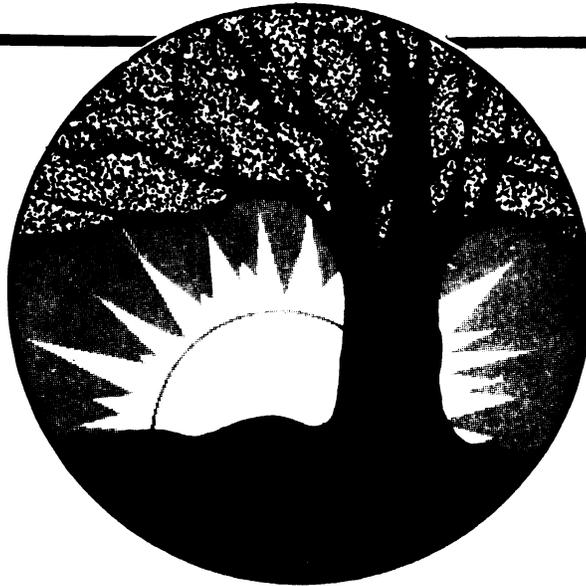


PERFORMANCE AUDIT

Health Related Boards
December 2009



Justin P. Wilson
Comptroller of the Treasury



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December 29, 2009

The Honorable Ron Ramsey
Speaker of the Senate
The Honorable Kent Williams
Speaker of the House of Representatives
The Honorable Bo Watson, Chair
Senate Committee on Government Operations
The Honorable Susan M. Lynn, 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 23 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,

Arthur A. Hayes, Jr., CPA
Director

AAH/dlj
09-017

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit
Health Related Boards
December 2009

AUDIT OBJECTIVES

The objectives of the audit were to evaluate selected aspects of the complaint handling, investigation, and discipline process; evaluate selected aspects of the initial licensing process; evaluate the health related boards' self-sufficiency status, including both unusually high and low fund balances; evaluate selected aspects of the Division of Health Related Boards' organization; identify the current status of efforts to replace the Regulatory Boards System computer tracking system; and gather information about whether health practitioners with felony convictions should be allowed to practice in Tennessee.

FINDINGS

As Noted in Two Prior Performance Audits Since 2003, Several Boards Do Not Meet Financial Self-sufficiency Requirements Imposed by State Law; Overall, Prior Surpluses Available to Offset Deficits Have Been Transferred to the State's General Fund, So That Action Needs to Be Taken to Avoid Adverse Impact on Board Operations and the Public Affected by the Boards' Oversight

Consistent with prior performance audits, several health related boards have not met their statutory obligation to remain financially self-sufficient in recent years. Section 4-29-121(a), *Tennessee Code Annotated*, effectively requires each health related board's revenues to meet or exceed its costs on an annual basis. However, eight health related boards were not self-sufficient in both fiscal years 2007 and 2008. While the Department of Health has acted to minimize board costs, some boards have been hesitant to raise fees necessary to meet their

statutory obligation. To further complicate matters, significant portions of other boards' surpluses (which were previously used to offset past-year board deficits) have been transferred to the state's General Fund to help address the budget crisis (page 4).

The General Assembly May Wish to Consider Changing How Tennessee Regulates Hearing Instrument Specialists

The General Assembly may wish to consider terminating the Council for Licensing Hearing Instrument Specialists and reassigning its regulatory responsibilities to either the Board of Communication Disorders and Sciences or the Department of Health. Hearing instrument specialists are currently regulated by the council, which has broad, independent regulatory decision-making authority, but is administratively attached to the board. However, this council model may not be the most efficient regulatory approach for this

profession. The council has heard relatively few, mostly consumer-protection-related complaints against licensees. Additionally, it has struggled to remain financially self-sufficient (page 12).

The National Practitioner Data Bank Provides an Opportunity for the Division of Health Related Boards to Further Protect the Public

The department can supplement its efforts to identify problems with practitioners who move from other states and seek Tennessee licensure. Specifically, the department can expand its use of the federal National Practitioner Data Bank, which includes multiple state licensing, malpractice, and other information about professionals in select health related fields. Although not required to do so, the department already uses this data bank and other methods to verify some practitioner history information on a case-by-case basis, especially when a problem is suspected. The department can further protect the public by automatically querying the data bank every time a practitioner in a covered profession applies for licensure. Under current budget conditions, the department likely will not be able to absorb the costs of these expanded queries. However, the department could review the health related boards' authority, and seek authority as needed, to charge applicants a fee to cover the query's cost (page 16).

The Division Needs Better Methods and Information to Monitor Its Licensing Timeliness

The Division of Health Related Boards' outdated computer system, as well as its incomplete and inconsistent performance measurement data and methods, does not allow it to easily and accurately assess whether it processes initial professional license applications in a timely manner. Licensing is one of the boards' primary tools to protect the public, by ensuring that only qualified health practitioners are allowed to practice in Tennessee. Therefore, it is particularly important that the division be able to monitor and report how quickly it processes initial license applications. However, the division's current performance measurement methods do

not provide enough information to thoroughly analyze timeliness. For example, the current computer system does not allow the division to track individual steps within the licensing process. As a result, the division cannot separate applicant-caused delays from delays caused by the staff. Additionally, the division's performance measurement process continues to be hampered by delays in replacing its inadequate computer system (page 18).

The Division Needs a Systematic Process to Track Health Care Facilities Inspections

Although the division frequently processes initial licensing applications in a timely manner, it can improve its operations by developing a consistent, systematic method of tracking those initial licensing inspections conducted by another Department of Health unit. In order to avoid duplication of efforts and ensure consistency among closely related facility inspections, the Division of Health Care Facilities conducts initial inspections of medical laboratories and medical doctors' office-based surgical suites on behalf of their respective boards. While some boards' managers closely monitor and inquire about the progress of these inspections, other inspections may languish for long periods of time without formal, systematic follow-up (page 24).

Health Related Boards Have Limited Disciplinary Monitoring Functions and Resources

Three health related board units are responsible for monitoring disciplined practitioners. Specifically, Board of Pharmacy and Emergency Medical Services Board staffs monitor practitioners disciplined by their respective regulatory boards. The department's Office of Investigations monitors all other health related boards' practitioners. Of these three units, only the Office of Investigations has a formal monitoring process; but the office's process is limited by its workload. For example, office management and the disciplinary coordinator estimated that 700 or more practitioners are under monitoring at any one time, making it difficult for the office to track monitored practitioners in detail. The department can take several steps to help address these problems.

For example, the Board of Pharmacy and the Emergency Medical Services Board should develop a formal, written disciplinary monitoring process, and the office could consider prioritizing disciplinary cases. After all efforts have been made to enhance efficiency and the state's budget outlook improves, the department should consider whether it would be helpful and cost-effective to add new monitoring staff positions (page 28).

The Department of Health Should Further Integrate Functions of the Board of Pharmacy Into the Division of Health Related Boards in Order to Improve Both the Efficient Use of Resources and the Effectiveness of Its Regulatory Obligations to Protect the Public

The Department of Health can improve its efficiency and effectiveness by further

integrating select Board of Pharmacy functions with the other health related boards. The General Assembly moved the board from the Department of Commerce and Insurance to the Department of Health's Division of Health Related Boards in July 2007. Since then, the board has integrated some, but not all, of its functions with the division's other boards. In order to enhance efficiency and effectiveness, the board's review of whether pharmacists and other regulated professionals have met their continuing education requirements could be merged into the more robust centralized unit which conducts the other health related boards' continuing education audits. Additionally, there may be opportunities for the pharmacy investigators and the other health related boards' investigators to cooperate, as encouraged by state law (page 32).

OBSERVATIONS AND COMMENTS, AND ADDITIONAL AUDIT WORK PERFORMED

The audit also discusses the following issues: Tennessee statutes governing the licensure of convicted felons; the Polysomnography Professional Standards Committee's status; workload challenges facing the Office of Investigations; and the need for board members to receive at least some Title VI training (page 36).

ISSUE FOR LEGISLATIVE CONSIDERATION

The General Assembly may wish to consider terminating the Council for Licensing Hearing Instrument Specialists, and reassigning the council's responsibilities to the Board of Communication Disorders and Sciences or a Department of Health operated registry. If the General Assembly wishes to assign the responsibility to the board, it may wish to consider changing the board's composition to provide for a hearing instrument specialist to sit on the board. Similarly, if the General Assembly wishes to create a new registry for hearing instrument specialists, it may wish to consider providing the department with full licensing, investigative, and disciplinary authority (page 42).

Performance Audit Health Related Boards

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Performance Audit Health Related Boards

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of 23 health-related boards was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Sections 4-29-231 and 4-29-232, *Tennessee Code Annotated*, the 22 boards listed below were scheduled to terminate June 30, 2010, or June 30, 2011, as indicated below.

Scheduled To Terminate June 30, 2010

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

Scheduled to Terminate June 30, 2011

Board of Dentistry
Board of Medical Examiners
Board of Respiratory Care
Massage Licensure Board
Polysomnography Professional Standards Committee

Additionally, the Board of Athletic Trainers is included in this audit under Section 4-29-119(a), *Tennessee Code Annotated*. The board is not statutorily assigned a termination date, and thus became subject to this review when identified by staff of the Office of the Comptroller of

the Treasury. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of these entities and to report the results to the Joint Government Operations Committee of the General Assembly. This performance audit is intended to aid the committee in determining whether the entities should be continued, restructured, or terminated.

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. To evaluate selected aspects of the complaint handling, investigation, and discipline process. The evaluation focused on evaluating the investigators' workloads; identifying the extent to which disciplined practices are monitored; comparing select Tennessee investigative and disciplinary practices to other states' and/or best practices; and monitoring related legislation considered by the General Assembly in its 2009 session.
2. To evaluate selected aspects of the initial licensing process. The evaluation focused on identifying whether initial license applications are issued in a timely manner, and the extent to which applicants' disciplinary records from other states are considered in licensing decisions.
3. To evaluate the health related boards' self-sufficiency status, including both unusually high and low fund balances.
4. To evaluate selected aspects of the Division of Health Related Boards' organization. The evaluation focused on examining the relationship between the Board of Pharmacy and the division, and whether the Council for Licensing Hearing Instrument Specialists should continue as an independent entity.
5. To identify the current status of efforts to replace the Regulatory Boards System computer tracking system.
6. To gather information about whether health practitioners with felony convictions should be allowed to practice in Tennessee.

SCOPE AND METHODOLOGY OF THE AUDIT

We reviewed the activities and procedures of the 23 boards and the Division of Health Related Boards, focusing on procedures in effect during fieldwork (August 2008 to October 2009). We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The methods used included

1. 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;
5. examination of prior performance audits, financial and compliance audit reports, and audit reports from other states;
6. review of online information from state agencies; and
7. review of a select sample of initial licensing applications.

ORGANIZATION AND RESPONSIBILITIES

The Division of Health Related Boards was established within the Department of Health pursuant to Section 63-1-101, *Tennessee Code Annotated*, to provide administrative and staff support to the various health boards, committees, and councils, which license and regulate health care professionals in Tennessee. The division is further authorized by Section 63-1-115 to employ investigators or other employees to enforce the laws regulating the practice of health professionals within Tennessee.

The health related boards are generally responsible for safeguarding the public by regulating and enforcing standards of practice for select health care professions in Tennessee. The boards, with the department's assistance, exercise their regulatory powers by administering and/or requiring examinations of licensing applicants, issuing licenses to qualified practitioners, making rules and regulations regarding professional practice standards, approving continuing education requirements, investigating complaints against licensees, and conducting disciplinary hearings.

Each board attached to the Division of Health Related Boards is required by Section 4-29-121 to be financially self-sufficient. Additionally, all health related boards are required to have at least one citizen member under Section 63-1-124, *Tennessee Code Annotated*.

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.

See Appendix 2 for a summary of each board's financial status.

FINDINGS AND RECOMMENDATIONS

- 1. As noted in two prior performance audits since 2003, several boards do not meet financial self-sufficiency requirements imposed by state law; overall, prior surpluses available to offset deficits have been transferred to the state's General Fund, so that action needs to be taken to avoid adverse impact on board operations and the public affected by the boards' oversight**

Finding

Consistent with prior performance audits, several health related boards have not met their statutory obligation to remain financially self-sufficient in recent years. Tennessee statute effectively requires each health related board's revenues to meet or exceed its costs on an annual basis. However, eight health related boards were not self-sufficient in both fiscal years 2007 and 2008. While the Department of Health has acted to minimize board costs, some boards have been hesitant to raise fees necessary to meet their statutory obligation.

Boards Continually Struggle to Meet Statutory Requirements

Tennessee statute effectively requires health related boards to be self supporting—to collect fees in an amount sufficient to pay the cost of operating the board. Specifically, Section 4-29-121(a), *Tennessee Code Annotated*, requires the Commissioner of the Department of Finance and Administration to provide a list of all regulatory boards, including health related boards, that were not self-sufficient during the preceding fiscal year to the Senate and House of Representatives Government Operations Committees, as well as to the Office of Legislative Budget Analysis. In addition, under Section 4-29-121(b), any such regulatory board identified as not being self-sufficient for two consecutive fiscal years will be reviewed by a joint evaluation committee of the legislature in the next legislative session.¹ This would apply to boards subject to this audit, as well as other health related boards.

Prior 2003 and 2005 performance audits of the health related boards identified boards that had not met their statutory obligation to remain self-sufficient. For example, the 2005 report found that six of the health related boards were not self-sufficient in the fiscal year ending June 30, 2004.

Twelve boards have not been self-sufficient in recent years

A considerable number of boards continue to struggle with self-sufficiency. Appendix 2 provides financial information for every health related board for fiscal years 2007 and 2008 (the most recent years for which data were available during this audit). Of the 22 health related

¹ The Emergency Medical Services Board is not subject to this requirement because it is not attached to the Division of Health Related Boards. Rather, it is structured as an independent division under the Bureau of Health Licensure and Regulation.

boards subject to this audit and with statutory self-sufficiency requirements, the eight (or 36%) listed in Table 1 were not self-sufficient for the fiscal years ending June 30, 2007 and 2008.

Table 1
Boards Not Self-Sufficient During Fiscal Years Ending June 30, 2007 and 2008

Board/Committee/Registry	Net Income for FY2007	Net Income for FY2008	Current Status of Efforts to Increase Fees As of November 1, 2009
Board of Dietitian/Nutritionist Examiners	(\$21,345)	(\$19,155)	No official steps taken toward fee increases
Council for Licensing Hearing Instrument Specialists	(\$6,766)	(\$10,835)	Rulemaking in process to increase licensing fees.
Board of Medical Examiners	(\$158,370)	(\$176,770)	No official steps taken toward fee increase.
Board of Athletic Trainers	(\$21,303)	(\$5,984)	No official steps taken toward fee increase.
Board of Nursing	(\$1,394,690)	(\$171,855)	Rulemaking in process to raise fees.
Board of Examiners for Nursing Home Administrators	(\$52,909)	(\$21,354)	No official steps taken toward fee increase.
Council of Certified Professional Midwifery	(\$4,451)	(\$2,246)	Rulemaking in process to raise fees. Additionally, council asked its legal counsel to explore the possibility of a one-time assessment to address deficit.
Massage Licensure Board	(\$307,464)	(\$199,625)	Fees increased via rule change effective June 2009.

Source: Financial information from Director of the Health Related Boards. Status information compiled from board meeting minutes, board meetings attended by auditors, and information provided by board directors.

In addition, the Board of Respiratory Care, the Board of Communication Disorders and Sciences, and the Board of Veterinary Medical Examiners were not self-sufficient in the fiscal year ending June 30, 2007, but were self-sufficient in the fiscal year ending June 30, 2008.

While these boards have improved their financial status since 2007, they would still be considered somewhat at risk given their recent history.

One board, the Polysomnography Professional Standards Committee (which was created to regulate sleep medicine professions), did not exist in the fiscal year ending June 30, 2007, and was not self-sufficient in fiscal year 2008. However, it is not yet licensing practitioners and thus has no fee income. As a result, it does not yet have the capacity to be self-sufficient. Its expenses, and thus deficit, were under \$5,000 in the fiscal year ending June 30, 2008.

To ensure the 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 those boards with the surpluses from other boards. However, these surpluses have been greatly reduced and there may not be enough funds available in future fiscal years to cover the losses. Specifically, under Section 4-3-1016, *Tennessee Code Annotated*, a significant portion of boards' surplus funds were transferred to the state General Fund (often referred to as being "swept") effective the fiscal year ending June 30, 2008, to help address the state's fiscal crisis. The fund amounts swept from each health related board are shown in Appendix 2. Because these funds will not be readily available in future years, it is especially important that the Department of Health and the boards act quickly and decisively to close any and all deficits.

The Department Is Working to Reduce Costs

The Department of Health has taken several steps to assist the boards to both maximize revenues while reducing costs. For example, in an effort to recoup costs and ensure disciplined practitioners meet their financial responsibilities, the department worked with the state's Attorney General's Office to develop a formal process to collect unpaid disciplinary debts. Specifically, when boards decide that licensees have violated standards, the resulting disciplinary orders and agreements can include fines, as well as requirements to reimburse the state for its investigative and other case costs. When disciplined practitioners fail to pay these obligations, the department's Office of Investigations can now notify the state's Attorney General's Office, which then can take legal action to collect monies due to the state.

Additionally, the state and the department specifically are working to reduce the boards' administrative costs. For example, a hiring freeze was implemented, salaries frozen, and supply costs reduced. Similarly, all travel is carefully scrutinized, in that it must be requested 120 days in advance and be approved by the commissioner. Additionally, staff have been directed to reduce energy costs, such as ensuring all office lights are turned off at the end of the work day.

The department has also encouraged boards to act to ensure their self-sufficiency. For example, the department has encouraged boards to reduce the frequency/number of board meetings and review contract costs. Board staff have also initiated frank conversations at public board meetings to ensure board members understand their board's financial situation, the importance of remaining self-sufficient, and the potential to reduce any deficits, including raising fees.

Some Boards Are Hesitant to Raise Fees

While the Department of Health is actively working to reduce the boards' costs, the department estimates that resulting savings may not be enough in some cases to ensure board self-sufficiency and reduce any board deficits. As a result, boards which are not already self-sufficient need to seriously consider raising their licensing fees. However, some boards have been hesitant to do so.

Board fees are typically set in each board's official rules. Therefore, in order to raise their licensing fees, boards typically must work through the rulemaking process. Some board members and board management have estimated that this process can take years. However, an attorney representing the boards states that the process can be substantially shortened for high priority situations.

Some boards have been more proactive in raising fees than others. Table 1 (page 5) provides summary information about the steps taken to increase fees by each board which was not financially self-sufficient for the fiscal years ending June 30, 2007 and 2008. Of the eight boards who have failed to meet their self-sufficiency requirements, the following four have taken no official action to adjust their fees:

- Board of Dietitian/Nutritionist Examiners, which experienced a deficit of \$19,155 for the fiscal year ending June 30, 2008. This board declined to raise fees at its March 2009 meeting because of fears it would reduce the number of licensees and because the board perceived that licensees could not afford increased fees.
- Board of Medical Examiners, which experienced a deficit of \$176,770 for the fiscal year ending June 30, 2008. This board has relied on its prior year's surplus to support current-year deficits. However, a significant portion of these surpluses have been swept and are no longer available. Specifically, the board had experienced enough surpluses in prior years so that even when it experienced deficits of \$158,370 and \$176,770 in fiscal years 2007 and 2008, respectively, its overall fund balance remained positive at \$867,337 as of June 30, 2008. However, \$759,034 of this fund balance was transferred (or "swept") to the state's General Fund to help address the state's fiscal crisis, as permitted by state law. This left the board with a post-sweep fund balance of \$108,303. This remaining balance is less than the board's prior year deficit and will not be sufficient to cover the resulting losses if revenue is not increased.
- Board of Athletic Trainers, which experienced a deficit of \$5,984 for the fiscal year ending June 30, 2008. This board has not officially addressed fee increases during its most recent meetings in November 2008, May 2009, and October 2009.
- Board of Examiners for Nursing Home Administrators, which experienced a deficit of \$21,354 for the fiscal year ending June 30, 2008. This board discussed fee increases in its most recent June and August 2009 meetings but tabled any official action both times.

Without further action from these boards, it is questionable whether they can restore their self-sufficiency, as well as make up any past-year deficits.

The Department Can Take Additional Steps

While the boards are ultimately, legally responsible for assuring their self-sufficiency, the Department of Health can take additional steps to help board members understand their responsibilities and also ensure that each board is appropriately charged its fair portion of administrative costs. For example, the department may be able to assist by further educating board members about financial matters. Based on observations of board meetings and reviews of board meeting minutes, auditors noted that board members sometimes seemed confused about how to read and interpret their boards' financial reports, which are prepared by the department's administrative staff. Additionally, they did not always seem fully aware of or understand department actions to reduce costs and their statutory obligation to remain annually self-sufficient.

The department also needs to ensure each board pays its appropriate portion of the department's overhead and administrative costs. The department currently uses a somewhat complex set of formulas to determine how much of department overhead costs each board should pay. However, the current calculation may not be as accurate as possible. For example, rent for health related boards' facilities is divided among the boards, mostly based on an estimated proportion of time the shared staff spends to support each board. While this makes some sense in that more staff time may represent more office space used, it does not take into consideration how boards utilize some shared spaces, such as how large a conference room is required for each board meeting or how frequently those board meetings occur. Additionally, the reliance on estimated staff time, as opposed to actual staff time, may lead to errors.

There are different methods available to allocate administrative costs among the boards. For example, one possible method allocates rent costs among boards based on the actual square footage each board uses. The division's Assistant Commissioner, who recently moved from the Department of Commerce and Insurance to the Department of Health administration acknowledges that the current formula may not be ideal and expressed an interest in improving it.

Recommendation

The Department of Health and the Health Related Boards need to take several steps to ensure the boards remain annually self-sufficient as required by law. First, all health related boards, not just those subject to this audit, that have not been self-sufficient for the past two fiscal years need to promptly increase fees so that revenue exceeds costs and any deficits are corrected. Second, the department should help board members by further educating them on board finance, department financial processes, board financial reports, and boards' statutory obligation to maintain annual self-sufficiency without reliance on prior years' surpluses. Additionally, the department should research and adopt more accurate and easily applied

formulas for calculating overhead costs, to ensure that each board pays its fair share of those costs.

Management's Comments

Comments by the Department of Health

We concur.

a) Board of Dietitian/Nutritionist Examiners

The expenditures greater than revenues for FY 2007 and 2008 are attributed to expenses assessed to the board for its share of the costs of moving from the Cordell Hull Building to the offices in Metro Center, implementing criminal background checks as a requirement for licensure, and increased IT costs.

At the March 2009 meeting, the board staff presented a chart that indicated the projected revenue increases for incremental fee increases. The matter was discussed, but there was no motion made to increase fees. There was also a discussion of decreasing the number of board meetings to one per year, but this was not acceptable to the board.

b) The Council for Licensing Hearing Instrument Specialists

The expenditures greater than revenues for FY 2008 are attributed to expenses assessed to the council for its share of the costs of moving from the Cordell Hull Building to the offices in Metro Center, implementing criminal background checks as a requirement for licensure, and increased IT costs.

At the March 2009 meeting, the council staff presented a chart that indicated the projected revenue increases for incremental fee increases. The matter was discussed, and the council voted to increase fees at its August 2009 meeting. The rules have since been drafted and are undergoing internal review. There was also a discussion of decreasing the number of council meetings per year, but this was not acceptable to the council.

c) Board of Medical Examiners

The expenditures greater than revenues for FY 2007 and 2008 are attributed to expenses assessed to the board for its share of the costs of moving from the Cordell Hull Building to the offices in Metro Center, implementing criminal background checks as a requirement for licensure, and increased IT costs.

Revenue needs and fee amounts are based on estimated expenses and revenue collections. Revenue collected that exceeds expenditures remains with the agency and is considered when calculating total revenue needed for the following year. At each of its meetings, the board reviews a current budget, which includes a projection of the funds carried over

from one year to the next. While the projected carryover was positive, the board took no action to either increase or reduce fees; however, the board will be asked to consider amending its rules if the current expenditures exceed the current revenues.

d) Board of Athletic Trainers

The Board of Athletic Trainers was administratively attached to the Board of Medical Examiners until 2006.

The expenditures greater than revenues for FY 2007 and 2008 are attributed to expenses assessed to the board for its share of the costs of moving from the Cordell Hull Building to the offices in Metro Center, implementing criminal background checks as a requirement for licensure, and increased IT costs. The board meets twice annually. At the May 21, 2009, meeting the board discussed the financial report for FY 2008 and the possibility of a fee increase. The board deferred action until the October 29, 2009, meeting in order to review the report for FY 2009; however, the report was not available for that meeting and the matter was once again deferred.

e) Board of Nursing

The expenditures greater than revenues for FY 2007 and 2008 are attributed to expenses assessed to the board for its share of the costs of moving from the Cordell Hull Building to the offices in Metro Center, implementing criminal background checks as a requirement for licensure, and increased IT costs.

Revenue needs and fee amounts are based on estimated expenses and revenue collections. Revenue collected that exceeds expenditures remains with the agency and is considered when calculating total revenue needed for the following year. In the past, the board had determined accumulated surpluses were sufficient to assure the board's self-sufficiency overall.

The board voted in February 2009 to decrease funding of its contract with the Tennessee Center for Nursing by approximately 25% and to increase renewal fees for registered and practical nurses. Amended rules were adopted September 25, 2009, and will be effective on February 16, 2010.

f) Board of Nursing Home Administrators

The expenditures greater than revenues for FY 2007 and 2008 are attributed to expenses assessed to the board for its share of the costs of moving from the Cordell Hull Building to the offices in Metro Center, implementing criminal background checks as a requirement for licensure, and increased IT costs.

At the June 2009 meeting, the board staff presented a chart that indicated the projected revenue increases for incremental fee increases. The matter was discussed, and the board

acknowledged the need to raise the application fee to make up the deficit, but there was no motion made to increase the fee at that meeting.

g) Council of Certified Professional Midwifery

The expenditures greater than revenues for FY 2007 and 2008 are attributed to expenses assessed to the council for its share of the costs of moving from the Cordell Hull Building to the offices in Metro Center, implementing criminal background checks as a requirement for licensure, and increased IT costs.

At the June 2009 meeting, the council staff presented a chart that indicated the projected revenue increases for incremental fee increases. The matter was discussed, and the council voted to increase fees. The rules necessary to implement this fee increase have not yet been drafted.

h) Massage Licensure Board

The expenditures greater than revenues for FY 2007 and 2008 are attributed to expenses assessed to the board for its share of the costs of moving from the Cordell Hull Building to the offices in Metro Center, implementing criminal background checks as a requirement for licensure, and increased IT costs.

The Board adopted amended rules increasing fees on October 27, 2008, and the rules went into effect on June 23, 2009.

Comment by the Chair of the Board of Dietitian/Nutritionist Examiners

We concur in part. There was a deficit in 2008 and also fees were not raised in March 2009 at our meeting. However, many dietitians have lost jobs due to the poor economy. We were afraid that many members would feel that not renewing their licenses would be a means of cutting personal expenses, and we would experience decreases in membership. Also the meeting was within days of the “sweep” and the Board had many questions as to how this could be done since it was the Dietitian/Nutritionist’s money. As we asked questions of our Executive Director, we were told to move on and forget it instead of receiving answers. We had been told by the Executive Director at a previous meeting that it was unlikely that the General Assembly would take the Board’s money so we were shocked and confused by these events to say the least. Furthermore, we were told in 2007, at budget time, that many large expenses were due to the move with the cost of new computers and equipment and moving expenses and that we would expect some of these expenses to decrease once these costs were absorbed. Unfortunately, we have only seen increases in expenses. On numerous occasions we have asked for an accounting of how our money is being spent and exactly what is included in various items listed on our P & L sheet, but each time we get no direct answers. We have been told that someone will check on these items and be prepared to discuss them at the next meeting, but when it comes up again, there are still no direct answers. It seems hard to believe that the staff does not have to account for how our money is spent, and that they don’t have to prepare a detailed budget. Rather we get

a very general accounting with a few categories and they (staff) can't explain what's included in each. I can't get by with this at my work; I am required to account for everything.

Our Board will be meeting March 18, 2010, and this will be brought up again, at which time I'm sure the Board will do what is necessary to make our Board financially self-sufficient.

Comment by the Chair of the Massage Licensure Board

The massage board was consistently told "not to worry" by the administrative staff. At several board meetings during 2007 and 2008, the board requested the presence of the budget staff member to explain the deficit and to recommend a solution. The Massage Board tried to raise fees in 2007 but the administrative staff again told us to "hold off". The administrative staff could never produce final closing financial expenditures until months after the close of a fiscal year; thus, allowing the board to go into the red after it was too late to act. In 2008 the board finally **pushed** the issue and voted to raise fees. The board then requested the fees be increased quickly, utilizing the "Emergency Rules" process. The department of health would not consider this option and quickly told the board "**NO**".

The board has never received accurate financial reports that properly reflect expenditures. The finances are divided among the boards and do not reflect **actual** cost of the Massage Licensure Board accurately. Therefore, the board has no choice but to accept the department's statements that recommend "waiting" to raise fees (i.e., the board requested the detailed financial information at every board meeting, but were given the **same** estimated financial report for at least 4 board meetings).

The Massage Board has consistently paid **more** than its fair share over the years.

2. The General Assembly may wish to consider changing how Tennessee regulates hearing instrument specialists

Finding

The General Assembly may wish to consider terminating the Council for Licensing Hearing Instrument Specialists and reassigning its regulatory responsibilities to either the Board of Communication Disorders and Sciences or the Department of Health. Hearing instrument specialists are currently regulated by the council, which has broad independent regulatory decision-making authority, but is administratively attached to the board. However, this council model may not be the most efficient regulatory approach for this profession. The General Assembly has several options to reduce costs while maintaining public protection, each with unique advantages and disadvantages.

Hearing Instrument Specialists Are Currently Regulated Through a Semi-Autonomous Council

The Council for Licensing Hearing Instrument Specialists was created in 1995 and regulates professionals who dispense and fit hearing instruments, commonly referred to as hearing aids. Under Section 63-17-201(8), *Tennessee Code Annotated*, hearing instrument specialists can use an audiometer to measure or evaluate human hearing, as well as select or adapt hearing instruments to compensate for hearing loss.

The council is administratively attached to the Board of Communication Disorders and Sciences, but holds many independent regulatory powers. For example, Section 63-17-203 authorizes the council to perform many duties, including:

- issuing and renewing licenses;
- disciplining licensees, including denying, suspending, or revoking licenses;
- establishing minimum practice standards; and
- prescribing continuing education requirements.

However, the Board of Communication Disorders and Sciences also maintains some statutory and other relationships to the council. For example, although the council is authorized by Section 63-17-203(8) to initiate and adopt rules, such rules must be approved by the board.

The Current Council-based Regulatory Model May Not Be Optimal

A semi-independent council model, as is currently used in Tennessee, may not be the most efficient approach to protecting the public by regulating hearing instrument specialists. Using a licensing board/council model to regulate professionals may be particularly helpful when the complaints and/or investigations heard by the board/council against licensees are so consistently technical or unique to that profession that a person without the technical professional expertise could not understand or apply statutory criteria when deciding disciplinary cases. However, the cases heard in recent years by the council have been few and not technical, thus suggesting that a full, dedicated board may not be necessary.

Specifically, the council only heard disciplinary cases regarding five practitioners between January 2006 and 2009. Auditors without any technical background or training concerning hearing instruments reviewed these cases and were able to understand all pertinent case facts and the bases of the decisions. All reviewed cases concerned consumer protection issues, as opposed to highly technical, medical issues. This suggests that it may not be necessary to permanently maintain a full, dedicated board of hearing instrument specialists to achieve public protection.

The council is financially struggling – Additionally, the council has recently struggled to be financially self-sufficient, as required by state statute. As shown in Table 2, the council has not been self-sufficient for two of the last three fiscal years for which actual data were available for this audit.

Table 2
Council for Licensing Hearing Instrument Specialists
Financial Report
Fiscal Years Ending June 30, 2006 Through 2008

Budget Category	Fiscal Year Ending June 30, 2006	Fiscal Year Ending June 30, 2007	Fiscal Year Ending June 30, 2008
Total Revenues	\$47,179.38	\$45,447.11	\$51,306.57
<u>Total Expenses</u>	<u>\$42,009.54</u>	<u>\$52,213.33</u>	<u>\$62,141.78</u>
Total Net	\$5,169.84	(\$6,766.22)	(\$10,835.21)

In the wake of these past two years' losses, the council's current fund balance as of June 30, 2008, was -\$35,560. In order to ensure it is self-sufficient in the future, as well as make up the negative fund balance, the council's Unit Director estimates that the council will need to increase its initial licensing fees to over \$1,000. In comparison, medical doctors' initial fees are only approximately \$500.

In June 2009, the council voted to begin the rulemaking process in order to increase several of its licensing fees by approximately 20% in order to raise its revenues. However, the rulemaking process can be lengthy.

The General Assembly Could Assign the Council's Responsibilities to Another Board or to the Department of Health

If the General Assembly wishes to move away from the current council model for regulating hearing instrument specialists, it has several options. For example, the council could be absorbed by another board or changed into a department-operated registry.

The board could absorb the council's regulatory responsibilities – The General Assembly could eliminate the council and assign its regulatory responsibilities to the already closely related Board of Communication Disorders and Sciences. Like hearing instrument specialists, audiologists (who are already regulated by the board) are legally authorized to fit hearing instruments. Therefore, the board already has technical experience in dealing with hearing instrument issues.

By shifting responsibilities to the board, the state would continue to provide a knowledgeable decision-making entity, thus maintaining the current level of public protection. Additionally, the costs associated with the council's meetings would be eliminated. However, while this model would maintain public protection, it would not completely solve financial problems associated with hearing instrument specialist regulation. The board's fiscal year 2008 net of \$13,932 is more than the council's net loss of \$10,835, and thus the combined board would have been annually self-sufficient. However, even with cost savings, the board would

likely need to raise revenues in order to make up for the council's negative fund balance. As of June 30, 2008, the board's fund balance was \$9,986 while the council's fund balance was -\$35,560.

If the General Assembly decides to terminate the council and move its responsibilities to the board, it may wish to consider adjusting the board's composition. Specifically, a representative of the hearing instrument specialist community could be added to the board to provide an opportunity for the community's input into its own regulation. However, adding a hearing instrument specialist to the board would offset some savings generated from the council's termination.

A registry could be formed to regulate hearing instrument specialists – The General Assembly could also consider terminating the council and creating a new department-operated registry to regulate the profession. Registries are generally administered by a state department, which makes any and all licensing, disciplinary, and policy and rulemaking decisions without the involvement of a board or council.

Several health-related professions are already regulated through registries in Tennessee. For example, the electrolysis profession was previously regulated by a board. However, the General Assembly shifted regulation to a registry in 2009, due in part to financial concerns about the board. The department holds public protection powers such as authority to screen applicants to ensure they meet educational and/or other licensing requirements, investigate complaints, and impose discipline (including suspending and revoking registrations) when professional standards are violated. Likewise, a registry is considered to be a health related board and, therefore, is statutorily required to be self-sufficient.

Recommendation

The General Assembly may wish to consider terminating the Council for Licensing Hearing Instrument Specialists and reassigning the council's responsibilities to the Board for Communication Disorders and Sciences or a Department of Health-operated registry. If the General Assembly wishes to assign the responsibilities to the board, it may wish to consider changing the board's composition to provide for a hearing instrument specialist to sit on the board. Similarly, if the General Assembly wishes to create a new registry for hearing instrument specialists, it may wish to consider providing the department with full licensing, investigative, and disciplinary authority.

Management's Comment

Comment by the Department of Health

This is a matter best left to the discretion of the General Assembly. It should be noted that in June 2009, the council voted to increase its licensing fees by approximately 20% in order to

increase its revenues. As indicated in the response to Finding 1 above, the rules have not yet been drafted.

3. The National Practitioner Data Bank provides an opportunity for the Division of Health Related Boards to further protect the public

Finding

The federal government created the National Practitioner Data Bank through the *Health Care Quality Improvement Act of 1986*. The act's intent is to encourage state licensing boards and other entities to identify and discipline practitioners who engage in unprofessional behavior and to restrict the ability of incompetent health care providers to move from state to state without disclosure or discovery of adverse actions taken against them. While the department is not required by the federal government or by state statute/rules to query the database, the federal government encourages states to do so. The data bank can include information on adverse actions involving license discipline, clinical privileges, professional society membership, malpractice payments, and exclusions from Medicare and Medicaid.

Medical malpractice payers, medical/dental state licensing boards, hospitals and other health care entities, professional societies with formal peer review, the Health and Human Services Office of Inspector General, and the U.S. Drug Enforcement Administration report to the data bank. Professions covered by the data bank include physicians, dentists, dietitian/nutritionists, registered nurses, pharmacists, podiatrists, massage therapists, respiratory therapists, audiologists, and midwives among many others.

The U.S. Department of Health and Human Services recommends, but does not require, that state licensing authorities and other health care entities use the data bank to alert the entities that there may be a problem with a practitioner's competence or conduct. Further, the federal government states that the data bank should not be used as the sole source of information, but rather as a supplement to other information useful in evaluating current competence, such as peer recommendations and verification of training and experience. Similarly, nothing in state statute or rules currently appears to mandate the department to use the data bank.

The Data Bank Could Supplement Existing Practices

The data bank provides an additional opportunity for the division to supplement its current efforts to protect consumers from practitioners who have poor records in other states. The division already uses the data bank in some circumstances. Specifically, the Office of Investigations has access to query the data bank when a problem is suspected or to follow up on previously disciplined practitioners.

Similarly, the Board of Medical Examiners currently requests data bank queries during the licensing process on an as-needed basis. The board also accesses an alternative database

operated by the Federation of State Medical Boards for all applicants in covered professions. However, this database does not include information on hospital privileges or malpractice suits, which is included in the National Practitioner Data Bank. This suggests that the data bank could be a useful and efficient tool to provide information not currently available in all cases to the boards.

Additionally, individual board administrators already sometimes proactively request information from other states when reviewing applications. For example, one administrator explained that when an applicant discloses that he or she had lived in another state but did not practice in that state, the administrator might take the initiative to contact the other state's licensing authority to ensure that the applicant was truthful and not failing to disclose a past disciplinary action.

The division could supplement these efforts by also systematically querying the data bank before licensing applicants. This would provide an additional tool to the division to identify problematic practitioners and further reduce dependency on applicants to truthfully disclose all potential problems.

Licensing Fees May Need to Be Adjusted

The division would incur additional costs if it routinely queried the data bank for all covered professional applicants. The division reports that the data bank charges it \$9.50 per query to cover costs. Given the current budget environment, the division is unlikely to be able to absorb this cost. However, given the importance of protecting Tennessee citizens from dangerous practitioners, the division and individual boards may wish to review their current authority and, if necessary, request authority from the General Assembly to charge each applicant a one-time fee to cover the query cost.

Recommendation

Division of Health Related Boards staff should supplement existing efforts to identify problematic applicants by systematically querying the National Practitioner Data Bank whenever an applicant in a covered profession applies for Tennessee licensure. To cover this cost, the division and individual boards should investigate their current authority and, if necessary, request authority from the General Assembly, to charge each covered applicant a one-time fee to cover the query cost.

Management's Comments

Comment by the Department of Health

We concur.

As pointed out by the auditors, the Health Related Boards staff has a number of sources of information from which it can draw to conduct background checks on applicants and does, at times, access the databases maintained by the Federation of State Medical Boards and the National Practitioner Data Bank. Additionally, the staff does occasionally contact other states concerning a particular applicant.

As also noted by the auditors, the Division of Health Related Boards is not required by statute to query the National Practitioner Data Bank for each application. Furthermore, the data bank may not have complete data. Public Citizen has reported that hospitals have repeatedly failed to file every instance of doctors being disciplined for unprofessional behavior or incompetence. Thus, to mandate that the data bank be queried would not likely produce the desired result in every instance. Nonetheless, the Division will consider ways it can more fully and systematically integrate the use of the data bank into its application processes.

Comment by the Chair of the Massage Licensure Board

We concur that all boards should use the Data Bank for every applicant and add a one-time \$10 fee.

Other Comments Received

We also received general comments (not related to a particular finding) via e-mail, from the Chairs of the Board of Podiatric Medical Examiners and the Advisory Committee for Acupuncture.

4. The division needs better methods and information to monitor its licensing timeliness

Finding

The Division of Health Related Boards' outdated computer system, as well as its incomplete and inconsistent performance measurement data and methods, does not allow it to easily and accurately assess whether it processes initial professional license² applications in a timely manner. Licensing is one of the boards' primary tools to protect the public, by ensuring that only qualified health practitioners are allowed to practice in Tennessee. Therefore, it is

² The finding uses the term "licenses" to refer to all types of permits to practice issued by the division, including certificates and formal licenses. Likewise, this finding's use of the term "board" refers to all audited health regulatory bodies, regardless of whether they are constituted as a formal board, council, or committee.

particularly important that the division be able to monitor and report how quickly it processes initial license applications. However, the division's current performance measurement methods and data are incomplete and do not allow reviewers to understand when systematic delays are due to factors within or outside of the boards' control. Additionally, the division's performance measurement process continues to be hampered by delays in replacing its inadequate computer system.

Licensing Timeliness Is Important to Practitioners and the Public

Licensing is one of the health related boards' primary means of safeguarding the public. By issuing licenses in a timely manner, the division enforces standards for health practitioners in Tennessee and allows qualified professionals to serve the public as soon as safely possible. Therefore, the division and other oversight bodies, such as the General Assembly, need to be able to easily and reliably monitor how quickly the division processes initial license applications. Without this information, the division and its stakeholders cannot identify potential timeliness problems so that they can be quickly addressed.

In 2001, the division developed a standardized benchmark calling for each health related board to issue or deny initial applications, as well as process license renewals, within 100 days of receipt. The division measures its performance against this standard by using its Regulatory Boards System computer program (RBS) to capture when each application/renewal payment is received and the corresponding license is issued. Each board's average number of days to issuance is then calculated and reported as an internal performance measure.

Division Actions to Replace the Problematic Computer System

The division's overall ability to monitor its functions, including initial licensing timeliness, continues to be hampered by long-standing and known problems with its Regulatory Boards System (RBS), a computerized license tracking system. Prior 2003 and 2005 performance audits identified problems with RBS, a program used by multiple departments statewide. For example, the November 2003 audit reported that it is difficult to generate reports, through the computer system, needed to monitor the timeliness of investigations.

These basic challenges continue to hamper the division's ability to monitor its own performance. For example, as discussed further below, the system is only capable of calculating the total time spent processing initial licensing applications, not the time elapsing between the various steps within the process. Reprogramming the system would be difficult because the respective vendors no longer support either the underlying data base program, or the RBS program itself.

In light of these and other problems, the Department of Health and other state agencies have worked together since at least 2003 to attempt to upgrade RBS and/or design a new Multi-Agency Regulatory System (MARS) to meet the state's licensure and enforcement tracking needs. However, this process has been significantly delayed and experienced problems with multiple vendors. Most recently, the state terminated a MARS contract on January 9, 2009 because of vendor non-performance. The Department of Health is now working on its own to

acquire a new department-only software package to track licensing and other regulatory functions.

Better Data and Calculation Methods Would Enhance Oversight

Although the division is hampered by its existing computer system, it can take steps to improve the data and methods it uses to monitor its initial licensing timeliness within existing resources. The division's current data and methods exclude some applicants, do not capture consistent data for all boards, and do not account for delays outside of the boards' control, such as each board's unique licensing requirements.

Current timeliness measures exclude some applications – Although its timeliness performance measurement wording suggests that all initial applications are included in its timeliness measures, only applications which ultimately result in an applicant receiving a license to practice are actually included in the reported calculations. This excludes applications which were ultimately rejected by the regulatory board, withdrawn by the applicant, or otherwise closed without a license to practice being issued. The current effect of limiting which applications are considered in the timeliness measure is not conclusively known. However, logic suggests that denied, withdrawn, and otherwise closed applications may be more problematic, and thus might take longer to process than successful applications. This suggests that the current performance measurement calculation results may appear more timely than actual performance.

Division staff do not use consistent or accurate coding when entering application information into RBS – The division is unable to use existing data to generate more useful, detailed licensing timeliness reports because codes used to describe applications' current status are not consistent or accurate across all regulatory boards. For example, we noted an application that was listed in RBS as expired, yet it was still in process. Similarly, RBS incorrectly listed another applicant as working under a temporary permit. Additionally, there is no one unified status coding scheme for all regulatory boards. Even different professions within the same boards use different status coding schemes. The status field problems were so severe that auditors had to specifically design their data analysis to avoid using this key field. As a result, our analysis is more limited than might otherwise be possible. Likewise, the division cannot reliably use this field to identify applications sitting for an abnormally long time in any particular part of the licensing process or to conduct other more detailed timeliness analysis.

Given that the RBS system is due to be replaced, it may not be cost-effective to retroactively correct already existing RBS data. However, going forward, especially as a new system is implemented, the division should develop and use uniform coding between professions and boards whenever possible and ensure staff understand the importance of entering accurate and timely information into the system.

The current performance measure method does not control for applicant-caused delays – When calculating timeliness, the division includes all time elapsing between when an application payment is received and when the associated license is issued. This calculation includes some delays which are outside of the boards' control. For example, applicants frequently cause licensing delays by failing to submit necessary paperwork. As a result, it is difficult to determine

whether board staff process applications as quickly as possible. For example, auditors reviewed a sample of ten animal euthanasia technician certificate applications submitted to the division between January 1, 2007, and December 31, 2008. In several of these files, the applicant caused significant processing delays which were outside of the board's control, yet would have effectively counted against the board staff in performance measures:

- An application was received on July 9, 2007. However, the applicant did not submit a required criminal background check until March 28, 2008. The license was issued only three days later on March 31, 2008. Although the board spent only three days processing the application once it was complete, the timeliness calculation would reflect a process involving more than eight months.
- An application was submitted on March 16, 2007. The applicant was notified by letter the same day that the application could not be processed because some required questions were not answered and a key supporting document was not notarized as required. The applicant did not rectify the problems for approximately four months. Once the application file was complete, board staff processed it within one day and the license was issued on July 23, 2007. In total, board staff spent less than two days processing the application, but the timeliness calculation would reflect the entire period between March and July.
- An application was submitted on July 9, 2007. The applicant was notified by letter on July 10, 2007, that the application could not be processed until a criminal background check was submitted. The background check results were not received until June 12, 2008. The license was issued one day later on June 13, 2008. Although the board spent only approximately 4 days processing the application, the timeliness calculation would have reflected almost one year.

The division's current RBS computer system also does not track the time spent on individual steps within the licensing process. Therefore, the division cannot easily use the system to remove times associated with delays outside of the boards' control when calculating timeliness. Additionally, for reasons discussed above, reprogramming the system to collect this information would be very difficult. For example, this change would require significant changes to the underlying programs' source code and the templates used to collect information on the approximately 120 professions overseen by the division.

Because of the system's age and scheduled replacement, it would likely not be a good investment of the state's resources to reprogram the system. Going forward, the division may wish to ensure that any new system includes the ability to analyze timelines in enough detail to identify division- versus client-caused delays.

Until a new system is operational, the division may be able to gather similarly useful information on a more limited basis. For example, as done by auditors for this report, the division could regularly select a sample of applications. The division could then review those applications' existing files (which generally include a checklist showing the dates that major

milestones occurred) to gather more detailed information about licensing time frames in order to isolate division- versus client-caused delays for at least the sample.

All boards are subject to the same benchmark despite unique licensing processes and requirements – In addition to including delays caused by problems outside of the boards’ control, the current universal 100-day timeliness benchmark includes unavoidable time lags caused by some boards’ unique licensing requirements. For example, veterinarian applicants are required to submit an application to their board 100 days prior to taking required national certification exams. As a result, even if the board immediately processes the application paperwork, the application must remain open for at least 100 days prior to the exam and any time after the exam before the results are available to the board. This minimum 100-day time lapse is included in the current timeliness calculation. As a result, the board logically cannot process initial license applications within the universal 100-day benchmark, thus rendering the benchmark meaningless. Similarly, psychologists applying for a Health Service Provider designation must submit an application to their board before sitting for the required exam and before earning the required 1,200 hours of postdoctoral experience.

Similar to previously discussed client-caused delays, the RBS system does not track enough information for the division to be able to exclude these mandated delays when calculating timeliness. If the division decides to regularly select and review a sample of initial licensing applications as described above, the division should specifically consider such mandated delays in its analysis. Alternatively, the division could develop unique benchmarks for each profession and/or board including an appropriate cushion for any mandated time delays. The division may also want to work with each health related board to review its licensing requirements to ensure that all similar built-in time delays are appropriate and necessary.

Recommendation

The Division of Health Related Boards should improve its ability to monitor its initial licensing timeliness. Because of its impact on operations, the division should continue efforts to obtain and implement a new, effective regulatory board tracking system as quickly and efficiently as reasonably possible. The division should specifically ensure that any new system provides the ability to analyze time delays outside of the boards’ control, including client-caused delays and time delays required by each board’s unique licensing requirements.

Until the new computer system is implemented, the division should gather more detailed timeliness information on a more limited scale. For example, the division should consider regularly selecting a sample of initial licensing applications, gathering more detailed licensing timeline information from its files, and analyzing for timeliness considering any delays outside of the boards’ controls. Similarly, the division should develop unique benchmarks for each profession based on its unique licensing requirements. The division may also want to work with each health related board to review its licensing requirements to ensure that all similar built-in time delays are appropriate and necessary.

Finally, regardless of new system implementation, the division should calculate, monitor, and report on all initial applications' timeliness, including rejected, withdrawn, or otherwise closed applications. In addition, data codes should be made uniform across all professions in order to ensure whatever data are collected in the future are as usable as possible.

Management's Comments

Comment by the Department of Health

We concur.

A report can be generated based on the in rank date (date the application is keyed into RBS) and the status date, which is the date the application is expired, denied, or withdrawn. This does not include information on why the application was expired, denied, or withdrawn, so that information would have to be handled manually. Most expired applications are due to the applicant not completing the application process in a timely manner, so this information would not be included in the timeliness measures since they were expired because the applicant failed to submit all the required documents.

The Division of Health Related Boards is working on revising the status codes in RBS to ensure consistency between boards. The example noted of an application that was listed in RBS as expired but that was still in process may be that the application had been open for a certain number of days and RBS automatically closed the application and changed the status to expired or closed. This problem can be solved by extending the number of days that the applications for that profession can remain open in RBS before automatically closing, and then a report could be generated each month showing the files that were closed so staff can review and either close the paper file, if needed, or reopen the application in RBS.

The reports in the current RBS system only calculate the time between the date the application is received and when the license is issued. The system does not track applicant-caused delays. An option would be to manually look at the files to see when a letter was sent to the applicant and when the requested information was received and to see if the applicant was required to appear before the board at a board meeting. This could be done but would be time consuming for staff. Manually looking at a percentage of the applications that were in process the longest to see if the delays in licensure were staff-caused or applicant-caused would be feasible until a new computer system is implemented. In cases of the file being referred to the board, since some of the boards meet less frequently than others, this would delay the applicants by weeks if not months for issues such as convictions or disciplinary actions in other states.

Benchmarks have been an issue since their development. Some of the professions cannot possibly meet the benchmarks if the applicants are applying by examination or require an inspection due to the requirements of the testing agencies, externships or schedules of inspectors. Unique benchmarks could be developed for these professions after review of the statutes and rules to determine what is required to issue the license.

Comment by the Chair of the Massage Licensure Board

As our board does not have a problem with license delay, our staff works efficiently and quickly to get applicants licensed. I don't see a need to spend a lot of money for a new program that our board would not utilize and would have to share the cost of.

5. The division needs a systematic process to track health care facilities inspections

Finding

Although the division frequently processes initial licensing applications in a timely manner, it can improve its process by developing a consistent, systematic method of tracking those initial licensing inspections conducted by another Department of Health unit. In order to avoid duplication of efforts and ensure consistency among closely related facility inspections, the Division of Health Care Facilities (HCF) conducts initial inspections of medical laboratories and medical doctors' office-based surgical suites on behalf of their respective boards. While some boards' managers closely monitor and inquire about the progress of these inspections, other inspections may languish for long periods of time without formal, systematic follow-up.

Initial Licensing Applications Are Often Processed Quickly

Despite challenges, such as the aging Regulatory Boards System (see Finding 4), division staff appear to frequently process initial licensing applications in a timely manner. Auditors reviewed a minimum of 10 applications submitted in 2007 and 2008 from each of 10 health related professions most at risk of exceeding the 100-day initial licensing timeliness benchmark.³ Because of the lack of clearly useful, defined timeliness goals, it is very difficult to conclusively assess whether these applications were processed in a timely manner. However, when auditors excluded delays out of the department's control, such as applicant- or licensing-requirement-caused delays, division staff often appeared to process initial applications fairly quickly. For example:

- a psychologist's license was issued the same day that the last remaining licensing requirement was met;

³ The ten professions/facilities reviewed by auditors were psychologists (10 reviewed out of a total of approximately 113 applicant files opened in 2007 through 2008), hearing instrument specialists (10 reviewed out of approximately 731 total), veterinarians (10 reviewed out of approximately 265 total), animal euthanasia technicians (10 reviewed out of approximately 99 total), veterinary facilities (10 reviewed out of approximately 104 total), veterinary medical technicians (10 reviewed out of approximately 100 total), nursing home administrators (10 reviewed out of approximately 131 total), registered respiratory therapists (10 reviewed out of approximately 569 total), office-based surgical suites (all 11 of 11 total reviewed), and medical laboratory facilities (10 reviewed out of approximately 34 total). These professions/facilities were identified as high risk based on department-generated information showing that on average they exceeded the 100-day benchmark in calendar year 2006, fiscal year ending June 30, 2007, and/or fiscal year ending June 30, 2008.

- six hearing instrument specialists' licenses were issued within four days of the applicants finishing their last remaining licensing requirement;
- a veterinarian was licensed within four days of providing the last required documentation; and
- an animal euthanasia technician was certified within 15 days.

In general and to the extent it can be assessed, it appears that board staff process applications in a timely manner, when delays outside of their control are considered.

Health Care Facilities Inspections Can Slow Processing

Auditors noted one circumstance under which administrative processing of licensing applications was systematically delayed. Specifically, when applicants' facilities were statutorily or otherwise required to be inspected by the Division of Health Care Facilities (HCF), as opposed to the Division of Health Related Boards, administrative licensing appeared to take a significantly longer number of days.

Two boards included in this audit are required to rely on HCF to conduct their initial licensing inspections. First, HCF is federally required to inspect medical laboratory facilities. Therefore, to avoid duplication of effort, they also conduct the initial licensing inspection for the Medical Laboratory Board. Similarly, the Board of Medical Examiners is effectively required under Section 63-6-221, *Tennessee Code Annotated*, to enter into some type of written understanding with HCF for the latter to conduct the initial certification inspections of medical doctors' office-based surgical suites. The latter requirement may have been developed in order to maintain consistency between ambulatory care center inspections, conducted by the Division of Health Care Facilities, and office-based surgical suite inspections.

Auditors reviewed a sample of 10 medical laboratory applications and all 11 medical doctors' office-based surgical suite initial licensing applications received from 2007 through 2008. Auditors noted that HCF inspections apparently contributed to processing delays. For example, of the medical laboratory applications reviewed:

- One application spent 77 days in the HCF inspection process. Board staff processed the application the same day they received the HCF inspection results.
- One application spent 79 days in the HCF inspection process. Board staff processed the application within one day of receiving the HCF inspection results.
- One application spent 139 days in the HCF inspection process. Board staff processed the application within one day of receiving the HCF inspection results.

- One application spent 102 days in the HCF inspection process. Board staff processed the application the same day they received the HCF inspection results.⁴

Similarly, several of the certification applications we reviewed for medical doctors' office-based surgical suites were apparently slowed by the HCF inspections. Unlike Medical Laboratory Board staff, Board of Medical Examiners staff are required to wait for the next board meeting before finishing application processing. Therefore, it is more difficult to distinguish the staff's, as opposed to the board's, timeliness. However, even when board time is included in the analysis, it appears that HCF inspection time often, but not always, contributed to a slowed process. For example, out of the 11 medical doctors' office-based surgical suite initial certification applications received in 2007 through 2008:

- One application spent 199 days in the HCF inspection process. The board issued the certificate 15 days after receiving the HCF inspection results.
- Two applications spent 416 days in the HCF inspection process. Both were being processed at the time of the review. Therefore, the total number of days to complete the licensing process was not available.
- One application spent 348 days in the HCF inspection process. The board issued the certificate 33 days after the application was complete.
- One application spent 121 days in the HCF inspection process. The board issued the certificate 7 days after receiving the HCF inspection results.
- One application spent 140 days in the HCF inspection process. The board issued the certificate 17 days after receiving the HCF inspection results.
- One application spent 106 days in the HCF inspection process. The board issued the certificate 7 days after receiving the HCF inspection results.
- One application had been in the HCF inspection process for 189 days as of the time of review. However, the inspection process was not yet complete.

In two cases, HCF inspections did not appear to cause major delays:

- One application spent 28 days in the HCF inspection process. The board issued the certificate 60 days after receiving the HCF inspection results.
- One application spent 19 days in the HCF inspection process. The board issued the certificate 21 days after receiving the HCF inspection results.⁵

In total, 8 of 10 medical doctor's office-based surgical suite certification applications reviewed experienced delays associated with the HCF inspection process.

⁴ The remaining 6 out of 10 applications reviewed could not be assessed because they were withdrawn before completing the licensing process, lacked a readable date stamp, were in the process of being inspected at the time of auditors' review, or other factors.

⁵ Auditors excluded the 11th medical doctors' office-based surgical suite certificate application from listing/analysis because it had to be inspected multiple times, complicating analysis.

Because it was outside of this audit's scope, auditors did not focus on why HCF staff take a long time to complete some inspections. However, the May 2008 performance audit of the Board for Licensing Health Care Facilities identified numerous problems and made several recommendations to improve HCF operations. However, it should be noted that HCF surveyors are also responsible for investigating potentially serious complaints, such as situations where nursing home residents may be in immediate danger, and it may be appropriate under such circumstances to give lower priority to initial licensing inspections.

Applications Requiring HCF Inspections Should Be Systematically Monitored

Currently, there is no division-wide, consistent approach to monitor applications while they are with HCF for an inspection to be performed. In at least one case, we noted documentation in the applicant's file that board management was concerned (and had followed up with written correspondence to HCF) about the length of time an application had been on hold while waiting for an inspection by HCF. In other cases, it was not clear what, if any, steps had been taken. Regardless, there is no consistent, procedure to monitor these applications. Without a process to track and monitor inspection status, the division cannot be sure that all such applications are handled properly and do not become "lost" in the system.

Recommendation

The Division of Health Related Boards should develop a systematic, division-wide process to monitor initial licensing applications that require a Division of Health Care Facilities inspection. Division and board management should use this tracking process to identify inspections which are taking an atypically long time and follow up with the Division of Health Care Facilities for additional information about the inspections' status.

Management's Comment

Comment by the Department of Health

We concur.

The medical laboratory board shares survey personnel with the federal CLIA (Clinical Laboratory Improvements Act) program, which is implemented by HCF. That program oversees clinical laboratory work in all states. The regional surveyors, although employees of the state, also work under contract with the federal government to conduct facility (initial and biennial) surveys in tandem with state board regulations.

Not every facility that performs laboratory testing is licensed by the medical laboratory act. Physicians' offices are regulated by CLIA so to perform **all** required state and federal surveys utilizing the state's regional surveyors is not possible. Time management by the surveyor becomes a paramount issue.

There are a total of six (6) regional surveyors (2 in each region), but for the past 2-3 years there have been as few as four (4) surveyors to perform all state surveys for CLIA and Tennessee.

HCF is mandated to share regional surveyor time between CLIA and the state for all laboratory operations. CLIA establishes a quota for inspections, something the state has not required from each regional area. The delegation and responsibility of each state survey as far as actual time management, schedules, etc., is under the direction of the CLIA program manager, and this program area has no involvement with the scheduling of any surveyor work schedule.

While board records reflect that no more than five or six applications per month are in need of monitoring for completion of the survey, the division of health related boards recognizes the value of having a process in place to ensure monitoring of all applications requiring interaction with other divisions in the department and will develop such a process.

As to the Board of Medical Examiners' office-based surgery surveys, follow-up inquiries are made by medical board staff to HCF in order to ascertain the status of the inspections. The Board of Medical Examiners' executive director has implemented a calendar system to inquire every 30 days until a survey is returned. It should be noted that the office-based surgery suites discussed in the audit were operational during the time frames indicated (2007 through 2008) because all of these facilities were already performing office-based surgery (pursuant to national certification) at the time the Tennessee statute became effective and were permitted to continue while the applications were pending.

6. Health related boards have limited disciplinary monitoring functions and resources

Finding

Three health related board units are responsible for monitoring disciplined practitioners. Specifically, Board of Pharmacy and Emergency Medical Services Board staff monitor practitioners disciplined by their respective regulatory boards. The department's Office of Investigations monitors all other health related boards' practitioners. Of these three units, only the Office of Investigations has a formal monitoring process; but the office's process is limited by its workload.

Office of Investigations' dedicated monitoring staff carries a heavy workload – The Office of Investigations has dedicated a disciplinary coordinator, a paralegal, to monitor all health related boards' disciplined professions, except those regulated by the Board of Pharmacy and Emergency Medical Services. Office management and the disciplinary coordinator estimated that 700 or more practitioners are monitored at any one time.

The degree and type of monitoring given to any one practitioner is based on the nature of the board-imposed discipline. For example, if a practitioner is ordered to pay monetary costs/fines, the coordinator would be responsible for sending them a letter to request payment,

receiving any payments, monitoring whether all payments are made as required, and notifying the Attorney General's Office to start legal proceedings to collect any unpaid debts. Similarly, if the practitioner is ordered to obtain additional continuing education, the disciplinary coordinator would be responsible for writing a letter directing the practitioner how to submit the required documentation of continuing education attendance, and tracking whether the required documentation is submitted within the proper time frame.

In all disciplinary cases, the coordinator must also enter the disciplinary order information in the boards' computer system and the department's public website, answer public questions about the website information, submit order information into the National Practitioner Data Bank when appropriate, attend all board meetings, and testify at board meetings when disciplined practitioners violate their board orders.

In light of all of the disciplinary coordinator's responsibilities, a workload of a reported 700-750 disciplined practitioners appears high. The Office of Investigations' management confirms that this workload effectively limits the disciplinary coordinator to ensuring that required documentation is submitted. The coordinator cannot be realistically expected to proactively monitor practitioners. However, those practitioners ordered to participate in a peer assistance program are more closely monitored by those programs, thus leaving the disciplinary coordinator to ensure the participant's documentation is in order.

Other health related boards' disciplinary monitoring efforts rely heavily on peer assistance programs and the professional community – Unlike the Office of Investigations, the Emergency Medical Services Board and the Board of Pharmacy report that they do not have formal, written procedures regarding the extent of monitoring. However, like the Office of Investigations, they report relying on peer assistance programs to monitor their participants. Additionally, both boards' directors report that their regulatory community is small enough that it would be difficult for a practitioner whose license is revoked or severely limited to continue practicing without coming to the board's or their employer's attention through inspections or license checks.

The Department Can Take Steps to Increase Monitoring

Formal systems need to be developed – The department needs to take steps to improve how it monitors disciplined practitioners. First, the Board of Pharmacy and the Emergency Medical Services Board need to develop a formal, written monitoring system. Without such a formal organized system, the boards cannot ensure the public is protected from practitioners who have violated professional standards. In the case of the Board of Pharmacy, one option may be to shift responsibilities for disciplinary monitoring to the Office of Investigations, which already has a more developed (but still limited) monitoring system.

Office could improve its monitoring efficiency – Second, the Office of Investigations' disciplinary monitoring workload could be immediately addressed by adding monitoring staff. However, this is unlikely under the current budget environment. However, the office might be able to promote the most efficient use of its existing resources by prioritizing monitoring cases and shifting some of the disciplinary coordinator's responsibilities to other staff.

Ideally, the disciplinary coordinator would be able to cover all cases thoroughly and equally. However, this is not realistic under the current resources and workload. Therefore, it may be helpful to prioritize monitoring efforts so that resources are directed toward the most critical cases.

The department should also consider whether there are opportunities to shift some of the disciplinary coordinator's responsibilities to other health related board staff. Other states' boards rely on board administrative staff to conduct some monitoring activities. For example, Kentucky, Arkansas, and Georgia all primarily rely on their individual boards' administrative staff. While the department does not need to shift all monitoring activities to individual board staff, these other states' practices suggest that board administrative staff may be able to perform some of the monitoring tasks. For example, board staff may be able to issue initial standard letters to disciplined practitioners outlining their obligations. However, the department would need to closely analyze the board staff's existing workload and training, to determine whether there are opportunities to shift some monitoring responsibilities.

Future computer system needs monitoring capabilities – All of the boards' disciplinary monitoring processes would be enhanced by a better computerized tracking system. As discussed in Finding 4, the health related boards currently use the antiquated and problematic Regulatory Boards System (RBS). Rather than use the troubled system, the Office of Investigations' disciplinary coordinator uses an independent spreadsheet to track disciplinary cases. However, a more sophisticated, fully automated system could have additional, useful functions, such as generating reports listing only those practitioners who have failed to submit required documentation. In contrast, the disciplinary coordinator must currently manually scan the spreadsheet to identify these potential violators. This increases the opportunity for human error and increases the workload.

As discussed in Finding 4, the department is in the process of obtaining a new computerized tracking system. Given the potential benefits, the department should consider the potential systems' monitoring capabilities when selecting and implementing a new system.

Recommendation

The Division of Health Related Boards needs to take several steps to enhance its disciplinary monitoring processes. First, the Board of Pharmacy and the Emergency Medical Services Board need to develop a formal, written disciplinary monitoring process. Second, the Office of Investigations should consider prioritizing its disciplinary cases, and work with boards' administrative staff to determine if some of the disciplinary coordinator's duties could be shifted to board administrative staff. Third, as the department acquires and implements a computerized tracking system, it should specifically consider the software's monitoring assistance capabilities. Finally, after all efforts have been made to enhance efficiency and the budget outlook improves, the department should consider whether it would be helpful and cost-effective to add new monitoring staff positions.

Management's Comments

Comment by the Department of Health

We concur.

The Division of Emergency Medical Services has developed a policy which will be presented to the board at the earliest opportunity for review/approval. The policy is similar to that used by the Office of Investigations. The Board of Pharmacy staff is in the process of adding a monitoring component to its existing disciplinary action database.

Relative to the second point concerning the Office of Investigations, while the volume may be *challenging*, the current workload does not *limit* enforcement capabilities. Federal and state reporting is timely and accurately completed. Files are monitored and processed for violations of board orders, and complaint files are opened against violators by the disciplinary coordinator for further disciplinary actions. Files are monitored for compliance, and orders of compliance are routinely processed via the disciplinary coordinator.

A separate and distinct monitoring file is created and maintained for each disciplined practitioner. A formal monitoring and tracking system is in place to monitor disciplined practitioners using the following mechanisms: excel tracking system for each profession; specialized board reports delivered at board meetings; a tickler system used for critical cases; and a quarterly audit of individualized disciplinary monitoring files.

A staff member from the boards' administrative staff was reassigned in Spring 2009 to assist the disciplinary coordinator. In addition, changes were made to reassign tracking for Continuing Education and Professional Privilege Tax cases to program staff, allowing the disciplinary coordinator, a legal assistant supervised by the Director (an attorney), to track and monitor the most critical of cases. Management is willing to consider whether shifting disciplinary monitoring duties to board administrative staff will enhance efficiency.

A proposed monitoring and collections tracking system has been submitted with the Request for Proposal for the new computer software system. This monitoring/tracking/collections system has been tailored to meet current, specific needs and to address increased volume of disciplined practitioners.

Comment by the Chair of the Massage Licensure Board

The Massage Board contracts with an individual Peer Assistance program. The best money we spend each year. Having a non-state or government peer assistance contract increased self-reporting and saves much time at board meetings for applicants who are required to appear, as the director screens them before we do the interviews.

7. The Department of Health should further integrate functions of the Board of Pharmacy into the Division of Health Related Boards in order to improve both the efficient use of resources and the effectiveness of its regulatory obligations to protect the public

Finding

The Department of Health can improve its efficiency and effectiveness by further integrating select Board of Pharmacy functions with the other health related boards. The General Assembly moved the board from the Department of Commerce and Insurance to the Department of Health's Division of Health Related Boards in July 2007. Since then, the board has integrated some, but not all, of its functions with the division's other boards. In order to enhance efficiency and effectiveness, the board could further integrate some functions with the other health related boards.

The Board of Pharmacy was created in 1893 and regulates Pharmacists, Pharmacies, Pharmacy Technicians, Manufacturers/Wholesalers/Distributors, Researchers, and Medical Service Representatives. The board has the authority to enforce laws pertaining to the practice of pharmacy and the manufacture, distribution, or sale of drugs; adopt rules establishing professional conduct and practice standards; issue and renew licenses/certifications to qualified professionals; take disciplinary action when professionals violate state statutes or rules; and inspect pharmacies and other regulated sites.

Board of Pharmacy Moved Into the Division of Health Related Boards

Effective July 2007, the General Assembly amended Title 63, Chapter 10, Parts 2 and 3, *Tennessee Code Annotated*, and moved the board from the Department of Commerce and Insurance to the Department of Health's Division of Health Related Boards. The move was, in part, intended to shift the board organizationally closer to other boards regulating health professions.

After the organizational shift, the board integrated some, but not all, of its functions with the other health related boards. For example, the board's fee collection, license renewal, and legal functions were centralized with the other health related boards. However, the board retained several functions that, for the other health related boards, are already centralized and provided by shared Department of Health staff. For example, the board retained its investigative and continuing education audit functions.

Integrating shared functions is one potential tool that related regulatory boards can use to optimize their efficiency and effectiveness. For example, integration may reduce overhead costs by sharing staff and other expenses. Similarly, it can help provide a coordinated and consistent regulatory approach. However, integrating functions may not always be possible or ideal. For example, if a board regulates a profession involving an extremely high level of unique and technical knowledge, investigative and other similar staff may also require a technical level of expertise not relevant to other boards.

The Continuing Education Audit Function Could Be Strengthened

To enhance effectiveness, the Department of Health should consider integrating two additional Board of Pharmacy functions into the process used for the other health related boards. First, the Board of Pharmacy's review of whether pharmacists and other regulated professionals have met their continuing education requirements could be merged into the more robust centralized unit which conducts the other health related boards' continuing education audits.

The board's current continuing education process is not as methodical, or as consistent, as it could be. For example, there is no standardized process for deciding how many practitioners to audit or selecting which specific practitioners will be audited. Rather, an administrative secretary uses her own criteria to choose practitioners for the audits she subsequently conducts. Additionally, there is no set percentage of practitioners to be selected for audit, nor can the actual audit rate be easily calculated because there is no process to create, retain, or maintain a list of individuals selected for audit, and no documentation of completed audits. As a result, the board cannot be sure that a fair or appropriate number of licensees are audited. This is critical because continuing education requirements are a significant tool to ensure professionals' ongoing competency.

In contrast, the other health related boards' continuing education audits are conducted by a centralized, dedicated unit with a more consistent, well documented process. For example, the centralized group schedules audits on a set percentage of audits per profession and has related policies and procedures (although currently in draft form). Additionally, the centralized unit uses an active tracking system which lists which professionals were selected for audit and the results by board.

Given the weaknesses in the Board of Pharmacy's continuing education audit process and the fact that the centralized health related boards' continuing education audit process is more consistent and well documented, the Department of Health may be able to enhance both its efficiency and effectiveness by shifting the board's continuing education audit function into the centralized, continuing education audit function. Furthermore, by integrating the continuing education audits, the department could better ensure that all continuing education audits are applied in a consistent manner and are appropriately completed for all health related boards.

Pharmacy Investigators May Be Able to Assist Other Boards' Investigators

The Board of Pharmacy has not integrated its investigative function with the other health related boards. It may not be reasonable to completely combine the boards' investigative functions. Unlike the other health related boards, the pharmacy board's investigators are statutorily required to be licensed pharmacists. Additionally, unlike their health related boards' shared counterparts, the pharmacy board's investigators have other non-investigative job duties. For example, pharmacy investigators also conduct training.

While full integration may not be reasonable, there may be opportunities for the two groups of investigators to better cooperate. State statute encourages this cooperation. Specifically, Section 63-10-304(a), *Tennessee Code Annotated*, states:

The pharmacist investigators may also assist in inspections and investigations undertaken by other health related boards attached to the division, and investigators assigned to these other health related boards may assist pharmacist investigators as appropriate.

As mentioned previously, the pharmacy board's investigators are also required by Section 63-10-304(a), *Tennessee Code Annotated*, to be pharmacists. Many of the other health related boards' investigations relate to drug abuse and/or drug management including the illegal diversion of drugs. For example, the department estimates that approximately 13% of all complaints received from January through September 2009 were drug related. Currently, these and most other health related boards' investigations are conducted by nurses. While nurses are expected to have a good overall understanding of sound health-related practice, there may be times when a pharmacist could provide additional insight or advice on appropriate drug control and management procedures.

Additionally, as discussed on page 40, the current caseload of the other health related boards' investigators appears unreasonably high despite Department of Health efforts to address the situation. Although it is difficult to compare the caseloads of the Board of Pharmacy's investigators to the caseload of the other health related boards' investigators, the pharmacy boards' investigators appear to carry a lower workload, at least related to the estimated number of investigations. When combined with the pharmacists' knowledge of drug control and management, there may be opportunities for the pharmacist investigators to provide assistance to the other health related boards' investigators.

Recommendation

The Division of Health Related Boards should take further steps to integrate the Board of Pharmacy's functions with its counterparts in the other health related boards. Specifically, the pharmacy board's continuing education audit function should be shifted to the already centralized health related boards' continuing education audit function. Additionally, division management should explore ways that the pharmacy board's investigators may be able to assist the other health related boards' investigators with technical issues and workload.

Management's Comments

Comment by the Department of Health

We concur.

The continuing education audit for the Board of Pharmacy will be integrated into the process used for the other health related boards.

The Board of Pharmacy investigators are currently assisting the investigators for the other health related boards, as follows:

- a) The Board of Pharmacy investigators review information from the Controlled Substance Monitoring database to see if the information reveals irregularities. The Pharmacy Investigators are more knowledgeable in this area and are better able to analyze the data.
- b) When asked to do so by the health related boards investigators, the Board of Pharmacy investigators enter pharmacies to obtain the hard copies of prescriptions that are the subject of the investigation.
- c) When asked to do so by the health related boards investigators, the Board of Pharmacy investigators enter practitioners' offices to check records to determine whether there is a legitimate practitioner/patient relationship.

Management will explore whether there are other opportunities for Board of Pharmacy investigators to assist the other Division investigators.

Comment by the President of the Board of Pharmacy

Since I am confident that the Tennessee Board of Pharmacy members are very serious and dedicated to the work of the Board, I defer to the Tennessee Board of Pharmacy to take action related to "we concur" or "we do not to concur." It appears that there are three main issues related to the Tennessee Board of Pharmacy that should be considered in the final report. Outlined below are the items identified with response that will hopefully aid in dialogue that will best assure improvements in the public safety and welfare of Tennesseans that receive pharmacy services.

Financial Stewardship

Due to the fact that the Board of Pharmacy is a board that has not been a financial burden to the state, the Board of Pharmacy was able to allow the General Fund to receive \$1.8 million of its reserves within the last few months. This is not the first time the Board of Pharmacy has been able to contribute to the General Fund. The board also was able to provide approximately \$ 1.2 million to the General Fund once in the 1990s when the state had similar budget concerns. The board has been proactive in trying to continue this level of stewardship by requesting an updated financial/budget report and hopefully will evaluate it at the January 2010 Board of Pharmacy meeting.

Continuing Education Audit Process

The draft report mentions having Health Related Boards' Central Unit perform continuing education audits for the board. The report states the Central Unit currently has a process with procedures that are in draft form. It is not clear how the Central Unit has done this work in the past. Prior to making any decision to change this work, the Division of Health Related Boards should respectfully seek a time to get on the agenda at a future Board of Pharmacy meeting.

This will allow the board to participate in failure mode effects analysis discussion that will result in the best and most economical proposal to assure that pharmacists are up to date on required continuing education.

Allowing the other Health Related Boards to benefit from the expertise of pharmacists in their work

It is encouraging that the audit highlighted the value in pharmacists helping with the work of the other boards. It appears from the draft report that the full workload of the pharmacist investigators may not be fully appreciated as they have to investigate practice sites across the state in addition to investigating complaints that come to the board. The number of pharmacies with a Tennessee business address is 1,856; manufacturers /wholesalers/distributors, 696; and researchers, 224. These sites have to be investigated before they are opened to serve the public, during any construction or move, and at least every two years thereafter. This is another area that the Division of Health Related Boards will need to respectfully seek a time to get on the agenda at a future Board of Pharmacy meeting to allow the board to participate in failure mode effects analysis discussion to assure that this will be the best and most economical proposal to improve the assurance that the other boards gain potential efficiency by utilizing the expertise of pharmacists. This approach may minimize the risk of putting the public at greater risk by such events as medication errors or counterfeit medications. It should also be noted that the entire salary, benefits, and other costs related to the pharmacist investigators come directly from Board of Pharmacy revenue by fees from licensees of the Board of Pharmacy.

Comment by the Chair of the Massage Licensure Board

We concur that pharmacy investigators may be able to assist other boards' investigators. We often hear complaints of someone being reported for infractions of law or rules and it is sometimes up to two years before the case comes before the board, so more investigators would be very helpful.

OBSERVATIONS AND COMMENTS

The topics discussed below did not warrant a finding but are included in this report because of their effect on the operations of the health related boards and on the citizens of Tennessee.

Since Tennessee Statutes Allow Health Practitioners With Felony Convictions to Practice, a Felony Bar May Be Appropriate

During the course of this audit, media attention was drawn to a medical physician who, despite having pled guilty, been convicted, and served prison time for two felony second-degree

murders, was eventually granted an unrestricted license to practice by the Tennessee Board of Medical Examiners, which had knowledge of these felonies. Subsequently, in February 2009, the physician and a partner were accused by Kentucky authorities of participating in organized crime by prescribing drugs in extremely large quantities out of their Tennessee offices, including to a visibly pregnant woman whose infant was later born drug addicted.

Statute Gives the Board Latitude in Handling Practitioners With Felony Convictions

Under Section 63-6-214(a) and (b), *Tennessee Code Annotated*, the Board of Medical Examiners is authorized to take a variety of actions against practitioners convicted of a felony, including denying new license applications, suspending or limiting existing licenses, reprimanding the licensee, or permanently revoking licenses. However, the board is only required to take some sort of action against the licensee in this situation. Statute does not define which specific action the board must take. Therefore, under current statute and if faced with the same situation, the board would still be legally allowed to similarly lift any and/or all practice limitations on a previously disciplined physician.

Auditors reviewed the board’s records pertaining to this physician to understand the timeline of events and why the board may have made the decision to allow the physician to practice without limitations. Table 3 summarizes the major licensing events leading up to the latest drug allegations.

**Table 3
Summary of Licensing Events for Accused Doctor
As Reported by the Department of Health**

Date	Action
December 1975	Physician licensed as a medical doctor, with a specialty in anesthesiology.
May 1989	Physician agrees to surrender medical license due to felony conviction.
May 1993	License reinstated with conditions after physician paroled. License restrictions include: <ul style="list-style-type: none"> • 5 years license probation • Must annually appear before the board. • Must obtain services from a specified impaired physicians program. • Can only work with a specified hospital.

Date	Action
March 1994	Physician requests modification of restrictions. Board broadens license practice location restrictions to include multiple specified hospitals. However, board rejects physician's other requests on the basis that it is "not comfortable...due to the nature of the original offense."
August 1994	Physician notifies the board in writing that his position at the hospital where he currently works (and which his license is limited to) may be ending due to budget problems.
November 1994	Board lifts all site restrictions. However, board also rejects physician's request to practice emergency medicine on the basis that he is not qualified in this field.
June 1995	Physician requests further modification of license restrictions. Board rejects request to practice outside of anesthesiology on the basis that the physician has not practiced in any other area of medicine since the 1970s. As a result, additional education would be required to move into a new specialty.
October 1995	Physician again requests further modification of license restrictions to practice outside of anesthesiology. Board rejects request on basis that the physician cannot prove that he obtained additional education since the prior request was rejected. Board also indicates that the physician may only request additional modifications under specific circumstances.
March 1997	Physician again requests further modifications to allow him to practice in family medicine. Board finds that the physician had met prior set requirements, agrees to the request, and changes license restrictions to allow physician to practice family medicine under supervision.
August 2001	Board lifts all license restrictions due to physician complying with all prior orders. Physician free to practice under an unencumbered license.

The board's meeting minutes do not contain enough detail to conclusively explain why the board eventually allowed the physician to practice without restrictions. However, auditors noted that the file contained multiple glowing recommendations about the physician from other physicians and other documentation about the physician's qualifications. Additionally, as noted above, the board appears to have made some attempt to critically review the physician's qualifications as it rejected multiple requests to expand his practice limitations.

The General Assembly Could Impose a Felony Bar

Although current statute allows the Board of Medical Examiners the latitude to fully restore licenses to persons convicted of felonies, the General Assembly always has the option to restrict the board's discretionary powers. For example, the General Assembly could consider enacting legislation commonly known as a "felony bar." A felony bar restricts persons convicted of a felony, and sometimes other serious crimes, from receiving a license to practice either permanently or for a set period of time after fulfilling their sentence. Likewise, if the person is already licensed/certified, their license/certification is automatically revoked upon a felony conviction either permanently or until a set period has elapsed.

For example, the State of Arizona has a felony bar restricting nurses convicted of felonies from receiving a license to practice for five years after the full completion of their sentence. The five-year period was adopted to provide enough time for the convicted person to completely fulfill all their requirements (such as victim restitution), while providing an opportunity to prove their rehabilitation and safety to practice.

The Federation of State Medical Boards does not make any recommendations regarding felony bars. Rather, the federation recommends that state medical boards have discretion in handling individual cases. However, the National Council of State Boards of Nursing does recommend a permanent felony bar for the most serious felonies and a five-year bar for other serious crimes with the flexibility for the board to override it under extreme circumstances.⁶

Management's Comment

Comment by the Chair of the Massage Licensure Board

We concur. We need some consistency in licensing applicants with prior felony convictions. I believe it would be best to go back to no license for any convicted felon.

Polysomnography Committee Status

The Polysomnography Professional Standards Committee was created in 2007 under Section 63-31-103, *Tennessee Code Annotated*, to regulate sleep medicine professionals in Tennessee. The committee, which is part of the Board of Medical Examiners, is effectively statutorily required by Section 63-31-106(a)(1), *Tennessee Code Annotated*, to begin licensing polysomnographers by July 1, 2010. Respiratory therapists who are licensed by the Board of Respiratory Care and who provide polysomnography services are not required to have a second license as a polysomnographic technologist; however, their competency in polysomnography

⁶ The National Council of State Boards of Nursing defines serious felonies to include murder, felonious assault, kidnapping, rape, aggravated robbery, sexual crimes involving children, criminal mistreatment of children or vulnerable adults, and exploitation of vulnerable individuals (e.g., financial exploitation in an entrusted role). Serious crimes include drug trafficking, embezzlement, theft, and arson.

must be documented through credentialing by a national board or other mechanism approved by the Board of Respiratory Care, in consultation with the Board of Medical Examiners.

The committee has met three times since its creation: August 2008, December 2008, and May 2009. The committee is also drafting rules and regulations, which are progressing through the rulemaking process as of November 2009. The committee is not yet issuing licenses or otherwise actively regulating polysomnography professionals. However, the board's director anticipates the committee will meet its statutory deadline to begin licensing by July 2010.

Division of Health Related Boards' Office of Investigations Faces Workload Challenges

The Office of Investigations, which is responsible for investigating complaints and other potential statutory and rule violations, for all health related boards except the Board of Pharmacy, is responding to an increasing workload. The office reports that the number of investigations, which is largely out of the office's control because it's mostly driven by the number of complaints filed, has significantly increased over time. For example, the office reports that the annual number of opened investigations almost doubled between 2000 and 2007 from 1,237 to 2,283 investigations.

While investigations are increasing, the office, like most other state agencies, is struggling with a hiring freeze. The office reports it has 19 authorized investigator positions. However, 5 of those 19 positions are currently vacant (as of October 2009) and cannot be filled due to the hiring freeze. Four of these open positions are located in Middle Tennessee, while the fifth position is located in East Tennessee. The office's director reports that she has requested, but has not received (as of October 2009), permission to fill three of the five frozen positions.

As the number of complaints received has increased, and the number of filled investigator positions has decreased, the office's remaining investigators have logically faced an increasing workload. While problems with the Regulatory Boards System make it difficult to produce reliable and useful workload reports (as discussed in Finding 4), it does appear that several of the investigators are carrying an unworkably high number of open investigations. It is important that these workloads be as reasonable as possible because, as investigators work more cases, the timeliness of investigations, and potentially the quality of their work, might suffer.

Office and department management are aware of the high caseloads and report having taken numerous steps to balance caseloads and streamline the investigative process, thus attempting to improve investigator efficiency and effectiveness and to minimize caseloads to the extent possible under current resource constraints. For example, the office reports

- shifting cases between investigators within the same region in order to more evenly distribute the investigative caseload, while still maintaining some geographic proximity between the investigator and accused practitioner;
- shifting open investigator positions and filling those positions for the West Tennessee region, prior to the hiring freeze going into effect;

- providing additional training on interviewing and interrogation skills to enhance investigators' efficiency and effectiveness; and
- improving the form the public uses to file complaints in order to improve initial information available to the investigators.

Even as the office continues to work with existing resources to improve efficiency, effectiveness, and caseloads, ultimately it may need to hire additional investigators as the state's budget outlook improves.

ADDITIONAL AUDIT WORK PERFORMED

Title VI Training

While gathering information regarding the boards' diversity status, auditors determined that the department does not appropriately require board members to receive Title VI training. The department reports that although board members receive workplace harassment prevention training, they are not required to receive Title VI training because board members are not state employees. However, board members are the primary decision makers for key health-related board actions, such as licensing and disciplining health-related professionals. Therefore, they should receive this training. (See Appendix 3 for more information about how this training could be provided.)

The Department of Health should mandate that all health related and similar board members receive Title VI training. This training could be provided in a variety of formats.

Management's Comment

See page 57 for the Department of Health's response.

RECOMMENDATIONS

LEGISLATIVE

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

1. The General Assembly may wish to consider terminating the Council for Licensing Hearing Instrument Specialists, and reassigning the council's responsibilities to the Board for Communication Disorders and Sciences or a Department of Health-operated registry. If the General Assembly wishes to assign the responsibilities to the board, it may wish to consider changing the board's composition to provide for a hearing instrument specialist to sit on the board. Similarly, if the General Assembly wishes to create a new registry for hearing instrument specialists, it may wish to consider providing the department with full licensing, investigative, and disciplinary authority.

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. The Department of Health and the Health Related Boards need to take several steps to ensure the boards remain annually self-sufficient as required by law. First, all health related boards, not just those subject to this audit, that have not been self-sufficient for the past two fiscal years need to promptly increase fees so that revenue exceeds costs and any deficits are corrected. Second, the department should help board members by further educating them on board finance, department financial processes, board financial reports, and boards' statutory obligation to maintain annual self-sufficiency without reliance on prior years' surpluses. Additionally, the department should research and adopt more accurate and easily applied formulas for calculating overhead costs, to ensure that each board pays its fair share of those costs.
2. Division of Health Related Boards staff should supplement its existing efforts to identify problematic applicants by systematically querying the National Practitioner Data Bank whenever an applicant in a covered profession applies for Tennessee licensure. To cover this cost, the division and individual boards should investigate their current authority and, if necessary, request authority from the General Assembly, to charge each covered applicant a one-time fee to cover the query cost.

3. The Division of Health Related Boards should improve its ability to monitor its initial licensing timeliness. Because of its impact on operations, the division should continue efforts to obtain and implement a new, effective regulatory board tracking system as quickly and efficiently as reasonably possible. The division should specifically ensure that any new system provides the ability to analyze time delays outside of the boards' control, including client-caused and time delays required by each board's unique licensing requirements.
4. Until the new computer system is implemented, the division should gather more detailed timeliness information on a more limited scale. For example, the division should consider regularly selecting a sample of initial licensing applications, gathering more detailed licensing timeline information from its files, and analyzing for timeliness considering any delays outside of the boards' controls. Similarly, the division should develop unique benchmarks for each profession based on its unique licensing requirements. The division may also want to work with each health related board to review its licensing requirements to ensure that all similar built-in time delays are appropriate and necessary.
5. Finally, regardless of new system implementation, the division should calculate, monitor, and report on all initial applications' timeliness, including rejected, withdrawn, or otherwise closed applications. Additionally, data codes should be made uniform across all professions in order to ensure whatever data is collected in the future is as usable as possible.
6. The Division of Health Related Boards should develop a systematic, division-wide process to monitor initial licensing applications that require a Division of Health Care Facilities inspection. Division and board management should use this tracking process to identify inspections which are taking an atypically long time and follow up with the Division of Health Care Facilities for additional information about the inspections' status.
7. The Division of Health Related Boards needs to take several steps to enhance its disciplinary monitoring processes. First, the Board of Pharmacy and the Emergency Medical Services Board need to develop a formal, written disciplinary monitoring process. Second, the Office of Investigations should consider prioritizing its disciplinary cases, and work with boards' administrative staff to determine if some of the disciplinary coordinator's duties could be shifted to board administrative staff. Third, as the department acquires and implements a computerized tracking system, it should specifically consider the software's monitoring assistance capabilities. Finally, after all efforts have been made to enhance efficiency and the budget outlook improves, the department should consider whether it would be helpful and cost-effective to add new monitoring staff positions.
8. The Division of Health Related Boards should take further steps to integrate the Board of Pharmacy's functions with its counterparts in the other health related boards. Specifically, the pharmacy board's continuing education audit function

should be shifted to the already centralized health related boards' continuing education audit function. Additionally, division management should explore ways that the pharmacy board's investigators may be able to assist the other health related boards' investigators with technical issues and workload.

Appendix 1

Health Related Boards Covered in This Audit

Note: In addition to the board members listed below, the Health Related Boards' Director serves as a non-voting ex-officio member on all Health Related Boards, pursuant to Section 63-1-133(a), *Tennessee Code Annotated*.

Entity	Enabling Statute (all <i>Tennessee Code Annotated</i> sections)	Professions/Facilities Regulated	Highlights of Statutorily Required Board Composition	Termination Date
Board of Athletic Trainers	63-24-102	Athletic Trainer	3 licensed athletic trainers; 1 licensed physician; 1 public representative (5 members total)	None
Board of Chiropractic Examiners	63-4-102	Chiropractic Physician; Chiropractic Therapy Assistant; Chiropractic X-Ray Technologist	5 chiropractic physicians; 2 public representatives (7 members total)	June 30, 2010
Board of Communication Disorders and Sciences	63-17-104	Speech Language Pathologist; Audiologist; Speech Pathologist Assistant	2 active, licensed speech language pathologists; 2 active, licensed audiologists; 1 active, licensed either speech language pathologist or audiologist; 1 public representative; 1 physician with specialty in otolaryngology (7 members total)	June 30, 2010

Entity	Enabling Statute (all <i>Tennessee Code Annotated</i> sections)	Professions/Facilities Regulated	Highlights of Statutorily Required Board Composition	Termination Date
Board of Dentistry	63-5-101	Dentist; Dental Hygienist; Dental Assistant	7 practicing dentists, 2 from each grand division, other position to alternate equally among the grand divisions; 2 practicing dental hygienists; 1 practicing registered dental assistant; 1 public representative (11 members total)	June 30, 2011
Board of Dietitian/Nutritionist Examiners	63-25-106	Dietitian/Nutritionist	5 members with 5 years or more experience teaching or practicing; 1 public representative (6 members total)	June 30, 2010
Board of Examiners for Nursing Home Administrators	63-16-102	Nursing Home Administrator	4 nursing home industry representatives; 1 hospital administrator; 1 physician; 1 nurse representative; 1 public representative; Commissioner of Health or designee to serve as ex-officio (9 members total)	June 30, 2010
Board of Examiners in Psychology	63-11-101	Psychologist; Psychological Assistant	2 university faculty members; 4 licensed psychologists; 2 licensed psychological examiners or licensed senior psychological examiners; 1 public representative (9 members total)	June 30, 2010

Entity	Enabling Statute (all <i>Tennessee Code Annotated</i> sections)	Professions/Facilities Regulated	Highlights of Statutorily Required Board Composition	Termination Date
Board of Medical Examiners	63-6-101	Medical Doctor; Medical X-Ray Operator; Radiologist Assistant; MD Office-Based Surgery; Special Training MD	9 physicians; 3 public representatives (12 members total)	June 30, 2011
Board of Medical Examiners' Committee on Physician Assistants	63-19-103	Physician Assistant	5 physician assistants; 1 physician assistant with specialty in orthopedics; 1 public representative (7 members total)	June 30, 2010
Board of Nursing	63-7-201	Advanced Practice Nurse; Registered Nurse; Licensed Practical Nurse	5 registered nurses; 3 licensed practical nurses; 2 advanced practice nurses; 1 public representative (11 members total)	June 30, 2010
Board of Optometry	63-8-103	Optometrist	5 licensed optometrists; 1 public representative (6 members total)	June 30, 2010

Entity	Enabling Statute (all <i>Tennessee Code Annotated</i> sections)	Professions/Facilities Regulated	Highlights of Statutorily Required Board Composition	Termination Date
Board of Pharmacy	63-10-301	Pharmacist; Pharmacy; Researcher; Pharmacy Technician; Manufacturers, Wholesalers, and Distributors	7 members total, of which 1 must be a public representative. The Tennessee Pharmacists Association makes recommendations for all appointments and all pharmacist members must be graduates of a recognized college of pharmacy and have been actively practicing for at least 5 years.	June 30, 2010
Board of Podiatric Medical Examiners	63-3-103	Podiatrist; Podiatric X-Ray Operator; Orthotist; Prosthetist Pedorthist	4 licensed podiatrists; 1 licensed orthotist, or prosthetist, or pedorthist; 1 public representative (6 members total)	June 30, 2010
Board of Respiratory Care	63-27-103	Licensed Registered Respiratory Therapist; Licensed Certified Respiratory Therapist	4 respiratory care practitioners holding a credential from the National Board for Respiratory Care at least 2 of whom shall be registered respiratory therapists; 1 physician having expertise in pulmonary medicine; 1 hospital administrator; 1 hospital employee licensed as a registered respiratory therapist; 1 public representative (8 members total)	June 30, 2011

Entity	Enabling Statute (all <i>Tennessee Code Annotated</i> sections)	Professions/Facilities Regulated	Highlights of Statutorily Required Board Composition	Termination Date
Board of Veterinary Medical Examiners	63-12-104	Veterinary Facility; Veterinarian; Certified Animal Control Agency; Veterinary Medical Technician; Certified Animal Euthanasia Technician	5 licensed doctors of veterinary medicine; 1 licensed veterinary technician; 1 public representative; State Veterinarian as a non-voting, ex-officio member (8 members total)	June 30, 2010
Committee for Clinical Perfusionists	63-28-112	Clinical Perfusionist	4 perfusionists; 1 hospital administrator from a facility where cardiac surgery is performed; 1 cardiac surgeon or cardiac anesthesiologist; 1 public representative (7 members total of which at least 2 members must be from each grand division)	June 30, 2010
Council for Licensing Hearing Instrument Specialists	63-17-202	Hearing Instrument Specialist	3 licensed hearing instrument specialists certified by the National Board for Certification — Hearing Instrument Sciences; 1 physician certified by the American Council of Otolaryngology; 1 user of hearing instruments for a period of at least five 5 years preceding that person's appointment to the council (5 members total)	June 30, 2010

Entity	Enabling Statute (all <i>Tennessee</i> <i>Code Annotated</i> sections)	Professions/Facilities Regulated	Highlights of Statutorily Required Board Composition	Termination Date
Council of Certified Professional Midwifery	63-29-103	Midwife	3 certified professional midwives; 1 certified nurse midwife; 1 physician; 1 public representative (6 members total)	June 30, 2010

Entity	Enabling Statute (all <i>Tennessee Code Annotated</i> sections)	Professions/Facilities Regulated	Highlights of Statutorily Required Board Composition	Termination Date
Emergency Medical Services Board ⁷	68-140-503	Paramedic; Paramedic Critical Care; EMT IV; EMT Basic; First Responder; EM Dispatcher; Written Exams Administrator; Practical Exams Administrator; Educational Institution; Ambulance Service; Ambulance	2 licensed physicians; 1 registered nurse; 1 hospital administrator; 1 EMT, EMT-P, registered nurse, or physician and who is also affiliated with a volunteer nonprofit ambulance service; 2 operators of ambulance services, each of whom maintains certification as an EMT or EMT-P; 1 rescue squad member who maintains certification as an EMT or EMT-P; 1 member from a list of nominees presented by the Tennessee Professional Firefighters Association who maintains certification as an EMT-P, EMT, or registered nurse; 1 member from a list of nominees presented by the Tennessee Civil Defense Association, who maintains certification as an EMT or EMT-P; 2 officials of county, municipal, or metropolitan governments which operate ambulance services; 1 paramedic instructor licensed in this state (13 members total, of which 4 must be from each of the grand divisions, plus 1 at large member)	June 30, 2010

⁷ *Tennessee Code Annotated* does not define the Emergency Medical Services Board as a health related board. Therefore, the Health Related Board's Director is not statutorily required to serve as an ex-officio board member.

Entity	Enabling Statute (all <i>Tennessee Code Annotated</i> sections)	Professions/Facilities Regulated	Highlights of Statutorily Required Board Composition	Termination Date
Massage Licensure Board	63-18-103	Massage Therapist; Massage Establishment	5 massage therapists licensed or eligible to be licensed, with at least five years' current experience; 2 public representatives (7 members total)	June 30, 2011
Polysomnography Professional Standards Committee	63-31-103	Polysomnographic Technologist ⁸	3 registered polysomnographic technologists; 1 physician who is certified in sleep medicine by a national certifying body recognized by the American Academy of Sleep Medicine; 1 director of an accredited, hospital-based sleep center; 1 respiratory therapist who is also a registered polysomnographic technologist; 1 public representative (7 members total)	June 30, 2011
Tennessee Advisory Committee for Acupuncture	63-6-1003	Acupuncturist	3 certified acupuncturists; 1 acupuncture detoxification specialist; 1 public representative (5 members total)	June 30, 2010

⁸ The committee is not yet issuing any licenses. Under Section 63-13-106, *Tennessee Code Annotated*, persons practicing polysomnography are not required to be licensed until July 1, 2010.

Entity	Enabling Statute (all <i>Tennessee Code Annotated</i> sections)	Professions/Facilities Regulated	Highlights of Statutorily Required Board Composition	Termination Date
Tennessee Medical Laboratory Board	68-29-109	Licensed Laboratory Personnel; Medical Laboratory Facility	1 pathologist licensed as a physician and certified in clinical and anatomical pathology by the American Board of Pathology and associated with a medical laboratory personnel education program; 2 pathologists licensed as a physician and certified in clinical and anatomical pathology by the American Board of Pathology; 1 hospital administrator; 1 independent laboratory management/administration representative; 1 hospital laboratory manager/administrative director licensed as a non-physician medical laboratory supervisor; 2 licensed medical technologist generalists; 1 licensed physician who is not a pathologist; 1 educator in a medical technology or medical laboratory technician program licensed as a medical laboratory technologist or as a non-physician laboratory supervisor; 1 licensed non-physician medical laboratory supervisor; 1 licensed cytotechnologist; 1 public representative (13 total members)	June 30, 2010

Appendix 2

Health Related Boards Financial Status For the Fiscal Years Ended June 30, 2007 and 2008

<u>Board/Committee/Registry</u>	<u>2007 Net Revenues Over Expenditures</u>	<u>2008 Net Revenues Over Expenditures</u>	<u>Cumulative Balance 6/30/08</u>	<u>Transfer To General Fund</u>	<u>Revised Cumulative Balance 6/30/08</u>
Chiropractic	\$32,766	\$73,612	\$238,035	\$208,311	\$29,724
Dentistry	218,745	502,156	870,594	761,885	108,709
Dietitian/Nutritionist	(21,345)	(19,155)	40,444	35,394	5,050
Dispensing Opticians	(5,481)	(40,437)	127,369	111,464	15,905
Electrolysis Examiners	(15,083)	(5,582)	(39,324)	0	(39,324)
Hearing Instrument Specialists	(6,766)	(10,835)	(35,560)	0	(35,560)
Social Workers	(1,769)	36,161	283,270	247,899	35,371
Medical Examiners	(158,370)	(176,770)	867,337	759,034	108,303
Athletic Trainers	(21,303)	(5,984)	10,058	8,802	1,256
Physician Assistants	22,940	5,475	224,655	196,603	28,052
Clinical Perfusionists	4,181	9,036	60,371	52,833	7,538
Acupuncture	15,850	23,076	84,354	73,821	10,533
Respiratory Care	(114,829)	73,662	44,663	39,086	5,577
Medical Lab	312,986	234,916	1,115,857	976,522	139,335
Nursing	(1,394,690)	(171,855)	954,144	835,001	119,143
Nursing Home Administrators	(52,909)	(21,354)	68,380	59,842	8,538
Occupational Therapy	(47,658)	(13,251)	421,240	368,640	52,600
Optometry	62,976	71,314	290,292	254,044	36,248
Osteopathic	778	18,324	(47,355)	0	(47,355)
Midwifery	(4,451)	(2,246)	(14,777)	0	(14,777)
Physical Therapy	(29,609)	(119,540)	1,137,580	995,533	142,047

<u>Board/Committee/Registry</u>	2007 Net Revenues Over Expenditures	2008 Net Revenues Over Expenditures	Cumulative Balance 6/30/08	Transfer To General Fund	Revised Cumulative Balance 6/30/08
Podiatry	71,180	75,021	163,254	142,869	20,385
Professional Counselors and Therapists	63,720	54,048	315,630	276,218	39,412
Psychology	58,685	92,233	342,517	299,748	42,769
Communication Disorders and Sciences	(25,266)	13,932	79,978	69,992	9,986
Veterinary	(19,574)	43,731	(106,052)	0	(106,052)
A&D Abuse Counselors	16,372	7,803	78,315	68,536	9,779
Massage	(307,464)	(199,625)	180,918	158,327	22,591
Reflexologist	(703)	928	(12,785)	0	(12,785)
Polysomnography Professional Standards	0	(4,782)	(4,782)	0	(4,782)
Pharmacy	<u>1,976,011</u>⁺	<u>120,472</u>	<u>2,096,483</u>	<u>1,834,699</u>	<u>261,784</u>
Totals	\$629,920	\$664,484	\$9,835,103	\$8,835,103	\$1,000,000

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

(+) This amount represents the surplus funds which transferred with the board from the Department of Commerce and Insurance to the Department of Health.

Source: Department of Health, Division of Health Related Boards, Report entitled "FY2006/07 and FY2007/08 Actual Comparison of Expenditures and Fees."

Appendix 3

Title VI and Title VII Information

Title VI

All programs or activities receiving federal financial assistance are prohibited by Title VI of the Civil Rights Act of 1964 from discriminating against participants or clients on the basis of race, color, or national origin. In response to the request from members of the Government Operations Committee, we compiled information concerning the Health Related Boards, the Emergency Medical Services Board, and Title VI requirements. The results of the information gathered are summarized below.

The Department of Health's department-wide *Title VI Compliance Plan and Implementation Manual* includes the Health Related and Emergency Medical Services boards. This plan and the department's overall compliance with the plan were audited and reported as a part of the Comptroller of the Treasury's October 2008 performance audit of the Department of Health. Therefore, limited audit work regarding Title VI was conducted for this current audit. However, we present the following information specifically related to the audited Health Related and Emergency Medical Services boards for the committee's convenience.

Federal Funds

The entities reviewed as part of this audit received the following federal funding in recent years:

- Emergency Medical Services received \$163,600 in federal funds in the fiscal year ending June 30, 2008.⁹ However, none of these monies are used for licensing or direct oversight of emergency medical personnel.
- The Division of Health Related Boards received \$53,500 in federal funds for the fiscal year ending June 30, 2008, for the Controlled Substance Monitoring Database, which is managed by the Board of Pharmacy. However, the monies were not expended that year. The same project, also using federal funds, is planned for the fiscal year ending June 30, 2010.

Board Member Training

The department does not appropriately require board members to receive Title VI training. Board staff do, however, receive such training. The department reports that although board members receive workplace harassment prevention training, they are not required to receive Title VI training because board members are not state employees. Rather, board members are appointed by the Governor for relatively short terms. However, board members are the primary decision makers regarding key health related board responsibilities, such as licensing

⁹ Emergency Medical Services and, therefore, these federal figures, includes the Emergency Medical Services Board (which is subject to this audit) and other functions which are not subject to this audit, such as statewide emergency medical disaster planning.

and disciplining health related professions. Therefore, because the Health Related Boards are subject to Title VI requirements, board members as critical decision makers would also be subject to Title VI and should receive Title VI training.

However, given that the board members are not state employees and often serve for short terms, it may be inefficient and unreasonable to require them to attend an entire separate Title VI training. Rather, the department may want to develop or use another avenue to provide this information to board members. For example, each board's legal counsel verbally reminds the board members of conflict-of-interest requirements at every board meeting. A similar reminder about Title VI information could be efficiently added. Likewise, the department could include Title VI information while training board members about workplace harassment issues.

Management's Comment

Comment by the Department of Health

We do not concur that the members of the health related boards should receive Title VI training because Title VI is not applicable to these boards.

The auditors indicate that the Board of Pharmacy manages the Controlled Substance Monitoring Database. It should be noted that while Board of Pharmacy-assigned staff is shared with the Controlled Substance Monitoring Database program, the Controlled Substance Monitoring Database is attached to the department, not the board (Tenn. Code Ann. § 53-10-304).¹⁰ The Board of Pharmacy itself has no decision-making authority over the Controlled Substance Monitoring Database. Similarly, the Emergency Medical Services Board has no decision-making authority over the federal funds the Division of Emergency Medical Services receives.

The auditors state that Title VI is applicable to all of the health related boards because board members are the primary decision makers regarding key health related board responsibilities, such as licensing and disciplining health related professions. The trigger for the applicability of Title VI is whether the entity receives federal financial assistance, not whether board members are decision makers regarding licensing and disciplinary functions (42 U.S.C. § 2000d). Each of the boards reviewed in this audit is an independent body, attached only administratively to the Department and not subject to the control or direction of the Department. None of the boards reviewed in this audit is a recipient of federal financial assistance, either directly or indirectly. As such, Title VI is not applicable to these boards, and Title VI training should not be required for these board members. [See 04 Op. Att'y Gen. 130 (2004).]

Title VII

All programs or activities receiving federal assistance must comply with Title VII of the Civil Rights Act of 1964 that prohibits employment discrimination based on race, color, religion,

¹⁰ Auditor's Note: Section 53-10-304(a), *Tennessee Code Annotated*, states, "There is created within the department a controlled substance database to be attached administratively and for purposes of staffing to the board of pharmacy. The executive director of the board shall be responsible for determining staffing."

sex, or national origin. The tables below detail the breakdown of commission members and agency staff by gender and ethnicity.

Department of Health statistics concerning the Health Related Boards staff and gender composition are presented below.

**Staff of Division of Health Related Boards
by Title, Gender, and Ethnicity¹¹
As of March 2009**

Title	Gender		Ethnicity				
	Male	Female	Asian	Black	Hispanic	White	Other
Accounting Technician 2	0	1	0	1	0	0	0
Administrative Assistant 1	0	2	0	1	0	1	0
Administrative Secretary	0	1	0	0	0	1	0
Administrative Services Assistant 2	0	7	0	1	0	6	0
Administrative Services Assistant 3	1	2	0	1	0	2	0
Administrative Services Assistant 4	0	4	0	1	0	3	0
Administrative Services Assistant 5	1	0	0	0	0	1	0
Attorney 3	1	1	0	1	0	1	0
Clerk 2	0	1	0	0	0	1	0
Clerk 3	1	1	0	1	0	1	0
Dental Board Director	1	1	0	0	0	2	0
Distributed Computer Operator 2	0	1	1	0	0	0	0
Health Related Boards Director	0	1	0	0	0	1	0
Health Related Boards Investigations Director	0	1	0	0	0	1	0
Information Resource Support Specialist 2	0	1	0	1	0	0	0
Information Resource Support Specialist 3	0	1	0	0	0	1	0
Information Resource Support Specialist 4	2	1	0	0	0	3	0
Information Resource Support Specialist 5	0	1	0	1	0	0	0
Information Systems Analyst 4	0	1	0	0	0	0	1

¹¹ This table includes all Health Related Boards staff, including boards not subject to audit. Many staff work with multiple boards, making it difficult to separate the audited boards. Additionally, this table includes department staff who do not work directly for the Health Related Boards staff, but whose primary responsibilities are to support Health Related Boards functions. For example, this table includes attorneys who litigate Health Related Boards cases but are not Health Related Boards employees.

Title	Gender		Ethnicity				
	Male	Female	Asian	Black	Hispanic	White	Other
Information Systems Manager 1	1	0	0	0	0	1	0
Legal Assistant	1	1	0	1	0	1	0
Licensing Technician	5	16	0	13	0	7	1
Medical Board Director	0	1	0	0	0	1	0
Nursing Board Director	0	1	0	0	0	1	0
Pharmacist 2	4	0	0	0	0	4	0
Pharmacy Board Director	1	0	0	0	0	1	0
Physician	1	0	0	0	0	1	0
Programmer/Analyst 3	1	0	0	0	0	1	0
Public Health Nursing Consultant 1	1	9	0	0	0	10	0
Public Health Nursing Consultant 2	1	4	0	0	0	5	0
Regulatory Board Administrative Assistant 1	0	6	1	2	0	3	0
Regulatory Board Administrative Assistant 2	2	15	0	4	0	13	0
Regulatory Board Administrative Assistant 3	1	2	0	0	0	3	0
Regulatory Board Administrative Director 1	0	3	0	0	0	3	0
Regulatory Board Administrative Manager	0	2	0	1	0	1	0
Regulatory Board Investigator	0	2	0	0	0	2	0
Statistician 2	1	0	0	0	0	1	0
Veterinarian Staff	1	0	0	0	0	1	0
Veterinarian Board Director	0	1	0	0	0	1	0
Totals	28	92	2	30	0	86	2
Percentages	23%	77%	1.7%	25%	0%	71.7%	1.7%

Department statistics concerning the Emergency Medical Services staff and gender composition are presented below.

**Staff of the Division of Emergency Medical Services¹² by Title, Gender, and Ethnicity
As of March 2009**

Title	Gender		Ethnicity				
	Male	Female	Asian	Black	Hispanic	White	Other
Administrative Services Assistant 3	0	1	0	0	0	1	0

¹² This table includes all Emergency Medical Services staff, some of whom are not responsible for regulating emergency medical professionals or otherwise supporting the Emergency Medical Services Board, which is the subject of this audit.

Title	Gender		Ethnicity				
	Male	Female	Asian	Black	Hispanic	White	Other
Emergency Medical Services Consultant 1	4	2	0	0	0	6	0
Emergency Medical Services Consultant 2	3	1	0	0	0	4	0
Emergency Medical Services Director	1	0	0	0	0	1	0
Information Resource Support Specialist 3	1	0	0	0	0	1	0
Information Resource Support Specialist 4	1	0	0	0	0	1	0
Licensing Technician	0	2	0	0	0	2	0
Public Health Educator 3	0	1	0	0	0	1	0
Radio Systems Analyst	1	0	0	0	0	1	0
Regulatory Board Administrative Assistant 2	0	1	0	0	0	1	0
Statistical Analyst 1	0	1	0	1	0	0	0
Totals	11	9	0	1	0	19	0
Percentages	55%	45%	0%	5%	0%	95%	0%

Board Members

Department-provided information about the audited health related board members is presented below.

**Audited Health Related Boards
Board Members by Gender and Ethnicity
As of March 2009**

Board	Gender		Ethnicity				
	Female	Male	Asian	Black	Hispanic	White	Other
Acupuncture	5	0	0	0	0	5	0
Athletic Trainers	1	4	0	1	0	4	0
Chiropractic Examiners	3	4	0	0	0	7	0
Clinical Perfusionists	2	5	0	2	0	5	0
Communication Disorders	4	3	0	2	0	5	0
Dentistry	5	6	1	1	0	9	0
Dietitian & Nutritionist	6	0	1	2	0	3	0
Hearing Instrument Specialists	0	5	0	0	0	5	0
Massage	5	1	0	0	1	5	0
Medical Examiners	2	10	0	3	0	9	0
Medical Laboratory	6	6	0	3	0	9	0
Midwifery	5	1	0	1	0	5	0
Nursing	11	0	0	2	0	9	0
Nursing Home Administrators	3	5	0	2	0	6	0
Optometry	2	4	0	1	0	5	0
Pharmacy	4	3	0	1	0	6	0
Physician Assistants	2	5	0	2	0	5	0
Podiatry	2	4	0	1	0	5	0
Polysomnography	4	3	0	0	0	7	0
Psychology	5	4	0	2	0	7	0
Respiratory Care	3	4	0	3	0	4	0
Veterinary	3	4	0	3	0	4	0
Totals	83	81	2	32	1	129	0
Percentages	51%	49%	1.2%	19.5%	.6%	78.7%	0%

Department-provided information about the Emergency Medical Services Board members is presented below.

**Emergency Medical Services Board
Board Members by Gender and Ethnicity
As of March 2009**

Title	Gender				Ethnicity		
	Male	Female	Asian	Black	Hispanic	White	Other
Emergency Medical Services Board	11	2	0	3	0	10	0
Percentages	85%	15%	0%	23%	0%	77%	0%