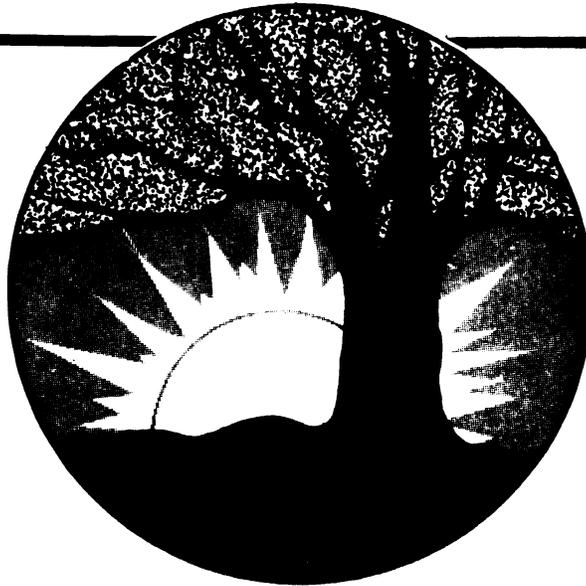


PERFORMANCE AUDIT

Health Related Boards

December 2005



John G. Morgan
Comptroller of the Treasury



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John G. Morgan
Comptroller

December 8, 2005

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 17 health-related boards. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

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

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/dlj
04-111

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit
Health Related Boards
December 2005

AUDIT OBJECTIVES

The objectives of the audit were to determine the following: if board staff are notifying the Governor's Office of impending board membership expirations in a timely manner; if boards complied with department conflict-of-interest policies; if the boards or the Department of Health has developed time guidelines for handling complaints and if complaints against practitioners are reviewed, investigated, and processed timely; if the boards have developed and implemented disciplinary guidelines (including the assessment of disciplinary costs); the effectiveness of the boards' policies and activities regarding lapsed licenses; the boards' progress in defining and assessing criteria for continuing competence of practitioners; if all the boards are self-sufficient; if processes are in place to ensure that board-developed examinations are up to date, psychometrically sound, and properly protected; the boards' progress in implementing new policies concerning alternative dispute resolution; and the department's progress in conducting internal audits of the boards. Additional objectives are to summarize and assess information documenting the boards' and department's compliance with Title VI requirements and to develop recommendations, as needed, for administrative and legislative action which might result in more efficient and/or more effective operation of the boards and the Department of Health.

FINDINGS

Board-Developed Examinations May Be Considered Public Information Under the Provisions of the Public Records Act

Public records statutes may make it difficult to protect board-developed examinations from review by applicants before they take the examination. Such access to a testing instrument negatively impacts the integrity of the examination process and lessens the usefulness of the test as a measure of the applicants' knowledge of their profession (page 14).

Several Boards Have Not Been Self-Sufficient in Recent Years

The November 2003 performance audit of six health-related boards found that several of the boards had not met self-sufficiency requirements (i.e., their fee-generated revenues in a given year were not sufficient to cover their expenses). During the current audit, we found that the Boards

of Dentistry, Optometry, and Veterinary Medical Examiners, as well as the Council of Certified Professional Midwifery, were not self-sufficient during fiscal year 2003. (The Boards of Dentistry, Optometry, and Veterinary Medical Examiners were also not self-sufficient in fiscal year 2002.) Only one board, the Council of Certified Professional Midwifery, was not self-sufficient in fiscal year 2004 (page 15).

The Boards Do Not Adequately Follow Up on Expired Licenses, and Not All Boards Impose Additional Penalties or Additional Renewal Requirements When Professionals Have Worked With Expired Licenses or Their Licenses Have Been Expired for Extended Periods of Time

Approximately two months before licenses expire, the Division of Health Related Boards' computer system generates renewal letters that are sent to

licensees. If renewal fees are not received and the license is allowed to expire, however, the boards do not attempt to determine whether the licensee is still practicing, has retired, is working in another state, etc. With the exception of the Board of Veterinary Medical Examiners, which makes a courtesy phone call to each individual whose license has expired, none of the boards take any action to contact persons following the expiration of their licenses. Lack of such follow-up may allow individuals to continue to practice without a valid license and without receiving the continuing education necessary to ensure they are knowledgeable of advances, technological changes, etc., that help keep them qualified and competent to practice in their profession. In addition, if a substantial number of persons continue to practice without renewing their licenses, the loss of revenue to a board could hinder the board in meeting its self-sufficiency requirements (page 18).

The Division of Health Related Boards Does Not Always Follow Its Policies Regarding the Board Member Appointment Process, and Membership Appointments Are Not Always Timely

The division has taken a variety of actions, including implementing policies and establishing time frames, in an attempt to improve the timeliness of the board member appointment process. The division does not always follow its own policies, however, and the rather lengthy process of gathering and submitting nominations and obtaining appointments can result in lengthy board vacancies or members serving for months after their terms have expired (page 21).

Not All Boards Require and Monitor Continuing Competence

One of the boards reviewed does not require practitioners to obtain continuing education or demonstrate continuing professional competence as a condition of license renewal. The absence of such a requirement hinders the board's ability to ensure that practitioners remain competent and qualified throughout their careers and that the health, safety, and welfare of Tennesseans served by those practitioners are protected. In addition, not all boards that require continuing education as a condition of license renewal monitor licensees for compliance with continuing education requirements (page 26).

The Boards' Conflict-of-Interest Policies and Procedures Need Improvements in Several Areas

The March 1999 performance audit of the Health Related Boards found that the boards did not have a conflict-of-interest policy. Since that time, the Division of Health Related Boards has developed a policy, which we reviewed along with the division's conflict-of-interest statement and the Department of Health's conflict-of-interest policy and statement, as well as statements signed by board members. We found (1) a lack of clarity regarding which statement board members are to sign as well as variances in signing; (2) inconsistencies within the Department of Health's policy and statement; and (3) weaknesses in both policies and statements regarding regular updates and disclosures of potential conflicts of interest (page 27).

OBSERVATIONS AND COMMENTS

The audit also discusses the following issues: a lack of regular updates to some board-developed examinations; the division's continued efforts to improve the practitioner complaint-resolution process; and improvements related to disciplinary guidelines and assessment of disciplinary costs (page 4).

Performance Audit Health Related Boards

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
Purpose and Authority for the Audit	1
Objectives of the Audit	2
Scope and Methodology of the Audit	3
Organization and Responsibilities	3
OBSERVATIONS AND COMMENTS	4
Board-Developed Examinations Are Not Always Regularly Updated	4
The Division of Health Related Boards Has Continued Its Efforts to Improve the Practitioner Complaint-Resolution Process	4
Improvements Related to Disciplinary Guidelines and Assessment of Disciplinary Costs	10
Additional Audit Work Performed	12
FINDINGS AND RECOMMENDATIONS	14
1. Board-developed examinations may be considered public information under the provisions of the Public Records Act	14
2. Several boards have not been self-sufficient in recent years	15
3. The boards do not adequately follow up on expired licenses, and not all boards impose additional penalties or additional renewal requirements when professionals have worked with expired licenses or their licenses have been expired for extended periods of time	18
4. The Division of Health Related Boards does not always follow its policies regarding the board member appointment process, and membership appointments are not always timely	21
5. Not all boards require and monitor continuing competence	26
6. The boards' conflict-of-interest policies and procedures need improvements in several areas	27

TABLE OF CONTENTS (Cont.)

	<u>Page</u>
RECOMMENDATIONS	31
Administrative	31
APPENDICES	
Appendix 1 – Description of the Health Related Boards Covered in This Audit	33
Appendix 2 – Health Related Boards Current Net Income	38
Appendix 3 – Title VI Information	39

Performance Audit Health Related Boards

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of 17 health-related boards was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-226, *Tennessee Code Annotated*, the 17 boards listed below were scheduled to terminate June 30, 2005. On May 25, 2005, the General Assembly passed House Bill 2191, which extended these and other entities in the 2005 Sunset Cycle that had not yet been heard, for one year or until a public hearing can be held:

- Board of Chiropractic Examiners
- Board of Communication Disorders and Sciences
- Board of Dentistry
- Board of Dietitian/Nutritionist Examiners
- Board of Examiners for Nursing Home Administrators
- Board of Examiners in Psychology
- Committee on Physician Assistants
- Board of Nursing
- Board of Optometry
- Board of Registration in Podiatry
- Board of Veterinary Medical Examiners
- Committee for Clinical Perfusionists
- Council of Certified Professional Midwifery
- Council for Licensing Hearing Instrument Specialists
- Emergency Medical Services Board
- Advisory Committee for Acupuncture
- Medical Laboratory Board

The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the boards and to report to the Joint Government Operations Committee

of the General Assembly. The audit is intended to aid the committee in determining whether the boards should be continued, restructured, or terminated.

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to determine if board staff are notifying the Governor's Office of impending board membership expirations in a timely manner;
2. to determine if boards complied with department conflict-of-interest policies;
3. to determine if the boards or the Department of Health has developed time guidelines for handling complaints and if complaints against practitioners are reviewed, investigated, and processed timely;
4. to determine if the boards have developed and implemented disciplinary guidelines (including the assessment of disciplinary costs) that promote consistency in disciplining practitioners;
5. to determine the effectiveness of the boards' policies and activities regarding lapsed licenses;
6. to determine the boards' progress in defining and assessing criteria for continuing competence of practitioners;
7. to determine if all the boards are self-sufficient;
8. to determine if processes are in place to ensure that board-developed examinations are up to date, psychometrically sound, and properly protected from applicants until after they take the exam;
9. to determine the boards' progress in implementing new policies concerning alternative dispute resolution;
10. to determine the department's progress in conducting internal audits of health-related boards;
11. to summarize and assess information documenting the boards' and department's compliance with Title VI requirements; and
12. to develop recommendations, as needed, for administrative and legislative action which might result in more efficient and/or more effective operation of the boards and the Department of Health.

SCOPE AND METHODOLOGY OF THE AUDIT

We reviewed the activities and procedures of the boards and the Division of Health Related Boards, focusing on procedures in effect for fiscal years 2003 through 2004. 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 included

1. a review of applicable statutes, rules, and policies;
2. examination of board-related financial information, documents, reports, and meeting minutes;
3. interviews with Department of Health staff;
4. attendance at board meetings; and
5. a review of a sample of open and closed complaint and case files.

ORGANIZATION AND RESPONSIBILITIES

Pursuant to Section 63-1-101, *Tennessee Code Annotated*, the Department of Health's Division of Health Related Boards' purpose is to provide all administrative, fiscal, inspection, clerical, and secretarial functions to the health-related boards. The division is charged with the responsibility of regulating health care professionals to help assure the quality of health care and protect the public's health, safety, and welfare. Section 63-1-115 authorizes the division to employ investigators, inspectors, or agents to carry out its administration and enforcement of laws regulating the health professions. The division can petition circuit or chancery court to forbid persons practicing without a license from continuing to practice.

The boards, assisted by their administrative staffs, perform regulatory functions which include giving examinations, issuing licenses, making rules and regulations governing the standards of the professional practice, setting fees, approving continuing education requirements, and conducting disciplinary hearings. All board members are appointed by the Governor (except for the members of the Council of Certified Professional Midwifery, who are appointed by the Commissioner of Health), and all boards are required under Section 63-1-124, *Tennessee Code Annotated*, to have at least one citizen member. The boards collect fees to defray their operating costs, and Section 4-29-121 requires that each board attached to the Division of Health Related Boards be financially self-sufficient. (See page 15 for additional information on the boards' self-sufficiency.)

The Emergency Medical Services Board is attached to Emergency Medical Services, which is structured as an independent division under the Bureau of Health Licensure and Regulation.

See Appendix 1 for a brief description of each of the boards included in the scope of this audit.

OBSERVATIONS AND COMMENTS

BOARD-DEVELOPED EXAMINATIONS ARE NOT ALWAYS REGULARLY UPDATED

Instead of using national or contractor-developed examinations, several of the boards covered in this audit have developed their own examinations, such as written and oral jurisprudence examinations, practical skills examinations, and specialty certification examinations. The boards have not, however, always regularly updated these examinations. During our review, we found that one board's written practical skills examination had not been updated since 1979. (This examination was subsequently updated in October 2004.) Some other boards' examinations had been used for many years before being updated only recently.

Because health professionals need to be current on recent advancements in medical science and technology in order to be qualified to practice, the quality of board-developed examinations may suffer if regular updates do not occur. The integrity of board-developed examinations that are not regularly updated may also be negatively affected by Section 4-19-101, *Tennessee Code Annotated*, which makes examination papers "subject to review upon request" for at least a year, and Section 4-19-102, which gives applicants for all professions the right to retake examinations an unlimited number of times. This could allow an applicant to fail the examination, obtain the examination answers, and then repeat those answers the next time the examination is offered. (See Finding 1 for additional discussion of factors affecting the integrity of board-developed examinations.)

The Director of the Division of Health Related Boards stated that the boards are inconsistent in updating the examinations but that board members regularly discuss passing rates as one means to determine if updating is necessary. She also indicated that jurisprudence examinations were amended as frequently as rule or statute changes dictate. Of the boards reviewed in this audit, only the Emergency Medical Services Board had a formal, set schedule for updating its board-developed examinations. Division of Health Related Boards management should work with the boards and board staff to ensure that boards develop a review schedule for their board-developed examinations and routinely review and update those examinations if necessary.

THE DIVISION OF HEALTH RELATED BOARDS HAS CONTINUED ITS EFFORTS TO IMPROVE THE PRACTITIONER COMPLAINT-RESOLUTION PROCESS

The November 2003 performance audit of the Division of Health Related Boards noted that the division had taken positive steps to address prior weaknesses in processing complaints

against practitioners in a timely and consistent manner, but that the complaint resolution process remained lengthy. Our current review of the practitioner complaint resolution process found that the division has continued in its improvement efforts in several areas (see below). The planned upgrade of the Regulatory Boards System to allow for a significant improvement in the monitoring of the stages in the complaint/case process, however, has been delayed until at least fall 2006 (see page 8).

Monitoring

As a result of the November 2003 performance audit, the division formed the Audit Task Force, a work group that meets monthly to review complaint data to identify areas that need improvement. Both the Bureau of Investigations (BIV) and the Office of the General Counsel (OGC) have provided the Task Force with information that has identified trouble spots in the complaint resolution process. This has allowed the division to continue making needed improvements.

While in the BIV, where complaints are first handled, the file is termed a “complaint.” There are two levels of review in the BIV:

- At the P1 review (conducted by complaint coordinator, board consultant, and board staff), complaints are either closed for lack of merit or sent for investigation.
- Once an investigation is complete, a complaint is scheduled for a P2 review. The board consultant, board staff, and Office of General Counsel (OGC) staff conduct the review to determine whether the complaint will be closed with no action, will be closed with informal actions taken, meets the conditions for referral to Alternative Dispute Resolution, or will be referred for formal disciplinary action to the OGC.

The Bureau of Investigations has established a benchmark of 120 days to complete all key tasks and close the complaint.

Task	Days Allocated	Cumulative Days in Bureau of Investigations
P1 Review	15	15
Investigation	90	105
P2 Review	15	120

Bureau of Investigations personnel hold weekly meetings to track timeliness and look at any mitigating circumstances that may influence the time a complaint has spent at one or more stages of the process. (For example, because of the small number of professionals regulated, the Council of Certified Professional Midwifery has no consultant either on staff or on contract, which could potentially delay the investigation). Such information is then communicated to the Audit Task Force.

Once a complaint is transferred to OGC, it is termed a “case” for OGC tracking purposes. (One OGC case could involve more than one BIV complaint because multiple complaints can be combined.) In May 2004, the Audit Task Force established benchmarks for OGC timeliness. The following is a list of target dates for completing key tasks associated with preparing and presenting contested cases received in OGC during and after 2004. Overall, a case should take no longer than 365 days for closure in OGC.

Task	Days Allocated	Cumulative Days in Office of General Counsel
Assign to Attorney	1	1
Transfer to New Attorney	14	15
Review File & Send to Expert	30	45
Pending Expert Review	90	135
Formal Notice of Charges [320(c) Letter] Sent	30	165
Notice of Charges Filed	10	175
Discovery Completed/Hearing Set	145	320
Hearing Concluded	45	365

One area that has been identified as a “bottleneck” by the task force in the processing of cases is obtaining an expert opinion. Experts are asked to return an opinion within 30 to 45 days. The process often takes longer than that, and it is sometimes difficult to find a practitioner willing to participate. In an effort to expedite some of these cases, the OGC will sometimes use Consent Orders. Under the terms of a Consent Order, the respondent (i.e., the practitioner cited in the complaint) willingly enters into an agreement to resolve all pending allegations (an Agreed Order). If the Consent Order is not signed and returned in the time allowed (i.e., 15 days), the OGC sends the respondent a formal notice of charges [a 320(c) letter].

Complaint Reviews

For the boards included in this audit’s scope, we reviewed complaint information provided by the division for January 1, 2003, through September 30, 2004. From the information provided, we determined that the boards received 1,531 complaints, of which 1,101 (72%) were closed during the period reviewed. (See Table 1.) The average number of complaint days for those boards with closed complaints ranged from 36 days to 197 days, under the stated goal of 120 complaint days for five boards and over the stated goal for seven boards.

The prior audit identified numerous examples of complaints taking lengthy amounts of time (one complaint had been open 2,897 days, or almost 8 years). Our current review found that the majority of those older complaints have been closed and that new complaints are being worked more efficiently.

Table 1
Complaints Received From January 1, 2003, Through September 30, 2004*

Board	Complaints Received	Complaints Closed	Average Number of Complaint Days
Board of Chiropractic Examiners	44	35	147
Board of Communication Disorders and Sciences/Council for Licensing Hearing Instrument Specialists	16	15	107
Board of Dentistry	387	305	144
Board of Examiners for Nursing Home Administrators	94	90	43
Board of Examiners in Psychology	48	34	172
Board of Nursing	795	555	150
Board of Optometry	20	16	100
Board of Registration in Podiatry	14	11	112
Committee on Physician Assistants	26	13	135
Council of Certified Professional Midwifery	4	1	36
Emergency Medical Services Board	68	13	197
Medical Laboratory Board	14	13	150
Advisory Committee for Acupuncture	1	0	N/A
Board of Dietitian/Nutritionist Examiners	0	N/A	N/A
Committee for Clinical Perfusionists	0	N/A	N/A
Board of Veterinary Medical Examiners	0	N/A	N/A
	Total 1,531	Total 1,101	

* A file is considered a "complaint" while with the Bureau of Investigations. A complaint sent to the Office of General Counsel (see Table 2) is then considered a "case."

Case Reviews

As with complaints, we reviewed case information provided by the division for the dates January 1, 2003, through September 30, 2004. From the information provided, we determined there were 952 open cases, of which 443 (47%) were closed during the period reviewed. Of the 443 closed cases, approximately 231 were received by the Office of General Counsel (OGC) after January 1, 2003. (See Table 2.) The average number of case days for the reviewed boards' closed cases ranged from 51 days to 823 days. Although most boards' averages were higher than the stated goal of 365 days, these averages reflect the fact that many older complaints were transferred to OGC during this time period. It is also important to note that the prior audit found numerous examples of cases open for three years or longer. In addition, OGC staff have now identified bottlenecks in the process and are working with the boards to improve the process. A review of just those 200 cases that were opened after January 1, 2003, and closed by September 30, 2004, found board averages ranging from 51 days to 233 days, well below the 365-day goal for all boards.

Replacement of the RBS System

The November 2003 performance audit noted that the Division of Health Related Boards' computer system could not generate the type of reports necessary for adequate analysis of complaint/case processing. The division concurred with that assessment and indicated that the Department of Health was in the process of upgrading the Regulatory Boards System (RBS) to allow for significant improvement in the monitoring of the stages in the complaint/case process. During our current audit, however, we learned that a completely new system was being developed to replace RBS, not upgrade it.

According to department staff, they worked with the contractor to design a system tailored to meeting the division's licensure and enforcement tracking needs. Staff specifically requested analysis and management tools, and they anticipated that the system would eliminate redundant entry of basic information by automatically pulling this information from one field (e.g., licensure) to another field (e.g., enforcement). The system, which was being designed to incorporate both BIV and OGC work, was anticipated to go online June 1, 2005. After the completion of our audit field work, we learned (during conversations with Health Related Boards and Office for Information Resources staff) that the contractor had asked to be released from the contract because of insufficient capital to complete the project. As a result, the contract had to be re-bid and the new system is not estimated to be operational until at least fall 2006.

Table 2
Open Cases as of January 1, 2003, Through September 30, 2004*

Board	Open Cases	Cases Closed	For Cases Closed, Average Number of Case Days
Board of Chiropractic Examiners	10	4	570
Board of Communication Disorders and Sciences/Council for Licensing Hearing Instrument Specialists	15	4	51
Board of Dentistry	304	139	472
Board of Dietitian/Nutritionist Examiners	1	0	N/A
Board of Examiners for Nursing Home Administrators	30	8	372
Board of Examiners in Psychology	36	15	810
Board of Nursing	482	234	323
Board of Optometry	3	3	823
Board of Registration in Podiatry	4	2	652
Committee on Physician Assistants	9	5	656
Emergency Medical Services Board	50	29	277
Medical Laboratory Board	8	0	N/A
Advisory Committee for Acupuncture	0	N/A	N/A
Council of Certified Professional Midwifery	0	N/A	N/A
Committee for Clinical Perfusionists	0	N/A	N/A
Board of Veterinary Medical Examiners	0	N/A	N/A
	Total 952	Total 443	

* Includes all open cases, not just those opened between January 1, 2003, and September 30, 2004. A file is considered a "complaint" while with the Bureau of Investigations. (See Table 1.) A complaint sent to the Office of General Counsel is then considered a "case."

IMPROVEMENTS RELATED TO DISCIPLINARY GUIDELINES AND ASSESSMENT OF DISCIPLINARY COSTS

Disciplinary Guidelines

The November 2003 performance audit of the Health Related Boards found that most boards did not have disciplinary guidelines and that for those that did, the guidelines seemed lenient. The audit concluded that while boards were not statutorily required to develop and implement disciplinary guidelines, Health Related Boards' efforts to achieve greater consistency in disciplinary action might be limited as a result of the absence of guidelines. The audit recommended that all boards develop and implement disciplinary guidelines. The Division of Health Related Boards concurred in part with the finding. Division and board personnel stated that since some boards handle very few disciplinary cases, those boards have spent very little time discussing the development and utilization of disciplinary guidelines. At that time, the division reported that the subject would be brought before each board for discussion.

During the current audit, we found that the boards included in this audit have (with one exception) promulgated disciplinary guidelines through their rulemaking process. The Council of Certified Professional Midwifery adopted disciplinary guidelines as a board policy at its August 31, 2005, meeting.

Assessment of Disciplinary Costs

The November 2003 performance audit found that the boards had not used their authority to assess investigative and legal disciplinary costs to practitioners. Some of the boards have specific statutory authority to assess such costs, and legislation passed in 2003 (codified as Section 63-1-144, *Tennessee Code Annotated*) authorized health-related boards overall to assess disciplinary costs, including costs of the Office of General Counsel (OGC). Based on information obtained during the current audit, it appears that boards are, for the most part, assessing disciplinary costs when appropriate (i.e., when they have imposed sanctions on a licensee in any disciplinary contested case proceeding). The Emergency Medical Services Board is not covered under the general legislation passed in 2003 and has no specific statutory authority to assess disciplinary costs, but the board is not prohibited from assessing such costs.

OGC attorneys stated that they routinely ask boards to incorporate the assessment of disciplinary costs into board orders, whether Agreed Orders or formal disciplinary actions. Table 3 summarizes disciplinary actions for calendar years 2003, 2004, and the first three months of 2005. (Those boards that are included in the scope of this audit but not listed in the table had no disciplinary actions during the period.) In 2003, 46% of disciplinary actions included the assessment of a civil penalty, and 38% included the assessment of administrative costs. In 2004, 43% of disciplinary actions included the assessment of a civil penalty, and 35% included the assessment of administrative costs. In the first three months of 2005, 55% of disciplinary actions included the assessment of a civil penalty, and 31% included the assessment of administrative costs. Types of actions that often did not result in the assessment of administrative disciplinary costs included reprimands (a less severe action), cases settled through Agreed Orders, cases involving non-licensees, and cases where licensees were placed on probation after entering an

approved assistance program to deal with drug abuse problems. In addition, some revocations did not result in the assessment of administrative costs, typically in cases where the former licensee was facing more serious consequences (e.g., criminal convictions and/or major monetary penalties).

Table 3
Disciplinary Actions and Related Assessments
For Calendar Years 2003, 2004, and 2005 (through March)

Year	Board	Number of Disciplinary Actions	Number of Times Civil Penalties Assessed	Number of Times Administrative Costs Assessed
2003	Board of Examiners in Psychology	2	–	–
	Board of Optometry	3	2	2
	Board of Dentistry	38	9	10
	Emergency Medical Services Board	4	6	1
	Board of Nursing	79	42	37
	Board of Examiners for Nursing Home Administrators	1	–	–
	Board of Veterinary Medical Examiners	9	4	1
Total	7 Boards	136	63	51
2004	Board of Examiners in Psychology	6	3	5
	Board of Chiropractic Examiners	1	–	–
	Board of Communication Disorders and Sciences	1	2	–
	Board of Dentistry	20	4	8
	Emergency Medical Services Board	4	–	–
	Board of Nursing	109	46	37
	Board of Examiners for Nursing Home Administrators	2	–	–
	Board of Veterinary Medical Examiners	12	12	4
Total	8 Boards	155	67	54
2005	Board of Chiropractic Examiners	1	1	–
	Board of Communication Disorders and Sciences	1	–	1
	Board of Dentistry	14	5	5
	Medical Laboratory Board	1	–	–
	Board of Nursing	32	17	10
	Board of Examiners for Nursing Home Administrators	–	1	–
	Board of Veterinary Medical Examiners	2	4	–
Total	7 Boards	51	28	16

ADDITIONAL AUDIT WORK PERFORMED

We also performed limited work in the following three areas, which we have noted as issues for study in future audits.

Alternative Dispute Resolution Process

Alternative Dispute Resolution (ADR) represents an informal mediation or hearing process that makes use of screening panels. The November 2003 performance audit of six Health Related Boards found that Alternative Dispute Resolution case results were not always documented, and timeliness should be improved. The audit recommended that the Division of Health Related Boards should establish a written policy indicating what materials must be included in all complaint files and that the division and the Bureau of Investigations should identify areas where case processing time could be decreased and processing delays reduced. The Bureau of Health Licensure and Regulation developed policies and procedures effective April 2004, to provide guidelines for using ADR. The policies and procedures include both the process for using ADR and the criteria for determining if cases are appropriate for ADR.

The ADR Coordinator forms a panel of at least three members chosen from board-approved resources, such as consultants and prior or current board members. If current board members act as a member of a panel, they cannot also participate in a contested hearing regarding the case and must recuse themselves from any other involvement in that case. Cases are considered appropriate for ADR if they are non-contested, low risk (the facts are not egregious enough to warrant immediate discipline), and are a clear violation of the entity's practice act (i.e., statutes, rules and regulations). Appropriate examples would include practice act violations; drug-related, first-time offenders; and malpractice/negligence cases, all of which include admission of the actions in question by the respondent. Examples could also include conviction of a crime, discipline in another state, and unethical conduct. The General Counsel has stated that ADR should be used exclusively for first-offense cases where the practitioner admits guilt. Our review of ADR files found that these policies appeared to be followed.

For each of the boards included in this audit, we wanted to identify any cases where the ADR process was used. The division identified 36 cases that had been referred for ADR; however, only 18 cases actually started the process as an ADR case. (If the respondent declines to have his or her case handled through the ADR process, the case goes through the standard process.) Of these 18 cases, only 3 were ultimately resolved by an ADR screening panel. For 15 of the 18 files reviewed, it appeared that ADR was attempted and failed, sending the case back into the Office of General Counsel's process. The outcomes of the three cases completed as ADR cases appeared consistent with the outcomes of other reviewed cases. Those electing to go through ADR did not appear to get any reduction in disciplinary action. Because of the small number of cases, however, we were limited in our ability to draw extensive conclusions about the ADR process.

Psychometric Soundness of Board-Developed Licensure Examinations

A psychometrically sound examination is an examination that has been demonstrated to be valid and reliable. (To say that an examination is valid means that the examination tests what it is supposed to test. Reliability relates to the consistency of the test.) Tests that have been found to be valid and reliable should be easier to defend if challenged (e.g., in court) and should help ensure that applicants have the needed knowledge and/or skills to be licensed and are treated fairly and consistently during the examination process.

With one exception, the statutes of the boards included in this audit do not include psychometric soundness as a requirement for their examinations. Section 63-17-201(7), *Tennessee Code Annotated*, requires that licensed hearing instrument specialists pass “a council-approved psychometrically-sound examination.” The Council for Licensing Hearing Instrument Specialists complies with this statute by requiring licensees to take a national written exam from the International Hearing Society (which has been psychometrically validated), in addition to its own written, practical skills exam, which has not been validated. According to the Director of the Division of Health Related Boards, however, the division has actively been lobbying all boards to use only test instruments that are psychometrically sound.

Several other boards also require passage of a national examination as a condition of licensure. Reviews of information describing such examinations often included detailed descriptions of the procedures followed to ensure validity and reliability of the tests. However, eight of the boards covered in this audit (the Emergency Medical Services Board, the Council for Licensing Hearing Instrument Specialists, the Board of Examiners in Psychology, the Board of Chiropractic Examiners, the Board of Optometry, the Board of Registration in Podiatry, the Board of Examiners for Nursing Home Administrators, and the Board of Dentistry) administer examinations they have developed internally for licensure, specialty certification, and/or renewal. Of the eight boards, only the Emergency Medical Services Board has had its internally developed test instruments validated for psychometric soundness. According to Emergency Medical Services staff, the First Responder examination was validated by two state community colleges using commercial validation software; the EMT Basic IV renewal examination was validated with software when it was written; and the Paramedic renewal examination, currently under revision, will be validated with software as well.

Internal Audits of the Boards

The November 2003 performance audit found that no internal audits had been conducted for the Division of Health Related Boards or for individual boards since 1998. According to information provided by the Department of Health’s Office of Internal Audit, the office has now developed a schedule to audit all health-related boards during fiscal years 2004 through 2009, and thereafter on a continual rotating basis. During our work on the current performance audit, Internal Audit was conducting audits of the Board of Nursing, the Massage Licensure Board, and the Council of Certified Professional Midwifery. We reviewed the internal audit report for the Board of Nursing, which was completed in July 2004, and which recommended several areas of improvement in the board’s processes.

FINDINGS AND RECOMMENDATIONS

1. Board-developed examinations may be considered public information under the provisions of the Public Records Act

Finding

Public records statutes may make it difficult to protect board-developed examinations from review by applicants before they take the examination. Such access to a testing instrument negatively impacts the integrity of the examination process and lessens the usefulness of the test as a measure of the applicants' knowledge of their profession. (Also see page 4, which discusses past problems with routine updating of such exams, and page 13, which discusses that many of such exams have not been validated for psychometric soundness.)

During a July 2004 meeting of the Council for Licensing Hearing Instrument Specialists, the council discussed a situation in which an individual had requested and obtained a copy of the council's written practical-skills examination and answer key. The staff attorney noted that since the exam was created by and belonged to the council, it was a state document and a matter of public record. (Examinations that are the property of a national professional association or a private company contracting with the state would not be considered a public record.) Council members were concerned because the individual had already failed the exam once before obtaining the answer key and subsequently just repeated the answers from the key when retaking the examination.

In December 2004, the Director of the Health Related Boards established an unwritten policy that the division would no longer release board-developed testing instruments. However, it appears that this policy conflicts with the Public Records Act. Section 10-7-301(6), *Tennessee Code Annotated*, defines public records as

all documents, papers, letters, maps, books, photographs, microfilms, electronic data processing files and output, films, sound recordings, or other material, regardless of physical form or characteristics made or received pursuant to law or ordinance or in connection with the transaction of official business by any governmental agency.

Section 10-7-301(2) defines a "confidential public record" as "any public record which has been designated confidential by statute and includes information or matters or records considered to be privileged and any aspect of which access by the general public has been generally denied." Thus, it appears that board-developed licensure examinations are in fact public records since they have not been designated confidential.

Recommendation

Division of Health Related Boards management should work with the Department of Health's Office of General Counsel to protect board-developed examinations without violating statutory requirements. One option would be to propose legislation to the General Assembly designating board-developed examinations confidential. Another option might be to closely monitor any reviews of past test papers, to ensure that exam questions are not copied and no notes are taken.

All Health Related Boards currently using board-developed examinations should also consider discontinuing the use of internally developed examinations and instead using national examinations or contractor-developed examinations that would not be considered public information and that have been validated for psychometric soundness.

Management's Comment

We concur. The Division will continue to abide by the December 2004 policy that prohibits the release of board-developed test instruments until such time as that policy is challenged and the release is ordered. We will work with the Office of General Counsel to protect these examinations. The Division will encourage each board using board-developed examinations to discontinue the use of those examinations and instead use those as recommended.

2. Several boards have not been self-sufficient in recent years

Finding

The November 2003 performance audit of six health-related boards found that several of the boards had not met self-sufficiency requirements (i.e., their fee-generated revenues in a given year were not sufficient to cover their expenses). During the current audit, we reviewed department financial reports, as well as reports from the State of Tennessee Accounting and Reporting System, and found that the Boards of Dentistry, Optometry, and Veterinary Medical Examiners, as well as the Council of Certified Professional Midwifery, were not self-sufficient during fiscal year 2003. (The Boards of Dentistry, Optometry, and Veterinary Medical Examiners were also not self-sufficient in fiscal year 2002.) Only one board, the Council of Certified Professional Midwifery, was not self-sufficient in fiscal year 2004. The chart on page 16 details the current net incomes at fiscal years ending June 30, 2004, 2003, and 2002, for these four boards.

**Boards Not Self-Sufficient During Fiscal Years 2002, 2003, or 2004
Current Net Income at Fiscal Year End**

Board	2004	2003	2002
Board of Dentistry	\$49,055	(\$95,757)	(\$134,429)
Board of Optometry	\$28,563	(\$267,091)	(\$63,050)
Council of Certified Professional Midwifery	(\$466)	(\$3,596)	\$758
Board of Veterinary Medical Examiners	\$4,362	(\$37,799)	(\$113,062)

Source: Director of Administrative Services, Bureau of Health Licensure and Regulation.

(Appendix 2 details net income for fiscal years 2002 through 2004, for all boards attached to the Division of Health Related Boards.) To ensure uninterrupted operation of boards which have deficits during a particular year, the Division of Health Related Boards and the Department of Finance and Administration cover the deficits of some boards with the surpluses from other boards.

Section 4-29-121, *Tennessee Code Annotated*, requires all regulatory boards administratively attached to the Division of Health Related Boards to be self-sufficient. (The Emergency Medical Services Board is attached to Emergency Medical Services, which is structured as an independent division under the Bureau of Health Licensure and Regulation, and the board's enabling legislation does not specifically require self-sufficiency.) By June 30 of each year, the Commissioner of Finance and Administration is required to certify to the Joint Government Operations Committee and the Tennessee Code Commission, a listing of all health-related boards that did not collect sufficient revenues to pay the cost of operations during the fiscal year. If a board or committee incurs deficits over two consecutive years, Section 4-29-121(b) requires that the board be reviewed by a joint evaluation committee (i.e., the Joint Government Operations Committee) and be subject to a revised termination date of June 30 of the fiscal year immediately following the second consecutive year the board operated at a deficit. For fiscal years 2002 through 2004, this would have included the Boards of Dentistry, Optometry, and Veterinary Medical Examiners, and the Council of Certified Professional Midwifery.

According to the leadership of the Joint Government Operations Committee, as of December 2004, the certification of a listing of boards and committees lacking self-sufficiency had not occurred. On March 11, 2005, however, the Department of Finance and Administration did send a memorandum to the Joint Government Operations Committee, certifying a list of health-related and professional regulatory boards that had not collected fees in an amount sufficient to pay operating costs in the two consecutive years ending June 30, 2003, and 2004. In a response to the June 2005 performance audit of the Professional Regulatory Boards, the Department of Finance and Administration stated, "This memorandum was late, and we did not certify a list earlier in the time period covered by the performance audit. In the future, we annually will certify to the Joint Government Operations Committee and the Tennessee Code Commission a list of boards that do not collect fees sufficient to pay operating costs in any fiscal

year . . . As a practical matter, it is not possible to do this on June 30, but we will respond as timely as possible for the closing of each fiscal year.”

Bureau of Health Licensure and Regulation management stated that both the bureau and the individual boards monitor financial self-sufficiency throughout the year, and adjust fees and/or expenditures as appropriate to meet statutory self-sufficiency requirements. Several of the boards within the scope of this audit (including the four boards cited above as not meeting self-sufficiency requirements) have implemented one or more fee increases since July 1, 2002:

Board of Chiropractic Examiners

Board of Communication Disorders and Sciences

Board of Dentistry

Council for Licensing Hearing Instrument Specialists

Board of Optometry

Council of Certified Professional Midwifery

Board of Registration in Podiatry

Board of Examiners in Psychology

Board of Veterinary Medical Examiners

During this same period, the Board of Dietitian and Nutritionist Examiners was in the process of implementing a fee decrease. The board had a cumulative surplus of \$146,728 at fiscal year-end June 30, 2004.

Regarding the boards experiencing deficits, bureau management noted that court costs have had a significant impact on the overall expenses of the Board of Dentistry and the Board of Optometry in the last several years, and have adversely affected their ability to be self-sufficient. The Board of Dentistry increased fees in June 2002 and again in September 2004. The Board of Optometry increased fees in January 2005. Both boards were self-sufficient in fiscal year 2004. The bureau attributes the Council of Certified Professional Midwifery’s lack of self-sufficiency to the newness of the council (it was created in 2000, and began meeting and collecting fees in January 2002) as well as to the small number of licensees (only 26 licensed midwives in the state as of December 2004—nurse midwives, a much larger group, are regulated by the Board of Nursing). Because of this small population, midwifery applicants and licensees are subject to very high licensing fees. The council passed a fee increase at their December 2004 meeting, raising both application and renewal fees to \$1,000. This increase is estimated to generate an additional \$7,000 in revenue for the council.

Collectively, the health-related boards have made significant progress in their self-sufficiency efforts since the 2003 audit. In fiscal year 2002, 18 (62%) of the 29 boards were not self-sufficient. Only eight (28%) were not self-sufficient in fiscal year 2003, and six (21%) of the boards were not self-sufficient in fiscal year 2004.

Recommendation

Division of Health Related Boards and Bureau of Health Licensure and Regulation management should continue to review the revenues and expenditures of the individual boards throughout the year, and recommend increasing fees and/or decreasing expenditures as necessary to meet statutory self-sufficiency requirements.

Division of Health Related Boards management may wish to consider recommending the consolidation of boards with a small base of licensees into related boards with a larger base of licensees, so they can operate more efficiently and effectively and be able to meet self-sufficiency requirements.

Management's Comment

We concur. As indicated in the finding, all of the four boards within the scope of the audit that had difficulty meeting the self-sufficiency requirements have implemented fee increases since July 1, 2002. The boards overall have indeed made progress in achieving and maintaining financial self-sufficiency.

As recommended, management will continue in its efforts to monitor the financial status of all health related boards, committees, and councils and to advise them on the need to increase or decrease fees based on revenue and expenditure levels.

The possibility of consolidation of smaller boards with larger boards of similar scopes of practice has been mentioned in a limited capacity and was not well received. Boards value their ability to oversee and guide the direction of their particular profession and relinquishing the autonomy of their right to do so is not something they have wished to consider.

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- 3. The boards do not adequately follow up on expired licenses, and not all boards impose additional penalties or additional renewal requirements when professionals have worked with expired licenses or their licenses have been expired for extended periods of time**

Finding

Approximately two months before licenses expire, the Division of Health Related Boards' computer system generates renewal letters that are sent to licensees. If renewal fees are not received and the license is allowed to expire, however, the boards do not attempt to determine whether the licensee is still practicing, has retired, is working in another state, etc. With the exception of the Board of Veterinary Medical Examiners, which makes a courtesy phone call to each individual whose license has expired, none of the boards take any action to contact persons following the expiration of their licenses. Lack of such follow-up may allow

individuals to continue to practice without a valid license and without receiving the continuing education necessary to ensure they are knowledgeable of advances, technological changes, etc., that help keep them qualified and competent to practice in their profession. In addition, if a substantial number of persons continue to practice without renewing their licenses, the loss of revenue to a board could hinder the board in meeting its self-sufficiency requirements.

Based on a review of the boards' rules and/or policy statements, when a license has expired, most boards impose (in addition to normal licensing fees and proof of continuing education) a monthly monetary penalty (for which there is no cap) in addition to the flat late-renewal fee when a person has worked over three months on an expired license. If the person is not working, there is no penalty. Exceptions to this general practice are detailed below:

- In addition to requiring payment of a reinstatement fee, the Emergency Medical Services Board requires examinations be taken if the license expired without "good cause."
- The Board of Nursing gives no grace period when a license expires, imposes a late renewal fee, and has the power to impose a Type A Civil Penalty of \$500 to \$1,000 for practicing without a license.
- The Council of Certified Professional Midwifery imposes a reinstatement fee and a late renewal fee but no monthly monetary penalty.
- The Board of Veterinary Medical Examiners imposes a late renewal fee but no monetary penalty until the licensee has worked over six months on an expired license.
- The Board of Communication Disorders and Sciences imposes no monetary penalty beyond a late renewal fee until the five-year mark, at which time a new license must be applied for.
- The Board of Dietitian/Nutritionist Examiners caps the amount of penalty that can be assessed for practicing beyond three months without a license.

Additionally, the Board of Chiropractic Examiners, Council for Licensing Hearing Instrument Specialists, Medical Laboratory Board, Board of Nursing, Board of Optometry, Committee on Physician Assistants, and Board of Registration in Podiatry do not impose any additional requirements such as taking a refresher course or applying for a new license, when a license has been expired for an extended period of time. The Board of Dentistry has rules allowing the board to impose additional requirements if a license has been expired over two years but does not specify the requirements.

Recommendation

Division of Health Related Boards management should require board staff to follow up to ensure that individuals with expired licenses are no longer practicing in the state. Management and board staff should review each board's reinstatement policies and work with board members to ensure that all boards impose additional requirements, such as taking a refresher course or

applying for a new license, as a condition of renewal for licenses expired for extended periods of time.

Management's Comment

We do not concur. Prior to January 2002, the Division sent follow-up notices to those who failed to timely renew their licenses. That practice was discontinued based on advice from the Office of General Counsel and a review of the costs involved and the efficacy of the letters. This change resulted in savings to the boards in staff time, supplies, and correspondence charges. Upon review after implementation, it was found that the discontinuance had no impact on the renewal rates for the professions.

At this time, all boards except Hearing Instrument Specialists have adopted policies to deal with professionals who continue to practice on a lapsed license. The policies, which generally impose a monthly monetary penalty, are in addition to the statutory requirement of the payment of all past renewal fees and regulatory fees, a specific reinstatement fee, a late renewal fee, and showing proof of continuing education or competency (if required for that profession). The purpose of these policies was to acknowledge that a practitioner may inadvertently forget to renew a license and to allow that practitioner to renew without undue hardship or cost. The policy does not apply to those cases wherein the licensee purposely failed to renew their license. Cases falling outside the parameters of the policy are referred to the Bureau of Investigations for processing for disciplinary action.

Additionally, there are safeguards in place to address some of the professions that work in facility settings both internally within the Department and externally. Surveyors from the Division of Health Care Facilities perform surveys of those regulated health-care facilities and inspectors from the Board of Veterinary Medical Examiners review personnel files of those professions working in the surveyed and inspected facilities to ensure compliance with the licensure requirements. All licensed facilities have a responsibility to ensure the proper licensure of their employees. Externally, licensure of practitioners participating in the Medicare-Medicaid system is closely monitored by those systems. Failure to maintain the required licensure will result in non-payment of fees by those systems.

Reapplication after expiration is not a practical solution to address this situation. Often the licensure requirements and standards are raised and it would be likely that the licensee would not be able to meet those requirements. Testing is a common requirement of licensure and it would be an undue hardship and serve no purpose to require the retesting of a licensee.

Auditor's Comment

We believe that board staff should, at a minimum, follow up to ensure that individuals with licenses expired beyond the standard grace period are no longer practicing in the state.

4. The Division of Health Related Boards does not always follow its policies regarding the board member appointment process, and membership appointments are not always timely

Finding

The division has taken a variety of actions, including implementing policies and establishing time frames, in an attempt to improve the timeliness of the board member appointment process. The division does not always follow its own policies, however, and the rather lengthy process of gathering and submitting nominations and obtaining appointments can result in lengthy board vacancies or members serving for months after their terms have expired.

Appointment Process Policy

In April 2002, the Division of Health Related Boards implemented a policy defining time frames for acquiring nominations for board membership, information to be included in nominee packets sent to the Governor's Office, and a time frame for sending the nominee packets to the Governor's Office. The responsibilities for this process were spread across several division staff. In September 2004, the division revised this policy by centralizing the responsibilities to one person and requiring the nominating process to begin six months before membership terms expire instead of the three months required previously. The revised policy requires that:

1. an initial written request be sent to the executive director of the nominating association six months prior to the expiration of a board member's term;
2. a Department of State, Tennessee Open Appointment, Notice of Vacancy Form be completed and submitted to the Secretary of State at least 45 days prior to the expiration of a member's term, within 15 days of the creation of a new position or within 15 days of an unscheduled vacancy;
3. upon receipt of the list of nominees, a nominee information packet be created which includes
 - a. a list of the names of nominees,
 - b. a list of current board members for the profession,
 - c. a chart indicating a breakdown of the composition of the board,
 - d. resumes and nominee information received,
 - e. a copy of the nominees' licensure data,
 - f. a copy of the Practitioner Profiles, and
 - g. a report of any complaints or disciplinary information from the Office of Investigations; and
4. a system to track the status of the vacancy be maintained by the Director of Health Related Boards' office.

Once all the information is gathered, staff send a memo to the Assistant Commissioner of the Bureau of Health Licensure and Regulation, which is then forwarded to the Commissioner of Health. According to the policy, the Commissioner reviews and comments on the nominee packet and returns it to the Director of Health Related Boards' office within seven days. The nominee packet is then forwarded to the Governor's Office of Boards and Commissions by the first day of the month prior to the month of the term's expiration date.

File Review

To determine if the policy outlined above has been followed, we reviewed 112 files containing board nomination and appointment information for the 17 boards included in this audit. Our review (which focused on nominations and appointments after the April 2002 policy was implemented and included a few after September 2004 when the policy was revised) determined that division policy is not always followed and that information in the files was disorganized and often difficult to track. Table 4 summarizes the results of our review of nominee information packets and the extent to which the packets had been prepared and contained the information required by policy. We found complete packet information in only 11 (10%) of the 112 files and no nominee packet information in 49 (44%) of the files.

We also reviewed files to determine whether the Secretary of State's Office was notified of vacancies 45 days before membership expiration and within 15 days after a vacancy for any other reason, as required by policy and by Section 10-7-605, *Tennessee Code Annotated*. We were able to find documentation of contacts with the Secretary of State's Office in 87 (78%) of the 112 files. Of those 87 files, 13 had special circumstances requiring 15 days' notice, and 74 required 45 days' notice. For the 13 positions vacated under special circumstances, 8 (62%) met the 15-day requirement. Of the 74 positions vacated under normal circumstances, 70 (95%) met the 45-day requirement. (See Table 5.)

Finally, we reviewed division files to determine whether the 112 files contained documentation of other contacts required by the policy (specifically, the nominating association, the Assistant Commissioner of the Bureau of Health Licensure and Regulation, the Commissioner of Health, and the Governor's Office). Our review indicated that documentation of such contacts was not consistently maintained.

According to Health Related Boards staff, the Commissioner of Health currently requests that the nominee packet be sent to his office, where a memo is drafted for the Governor's Office. The memo simply lists the nominees and the Commissioner's recommendation. No resumes or other nominee packet information are sent to the Governor's Office.

Table 4
File Review of Nominee Packets
December 2004

Board	All Nominee Packet Information Found	Partial Nominee Packet Information Found	No Nominee Packet Information Found	Total Files Reviewed
Board of Chiropractic Examiners	0	1	3	4
Board of Communication Disorders and Sciences	1	2	4	7
Board of Dentistry	2	4	2	8
Board of Dietitian/Nutritionist Examiners	2	1	3	6
Board of Examiners for Nursing Home Administrators	1	4	3	8
Board of Examiners in Psychology	2	0	4	6
Committee on Physician's Assistants	0	2	3	5
Board of Nursing	3	1	0	4
Board of Optometry	0	1	2	3
Board of Registration in Podiatry	0	3	1	4
Board of Veterinary Medical Examiners	0	2	4	6
Committee for Clinical Perfusionists	0	2	5	7
Council for Licensing Hearing Instrument Specialists	0	2	2	4
Council of Certified Professional Midwifery	0	8	4	12
Emergency Medical Services Board	0	8	6	14
Advisory Committee for Acupuncture	0	3	2	5
Medical Laboratory Board	0	8	1	9
Totals	11	52	49	112

**Table 5
Compliance With Secretary of State Notice of Vacancy Statute
File Review December 2004**

	Expiration Notice to Secretary of State Complies With 45-Day Requirement		Special Circumstances Notice to Secretary of State Complies With 15-Day Requirement		No Information	Total Files Reviewed
	Yes	No	Yes	No		
Board						
Board of Chiropractic Examiners	2	1	0	0	1	4
Board of Communication Disorders and Sciences	5	0	1	1	0	7
Board of Dentistry	5	0	1	1	1	8
Board of Dietitian/Nutritionist Examiners	5	0	0	0	1	6
Board of Examiners for Nursing Home Administrators	7	0	0	0	1	8
Board of Examiners in Psychology	2	0	1	1	2	6
Committee on Physician's Assistants	3	0	1	0	1	5
Board of Nursing	4	0	0	0	0	4
Board of Optometry	1	0	0	0	2	3
Board of Registration in Podiatry	4	0	0	0	0	4
Board of Veterinary Medical Examiners	4	1	1	0	0	6
Committee for Clinical Perfusionists	3	0	2	1	1	7
Council for Licensing Hearing Instrument Specialists	0	1	0	0	3	4
Council of Certified Professional Midwifery	7	1	0	1	3	12
Emergency Medical Services Board	13	0	1	0	0	14
Advisory Committee for Acupuncture	5	0	0	0	0	5
Medical Laboratory Board	0	0	0	0	9	9
Totals	70	4	8	5	25	112

Board Vacancies or Expired Terms

We also reviewed board membership to identify positions that were vacant or expired for more than a few months. (We considered positions vacant when an individual resigned from the board or when, upon expiration of a membership term, that member was not willing to serve

until a replacement could be named. A position was considered expired when, even though the term has expired, the member is still listed on the division's board roster and will continue to serve until a new appointment or reappointment is made.) The following are a few examples we identified of positions not filled in a timely manner:

- Medical Laboratory Board – a Pathologist Non-educator position expired December 31, 2004. Still unfilled as of June 2005.
- Council for Licensing Hearing Instrument Specialists – citizen position expired June 30, 2004. Not filled until March 2005.
- Board of Communication Disorders and Sciences – physician position expired on June 30, 2004. Physician reappointed on December 21, 2004.
- Committee for Clinical Perfusionists – thoracic surgeon position expired July 31, 2003, filled November 2004. Perfusionist position expired July 31, 2004. Not filled as of June 2005. Citizen position was vacant (the result of a resignation) as of September 2003. Filled in early June 2005.

Recommendation

Division of Health Related Boards management should review current policies and procedures regarding the board appointment process and make changes and clarifications as needed to streamline the process, reflect current procedures, and ensure the process is adequately documented. Management should then monitor the process to ensure division policies are followed, division and statutory time frames are met, and appropriate documentation of nominee information and division actions is maintained in the files.

Management's Comment

We concur. The policies involved in the board appointment process have evolved over the past three years. The documentation that is required under the current policy has been in effect since 2004. The same documentation was not required prior to that time and would not be found in the files. The Division has developed a detailed tracking system to improve the timeliness of delivering the nominees to the Governor's Office for processing. The Division will add this performance process to our Continuous Quality Improvement program to be monitored quarterly to ensure compliance with the policy.

5. Not all boards require and monitor continuing competence

Finding

One of the boards reviewed does not require practitioners to obtain continuing education or demonstrate continuing professional competence as a condition of license renewal. The absence of such a requirement hinders the board's ability to ensure that practitioners remain competent and qualified throughout their careers and that the health, safety, and welfare of Tennesseans served by those practitioners are protected. In addition, not all boards that require continuing education as a condition of license renewal monitor licensees for compliance with continuing education requirements.

Continuing education and competency require that professionals receive information on current issues in order to remain knowledgeable about current standards and emerging trends. By state statute or rule, most boards require practitioners to complete a specific number of hours of continuing education or competence as a condition of license renewal. Some boards require a national certification that includes continuing education requirements. The Board of Dietitian/Nutritionist Examiners, however, does not require any continuing education or competency to renew and maintain licensure.

A few of the boards reviewed have not yet conducted audits of continuing education:

- Advisory Committee for Acupuncture
- Committee for Clinical Perfusionists
- Board of Dietitian/Nutritionist Examiners (no continuing education requirement)
- Board of Nursing (has only had continuing education requirement for 2 years)
- Medical Laboratory Board (continuing education rules only became effective in October 2005)
- Council of Certified Professional Midwifery

For those boards conducting audits of continuing education, the frequency of the audits varies. Only the Emergency Medical Services Board is continuously monitoring its licensees' continuing education through monthly random audits of 10 percent of renewals. Until last year, the Board of Veterinary Medical Examiners' continuing education was checked during biennial clinic inspections. Now the board plans to conduct random audits of 30 to 40 percent of licensees each year. The Boards of Chiropractic Examiners, Optometry, Registration in Podiatry, and Examiners in Psychology conducted continuing education audits in 1999 and again during May, June, and July 2005. The Committee on Physician Assistants conducted an audit in January 2005. The Board of Communication Disorders and Sciences, the Council for Licensing Hearing Instrument Specialists, and the Board of Examiners for Nursing Home Administrators conducted continuing education audits in 2003. The Board of Dentistry last conducted an audit in 1999.

Recommendation

The Board of Dietitian/Nutritionist Examiners should pursue rule changes requiring licensees to receive continuing education as a condition of licensure renewal, thereby assuring that practitioners remain knowledgeable about current standards and emerging trends. If department legal staff determine that specific statutory authority is necessary before the board can promulgate continuing education rules, the department should develop proposed legislation for consideration by the General Assembly.

All boards should develop (and implement) a regular schedule for periodically conducting audits, whether random or specific, of licensees' compliance with continuing education requirements.

Management's Comment

We concur. The Office of the Attorney General has informally opined that there must be specific statutory authority to require licensees to obtain continuing education or meet continued competency standards. Legislation will be required to implement a continuing education or continued competency requirement.

The Division is reorganizing so that there will be a position specifically assigned to such audits. A policy will be implemented that establishes a schedule for audit so that a percentage of licensees will be audited on a biennial basis. The Division will add this performance process to our Continuous Quality Improvement program to be monitored and reviewed at least annually to ensure compliance with the policy.

6. The boards' conflict-of-interest policies and procedures need improvements in several areas

Finding

The March 1999 performance audit of the Health Related Boards found that the boards did not have a conflict-of-interest policy. Since that time, the Division of Health Related Boards has developed a policy, which we reviewed along with the division's conflict-of-interest statement and the Department of Health's conflict-of-interest policy and statement, as well as statements signed by board members. We found (1) a lack of clarity regarding which statement board members are to sign as well as variances in signing; (2) inconsistencies within the Department of Health's policy and statement; and (3) weaknesses in both policies and statements regarding regular updates and disclosures of potential conflicts of interest.

Policy Unclear and Board Members Not Consistent in Signing

Division Policy 302.01, implemented in September 2002, states,

All Board members/appointees will be educated on the Department's Conflict of Interest Policy through written instructions included in their board packets and at board meetings. Board members will be required to sign a conflict of interest statement upon appointment or as soon as practical thereafter. The board coordinator will keep the signed copies on file in the Central Office of Health Related Boards.

This policy does not specify, however, whether board members are required to sign the Board Member Conflict of Interest Statement or the Department of Health Conflict of Interest Statement. During our review, we found that board members had signed one statement or the other, both statements, or neither statement. We reviewed a total of 148 files for all members of the 17 boards covered in this audit. Thirty-five board members had not signed a statement; 32 had signed both the Department of Health statement and the board member statement; 26 had signed only the Department of Health statement; and 55 had signed only the board member statement. Table 6 details, by board, the results of the file review.

Inconsistencies Within the Department of Health Conflict-of-Interest Policy and Statement

The Department of Health's Bureau of Health Licensure and Regulation Conflict of Interest Policy appears to be internally inconsistent. The policy itself states that all full-time and part-time employees of the bureau will adhere to the Department of Health's conflict-of-interest policy. In contrast, the applicability section of the statement specifically states that the policy applies to all full-time employees of the department (which would seem to exclude board members), and all definitions and statements refer to employees, not board members. The policy further requires employees and board members to receive awareness training on the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA training requirement is the first mention of board members in the policy. The procedures section of the policy requires all employees and board members to read and sign the conflict-of-interest policy.

Weaknesses in Both Policies and Statements Regarding Regular Updates and Disclosures of Potential Conflicts of Interest

In the Board Member Conflict of Interest Statement, disclosures of potential conflicts are required only on a case-by-case basis. According to the Director of the Health Related Boards, the conflict-of-interest policy is covered at each board meeting; however, the Board Member Conflict of Interest Statement is only signed upon appointment to the board—board members do not regularly sign and update their statements.

Table 6
Conflict-of-Interest File Review
November 2004

Board	Number Signing Board Member Statement Only	Number Signing Department of Health Statement Only	Number Signing Both Statements	Number Signing Neither Statement	Total Files Reviewed
Board of Chiropractic Examiners	1	0	0	8	9
Board of Communication Disorders and Sciences	6	1	1	0	8
Board of Dentistry	5	0	4	3	12
Board of Dietitian/ Nutritionist Examiners	5	0	0	3	8
Board of Examiners for Nursing Home Administrators	4	1	3	0	8
Board of Examiners in Psychology	7	1	1	0	9
Committee on Physician Assistants	1	3	3	1	8
Board of Nursing	9	3	0	0	12
Board of Optometry	0	5	0	1	6
Board of Registration in Podiatry	0	0	0	5	5
Board of Veterinary Medical Examiners	5	0	0	2	7
Committee for Clinical Perfusionists	3	1	0	2	6
Council for Licensing Hearing Instrument Specialists	5	1	0	0	6
Council of Certified Professional Midwifery	3	1	5	3	12
Emergency Medical Services Board	0	7	0	7	14
Advisory Committee for Acupuncture	1	2	2	0	5
Medical Laboratory Board	0	0	13	0	13
Totals	55	26	32	35	148

In the Department of Health Conflict of Interest Statement, there is no option for disclosure of conflicts at all—employees are simply not allowed to have conflicts, and an employee with a conflict is subject to disciplinary action.

No statute requires written disclosure, and nothing came to our attention during this audit to indicate that board members were influenced by personal or professional conflicts of interest. However, board members routinely make licensure and disciplinary decisions intended to protect the public from practitioners who do not meet the qualifications of their profession or whose actions have harmed or endangered the public. Annual conflict-of-interest disclosures would help ensure that board members are able to make such decisions impartially and independently and that board decisions are not called into question because of members' possible conflicts.

Recommendation

Division of Health Related Boards management should assess which conflict-of-interest statement is most appropriate for board members to sign, revise the statement and policy as needed to include disclosures of potential conflicts, and then ensure that all board members annually sign that conflict-of-interest statement.

Management's Comment

We concur in part. The Division recognized during the audit that there was a need to revisit our process. Since that time, the Division has had all board members sign a new Divisional conflict of interest statement and those signed statements are maintained by the board appointment coordinator. The existing policy has been revised. There are now two policies, one for board members and one for staff. The revision should clear up the inconsistencies and further clarify the issue.

We do not concur that board members should be required to provide an annual conflict of interest disclosure, as none is required by law.

RECOMMENDATIONS

ADMINISTRATIVE

The Health Related Boards and the Department of Health should address the following areas to improve the efficiency and effectiveness of their operations.

1. Division of Health Related Boards management should work with the Department of Health's Office of General Counsel to protect board-developed examinations without violating statutory requirements. One option would be to propose legislation to the General Assembly designating board-developed examinations confidential. Another option might be to closely monitor any reviews of past test papers, to ensure that exam questions are not copied and no notes are taken.
2. All Health Related Boards currently using board-developed examinations should also consider discontinuing the use of internally developed examinations and instead using national examinations or contractor-developed examinations that would not be considered public information and that have been validated for psychometric soundness.
3. Division of Health Related Boards and Bureau of Health Licensure and Regulation management should continue to review the revenues and expenditures of the individual boards throughout the year, and recommend increasing fees and/or decreasing expenditures as necessary to meet statutory self-sufficiency requirements.
4. Division of Health Related Boards management may wish to consider recommending the consolidation of boards with a small base of licensees into related boards with a larger base of licensees, so they can operate more efficiently and effectively and be able to meet self-sufficiency requirements.
5. Division of Health Related Boards management should require board staff to follow up to ensure that individuals with expired licenses are no longer practicing in the state. Management and board staff should review each board's reinstatement policies and work with board members to ensure that all boards impose additional requirements, such as taking a refresher course or applying for a new license, as a condition of renewal for licenses expired for extended periods of time.
6. Division of Health Related Boards management should review current policies and procedures regarding the board appointment process and make changes and clarifications as needed to streamline the process, reflect current procedures, and ensure the process is adequately documented. Management should then monitor the process to ensure division policies are followed, division and statutory time frames

are met, and appropriate documentation of nominee information and division actions is maintained in the files.

7. The Board of Dietitian/Nutritionist Examiners should pursue rule changes requiring their licensees to receive continuing education as a condition of licensure renewal, thereby assuring that practitioners remain knowledgeable about current standards and emerging trends. If department legal staff determine that specific statutory authority is necessary before the board can promulgate continuing education rules, the department should develop proposed legislation for consideration by the General Assembly.
8. All boards should develop (and implement) a regular schedule for periodically conducting audits, whether random or specific, of licensees' compliance with continuing education requirements.
9. Division of Health Related Boards management should assess which conflict-of-interest statement is most appropriate for board members to sign, revise the statement and policy as needed to include disclosures of potential conflicts, and then ensure that all board members annually sign that conflict-of-interest statement.

Appendix 1

Description of the Health Related Boards Covered in This Audit

Board of Chiropractic Examiners

The Board of Chiropractic Examiners was created by Chapter 9, Public Acts 1923, currently codified as Section 63-4-102, *Tennessee Code Annotated*. The board regulates chiropractors and operators of X-ray equipment in chiropractic offices. The seven-member board consists of five physicians who have actively engaged in practice for at least five years and two consumer members who are not affiliated with the practice of chiropractic. All members are appointed by the Governor to serve five-year terms.

Board of Communication Disorders and Sciences

The Board of Communication Disorders and Sciences began in 1973 as the Board of Examiners of Speech Pathology and Audiology, and was restructured in 1995. Pursuant to Section 63-17-104, *Tennessee Code Annotated*, the board regulates speech language pathologists and audiologists. The seven-member board consists of one physician, one consumer member not affiliated with audiology or speech pathology, and a combination of five licensed speech language pathologists and audiologists. All members of the board are appointed by the Governor to serve three-year terms.

Board of Dentistry

The Board of Dentistry was created by Chapter 32, Public Acts 1957, currently codified as Section 63-5-101, *Tennessee Code Annotated*. The board regulates dentists, dental hygienists, and dental assistants. The 11-member board consists of seven practicing dentists, two practicing dental hygienists, one practicing registered dental assistant, and one citizen member. All members of the board are appointed by the Governor to serve three-year terms.

Board of Dietitian/Nutritionist Examiners

The Board of Dietitian/Nutritionist Examiners was created by Chapter 384, Public Acts 1987, currently codified as Section 63-25-106, *Tennessee Code Annotated*. The six-member board consists of five individuals who are state residents with at least five years of actual practice or teaching of dietetics and/or nutrition and one consumer. All members of the board are appointed by the Governor to serve three-year terms.

Board of Examiners for Nursing Home Administrators

The Board of Examiners for Nursing Home Administrators was created by Chapter 565, Public Acts 1970, currently codified as Section 63-16-102, *Tennessee Code Annotated*. The nine-member board consists of one ex-officio member (the Commissioner of Health or his designee), four members from the nursing home industry, one hospital administrator, one

physician, one nurse, and one consumer. All appointments are made by the Governor, and each appointed member serves a three-year term.

Board of Examiners in Psychology

The Board of Examiners in Psychology was created by Chapter 169, Public Acts 1953, currently codified as Section 63-11-101, *Tennessee Code Annotated*. The board regulates psychologists and psychological examiners. The nine-member board consists of two members of faculty with the rank of assistant professor or above of the accredited colleges and universities in the state and engaged in teaching, research, and/or administration of psychology; four licensed psychologists; two licensed psychological examiners or licensed senior psychological examiners; and one private citizen who is none of the above and has no professional or commercial interest in the practice of psychology. All board members are appointed by the Governor to serve five-year terms.

Committee on Physician Assistants

The Committee on Physician Assistants was created by Chapter 376, Public Acts 1985, currently codified as Section 63-19-103, *Tennessee Code Annotated*. The committee, working with the Board of Medical Examiners, regulates physician assistants and orthopedic physician assistants. The seven-member committee consists of five physician assistants, one orthopedic physician assistant, and one health care consumer. All members are appointed by the Governor and serve four-year terms.

Board of Nursing

The Board of Nursing was created in 1911; however, the board in its current form was created by Chapter 78, Public Acts 1967, currently codified as Section 63-7-201, *Tennessee Code Annotated*. The board issues licenses to registered nurses and practical nurses and issues advanced practical nurse certificates of fitness to nurse practitioners, nurse anesthetists, nurse midwives, and clinical nurse specialists. The nine-member board consists of five registered nurses, three licensed practical nurses, and one consumer member who is not a nurse and is not commercially or professionally associated with the health-care industry. The Governor appoints all members to serve four-year terms or until their successors are appointed.

Board of Optometry

The Board of Optometry was created by Chapter 99, Public Acts 1925, currently codified as Section 63-8-103, *Tennessee Code Annotated*. The six-member board consists of five licensed optometrists with at least five years of experience and one member who is a health-care consumer. All members are appointed by the Governor to serve five-year terms.

Board of Registration in Podiatry

The Board of Registration in Podiatry was created by Chapter 31, Public Acts 1931, currently codified as Section 63-3-103, *Tennessee Code Annotated*. The five-member board

consists of four persons who have been licensed podiatrists in this state for a period of at least two years and one citizen member. All members are appointed by the Governor to serve three-year terms.

Board of Veterinary Medical Examiners

The Board of Veterinary Medical Examiners was created by an act of the legislature in 1905; however, the board as it is organized today was created by Chapter 80, Public Acts 1967, currently codified as Section 63-12-104, *Tennessee Code Annotated*. The board regulates veterinarians, veterinary medical technicians, and euthanasia technicians. The seven-member board consists of five licensed doctors of veterinary medicine, one licensed veterinary technician, and one member from the general public. All members are appointed by the Governor to serve five-year terms.

Committee for Clinical Perfusionists

The Committee for Clinical Perfusionists was created by Chapter 239, Public Acts 1999, currently codified as Section 63-28-112, *Tennessee Code Annotated*. The committee, working with the Board of Medical Examiners, licenses qualified clinical perfusionists in this state. (Perfusion involves the functions necessary for the support, treatment, measurement, or supplementation of the cardiovascular, circulatory, or respiratory systems, or other organs, or a combination of these activities, and ensuring the safe management of physiologic functions by monitoring and analyzing the parameters of the systems under an order and under the supervision of a licensed physician.) The seven-member committee has four perfusionist members, one hospital administrator from a health-care facility where cardiac surgery is performed, one physician who is a cardiac surgeon or cardiac anesthesiologist, and one member from the general public. All members are appointed by the Governor to serve six-year terms.

Council of Certified Professional Midwifery

The Council of Certified Professional Midwifery was created by Chapter 576, Public Acts 2000, currently codified as Section 63-29-103, *Tennessee Code Annotated*. The council, working with the Board of Osteopathic Examination, is responsible for regulating midwives (other than nurse midwives, who are regulated by the Board of Nursing). The nine-member council consists of four certified professional midwives, one consumer, one certified nurse midwife, one obstetrician, one family physician, and one pediatrician. All members are appointed by the Commissioner of Health and serve four-year terms.

Council for Licensing Hearing Instrument Specialists

The Council for Licensing Hearing Instrument Specialists was created by Chapter 481, Public Acts 1995, currently codified as Section 63-17-202, *Tennessee Code Annotated*. The council regulates persons who dispense and fit hearing instruments. The five-member council consists of three qualified hearing instrument specialists; one physician with certification from the American Council of Otolaryngology; and one citizen member who has used a hearing

instrument for at least five years and never engaged in the practice of dispensing and fitting, audiology, or medicine. All members are appointed by the Governor to serve five-year terms.

Emergency Medical Services Board

The Emergency Medical Services Board was created by Chapter 440, Public Acts 1983, currently codified as Section 68-140-503, *Tennessee Code Annotated*. The board is responsible for approving schools, prescribing courses for EMS personnel, promulgating rules and regulations governing licenses and permits, and establishing standards for the activities and operations of emergency medical and ambulance services. The 13-member board consists of

- two physicians;
- one registered nurse;
- one hospital administrator;
- one member licensed as an Emergency Medical Technician (EMT), EMT-Paramedic (EMT-P), registered nurse, or physician and who is affiliated with a volunteer ambulance service;
- two operators of ambulance services (licensed as an EMT or EMT-P);
- one rescue squad member (licensed as an EMT or EMT-P);
- one EMT-P, EMT, or registered nurse nominated by the Tennessee Professional Firefighters Association;
- one EMT or EMT-P nominated by the Tennessee Civil Defense Association;
- two officials of local governments that operate ambulance services; and
- one paramedic instructor from an accredited paramedic program in Tennessee.

Four members are appointed from each of the state's three grand divisions, and one member is appointed at large. All members are appointed by the Governor for four-year terms.

Advisory Committee for Acupuncture

The Advisory Committee for Acupuncture was created by Chapter 685, Public Acts 2000, currently codified as Section 63-6-1003, *Tennessee Code Annotated*. The committee, working with the Board of Medical Examiners, regulates persons who practice acupuncture. The five-member committee consists of three acupuncturists, one acupuncture detoxification specialist, and one consumer member who is not employed in a health care profession. All members are appointed by the Governor for four-year terms.

Medical Laboratory Board

The Medical Laboratory Board was created by Chapter 355, Public Acts 1967, currently codified as Section 68-29-109, *Tennessee Code Annotated*. The board regulates medical laboratories and laboratory personnel. This 13-member board consists of

- three pathologists,
- one hospital administrator,
- one independent laboratory management/administrative representative,
- one hospital laboratory manager/administrative director,
- two licensed medical technologist generalists,
- one licensed physician (not a pathologist),
- one educator in a medical technology or medical laboratory technician program,
- one licensed non-physician medical laboratory supervisor,
- one licensed cytotechnologist, and
- one private citizen to represent the public interest.

All members are appointed by the Governor to serve four-year terms.

Appendix 2

**Health Related Boards Current Net Income
For the Fiscal Year Ended June 30**

Board/Committee	2004	2003	2002
Alcohol & Drug Abuse Counselors	\$ (3,661)	\$ (20,452)	\$ (42,967)
Chiropractic Examiners	\$45,030	30,742	(39,868)
Communication Disorders & Sciences	13,213	7,060	(3,252)
Dentistry	49,055	(95,757)	(134,429)
Dieticians & Nutritionists	12,188	21,185	2,785
Dispensing Opticians	6,914	16,689	18,606
Electrolysis Examiners	(2,912)	7,388	(6,584)
Hearing Instrument Specialists	7,375	13,956	(9,997)
Massage Licensure	(182,389)	65,583	240,871
Medical Examiners	532,468	548,075	(208,519)
Acupuncture	15,566	17,470	(12,052)
Athletic Trainers	8,470	8,602	(3,009)
Clinical Perfusionists	12,918	56,250	(3,119)
Physician Assistants	23,861	31,428	(10,039)
Medical Laboratory	61,164	168,863	128,942
Nursing	658,185	887,979	508,960
Nursing Home Administrators	4,440	6,936	15,934
Occupational Therapy	32,514	49,241	54,738
Optometry	28,563	(267,091)	(63,050)
Osteopathic Physicians	19,729	(3,710)	(2,541)
Midwifery	(466)	(3,596)	758
Physical Therapy	61,095	53,610	97,308
Podiatry	16,938	11,586	(12,882)
Professional Counselors, Marital & Family Therapists, & Clinical Pastoral Therapists	62,132	45,789	14,017
Psychology	119,798	75,396	(19,691)
Reflexologist Registry	(930)	(1,282)	(2,469)
Respiratory Care	(6,150)	(11,651)	17,215
Social Workers	47,096	36,660	(22,864)
Veterinary Medical Examiners	4,362	(37,799)	(113,062)
Year End Totals	\$ 1,646,563	\$ 1,719,150	\$ 389,740

Note: Boards/Committees covered in this audit are noted in bold type.

Source: Director of Administrative Services, Bureau of Health Licensure and Regulation.

Appendix 3

Health Related Boards Title VI Information

Title VI of the Civil Rights Act of 1964 requires that “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving federal financial assistance.” 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’s Health Related Boards, and the department’s efforts to comply with Title VI requirements. The results of the information gathered are summarized below.

According to the State of Tennessee’s *The Budget-Fiscal Year 2005-2006*, the Health Related Boards program received no direct federal funding during fiscal years 2004 or 2005 (estimated). However, the Emergency Medical Services program (to which the Emergency Medical Services Board is attached) received \$373,900 in federal funds in fiscal year 2004 and was estimated to receive \$672,500 in fiscal year 2005. The Department of Health (to which all of the boards covered in this audit are administratively attached) received over \$238 million in federal funds during fiscal year 2004 and an estimated \$265 million in 2005.

The Department of Health submitted to the Office of the Comptroller of the Treasury its *Title VI Compliance Plans and Implementation Manuals for Fiscal Years 2004-2005 and 2005-2006* by the statutorily required dates. In addition to the Comptroller’s Office, the department also submits copies of its plans to the General Assembly, the Title VI Compliance Commission, and the U.S. Department of Health and Human Services’ Office of Civil Rights. According to the Title VI Plan, the Department of Health’s Title VI objectives are:

1. To develop and implement a comprehensive Title VI Compliance Plan for use in the department’s effort to ensure that all persons receive services and benefits in a non-discriminatory manner.
2. To constantly train new hires and sub-recipients.
3. To inform the public through statewide collaborative workshops and training meetings.

The Department of Health has a Title VI Program Director and a full-time Title VI Compliance Program Manager. In addition, the department has Title VI Regional Coordinators who represent the department’s various bureaus and assist with Title VI program monitoring throughout the state. The department also has a Title VI Coordinating Committee, which consists of 17 members (13 of whom are minorities), including four community representatives. Title VI staff’s responsibilities include:

- planning and developing the department's Title VI Compliance Plan and Implementation Manual;
- visiting facilities;
- training staff, as well as sub-recipients;
- conducting Title VI educational sessions across the state;
- communicating policy;
- monitoring;
- conducting investigations; and
- reporting findings to the Title VI coordinator.

Civil rights training for all Title VI enforcement staff is provided through workshops conducted by the Title VI Program Director, the U.S. Department of Health and Human Services' Office of Civil Rights, and the Tennessee Title VI Compliance Commission.

Title VI Training and Information Dissemination

According to the Department of Health's Title VI plan, the following methods are used to advise department staff, applicants and recipients of services, and vendors of the requirements of Title VI:

Internal

1. An in-service training program for all regional health department coordinators is to be provided by the Title VI Program Director/Coordinator.
2. An in-services training program concerning Title VI will be provided annually by the regional coordinators to all new county and local health department employees.
3. Title VI information will be distributed to all new employees during their orientation.
4. The department's non-discriminatory policy will be distributed and posted in a conspicuous place within all departmental facilities.

External

1. The Title VI policy statement is included in all contracts and grants.
2. Information concerning the department's non-discriminatory policy regarding Title VI is provided to all contractors, vendors, clients, recruiting sources, and the general public.
3. Non-discrimination statements are included on pamphlets, posters, fliers, and newspaper advertisements when government services are offered or discussed.

The department also (1) provides brochures and other written materials regarding Title VI to local health departments and community sites (e.g., county Department of Human Services

offices, community centers, churches, and others who might be serving minorities and willing to post or distribute materials) and (2) issues news releases if pertinent new information is received from the federal government.

The department has developed procedures for addressing the language assistance needs of persons with Limited English Proficiency (LEP). The Title VI Plan outlined steps to comply with Title VI-LEP:

- assess language needs;
- develop a comprehensive written policy on language access; and
- ensure interpreters are trained and competent.

The Title VI plan contained several examples of translated written materials such as department forms, applications, brochures, and educational materials available to persons with LEP.

According to the department's Title VI Training Reports for fiscal years 2004 and 2005, nearly 3,000 department staff and 900 sub-recipients received Title VI training in fiscal year 2004. In fiscal year 2005, Title VI staff and committee members received LEP training from the U.S. Department of Health and Human Services; LEP training videos were used to train other department employees as needed. In addition, department sub-recipients received LEP training, training videos, and updated brochures and posters in English and Spanish. In May 2005, the department hosted the Southeast Regional Civil Rights Training Conference.

Monitoring and Tracking of Title VI Compliance

The department's Title VI Plan details methods used to monitor compliance with Title VI. For department divisions and programs, Title VI staff review data and conduct reviews as needed. Regional staff in the Bureau of Health Services perform quality assurance audits that include some Title VI compliance measures. Title VI regional coordinators conduct on-site reviews of local health departments. Sub-recipients must sign and return Assurance of Compliance forms indicating that they will comply with Title VI requirements (in addition to other requirements noted). In addition, sub-recipients must complete a Title VI compliance questionnaire to help the department identify potential noncompliance areas and sub-recipients who need further review. During 2004, as part of its Civil Rights audit work, the department's Internal Audit division reviewed Title VI compliance using a checklist developed by the Department of Finance and Administration's former Program Accountability Review Section. We reviewed Internal Audit's work on two sub-recipients that contract with the Health Related Boards—the checklist was followed, and no discrepancies were noted.

If non-compliance with Title VI is identified, the department's policy is to give the recipient 30 days to notify the department of its plan to voluntarily comply with Title VI. Sixty days will be given for preparation of the plan, after which, the Title VI Office will begin administrative procedures necessary to ensure compliance or seek termination of federal funds through the department's legal office.

Title VI Complaints

During fiscal year 2004, the department reported receiving and investigating five complaints (two of which were informal) alleging violations of Title VI. Of the formal complaints, one was made by a terminated department employee and was found to be invalid, one was made by a client and was resolved when the employee involved resigned, and the third alleged rudeness by a health department worker and was found to be invalid because of miscommunication. During fiscal year 2005, the department reported receiving six complaints. Two were referred to the Bureau of TennCare and the Human Rights Commission, respectively, and one was investigated by the U.S. Department of Health and Human Services' Office of Civil Rights. The remaining three were investigated by the Department of Health's Title VI Office and closed. Claimants requested that one complaint be dropped, and no noncompliance with Title VI was found. One complaint against a hospital was found to focus on issues unrelated to Title VI, and the complainant was pursuing legal action. The third complaint was resolved through LEP training and customer service training for staff, improved posting of information, and actions to improve service delivery.

Breakdown of Board Members, Health Related Boards Staff, and Health Contracts by Ethnicity

The tables below detail the breakdown of Health Related Boards contractors, board members, and staff by ethnicity (for contractors) and by ethnicity and gender (for board members and staff). As of January 24, 2005, 53 percent of board members were female and 18 percent were minorities (17 percent were African-American). As of November 2004, 82 percent of Health Related Boards staff were female and 29 percent were minorities (27 percent were African-American).

**Health Related Boards Contracts
As of January 2005**

Contractor	Program/Activity	Funding Source	Amount	Minority Contractor	Non-Minority Contractor
1. Allison Climer	Inspect veterinary facilities (West TN)	Licensure fees	\$55,941 (\$18,647 current year)		X
2. Allison Climer	Inspect veterinary facilities (Middle TN)	Licensure fees	\$67,992 (\$22,664 current year)		X
3. David Scott Bailey	Inspect massage establishments (Middle TN)	Licensure fees	\$51,126 (\$18,863 current year)		X
4. David Scott Bailey	Inspect massage establishments (West TN)	Licensure fees	\$27,000 (\$11,000 per year)		X
5. David Scott Bailey	Inspect massage establishments (East TN)	Licensure fees	\$58,686 (\$21,016 per year)		X
6. Delegated	Board matters/ Court actions	State	\$225,000	N/A	N/A

Contractor	Program/Activity	Funding Source	Amount	Minority Contractor	Non-Minority Contractor
7. Federation of State Boards of Physical Therapy	Examinations	No-cost contract	\$0	N/A	N/A
8. Federation of State Medical Boards of the U.S., Inc.	SPEX examination	No cost	\$0	N/A	N/A
9. Infoworks, Inc.	LRIS Imaging System	Licensure fees	\$51,000		X
10. International Hearing Society	Hearing Aid Dispensers	Examination fees	\$20,000 (\$4,000 per year)	N/A	N/A
11. James L Everett (Veterinary Medicine)	Inspection of Veterinary Facilities	Licensure fees	\$71,196 (\$23,732) per year		X
12. Lighthouse Prof. Services, Inc.	Assistance	Licensure fees	\$85,000		X
13. Tennessee Dental Association	Peer Assistance	Licensure fees	\$90,000	N/A	N/A
14. National Board of Podiatric Medical Examiners, Inc.	Examination	No-cost contract	\$0	N/A	N/A
15. National Board Exam Committee for Veterinary Medicine	Licenses Exam	No-cost contract	\$0	N/A	N/A
16. Professional Examination Services	Psychologist/Marital & Family Therapist examinations	No-cost contract	\$0	N/A	N/A
17. TN Center for Nursing, Inc.	Delivery of Quality Health Care	Licensure fees	\$541,888 (\$270,944 per year)	N/A	N/A
18. TN Medical Foundation	Peer Assistance for Impaired Physicians	Licensure fees	\$200,000 (\$100,000 per year)	N/A	N/A
19. TN Nurses Foundation, Inc.	Rehab/Peer Assistance Physician Assistants	Licensure fees	\$43,000 (\$16,000 per year)	N/A	N/A
20. TN Nurses Foundation, Inc.	Respiratory Care Peer Assistance	Licensure fees	\$16,000 per year	N/A	N/A
21. TN Nurses Foundation, Inc.	Lab Licensing Peer Assistance	Licensure fees	\$15,000 per year	N/A	N/A
22. TN Nurses Foundation, Inc.	Nursing Peer Assistance	Licensure fees	\$1,390,490 (\$466,830 per year)	N/A	N/A
23. TN Nurses Foundation, Inc.	Occupational Therapist/Physical Therapists Peer Assistance	Licensure fees	\$32,000 (\$16,000 per year)	N/A	N/A

**Emergency Medical Services Contracts
As of March 2005**

Contractor	Program/Activity	Funding Source	Amount	Minority Contractor	Non-Minority Contractor
1. Jackie Kirby, R.N.	Adult trauma review	Licensure fees	\$2,500		X
2. UT – Knoxville (Enderson)	Adult trauma review	Licensure fees	\$6,500	N/A	N/A
3. Richard C. Treat	Adult trauma review	Licensure fees	\$14,000		X
4. Emergency Medical Resources, PLLC	Medical director	Federal	\$25,000		X
5. UT – Memphis (Kudsk)	Adult trauma review	Licensure fees	\$6,500	N/A	N/A
6. Delegated	Board matters/ Court actions	State	\$13,000	N/A	N/A
7. Pam Castleman	Adult trauma review	Licensure fees	\$2,500		X
8. Vanderbilt University Medical Center	EMS for children	Federal	\$100,000	N/A	N/A

Sources: Tennessee Department of Health's Bureau of Administrative Services; and its *Title VI Compliance Plan and Implementation Manual FY 2004-2005 Appendices*.

**Health Related Boards
Breakdown of Board Members by Gender and Ethnicity
As of January 24, 2005**

Board	Gender		Ethnicity					
	Male	Female	Black	White	Asian	Hispanic	Other	Vacant
Advisory Committee for Acupuncture	1	4	0	4	1	0	0	0
Board of Alcohol & Drug Abuse Counselors	2	3	3	2	0	0	0	0
Board of Chiropractic Examiners	3	4	0	7	0	0	0	0
Board of Communication Disorders & Sciences	2	5	1	6	0	0	0	0
Board of Dentistry	8	3	1	10	0	0	0	0
Board of Dietitian/ Nutritionist Examiners	0	6	2	4	0	0	0	0
Board of Dispensing Opticians	2	4	0	6	0	0	0	0
Board of Electrolysis Examiners	4	0	0	4	0	0	0	1
Council for Hearing Instrument Specialists	5	0	1	4	0	0	0	0
Massage Licensure Board	1	6	1	6	0	0	0	0
Board of Medical Examiners	9	3	2	10	0	0	0	0
Medical Laboratory Board	2	10	3	9	0	0	0	1
Council of Certified Professional Midwifery	2	7	2	7	0	0	0	0
Board of Nursing	0	9	2	7	0	0	0	0
Board of Examiners for Nursing Home Administrators	3	5	1	7	0	0	0	0
Board of Occupational and Physical Therapy Examiners	2	7	2	7	0	0	0	0
Board of Optometry	4	2	0	6	0	0	0	0
Board of Osteopathic Examination	3	2	0	4	0	1	0	1
Committee for Clinical Perfusionists	5	1	2	4	0	0	0	1
Committee on Physician Assistants	3	3	2	4	0	0	0	1
Board of Registration in Podiatry	3	2	0	5	0	0	0	0
Board of Professional Counselors, Marital and Family Therapists and Clinical Pastoral Therapists	4	1	0	5	0	0	0	0
Board of Examiners in Psychology	5	4	1	8	0	0	0	0
Board of Respiratory Care	5	3	3	5	0	0	0	0

Board	Gender		Ethnicity					
	Male	Female	Black	White	Asian	Hispanic	Other	Vacant
Board of Social Workers	0	7	4	3	0	0	0	0
Board of Veterinary Medical Examiners	4	3	0	7	0	0	0	0
Emergency Medical Services Board	11	2	0*	13	0	0	0	0
Total	93	106	33	164	1	1	0	5

* As of October 2005, the Emergency Medical Services Board has one Black board member and 12 White board members.

Source: Tennessee Department of Health.

Staff of the Division of Health Related Boards*
By Title, Gender, and Ethnicity
As of November 15, 2004

Title	Gender		Ethnicity					
	Male	Female	Black	White	Asian	Hispanic	American Indian	Other
Accounting Technician	1	0	0	1	0	0	0	0
Administrative Assistant	0	3	1	2	0	0	0	0
Administrative Director-Regulatory Boards	0	3	0	3	0	0	0	0
Administrative Manager-Regulatory Boards	0	2	0	2	0	0	0	0
Administrative Assistant-Regulatory Boards	0	18	6	12	0	0	0	0
Administrative Services Assistant	3	12	4	11	0	0	0	0
Administrative Secretary	0	1	0	1	0	0	0	0
Clerk	1	5	2	4	0	0	0	0
Data Entry Operator	0	5	3	2	0	0	0	0
Dental Board Director	1	0	0	1	0	0	0	0
Distributed Computer Operator	0	1	0	0	1	0	0	0
Health Related Boards Director	0	1	0	1	0	0	0	0
Health Related Boards Investigations Director	0	1	0	1	0	0	0	0
Information Resource Specialist	2	6	2	5	1	0	0	0
Information Systems Manager	1	0	0	1	0	0	0	0
Legal Assistant-Health Related Boards	1	0	1	0	0	0	0	0
Licensing Technician	3	12	8	7	0	0	0	0
Medical Board Director	0	1	0	1	0	0	0	0
Medical Technologists Consultant	0	1	0	1	0	0	0	0
Nursing Board Director	0	1	0	1	0	0	0	0
Office Automation Specialist	0	1	0	1	0	0	0	0
Physician	1	0	0	1	0	0	0	0
Public Health Nursing Consultant	1	10	1	10	0	0	0	0
Regulatory Boards Investigator	3	3	1	5	0	0	0	0
Veterinary Board Director	0	1	0	1	0	0	0	0
Veterinarian Staff	1	0	0	1	0	0	0	0
Word Processing Operator	0	1	0	1	0	0	0	0
Total	19	89	29	77	2	0	0	0

* Does not include board members or attorneys.

Source: Tennessee Department of Health.