	0	9	0
Vital Records Manager	0	2	0	0	0	0	2	0
Vital Records Supervisor	0	5	0	2	0	0	3	0
Web Developer 1	1	0	0	0	0	0	1	0
Word Processing Operator 1	0	5	0	3	0	0	2	0
Word Processing Operator 2	0	2	0	0	0	0	2	0
Totals	495	1,966	24	305	10	6	2,107	9

APPENDIX 2
HEALTHY PEOPLE 2010
IDENTIFIED FOCUS AREAS AND LEADING HEALTH INDICATORS

Identified Focus Areas

Specific goals were developed for each of the following areas, to support Healthy People 2010's overarching goals of increasing quality and years of healthy life and eliminating health disparities. For example, the goal for Disability and Secondary Conditions is "Promote the health of people with disabilities, prevent secondary conditions, and eliminate disparities between people with and without disabilities in the U.S. population."

Access to Quality Health Services	Oral Health
Injury and Violence Prevention	Environmental Health
Arthritis, Osteoporosis, and Chronic Back Conditions	Physical Activity and Fitness
Maternal, Infant, and Child Health	Family Planning
Cancer	Public Health Infrastructure
Medical Product Safety	Food Safety
Chronic Kidney Disease	Respiratory Diseases
Mental Health and Mental Disorders	Health Communication
Diabetes	Sexually Transmitted Diseases
Nutrition and Overweight	Heart Disease and Stroke
Disability and Secondary Conditions	Substance Abuse
Occupational Safety and Health	HIV
Educational and Community-Based Programs	Tobacco Use
	Immunization and Infectious Diseases
	Vision and Hearing

Leading Health Indicators

The following indicators will be used to measure the nation's health through 2010. These indicators were selected on the basis of their ability to motivate action, the availability of data to measure progress, and their importance as public health issues.

Physical Activity	Mental Health
Overweight and Obesity	Injury and Violence
Tobacco Use	Environmental Quality
Substance Abuse	Immunization
Responsible Sexual Behavior	Access to Health Care

Source: U.S. Department of Health and Human Services, Healthy People 2010 Web site.