

Board for Licensing Health Care Facilities

August 2003

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STATE OF TENNESSEE
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John G. Morgan
Comptroller

August 26, 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 Board for Licensing Health Care Facilities. 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 board should be continued, restructured, or terminated.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/dlj
02-082

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit
Board for Licensing Health Care Facilities
August 2003

AUDIT OBJECTIVES

The objectives of the audit were to determine the board's and the Department of Health's legislative mandates and the extent to which the board and the department's Division of Health Care Facilities have carried out those mandates efficiently and effectively, and to make recommendations that might result in more efficient and effective operation of the board and the division.

FINDINGS

Lack of Legal Staff Resulted in Delays in Action on Abuse and Neglect Cases

From September 2001 through mid-April 2002, the Division of Health Care Facilities did not have an Office of General Counsel staff attorney assigned to work referred cases of abuse or neglect. During that time period of nearly eight months, 87 cases of suspected abuse or neglect were referred to the Division of Health Care Facilities for review. However, no final actions (i.e., placing an individual on the division's Abuse Registry or closing the case) could be taken on those cases during that time. Timely processing of abuse and neglect cases is vital to ensure that individuals guilty of abusing or neglecting a vulnerable person are identified on the Abuse Registry (and thus should not be hired to work in similar situations again) or that innocent individuals are exonerated as soon as possible (page 10).

The Division Did Not Always Investigate Complaints in a Timely Manner, and Some Guidance Regarding Investigations of Complaints Is Unclear

Both the July 1996 and the December 1998 performance audits of the board found that the Division of Health Care Facilities' investigations of complaints, particularly those alleging abuse and neglect, were not always timely. Our current review of complaint files, for a sample of facilities throughout the state, indicates that the timely investigation of serious complaints (i.e., priority 1 or 2) is still a problem. Failure to promptly investigate such complaints makes it more difficult for division staff to substantiate allegations, to react to and facilitate prompt correction of problems, and to ensure that facilities are providing the best possible care. In addition, differences between state and federal policies regarding complaints and the lack of clear direction in some areas from the Centers for Medicare and Medicaid Services (CMS) may create confusion for staff regarding requirements (page 12).

The Board Was Not Self-sufficient for the Year Ended June 30, 2002, and Failed to Report This Status by the Statutorily Required Date

Section 68-11-216, *Tennessee Code Annotated*, states that the General Assembly intends for the board to generate sufficient fees to pay operating costs including, but not limited to, licensure and inspection costs. If the board fails to collect sufficient fees, the Commissioner of Health is to certify and report this occurrence to the Government Operations Committee of each house and the Tennessee Code Commission on or before June 30, 2002, and each year thereafter. Based on our review of relevant financial reports, we determined that the board ended fiscal year 2002 with a \$206,752 deficit balance. Based on the deficit and the Closing Status Report date, we concluded the board was not in compliance with statutory requirements

that the board collect sufficient revenues to cover operating expenses and report any deficit by June 30, 2002 (page 19).

One Board Member's Position Has Remained Vacant for an Extended Period of Time

Section 68-11-203, *Tennessee Code Annotated*, requires that the Board for Licensing Health Care Facilities consist of 20 members. Board members are appointed by the Governor and serve a four-year term. As of June 2003, however, there were only 19 members serving on the board, and a Consumer Representative appointment had been vacant since January 31, 2001. When positions are allowed to remain vacant, the board is deprived of another perspective (deemed important by the General Assembly) in its decision making (page 21).

OBSERVATIONS AND COMMENTS

The audit also discusses the following issues: (1) continued weaknesses in the abuse registry, despite improvements; (2) limits in the range of enforcement actions available for use against some types of facilities; (3) discrepancies between complaint information found on the complaint log and information found in regional files; (4) methadone clinics in Tennessee; (5) the decrease in waivers of board rules; and (6) the Nursing Home Compare system (page 3).

ISSUES FOR LEGISLATIVE CONSIDERATION

The General Assembly may wish to consider revising the due date for the report regarding the board's self-sufficiency, since final information on revenues and expenditures may not be available on the last day of the fiscal year (page 19).

The General Assembly may wish to consider legislation allowing the Department of Health to impose civil penalties against all types of facilities (page 6).

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

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**Performance Audit
Board for Licensing Health Care Facilities**

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Performance Audit Board for Licensing Health Care Facilities

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

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

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to determine the authority and responsibility mandated to the board and the Department of Health by the General Assembly,
2. to determine the extent to which the board and department have met their legislative mandates,
3. to evaluate the efficiency and effectiveness of the board and the Department of Health's Division of Health Care Facilities, and
4. to recommend possible alternatives for legislative or administrative actions that may result in more efficient and effective operation of the board and the Division of Health Care Facilities.

SCOPE AND METHODOLOGY OF THE AUDIT

The board's and Health Care Facilities Division's activities and procedures were reviewed with the focus on procedures in effect at the time of fieldwork (March to October 2002). 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 used included

1. interviews with staff of the Board for Licensing Health Care Facilities and the Health Care Facilities Division,
2. review of Department of Health files,
3. site visits to the division's regional offices,
4. review of statutes and state and federal rules and regulations, and
5. review of prior audit reports and documents.

ORGANIZATION AND RESPONSIBILITIES

The primary statutory purpose of the Board for Licensing Health Care Facilities is to license and regulate hospitals, recuperation centers, nursing homes, homes for the aged, residential HIV supportive-living facilities, assisted-care living facilities, home-care organizations, residential hospices, birthing centers, prescribed child care centers, renal dialysis clinics, ambulatory surgical treatment centers, and facilities operated for the provision of alcohol and drug prevention and/or treatment services.

The Department of Health is empowered to license and regulate the above facilities through Title 68, Chapter 11, *Tennessee Code Annotated*; this licensing and regulation are to be accomplished through the Board for Licensing Health Care Facilities. Pursuant to Section 68-11-209, *Tennessee Code Annotated*, the board

has the duty and power to adopt such rules and regulations pertaining to the operation and management of any facilities required to be licensed under this part, and to rescind, amend or modify such rules and regulations from time to time, as are necessary in the public interest and particularly for the establishment and maintenance of standards of hospitalization required for the efficient care of patients or home for the aged, residential HIV supportive-living facility, or assisted-care living facility residents.

The board is required to meet at least twice a year and consists of 20 members who are appointed by the Governor to serve four-year terms:

- two medical doctors;
- one oral surgeon;
- one pharmacist;
- one registered nurse;

- two hospital administrators;
- one osteopath;
- three representatives of the nursing home industry;
- one architect;
- one operator of a home-care organization;
- one operator of a licensed residential home for the aged or a representative of the assisted-living industry;
- one representative of the drug and alcohol abuse service profession;
- two consumer members; and
- the Commissioner of Health, the Chair of the Tennessee Public Health Council, and the Executive Director of the Commission on Aging, all serving *ex officio*.

The Division of Health Care Facilities, Bureau of Manpower and Facilities, Department of Health, handles the administrative work of the board. The division monitors the quality of health care facilities through investigation of complaints and the certification and licensure of health care facilities across the state. The division has regional offices in Jackson, Knoxville, and Nashville, and a central office in Nashville. All surveys of health care facilities are conducted from the regional offices.

OBSERVATIONS AND COMMENTS

The issues listed below did not warrant findings but are included in this report because of their effect or potential effect on the operations of the Division of Health Care Facilities; the Board for Licensing Health Care Facilities; and the health, safety, and welfare of the people of the State of Tennessee.

THE ABUSE REGISTRY HAS BEEN IMPROVED, BUT WEAKNESSES STILL EXIST

The December 1998 performance audit of the board identified several weaknesses in the state's abuse registry. Since that time, the registry has been improved by expanding its scope. A few weaknesses remain, however.

The 1998 audit found that the abuse registry did not comply with state law because instead of listing the names of anyone found to have abused or intentionally neglected elderly or vulnerable individuals, it only listed the names of certified nurse aides. Now, however, Tennessee's Abuse Registry lists the names of all individuals who have been found to have abused or intentionally neglected elderly or vulnerable individuals, in accordance with both state

and federal regulations. As of June 6, 2003, the Abuse Registry listed 861 individuals. The chart below illustrates the various professions now listed on the registry.

<i>Profession</i>	<i>Number on Abuse Registry</i>
<i>Nurse Aide</i>	639
<i>Unknown</i>	79
<i>Developmental Technician</i>	36
<i>Nurse Technician</i>	22
<i>Licensed Practical Nurse</i>	16
<i>Housekeeper</i>	14
<i>Residential Technician</i>	13
<i>Nursing Home Employee</i>	12
<i>Community Living Specialist</i>	7
<i>Companion</i>	7
<i>Janitor</i>	3
<i>Locational Trainer</i>	3
<i>Psychiatric Technician</i>	3
<i>Registered Nurse</i>	3
<i>Community Living Assistant</i>	1
<i>Group Home Employee</i>	1
<i>Maid</i>	1
<i>Orderly</i>	1
Total	861

The 1998 audit also reported that certified nursing homes were the only health care facilities required to check the abuse registry before hiring an individual to provide care to vulnerable persons. Legislation passed in 1999 corrected this problem by expanding the requirement to all facilities licensed by the board. According to Division of Health Care Facilities personnel, however, the division’s surveyors are not required, as part of a facility’s annual survey, to check personnel records for evidence of abuse registry matching. Therefore, the division has no way of knowing if facilities are complying with the new legislation.

The weaknesses described in the 1998 audit regarding the sharing of abuse registry information among states appear to have changed little. According to division staff, there is still no national abuse registry, and there is little sharing of abuse registry data among states. As a result, an individual found to have abused in one state could move to another state and continue working with elderly or vulnerable individuals. The ability to share information with other states would be especially beneficial in Tennessee, where we are within easy driving distance of eight states (Alabama, Arkansas, Georgia, Kentucky, Mississippi, Missouri, North Carolina, and Virginia). For example, a facility located in Clarksville, Tennessee, could check to see if a potential employee had a substantiated case of abuse on record in Kentucky as well as in Tennessee.

The Division of Health Care Facilities should consider revising the instrument used during its annual survey of facilities, to include a requirement that surveyors check personnel records for evidence of abuse registry matching. In addition, the division should participate with

other states, federal agencies, and national advocacy groups in any efforts to compile abuse registry data nationally so that abusers could not move from state to state and continue working with vulnerable individuals.

THE RANGE OF ENFORCEMENT ACTIONS AVAILABLE FOR USE AGAINST SOME TYPES OF FACILITIES REMAINS LIMITED

The December 1998 Sunset Audit found that the range of enforcement actions available for use against some types of health care facilities might not be adequate to encourage compliance with regulations. Since that audit, the state has begun imposing state civil penalties against nursing homes. However, the amount of civil penalties imposed is small, and all other limitations in enforcement actions cited in that audit still exist. State civil penalties are only allowed by statute to be used against deficient nursing homes and in very limited cases against assisted-care living facilities. In addition, facilities must commit violations serious enough to warrant suspension or revocation before the Board for Licensing Health Care Facilities can take any action. Facilities with violations that do not warrant such actions simply have to submit a plan of correction. Federal civil penalties are also only available against deficient certified nursing homes, and these penalties can be avoided or reduced in many cases. These restrictions all translate into limited consequences for most facilities that violate regulations and laws.

Available State Enforcement Actions

State enforcement actions available to the board are limited to suspension or revocation of the facility's license, and suspension of admissions for nursing homes and homes for the aged. In addition to the enforcement actions available to the board, Section 68-11-801, *Tennessee Code Annotated*, gives the Commissioner of Health the power to impose civil monetary penalties against deficient nursing homes. Allowable penalties for use against deficient facilities range from \$250 for Type C Penalties to \$5,000, the maximum amount for Type A Penalties. If a second penalty is imposed for the same violation within 12 months of the first, the amount of the penalty imposed may be doubled.

The 1998 audit found that the Tennessee Department of Health had not used state civil penalties since the federal enforcement provisions were implemented in 1995. In their response to the 1998 audit finding, department staff responded that they were in the process of amending the state plan with the Health Care Financing Administration (now Centers for Medicare and Medicaid Services [CMS]) that would allow the state to use a combination of state and federal civil penalties. Information obtained from division personnel indicates that the department began imposing state civil monetary penalties in January 2000. The total amount imposed for each year (2000 through 2002) can be seen in the table below. (The division could not provide information on penalties actually collected.)

State Civil Penalties Imposed

2002	2001	2000
\$16,500	\$9,000	\$22,170

Available Federal Enforcement Actions

If the deficiencies cited are serious enough, division staff may recommend to the Centers for Medicare and Medicaid Services (CMS) that federal penalties be imposed against deficient federally certified nursing homes (those eligible to receive Medicare and Medicaid reimbursements). Federal penalties available include the following:

- requiring the development and implementation of a written Plan of Correction;
- state monitoring of the facility;
- directed in-service training for facility staff;
- denying payment for new admissions (or for all patients);
- assessing civil monetary penalties of \$50 to \$10,000 per day;
- temporarily taking over management of the facility; and
- terminating the facility’s Medicare/Medicaid certification.

Federal civil monetary penalties imposed during the last three years are summarized below. (The division could not provide information on penalties actually collected.)

Federal Civil Penalties Imposed

2002	2001	2000
\$1,348,950	\$1,085,800	\$3,102,802

The General Assembly may wish to consider legislation allowing the department to impose civil penalties against all types of facilities.

DISCREPANCIES EXIST BETWEEN COMPLAINT INFORMATION FOUND ON THE COMPLAINT LOG AND THE INFORMATION FOUND IN THE REGIONAL FILES

As part of this audit, we selected for review a random sample of 97 facility files from across the three regions of Tennessee. For the selected facilities, we obtained all surveys and complaints from October 1999 through August 2002. During site visits to the regions, we

compared the information found in the complaint files in the regions with the information found on the central complaint log. Our review identified 138 complaints in the regional files as compared to 175 complaints on the log. In addition, we found cases in which the information on the complaint log and the information in a regional file did not match. The results of our review are summarized below.

Region	Complaints in Regional Files			Total Complaints in Regional Files	Complaints on Complaint Log			Total Complaints on Log
	On Log/Same Information	Not on Complaint Log	Different Information		Not in Files at Region	Different Information	Same Information	
West	54	4	3	61	20	3	54	77
East	14	4	29	47	12	29	14	55
Middle	13	5	12	30	18	12	13	43
Total	81	13	44	138	50	44	81	175

Discrepancies between information in the regional files and on the complaint log raise concerns about the accuracy of complaint information and the possibility that complaint information could be lost before it reaches the regional offices for investigation. The Division of Health Care Facilities should review its processes for transmitting information to the regional offices and the controls in place to ensure the integrity of complaint information at the central office as well as the regional offices. The division should make any needed changes to ensure that department staff have complete and accurate complaint information when carrying out enforcement activities.

REGULATION OF METHADONE CLINICS IN TENNESSEE

The December 1998 performance audit of the board discussed the regulation of methadone clinics and recommended that the Department of Health continue to monitor methadone clinics under the new laws and rules of the General Assembly, keep members of the General Assembly informed, and make any rule changes needed to effectively regulate the clinics.

Tennessee’s methadone clinics are nonresidential narcotic treatment facilities that provide a combination of medical, mental health, and social services for treating opiate-dependent clients with the goal of the individual becoming free from any drug that is not medically indicated. There are currently six methadone clinics operating in Tennessee—one each in Knoxville, Chattanooga, Jackson, and Memphis and two in Nashville. Three additional certificates of need (one each in Johnson City, Knoxville, and Memphis) have been approved, but the clinics were not licensed to operate as of April 2003.

Methadone clinic services in Tennessee consist of three treatment methods: 30-day detoxification treatment, long-term detoxification treatment (180-day program), and narcotic

replacement maintenance treatment. Clients are admitted to the various methods based upon client requests and admission criteria defined in the state and federal rules.

According to a December 2001 report prepared by the Department of Health in consultation with the Methadone Task Force, Health Facilities Commission, and Board for Licensing Health Care Facilities and entitled “Response to Public Chapter 363 of the Acts of the 2001 General Assembly, Methadone Treatment Facilities,” a general population of at least 100,000 persons is required before establishing a methadone clinic. This estimate is believed to generate an average of 67 clients. Additionally, a program may not be established unless a minimum caseload of 60 patients is available.

The Tennessee Department of Mental Health and Mental Retardation (now the Department of Mental Health and Developmental Disabilities) began regulatory oversight of methadone treatment facilities in 1988. Oversight was transferred to the Department of Health’s Division of Health Care Facilities in March 1994. The department amended the rules and regulations in August 1999, and new federal regulations for methadone clinics were implemented in March 2001. All Tennessee clinics were surveyed in 2002 at least once. During these six annual surveys, a total of 40 deficiencies were issued for an average of 6.6 deficiencies per clinic. According to division staff, all of the clinics have submitted acceptable Plans of Correction and have been revisited and determined to be implementing their plans successfully.

Division personnel reported that in order to open a new methadone clinic in Tennessee, a facility must first receive a certificate of need from the Health Services and Development Agency (formerly the Health Facilities Commission). This certificate requires that the actual proposed location be declared. Once the certificate of need has been granted, the facility must apply for licensure with the Board for Licensing Health Care Facilities. The facility must submit blueprints of the proposed facility for approval by the engineering staff of the Division of Health Care Facilities. The facility will be surveyed before opening to verify that policies and procedures meet state and federal standards and that personnel are in place. Division of Health Care Facilities’ personnel are not responsible for notifying the public of proposed new facilities. Public notification is part of the Health Services and Development Agency’s certificate of need process.

See Appendix 2 for unaudited Department of Health program information concerning methadone treatment facilities.

WAIVERS OF BOARD RULES

The July 1996 performance audit of the board discussed the numerous waivers of board rules that facilities requested and the possible effect of outdated rules on the number of waivers requested and granted. The December 1998 performance audit discussed the changes since the 1996 audit—the board began tracking data on waivers in 1996 and, at the time of the 1998 audit, was working to draft and adopt new rules for all facility types. In calendar year 1997, health care facilities requested 178 waivers. Of these, 149 were granted, 20 were denied, and the rest were deferred, withdrawn by the facilities, determined not to be required, etc. The 1998 audit stated,

“Management believes the number of waivers requested will drop once new rules become effective, although some waivers will still be needed because no rules can cover every situation.”

Our analysis of waivers acted on by the board from January 1999 through May 2003 indicated that the number of waivers per year has been steadily decreasing during that period. (See table below.) The three waiver requests made most frequently concerned the nursing home administrator, sprinkler system installation/repair, and placing a license in inactive status.

**Number of Waivers Acted on by Board for Licensing Health Care Facilities
By Type of Action
January 1999 Through May 2003**

	1999	2000	2001	2002	2003
<i>Board Has No Authority</i>	0	0	1	0	0
<i>Deferred</i>	1	0	0	0	0
<i>Denied</i>	7	4	6	3	3
<i>Dismissed</i>	0	0	1	0	0
<i>Granted</i>	51	34	19	21	4
<i>Withdrawn</i>	1	2	3	0	0
<i>Total</i>	60	40	30	24	7

NURSING HOME COMPARE

In order to help citizens make informed choices about nursing homes, Medicare has developed a Web site (www.medicare.gov/nhcompare/home.asp) called Nursing Home Compare. The primary purpose of the Nursing Home Compare system is to provide detailed information about the past performance of every Medicare- and Medicaid-certified nursing home in the country. By using the Nursing Home Compare system, it is possible to obtain the following information:

- the number of beds in a facility;
- the type of ownership;
- data about quality measures including percent of residents with pressure sores, the percent of residents with physical restraints, etc.;
- inspection results information including health deficiencies found during the most recent state nursing home survey and any recent complaint investigations; and
- staff information including the average number of hours worked by registered nurses, licensed practical nurses, or vocational nurses, and the number of certified nursing assistants per resident per day.

FINDINGS AND RECOMMENDATIONS

1. Lack of legal staff resulted in delays in action on abuse and neglect cases

Finding

From September 2001 through mid-April 2002, the Division of Health Care Facilities did not have an Office of General Counsel (OGC) staff attorney assigned to work referred cases of abuse or neglect. During that time period of nearly eight months, 87 cases of suspected abuse or neglect were referred to the Division of Health Care Facilities for review. (Cases were referred from various departments, including the Tennessee Bureau of Investigation, the Tennessee Department of Mental Health and Developmental Disabilities, the Tennessee Department of Human Services, the Tennessee Board of Nursing, and each of the Division of Health Care Facilities' three regional offices.) However, no final actions (i.e., placing an individual on the division's Abuse Registry or closing the case) could be taken on those cases during that time. Timely processing of abuse and neglect cases is vital to ensure that individuals guilty of abusing or neglecting a vulnerable person are identified on the Abuse Registry (and thus should not be hired to work in similar situations again) or that innocent individuals are exonerated as soon as possible.

Our review of the Abuse Registry log maintained by division personnel found that as of March 2003, 63 of the 87 suspected abuse cases referred to the division from September 2001 through April 2002 (see Table 1) resulted in a placement on the Abuse Registry. It took an average (weighted) of four months for these cases to be reviewed by the OGC with cases referred in September 2001 taking approximately ten months and cases referred in April 2002 taking approximately one month (see Table 2).

Table 1
Disposition of Closed Cases
September 2000 Through March 2003

	Total Number of Cases Referred	Average Number of Months for OGC Review	Number of Names Posted to the Abuse Registry	Average Number of Months to Post to Abuse Registry	Number of Cases Closed Without a Registry Placement
Sept. 2000 – Aug. 2001	10	14	0	NA	10
Sept. 2001 – Apr. 2002	87	4	63	5	13
May 2002 – Dec. 2002	92	1	41	1	39
Jan. 2003 – Mar. 2003	36	0	7	1	18
Totals	<u>225</u>		<u>111</u>		<u>80</u>

NA= not applicable. No names were posted to the registry.

Table 2
Average Number of Months for OGC Review
For Cases Referred September 2001 Through April 2002

Month Referred to Division for Review	Number of Cases Received per Month	Number of Months for OGC Review
September 2001	2	10
October 2001	17	6
November 2001	14	5
December 2001	10	5
January 2002	7	4
February 2002	9	4
March 2002	9	2
April 2002	19	1
	Total Number of Cases Received	Average (Weighted) Number of Months for OGC Review
	87	4

Of the remaining cases referred between September 2001 and April 2002, 13 were closed with no placement to the registry (see Table 1), and 11 remained open as of March 2003 (see Table 3). For the 63 cases where charges of abuse or neglect were substantiated, it took approximately five months to post an individual's name to the Abuse Registry (see Table 1). As of the date of our review, the 11 open cases had been active an average of 14 months. (See Table 3.)

Table 3
Status of Open Cases
(September 2001 Through March 2003)

	Mailed a 30-Day Intent Letter	Hearing Requested	Referred to Investigations	Waiting for Conviction Papers	Average Number of Months Open
Sept. 2001 – Apr. 2002	0	7	3	1	14
May 2002 – Dec. 2002	0	12	0	0	8
Jan. 2003 – Mar. 2003	6	4	0	0	2
Totals	6	23	3	1	

To determine the impact the lack of an assigned staff attorney may have had on the Abuse Registry, we compared the status of the 87 cases referenced above with cases referred to the division from May 2002 through December 2002. Our review found that in this subsequent eight-month period, a total of 92 cases (see Table 1) were referred to the division for review. Of those 92 cases, 41 resulted in a placement on the registry, 39 were closed with no posting to the registry, and 12 remained open as of March 2003. For the 41 cases where charges of abuse or neglect were substantiated, it took approximately one month to post an individual's name to the

Abuse Registry (see Table 1). As of the date of our review, the 12 open cases had been active an average of 8 months (see Table 3).

We also compared the names and social security numbers of the 225 individuals referred to the Division of Health Care Facilities from September 2000 through March 2003 in order to determine if the lag in processing (September 2001 through April 2002) resulted in an individual caregiver receiving multiple complaints without being posted to the Abuse Registry. Although our review of the log found no duplicate names or social security numbers listed, the potential for harm still existed.

Recommendation

Department of Health management should monitor staffing and allocate resources so that legal staff are available to process abuse and neglect cases in a timely manner. Division and OGC personnel should continue to work the 11 open cases referred to the division between September 2001 and April 2002 to ensure that abusive individuals are appropriately placed on the registry.

Management's Comments

We concur. The department has developed a plan to address the 11 open cases and each has been assigned a high priority for action with management and OGC.

2. The division did not always investigate complaints in a timely manner, and some guidance regarding investigations of complaints is unclear

Finding

Both the July 1996 and the December 1998 performance audits of the board found that the Division of Health Care Facilities' investigations of complaints, particularly those alleging abuse and neglect, were not always timely. Our current review of complaint files, for a sample of facilities throughout the state, indicates that the timely investigation of serious complaints (i.e., priority 1 or 2—see below) is still a problem. Failure to promptly investigate such complaints makes it more difficult for division staff to substantiate allegations, to react to and facilitate prompt correction of problems, and to ensure that facilities are providing the best possible care. In addition, differences between state and federal policies regarding complaints and the lack of clear direction in some areas from the Centers for Medicare and Medicaid Services (CMS) may create confusion for staff regarding requirements.

Timeliness of Complaint Investigations

We reviewed complaint files from October 1999 to August 2002 for 12 facilities in West Tennessee, 11 in East Tennessee, and 9 in Middle Tennessee to determine the timeliness of complaint reviews/investigations and the frequency of substantiated complaints. In analyzing the timeliness of complaint investigations, we used the division’s policies as well as the time guidelines provided in the federal complaint form (see below). These two sources provide different guidelines for priority 3 complaints; therefore, we evaluated priority 3 complaints using both guidelines. (See p. 16 for a discussion of conflicting/unclear guidance regarding complaints.)

Division’s and CMS’s Complaint Investigation Guidelines

	Division’s Priority Scale		Guidance from CMS’s Medicare/Medicaid/CLIA Complaint Form (CMS – 562)
Priority 1	Immediate Jeopardy	Must make on-site visit within 48 hours	Investigate within 2 working days
Priority 2	Actual Harm	Investigate within 10 days	Investigate within 10 working days
Priority 3	Care or Services	Investigate within 20-90 days	Investigate within 45 days
Priority 4	Minor Complaint	Investigate at next on-site survey	Investigate at next on-site survey
Priority 5	Not in scope	Refer to another agency	Referral

Tables 4 through 7 below detail the results of the file review by region as well as the total results. From our review, we determined that approximately 36% of the priority 1 complaints and nearly 51% of the priority 2 complaints were not reviewed in the working days allowed by policy (see Table 7). Using the federal guidelines in effect during the period we reviewed, nearly 19% of the priority 3 complaints were investigated after 45 days. Based on division policies, however, only 6% of the priority 3 complaints we reviewed were not investigated timely.

Table 4
Results of Complaints File Review - West Tennessee

Priority Level	Investigation Time Frame	Number of Complaints Reviewed	Number Investigated Late	Percent of Total Complaints Investigated Late	Percent of Complaints Investigated Late, by Priority Level
1	2 working days	5	0	0%	0%
2	10 working days	28	11	12.4%	39.3%
3	45 days (CMS)	38	7	7.9%	18.4%
3	20-90 days (Board)	38	1	1.1%	2.6%
4	Next on-site visit	12	0	0%	0%
5	Division has no authority. Refer.	2	0	0%	0%
	Other action	2	0	0%	0%
N/A*	N/A	2	0	0%	0%
Total		89	18**	20.2%	

* N/A means the priority or date of review could not be determined from the file.

**Using CMS time frames.

Table 5
Results of Complaints File Review - East Tennessee

Priority Level	Investigation Time Frame	Number of Complaints Reviewed	Number Investigated Late	Percent of Total Complaints Investigated Late	Percent of Complaints Investigated Late, by Priority Level
1	2 working days	2	1	1.5%	50.0%
2	10 working days	21	15	22.7%	71.4%
3	45 days (CMS)	15	1	1.5%	6.7%
3	20-90 days (Board)	15	1	1.5%	6.7%
4	Next on-site visit	17	0	0%	0%
5	Division has no authority. Refer.	0	0	0%	0%
	Other Action	11	0	0%	0%
N/A*	N/A	0	0	0%	0%
Total		66	17**	25.7%	

* N/A means the priority or date of review could not be determined from the file.

**Using CMS time frames.

Table 6
Results of Complaints File Review - Middle Tennessee

Priority Level	Investigation Time Frame	Number of Complaints Reviewed	Number Investigated Late	Percent of Total Complaints Investigated Late	Percent of Complaints Investigated Late, by Priority Level
1	2 working days	4	3	10.0%	75.0%
2	10 working days	10	4	13.3%	40.0%
3	45 days (CMS)	11	4	13.3%	36.4%
3	20-90 days (Board)	11	2	6.9%	18.2%
4	Next on-site visit	0	0	0%	0%
5	Division has no authority. Refer.	0	0	0%	0%
	Other Action	0	0	0%	0%
N/A*	N/A	4	0	0%	0%
Total		29	11**	37.9%	

* N/A means the priority or date of review could not be determined from the file.

**Using CMS time frames.

Table 7
Results of Complaints File Review - Total

Priority Level	Investigation Time Frame	Total Number of Complaints	Number Investigated Late	Percent of Total Complaints Investigated Late	Percent of Complaints Investigated Late, by Priority Level
1	2 working days	11	4	2.2%	36.4%
2	10 working days	59	30	16.2%	50.8%
3	45 days (CMS)	64	12	6.5%	18.8%
3	20-90 days (Board)	64	4	2.2%	6.2%
4	Next on-site visit	29	0	0%	0%
5	Division has no authority. Refer.	2	0	0%	0%
	Other Action	13	0	0%	0%
N/A*	N/A	7	0	0%	0%
Total		185	46**	24.9%	

* N/A means the priority or date of review could not be determined from the file.

**Using CMS time frames.

Failure to investigate a serious complaint promptly could reduce the division's chance of substantiating that complaint because bruises or bedsores heal, facilities correct problems that would have warranted investigators' citing deficiencies, or witnesses' accounts of events become cloudy or unsure. Our review of complaint files indicated the following breakdown of complaints by category and whether the complaints were substantiated. (See Table 8.) (The number of complaints reviewed below differs from those in earlier tables in this finding because the numbers below detail individual allegations, more than one of which may have been included in a single complaint investigation).

Table 8
Results of Complaint File Review
Substantiated Versus Unsubstantiated Complaints

<u>Allegations</u>	<u>Substantiated</u>	<u>Unsubstantiated</u>	<u>Total</u>
Resident Abuse	6	32	38
Resident Neglect	3	28	31
Resident Rights	1	19	20
Patient Dumping	0	2	2
Environment	4	15	19
Care or Services	17	83	100
Dietary	1	3	4
Misuse of Funds/Property	0	4	4
Falsification of Records/Reports	0	2	2
Unqualified Personnel	1	4	5
Fraud/False Billing	1	2	3
Fatality	0	1	1
Other	2	28	30
Total	36	223	259
Percent of Total Complaints	13.90%	86.10%	

Overall, less than 14% of the allegations we reviewed were substantiated. The percentages of substantiated allegations ranged from 9% in the West Tennessee region to 17% in Middle Tennessee and 18% in East Tennessee. (See below for a discussion of differing guidance on what constitutes a substantiated complaint and what action is to be taken.)

Conflicting/Unclear Guidance Regarding Complaints

Conflicting or unclear guidance regarding time guidelines for investigating complaints and the definition of a substantiated complaint may create confusion for staff and others involved in complaint investigations.

Time Guidelines. State and federal policies for investigating priority 3 complaints during our review period conflicted (and continue to conflict), and recent federal changes to priority categories have added a further lack of clarity.

The Division of Health Care Facilities’ policies and procedures require that staff investigate priority 3 complaints within 20-90 days. However, CMS’s 562 complaint form for Medicare, Medicaid, and CLIA (Clinical Laboratory Improvement Amendments) facilities requires that priority 3 complaints be investigated within 45 days. The *State Operations Manual* 3281 E (guidance from CMS) does not directly address priority 3 complaints.

When CMS implemented the Aspen Complaint Tracking System (ACTS) in July 2002, the new system listed priority 3 complaints as “investigate within 45 days,” which is consistent with CMS form 562. However, because the division did not receive additional guidance from

CMS or a change to the *State Operations Manual*, the division started using a 45-to-90-days guideline, which is not consistent with either the division policy or the CMS form.

According to division staff, CMS's classification of priorities has changed twice since the implementation of the CMS ACTS complaint tracking system in July 2002. As of November 2002, the priority categories were as follows:

- A. IJ (Immediate Jeopardy) Defined as "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident."
- B. Non-IJ High
- C. Non-IJ Medium
- D. Non-IJ Low
- E. Non-IJ Admin/Review/off-site investigation
- F. Referral-Immediately
- G. Referral-other
- H. No Action Necessary

As of November 21, 2002, however, the division had not received time guidelines from CMS for these new priority categories.

According to staff, the division, under the direction of CMS, is in the process of implementing the new Aspen Complaint Tracking System. Staff have not yet received specific policies for this new system and are waiting until they do receive such information to change their policies.

Definition of Substantiated Complaints. We also found inconsistencies in the definitions of substantiated complaints among CMS form 562, the *State Operations Manual*, and the Division of Health Care Facilities' *Policies and Procedures Manual*. CMS form 562 defines a substantiated complaint as "An allegation that results in the citation of a Federal deficiency related to the allegation." The *State Operations Manual*, Section 3283 B, Item 7B (FINDINGS), refers to the 562 form and states,

Following the investigation, indicate the finding code appropriate to each allegation reported:

1= SUBSTANTIATED – One or more allegations were verified and deficiencies were cited that were related to the allegations being investigated or one or more allegations occurred and were verified but the allegations were corrected prior to the complaint investigation and no deficiencies were written.

The Division of Health Care Facilities' *Policies and Procedures Manual* defines a substantiated complaint as:

When the allegation(s) is validated. If any portion of the allegation is substantiated, the complaint is considered substantiated. A substantiated complaint may or may not result in a violation of law or regulation. Any violation of law or regulation that is identified during the complaint investigation will be cited.

Recommendation

The division should investigate all complaints, especially serious complaints, within the time frames established. The division should attempt to investigate all complaints (but particularly abuse and neglect complaints) as quickly as possible, to help ensure that legitimate complaints are substantiated.

Upon the receipt of policies from CMS regarding the Aspen Complaint Tracking System, division management should modify the Division of Health Care Facilities' *Policies and Procedures Manual* and ensure that the *State Operations Manual* is properly updated to reflect all changes with the implementation of the new system. Management should also ensure that the policies in these documents are consistent and provide clear guidance concerning complaint investigations.

Management's Comment

We concur. While all complaints were investigated, we recognize that at times the division was one or two days late in meeting the required timeframe. The department realizes the importance of priority 1 and 2 complaints; however, it is not always feasible to meet such tight timeframes because of increased workloads and current staffing levels.

In 2001, the response to complaint investigations was approximately 33% with improvement in 2002 to 50%. This was accomplished by using limited numbers of contract nurses. In 2003, the department's request of funding of nine contract nurse positions to assist with the investigation of complaints was approved. We are optimistic that we can improve on the 50%.

The departmental policy regarding complaint priority 3 timeframes will be revised to match CMS policy of response timeframe of 45 days.

3. The board was not self-sufficient for the year ended June 30, 2002, and failed to report this status by the statutorily required date

Finding

Section 68-11-216, *Tennessee Code Annotated*, states that the General Assembly intends for the Board for Licensing Health Care Facilities to generate sufficient fees to pay operating costs including, but not limited to, licensure and inspection costs. If the board fails to collect sufficient fees, the Commissioner of Health is to certify and report this occurrence to the Government Operations Committee of each house and the Tennessee Code Commission on or before June 30, 2002, and each year thereafter. If this deficit occurs for two consecutive fiscal years, the joint evaluation committees will review the board. Furthermore, the board will be subject to a revised termination date of June 30 of the fiscal year immediately following the second consecutive fiscal year during which the board operated at a deficit.

We reviewed three reports from the State of Tennessee Accounting and Reporting System for fiscal year 2002: the System Estimated versus Actual Revenue Report; the Spending/Receipt Plan year-to-date Status Report for the board; and the Spending/Receipt Plan year-to-date Status Report for state facility licensure activity. We also reviewed the board's Closing Status Report dated September 17, 2002. We determined that the board ended fiscal year 2002 with a \$206,752 deficit balance. (See Table 9.) Based on the deficit and the Closing Status Report date, we concluded the board was not in compliance with statutory requirements that the board collect sufficient revenues to cover operating expenses and report any deficit by June 30, 2002.

Recommendation

Board members and Division of Health Care Facilities staff should review the board's revenues and expenditures and determine what actions need to be taken for the board to achieve self-sufficiency. The board should report year-end results to the required entities as soon as possible. Additionally, the General Assembly may wish to consider revising the report's due date since final information on revenues and expenditures may not be available on the last day of the fiscal year.

Table 9
Board for Licensing Health Care Facilities
Revenues and Expenditures*
Fiscal Year Ending June 30, 2002

Revenues		\$1,617,199
Expenditures		
Board Operation		
Personal Services	\$124,550	
Employee Benefits	\$26,400	
Travel	\$7,413	
Printing, Duplication, and Film Processing	\$263	
Communication and Shipping Costs	\$7,724	
Professional and Administrative Services	\$2,374	
Supplies	\$918	
Rentals and Insurance	\$39,402	
Grants and Subsidies	\$2,817	
Professional Services From Other State Agencies	<u>\$11,517</u>	(\$223,378)
State Facility Licensure Activity		
Personal Services	\$889,009	
Employee Benefits	\$239,818	
Travel	\$140,146	
Printing, Duplication, and Film Processing	\$6,311	
Utilities and Fuel	\$373	
Communication and Shipping Costs	\$7,977	
Maintenance, Repairs, and Service Performed by Others	\$192	
Professional and Administrative Services	\$39,115	
Supplies	\$61,963	
Rentals and Insurance	\$49,366	
Motor Vehicle Operation	\$239	
Grants and Subsidies	\$15,819	
Equipment	\$1,495	
Professional Services From Other State Agencies	<u>\$148,750</u>	<u>\$1,600,573</u>
Total		<u>(\$206,752)</u>

* These revenues and expenditures do not include the federal revenues the Division of Health Care Facilities receives or the related expenditures staff incur in administering the federal certification program.

Source: Information compiled from State of Tennessee Accounting and Reporting System

Management's Comment

We concur. Bureau and division management will continue to review expenditures for any possible areas of reduction. Current restrictions on state spending have already caused this program, like all state programs, to review and implement plans for saving state dollars in every possible way. As Table 9 indicates, 88% of the expenditures are related to licensure inspection cost (State Facility Licensure Activity). These expenditures are a direct result of on-site visits by

survey staff to evaluate a facility's compliance with state laws concerning patient care, fire safety, etc. Reducing these expenditures could limit a vital service for the protection of citizens in Tennessee's health care facilities.

Therefore, it is the department's belief that to avoid an erosion of services provided to citizens in health care facilities, fees will have to be increased to achieve compliance with Section 68-11-216, *Tennessee Code Annotated*, in regard to self-sufficiency. Since the Board for Licensing Health Care Facilities has its fee structure set in statute it must have legislation introduced and passed to change its fees. Thus, the ability to implement the needed fee increase is out of the board's control. Nonetheless, the department will seek administration's support for legislation to allow the board to increase its fees to a level necessary to cover its costs during the next legislative session.

Another approach the department is considering is to request administration's support for legislation to allow the Board for Licensing Health Care Facilities to begin setting its fees through the rulemaking process as the other health-related boards authorized in Title 63 of *Tennessee Code Annotated* do. This would allow the board to react more quickly to changing financial circumstances and create a situation where the board could have more means to achieve and maintain a self-sufficient status.

In regard to reporting year-end financial results, management can calculate the board's closing status based on earlier fiscal year close-out information. For fiscal year 2002, revenues and expenditures were representative of the June 30, 2002 STARS reports dated January 25, 2003. Management waited as long as possible to calculate close-out figures to have greater accuracy of information. It would be extremely beneficial if legislation were introduced and passed to change the reporting date for year-end results from June 30 to December 31 of each year. Postponing it until then will allow calculations to be based on at least the fourth preliminary close-out reports from STARS.

4. One board member's position has remained vacant for an extended period of time

Finding

Section 68-11-203, *Tennessee Code Annotated*, requires that the Board for Licensing Health Care Facilities consist of 20 members. Board members are appointed by the Governor and serve a four-year term. As of June 2003, however, there were only 19 members serving on the board. We reviewed member listings to determine if any positions were perpetually vacant. These lists contained the date each position was available for appointment, the date the member was actually appointed, and term expiration. Based on our review, we found that a Consumer Representative appointment has been vacant since January 31, 2001. The Governor made an appointment for this position on April 16, 2002, approximately 14.5 months past availability; however, the individual declined to serve. According to division staff, as of June 2003, the

position remained open and therefore had been vacant for over 28 months. When positions are allowed to remain vacant, the board is deprived of another perspective (deemed important by the General Assembly) in its decision making. Overall, our review indicated that the time elapsed between board members' term expiration and appointment dates ranged from approximately 5 days prior to expiration to 17.9 months past expiration.

Recommendation

Appointments should be made in a timely, manner to ensure the board is compliant with statute. Board for Licensing Health Care Facilities' staff should work with the Governor's Office to ensure that the Governor has sufficient notice of upcoming vacancies and any other additional information he might need to make timely appointments.

Management's Comment

We concur. Currently all appointments have been made.

RECOMMENDATIONS

LEGISLATIVE

1. The General Assembly may wish to consider revising the due date for the report regarding the board's self-sufficiency, since final information on revenues and expenditures may not be available on the last day of the fiscal year (page 19).
2. The General Assembly may wish to consider legislation allowing the department to impose civil penalties against all types of facilities (page 6).

ADMINISTRATIVE

The Board for Licensing Health Care Facilities and the Division of Health Care Facilities should address the following issues to improve the efficiency and effectiveness of their operations.

1. Department of Health management should monitor staffing and allocate resources so that legal staff are available to process abuse and neglect cases in a timely manner. Division and OGC personnel should continue to work the 11 open cases referred to the division between September 2001 and April 2002 to ensure that abusive individuals are appropriately placed on the registry (page 12).

2. The division should investigate all complaints, especially serious complaints, within the time frames established. The division should attempt to investigate all complaints (but particularly abuse and neglect complaints) as quickly as possible, to help ensure that legitimate complaints are substantiated (page 18).
3. Upon the receipt of policies from CMS regarding the Aspen Complaint Tracking System, division management should modify the Division of Health Care Facilities' *Policies and Procedures Manual* and ensure that the *State Operations Manual* is properly updated to reflect all changes with the implementation of the new system. Management should also ensure that the policies in these documents are consistent and provide clear guidance concerning complaint investigations (page 18).
4. Board members and Division of Health Care Facilities staff should review the board's revenues and expenditures and determine what actions need to be taken for the board to achieve self-sufficiency. The board should report year-end results to the required entities as soon as possible (page 19).
5. Appointments should be made in a timely manner to ensure the board is compliant with statute. Board for Licensing Health Care Facilities staff should work with the Governor's Office to ensure that the Governor has sufficient notice of upcoming vacancies and any other additional information he might need to make timely appointments (page 22).
6. The Division of Health Care Facilities should consider revising the instrument used during its annual survey of facilities, to include a requirement that surveyors check personnel records for evidence of abuse registry matching. In addition, the division should participate with other states, federal agencies, and national advocacy groups in any efforts to compile abuse registry data nationally so that abusers could not move from state to state and continue working with vulnerable individuals (page 4).
7. The Division of Health Care Facilities should review its processes for transmitting information to the regional offices and the controls in place to ensure the integrity of complaint information at the central office as well as the regional offices. The division should make any needed changes to ensure that department staff have complete and accurate complaint information when carrying out enforcement activities (page 7).

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 discrimination against participants or clients based on race, color, or national origin. In response to a request from members of the Government Operations Committee, we compiled information concerning (1) federal financial assistance received by the Board for Licensing Health Care Facilities and the Health Care Facilities Division and (2) their efforts to comply with Title VI requirements internally and monitor Title VI compliance in facilities. The results of the information gathered are summarized below.

Internal Compliance Efforts

For fiscal year 2002, the division received federal financial assistance through Medicare's Titles XVIII and XIX totaling \$2,871,742 and \$2,817,416, respectively. Neither the board nor the division prepare a Title VI plan or report directly to a state or federal agency concerning Title VI. Instead, both use the Department of Health's *Title VI Compliance Plan and Implementation Manual*. We reviewed the Fiscal Year 2002-2003 plan for issues related to the board and the division.

According to the department's plan, the division's Title VI coordinator is responsible for ensuring that necessary Title VI functions are carried out in an effective and efficient manner. Some of these functions include

- planning, developing, and managing the Title VI program;
- developing criteria and standards for compliance reviews;
- coordinating on-site reviews with the Health Care Facility survey teams;
- preparing periodic reports reflecting findings, actions required, and results of follow-ups on each nursing home contacted during the reporting period;
- proposing and advocating new regulations and modifications of existing regulations to ensure equal access to long-term health care services by individuals; and
- conducting training workshops for Title VI surveyors and nursing home personnel on Title VI policies and procedures.

According to division staff, the main activities to ensure staff understand Title VI requirements are verbal instruction and handout materials provided to new employees during orientation. Additionally, the personnel officer completes an Equal Employment Opportunity report with each hire/register packet. Furthermore, according to the department's plan, the Tennessee Human Rights Commission will conduct civil rights training workshops for division staff and personnel.

Facility Compliance Monitoring

In addition to ensuring internal compliance, the division must ensure facilities receiving federal funds comply with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The goal is to improve access to health care facilities and to assess discriminatory practices and behavior based on race, color, and national origin in facilities licensed by the board. The division is responsible for disseminating information to health care facilities, conducting on-site reviews, interpreting state and federal regulations for staff and the public, preparing periodic investigative reports, and maintaining a complaint resolution system. If, during an on-site review or complaint investigation, a facility is found noncompliant with Title VI, the board and the department have several enforcement mechanisms available.

Section 68-1-113(c), *Tennessee Code Annotated*, allows the board to deny, suspend, or revoke a license issued to a health care facility, as the result of a Title VI violation. In addition to any such action by the board, Section 68-1-113(d) allows the Commissioner of Health to impose a civil penalty in an amount not to exceed \$5,000 for such a violation. Departmental Rule 1200-24-3-.03 specifies three penalty levels:

Type I penalties range from \$3,500 to \$5,000 and occur when a health care facility engages in discrimination which negatively impacts the health, safety, and welfare of multiple minority patients. For example, denying people admission to the facility; transferring multiple patients from one room to another; and clustering patients on the basis of race, color, and national origin meet this criteria.

Type II penalties, ranging from \$1,500 to \$3,500, may be assessed if the health care facility engages in discrimination which impacts a single minority patient, and the facility refuses to correct the violation. For instance, denying admission to a single individual; assigning a room or transferring a single individual; or denying an individual the opportunity to participate on a planning or advisory board based on race, color, and national origin, or providing segregated services are Type II violations.

Type III penalties, ranging from \$500 to \$1,500, may be assessed for civil rights violations that do not directly involve a specific individual. These include failures to (1) maintain and make available all data necessary to determine the facility's compliance with Title VI, (2) notify referral sources and the minority community that services are provided in a nondiscriminatory manner, (3) display compliance statements, and (4) include a nondiscriminatory statement in all vendor contracts and brochures and other information distributed to the public.

According to division staff, no penalties for Title VI noncompliance have been issued in the last few years.

According to statistics in the department's plan, the two most frequent noncompliance issues or complaints related to health care facilities nationally are patient mistreatment by staff

and unfair hiring, promoting, and layoff practices. However, according to the plan, there were no Title VI complaints during fiscal years 2000 through 2002.

As of September 2002, the Board for Licensing Health Care Facilities had 18 members, 14 of whom were males and 4 of whom were females. One member was Black, and 17 were White. The breakdown of Division of Health Care Facilities' staff by title, gender, and ethnicity is detailed below.

**Staff of Health Care Facilities, Department of Health, by Title, Gender, and Ethnicity
As of August 2002**

Title	Gender		Ethnicity					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Administrative Assistant 1	0	4	0	2	0	0	2	0
Administrative Secretary	0	3	0	0	0	0	3	0
Administrative Services Assistant 1	0	1	0	1	0	0	0	0
Administrative Services Assistant 2	1	4	0	1	0	0	4	0
Administrative Services Assistant 3	0	5	0	1	0	0	4	0
Administrative Services Assistant 4	0	1	0	0	0	0	1	0
Clerk 3	0	1	0	0	0	0	1	0
Dietetics Consultant	0	4	0	0	0	0	4	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 Supervisor	1	0	0	1	0	0	0	0
Fire Safety Specialist 1	8	2	0	2	0	0	8	0
Fire Safety Specialist 2	2	0	0	0	0	0	2	0
Health Facilities Program Manager 1	1	2	0	1	0	0	2	0
Health Facilities Program Manager 2	0	2	0	1	0	0	1	0
Health Facilities Survey Director	0	1	0	0	0	0	1	0
Health Facility Survey Manager	2	1	0	1	0	0	2	0
Health Facilities Surveyor	4	2	0	0	0	0	6	0
Information Resource Support Specialist 3	2	1	0	1	0	0	2	0
Information Resource Support Specialist 4	0	1	0	0	0	0	1	0
Information Resource Support Specialist 5	1	0	0	0	0	0	1	0
Licensing Technician	0	2	0	2	0	0	0	0
Medical Social Worker 2	0	2	0	1	0	0	1	0
Medical Technologist Consultant 1	1	2	0	1	0	0	2	0
Medical Technologist Consultant 2	0	3	0	0	0	0	3	0
Pharmacist 2	1	0	0	0	0	0	1	0
Public Health Nursing Consultant Manager	1	0	0	0	0	0	1	0
Public Health Nursing Consultant 1	4	43	0	1	0	0	46	0
Public Health Nursing Consultant 2	0	11	0	0	0	0	11	0
Public Health Regional Regulatory Program Manager	0	3	0	0	0	0	3	0
Secretary	0	3	0	1	0	0	2	0
	34	104	1	18	0	0	119	0

Appendix 2
Nonresidential Narcotic Treatment Facilities (Methadone Clinics)
Outcome/Performance Data 1999-2001

Statewide Totals	1999	2000	2001
Number of Patients Admitted	3,387	3,549	2,736
Number of Patients in Program at Year End	2,181	2,279	2,887
Total Program Capacity	2,900	3,370	6,060
Total Slots Available at Year End	729	1,091	3,173
Percentage of Patients Employed at Admission	48%	58%	48%
Percentage of Patients Currently Employed	67%	71%	68%
Percentage of Patients Classified Disabled	13%	13%	9%
Percentage Other*	21%	16%	16%

*Includes homemakers, students, retirees, and unemployed.

	1999	2000	2001
Incidences of Criminal Arrests After Admission	3%	3%	2%
Illicit Drug Use After Admission	28%	20%	21%
Continued Alcohol Use After Admission (minimum 1 positive urine drug screen)	7%	6%	25%

	1999	2000	2001
Patient Gender - Male	34%	39%	42%
Patient Gender - Female	66%	61%	60%
Patient Satisfaction	93%	92%	86%
Drop-out Rate			
Discharges	35%	24%	30%
Transfer Out	5%	6%	10%
Complete Treatment	6%	6%	3%
Recidivism Rate	9%	9%	18%
Receive Out-of-Program Services	39%	82%	47%

Out-of-State Patients	1999	2000	2001
Alabama	17	13	10
Arkansas	12	11	37
Georgia	23	52	51
Indiana			3
Kentucky	29	17	21
Missouri	1	0	1
Mississippi	45	83	82
North Carolina	6	4	3
Virginia	37	38	26

Appendix 2
Nonresidential Narcotic Treatment Facilities (Methadone Clinics)
Outcome/Performance Data 1999-2001 (Cont.)

Drug of Choice at Time of Admission	1999	2000	2001
Dilaudid	52%	46%	22%
Oxycodone/Hydrocodone	24%	22%	21%
Heroin	7%	13%	12%
Morphine	16%	19%	9%
Benzodiazepines			14%
Cocaine			11%
THC			11%

Positive Upon Admission	1999	2000	2001
Hepatitis B	3%	5%	4%
Hepatitis C	34%	32%	18%
HIV	1%	1%	1%

Number of Treatment Facilities in Tennessee and Contiguous States
As Reported by SAMHSA

State	Number	Rate per 1 Million Population
Alabama	17	3.8
Arkansas	3	1.1
Georgia	24	2.9
Kentucky	15	3.7
Mississippi	2	0.7
Missouri	12	2.1
North Carolina	18	2.7
Tennessee	6	1.1
Virginia	14	2.3

Source: Tennessee Department of Health.