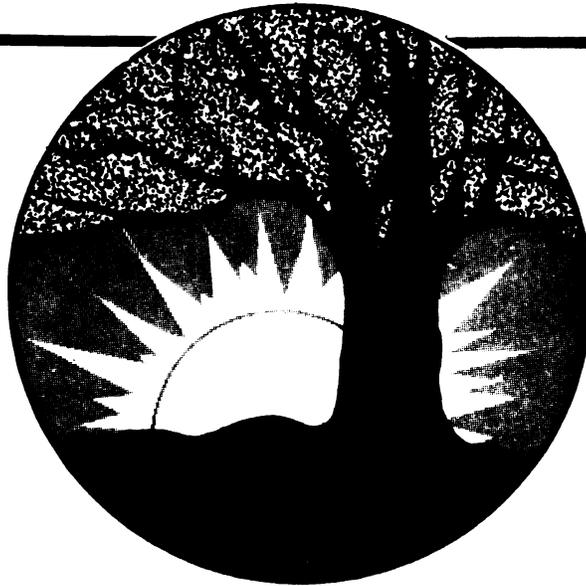


PERFORMANCE AUDIT

Department of Mental Health and Substance Abuse Services
and the Statewide Planning and Policy Council

January 2013



Justin P. Wilson
Comptroller of the Treasury



State of Tennessee
Comptroller of the Treasury
Department of Audit
Division of State Audit

Deborah V. Loveless, CPA, CGFM
Director

Dena Winningham, CGFM
Audit Manager

Nichole Curtiss, CGFM, CFE
In-Charge Auditor

Alan Hampton
Halmat Qazi
Ricky Ragan, CFE
Drew Sadler
Staff Auditors

Amy Brack
Editor

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-1402
(615) 401-7897

Performance audits are available on-line at www.comptroller.tn.gov/sa/AuditReportCategories.asp.
For more information about the Comptroller of the Treasury, please visit our website at
www.comptroller.tn.gov.



STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT

SUITE 1500
JAMES K. POLK STATE OFFICE BUILDING
NASHVILLE, TENNESSEE 37243-1402
PHONE (615) 401-7897
FAX (615) 532-2765

January 10, 2013

The Honorable Ron Ramsey
Speaker of the Senate
The Honorable Beth Harwell
Speaker of the House of Representatives
The Honorable Mike Bell, Chair
Senate Committee on Government Operations
The Honorable Judd Matheny, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Department of Mental Health and Substance Abuse Services and the Statewide Planning and Policy Council. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the Department of Mental Health and Substance Abuse Services and the Statewide Planning and Policy Council should be continued, restructured, or terminated.

Sincerely,

Deborah V. Loveless, CPA
Director

DVL/dww
12-069

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit

Department of Mental Health and Substance Abuse Services and the Statewide Planning and Policy Council

January 2013

AUDIT OBJECTIVES

The objectives of the audit were to determine the department's progress toward addressing prior audit findings related to licensure, including the complaint process, licensure database, and civil penalty assessment; assess the department's contract monitoring process; determine the Statewide Planning and Policy Council's compliance with state law; obtain information regarding the current pharmacy database implementation; obtain information regarding efforts to standardize processes at the Regional Mental Health Institutes (RMHIs); obtain information regarding the recent closure of Lakeshore RMHI; and gather and report Title VI information, staff demographic information, and performance measures data for inclusion in the audit report.

FINDINGS

Improvements Are Needed in Licensure Complaint Policies and Procedures and the Licensure Database to Improve Consistency, Timeliness, and Data Reliability

The 2006 performance audit of the department recommended setting time frames to monitor the timeliness of investigations and developing centralized computer tracking of all complaints. In the current database, there have been issues with open complaints and timeliness as well as documentation

inconsistencies and data reliability. Department management should review policies and procedures related to complaints to determine the best way to direct staff in what constitutes the official record to improve consistency, timeliness, and data reliability. Management should also review complaint data and determine an appropriate time period for complaints to be investigated and closed (page 8).

The Department Still Has Not Established the Statutorily Required Schedule for Civil Penalties, and Improvements Are Needed in the Process for Identifying Repeat Violators and Collecting Civil Penalties

The 2006 performance audit found that the department was not imposing civil penalties on facilities and had not established the statutorily required schedule of penalties. The department still has not established the schedule of penalties, but is issuing penalties. However, the violations and associated penalties are not documented in the licensure database. The lack of records in the database of violations and penalties impedes the identification of repeat violators. The Licensure Division should determine what is needed to fully document violations and resulting penalties in the database. The division should also promulgate a schedule for civil penalties as required by state law (page 11).

The Department Has Partially Met the Requirements of Subcontract Monitoring Specified in Policy 22, Yet Inconsistent Documentation Practices and Record Keeping Issues Prevented Auditors From Conclusively Verifying Compliance With Certain Measures

Finance and Administration's Policy 22 requires departments to annually review a minimum number and dollar amount of subrecipient contracts both fiscally and programmatically. During the audit, auditors discovered inconsistent documentation of contract numbers and program names, duplicate entries, and incorrect fiscal years and monitoring responsibilities. These issues ultimately undermined the integrity and reliability of the data reviewed. The department should adopt more uniform and consistent documentation procedures and consider any additional changes related to increasing data reliability to strengthen oversight (page 13).

OBSERVATIONS AND COMMENTS

The audit also discusses the following issues: the timeliness of licensure inspections; the Regional Mental Health Institutes' pharmacy database; standardized practices at the Regional Mental Health Institutes; and the closure of Lakeshore Regional Mental Health Institute (page 15).

Performance Audit
Department of Mental Health and Substance Abuse Services
and the Statewide Planning and Policy Council

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
Purpose and Authority for the Audit	1
Objectives of the Audit	1
Scope and Methodology of the Audit	2
History and Statutory Responsibilities	2
Organization	3
Statewide Planning and Policy Council	5
Revenues and Expenditures	7
FINDINGS AND RECOMMENDATIONS	8
1. Improvements are needed in licensure complaint policies and procedures and the licensure database to improve consistency, timeliness, and data reliability	8
2. The department still has not established the statutorily required schedule for civil penalties, and improvements are needed in the process for identifying repeat violators and collecting civil penalties	11
3. The department has partially met the requirements of subcontract monitoring specified in Policy 22, yet inconsistent documentation practices and record keeping issues prevented auditors from conclusively verifying compliance with certain measures	13

TABLE OF CONTENTS (CONT.)

	<u>Page</u>
OBSERVATIONS AND COMMENTS	15
A Majority of Licensure Inspections Occur, on Average, Between 12 and 14 Months After the Previous Inspection Date	16
Update on the Regional Mental Health Institutes' Pharmacy Database	17
Standardized Practices at the Regional Mental Health Institutes	18
Closure of Lakeshore Regional Mental Health Institute	19
RECOMMENDATIONS	21
Administrative	21
APPENDICES	22
Title VI and Other Information	22
Performance Measures Information	28
Statewide Planning and Policy Council Attendance	34

Performance Audit
Department of Mental Health and Substance Abuse Services
and the Statewide Planning and Policy Council

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Department of Mental Health and Substance Abuse Services and the Statewide Planning and Policy Council was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-234, the Department of Mental Health and Substance Abuse Services and the Statewide Planning and Policy Council are scheduled to terminate June 30, 2013. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agencies and to report to the Joint Government Operations Committee of the General Assembly. The audit is intended to aid the committee in determining whether the department and council should be continued, restructured, or terminated.

OBJECTIVES OF THE AUDIT

The objectives of the audit were to

1. determine the department's progress toward addressing prior audit findings related to licensure, including the complaint process, licensure database, and civil penalty assessment;
2. assess the department's contract monitoring process;
3. determine the Statewide Planning and Policy Council's compliance with state law;
4. obtain information regarding the current pharmacy database implementation;
5. obtain information regarding efforts to standardize processes at the Regional Mental Health Institutes (RMHIs);
6. obtain information regarding the recent closure of Lakeshore RMHI; and
7. gather and report Title VI information, staff demographic information, and performance measures data for inclusion in the audit report.

SCOPE AND METHODOLOGY OF THE AUDIT

The activities of the Department of Mental Health and Substance Abuse Services and the Statewide Planning and Policy Council were reviewed for the period January 2010 to December 2012. 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. Methods used included

1. review of applicable legislation and policies and procedures;
2. examination of the entity's records, reports, and information summaries;
3. interviews with department staff;
4. interviews with advocacy groups;
5. an interview with the U.S. Department of Health and Human Services Office of Inspector General; and
6. analysis of attendance and review of minutes for the Statewide Planning and Policy Council.

HISTORY AND STATUTORY RESPONSIBILITIES

The Department of Mental Health and Mental Retardation was created by Chapter 27 of the 1953 Public Acts, codified as Section 4-3-1601 et seq., *Tennessee Code Annotated*, to provide services to persons with mental illness and mental retardation. In June 2000, the General Assembly re-created the agency, changed its name to the Department of Mental Health and Developmental Disabilities, and passed a comprehensive revision of the mental health and developmental disability law, Title 33 of *Tennessee Code Annotated*. The revised law expanded the department's authority to coordinate, set standards, plan, monitor, and promote the development and provision of services and supports through the public and private sectors to meet the needs of persons with mental illness, serious emotional disturbance, or developmental disabilities. Also, by agreement with the Bureau of TennCare, the department oversaw and monitored the programmatic components of the TennCare Partners Program.

In July 2012, the department was reorganized and renamed the Tennessee Department of Mental Health and Substance Abuse Services. The department is now responsible for system planning; setting policy and quality standards; licensing personal support, mental health, and substance abuse services and facilities; system monitoring and evaluation; and disseminating public information and advocacy for persons with a diagnosis of mental illness, serious emotional disturbance, and substance use disorders. The department is also responsible for the state's four Regional Mental Health Institutes. (There were five RMHIs during the 2006 audit, but Lakeshore RMHI was closed during the course of this audit. Please see page 19 for further discussion of this issue.)

ORGANIZATION

The Department of Mental Health and Substance Abuse Services contains the Administrative Services Division; the Division of Substance Abuse Services; the Division of Clinical Leadership; the Division of Planning, Research, and Forensics; the Division of Mental Health Services; and the Division of General Counsel. (See organization chart on the following page.)

The Administrative Services Division directs the administrative responsibilities of the department. This division oversees purchasing, facility management operations, and major maintenance and capital outlay projects; provides budgeting and accounting functions, claims payments, data processing, and systems reporting; and develops and maintains automated systems applications for the central office and state-operated facilities.

Staff in the Commissioner's office provide and coordinate legal and medical advice, public information and education, licensing functions, and support services in the recruitment and retention of the workforce, as well as developing and implementing special programs and projects.

The Division of Substance Abuse Services is responsible for planning, developing, administering, and evaluating a statewide system of substance use, abuse, and addiction services for the general public, persons at risk for substance abuse, and persons abusing substances. The division partners with other government agencies, community organizations, and advocacy groups. Treatment and prevention services are provided by community-based agencies through individual contracts.

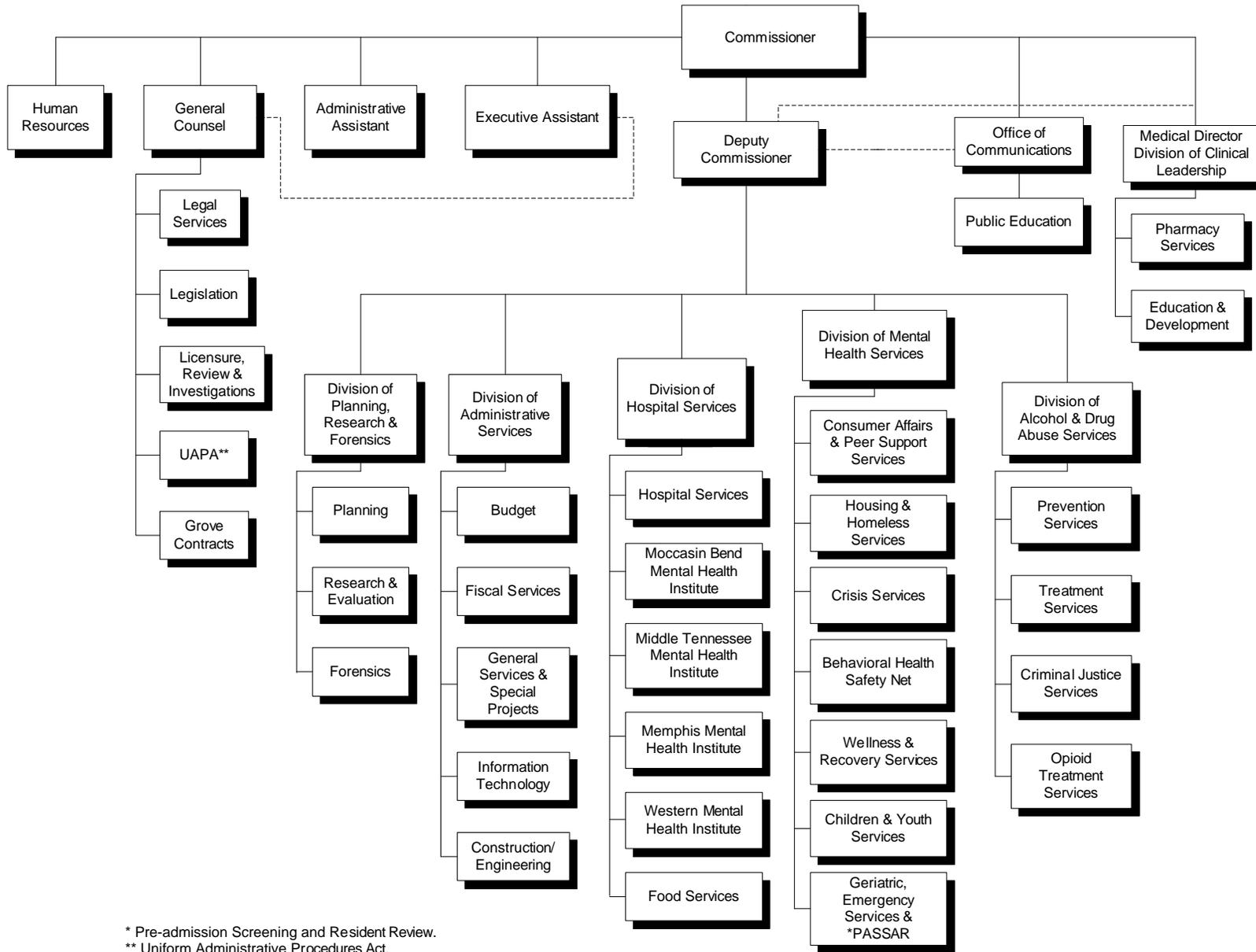
Also included in this division are the management and oversight of the Drug Courts. Executive Order 12 transferred the drug court programs from the Department of Finance and Administration to the Department of Mental Health and Substance Abuse Services effective July 1, 2012. The drug courts, established as an alternative to jails and prisons and designed to foster recovery, refer clients to substance abuse community agencies that provide intervention and treatment services, which are funded, contracted, and licensed by the department. As part of the transition, the drug courts will begin entering data into the Tennessee Web-based Information Technology System, the department database that all funded substance abuse treatment and prevention programs will use as of February 1, 2013.

The Division of Clinical Leadership is responsible for providing clinical oversight and policy development for the RMHIs and provides clinical consultation to various divisions of the department and other mental health agencies.

The Division of Planning, Research, and Forensics oversees and coordinates general mental health policy development and implementation throughout the department and for service areas. Some products of this division are the Three-Year Plan; the Finance and Administration Strategic Plan; the Mental Health Community Services Block Grant application; and the Implementation Report for the Mental Health Block Grant. This division has also conducted

Department of Mental Health and Substance Abuse Services

December 2012



* Pre-admission Screening and Resident Review.
 ** Uniform Administrative Procedures Act.

research to support decision making and evaluation of services; oversight of outpatient and inpatient forensic and juvenile court evaluations; and development and update of controlled substance rules.

The Division of Mental Health Services is responsible for developing, expanding, and monitoring a comprehensive continuum of services for citizens of Tennessee who are at risk of developing or have been diagnosed with serious emotional disturbance or serious and persistent mental illness. This division is also responsible for the Behavioral Health Safety Net of Tennessee, which is a program that provides mental health services for Tennesseans with serious and persistent mental illness who are uninsured. The division oversees crisis services, support, employment and education, transportation, and housing/homeless services, promoting recovery for persons diagnosed with mental illness and co-occurring disorders. It also investigates and resolves complaints for recipients; operates a helpline to aid individuals diagnosed with mental illness or substance abuse issues; and provides education on self-determination.

The Division of Hospital Services operates and oversees four Regional Mental Health Institutes that provide inpatient psychiatric services for adults: Moccasin Bend, Middle Tennessee, Western, and Memphis. (See page 6 for statistical information reported in The Budget, 2012-13.)

The Division of General Counsel provides representation, advice, and assistance to the Commissioner's office, departmental divisions, and RMHIs in legal and administrative proceedings, and oversees Health Insurance Portability and Accountability Act compliance and policy development. The Office of Licensure is responsible for protecting Tennesseans who need services for mental health, developmental disability¹, alcohol and drug abuse, and personal support. Through the application of departmental rules in licensure surveys and complaint investigations, this office inspects licensed facilities and conducts investigations of abuse and deficiency in facility operation or services.

STATEWIDE PLANNING AND POLICY COUNCIL

The Statewide Planning and Policy Council was established in Section 33-1-401, *Tennessee Code Annotated*. Part (b) of this section states that the council shall consist of not less than 11 members, excluding ex-officio members. The Governor is responsible for appointing the chair of the council. The Speaker of the Senate and the Speaker of the House of Representatives each appoint one legislator as a member. The commissioner serves ex officio as secretary of the council and appoints five members: two service recipients or members of families of service recipients, one representative for children, one mental health service provider, and one representing others affected by mental health issues. The commissioner must also appoint one representative of elderly service recipients and at least one at-large representative. The commissioner is allowed to make additional appointments of advocates to represent children and persons affected by substance abuse. The Governor is also an ex officio member and may

¹ Effective December 1, 2012, the department no longer licensed facilities providing only intellectual disability or developmental disability services. The Department of Intellectual and Developmental Disabilities will assume licensure responsibility for these facilities.

appoint representatives of state agencies as ex officio members. At least a majority of the council's membership must consist of current or former service recipients and members of service recipient families. The terms of the council members are three years, except for the chair and members appointed by the speakers who serve two-year terms. Members of this council receive no compensation other than travel expenses for attendance at meetings.

Section 33-1-402, *Tennessee Code Annotated*, stipulates the council's purpose is to advise the commissioner as to plans and policies to be followed in the service systems and the operation of departmental programs and facilities; recommend to the General Assembly legislation and appropriations for the programs and facilities; advocate for and publicize the recommendations; and publicize generally the situation and needs of persons with mental illness, or serious emotional disturbance, and their families.

The council, per Section 33-1-401(d), *Tennessee Code Annotated*, is required to meet quarterly, and the appointing authority may remove a member for failure to attend at least half of the scheduled meetings in any one-year period or for other good cause. There is no quorum requirement in statute; however, the council has adopted a policy stating that a majority of all members entitled to vote, including ex officio members, constitutes a quorum. Additionally, there is no conflict-of-interest requirement in law, but the council has adopted its own conflict-of-interest policy.

The council met 12 times between June 2009 and February 2012 and appears to fulfill membership requirements. (See Appendix 3.)

Table 1
Statistical Information from The Budget, Fiscal Year 2012-13
Regional Mental Health Institutes

	Lakeshore	Middle Tennessee	Western	Moccasin Bend	Memphis	Total
Annual Admissions						
2005-2006	3,215	4,210	2,475	3,330	1,581	14,811
2006-2007	2,138	3,528	2,026	2,512	1,816	12,020
2007-2008	2,404	3,256	1,761	2,389	1,912	11,722
2008-2009	2,539	3,275	1,232	1,964	1,983	10,993
2009-2010	2,217	3,102	1,341	1,866	1,901	10,427
2010-2011	2,400	3,150	1,350	1,875	1,901	10,676
2011-2012	2,400	3,150	1,350	1,882	1,901	10,683
2012-2013	0	3,150	1,450	2,764	1,800	9,164
Annual Releases						Total
2005-2006	3,202	4,422	2,445	3,220	1,583	14,872
2006-2007	2,118	3,529	2,046	2,500	1,809	12,002
2007-2008	2,386	3,264	1,778	2,374	1,904	11,706
2008-2009	2,586	3,338	1,300	1,990	1,993	11,207
2009-2010	2,239	3,110	1,353	1,885	1,903	10,490
2010-2011	2,400	3,150	1,350	1,898	1,903	10,701

	Lakeshore	Middle Tennessee	Western	Moccasin Bend	Memphis	Total
2011-2012	2,400	3,150	1,350	1,905	1,903	10,708
2012-2013	0	3,150	1,430	2,500	1,847	8,927
Average Daily Census						Total
2005-2006	153	249	237	124	82	845
2006-2007	143	248	230	124	63	808
2007-2008	153	232	199	134	62	780
2008-2009	141	204	156	123	65	689
2009-2010	98	172	121	102	60	553
2010-2011	98	163	119	101	56	537
2011-2012	95	165	125	107	56	548
2012-2013	0	185	130	110	56	481
Cost Per Occupancy Day*						Average
2005-2006	\$530.30	\$511.30	\$429.40	\$550.56	\$797.01**	\$525.44
2006-2007	\$570.53	\$556.39	\$472.96	\$576.98	\$968.26	\$570.52
2007-2008	\$556.80	\$615.42	\$567.57	\$571.30	\$1,082.83	\$621.26
2008-2009	\$646.26	\$681.19	\$741.50	\$649.81	\$1,120.73	\$723.46
2009-2010	\$727.09	\$688.93	\$728.93	\$636.77	\$937.47	\$721.44
2010-2011	\$692.13	\$724.79	\$719.33	\$640.10	\$911.63	\$721.18
2011-2012	\$928.79	\$703.05	\$760.69	\$653.85	\$1,112.52	\$787.57
2012-2013	\$0.00	\$680.91	\$705.59	\$632.17	\$1,059.80	\$720.55

* Last column indicates average cost per day for all institutions.

** Memphis MHI - 2005-2006 excludes \$12.5 million non-operating costs for capital outlay for a new facility.

REVENUES AND EXPENDITURES

Revenues by Source For the Fiscal Year Ending June 30, 2011

<i>Source</i>	<i>Amount</i>	<i>% of Total</i>
State	\$182,434,000	66.1%
Federal	49,168,400	17.8%
Other	44,341,300	16.1%
Total Revenue	\$275,943,700	100%

Expenditures by Account For the Fiscal Year Ending June 30, 2011

<i>Account</i>	<i>Amount</i>	<i>% of Total</i>
Administration	\$16,204,200	5.6%
Community Alcohol and Drug Abuse Services	42,938,600	18.6%

Account	Amount	% of Total
Community Mental Health Services	75,237,000	25.8%
Lakeshore RMHI	24,757,400	8.8%
Middle Tennessee RMHI	43,121,100	15.1%
Western RMHI	31,244,300	10.9%
Moccasin Bend RMHI	23,597,400	8.0%
Memphis RMHI	18,633,800	7.0%
Major Maintenance	209,900	.04%
Total Expenses	\$275,943,700	100%*

*Percentages may not total to 100 due to rounding.

**Budget and Anticipated Revenues
For the Fiscal Year Ending June 30, 2012**

<i>Source</i>	<i>Amount</i>	<i>% of Total</i>
State	\$194,472,100	62.1%
Federal	66,690,800	21.3%
Other	52,126,500	16.6%
Total Revenue	\$313,289,400	

FINDINGS AND RECOMMENDATIONS

1. Improvements are needed in licensure complaint policies and procedures and the licensure database to improve consistency, timeliness, and data reliability

Finding

To ensure data reliability, timeliness, and consistency with complaint documentation, improvements are needed in both policies and procedures and the database.

The 2006 performance audit found that the department lacked a centralized complaint intake system, thereby increasing the risk that complaints will not be reported. We recommended the development and implementation of a system for centralized complaint intake. We also recommended setting time frames to monitor the timeliness of investigations and the development and implementation of centralized computer tracking of all complaints to monitor timeliness, investigation outcomes, and to aid investigators in identifying repeat offenders.

The department maintains complaint hotlines in each of the three grand divisions and has implemented a centralized complaint database. Auditors were allowed access to the Department

of Mental Health and Substance Abuse Service’s Licensure Database to review complaints. Auditors reviewed all 515 complaints the department received for calendar year 2011. Of the 515 complaints reviewed, 74 came from Middle Tennessee, 79 from East Tennessee, and 362 from West Tennessee.

Open Complaints and Timeliness

According to the department’s database, as of September 13, 2012, we confirmed that 473 complaints were closed (60 Middle, 79 East, 334 West) but 42 (14 Middle, 0 East, 28 West) were still open. After notifying the department of the 42 open complaints on September 26, 2012, staff commented that “many of them were not marked closed in the system when the investigation was completed, most likely because of inadvertence, forgetfulness, or moving on to the next investigation.” After the department had an opportunity to investigate these open files, we reviewed them again. Of the 42 open files, 41 were later marked closed with one no longer having a record in the database. Three of the complaints had an altered assigned date; 15 were marked closed on October 10, 2012; and 16 had a close date of October 22, 2012. Five others were also marked closed in October 2012 as well. Five other cases were closed at times other than October 2012. Please see Table 2 for a detailed listing.

Table 2
Open Complaints Later Closed After Reporting to Department on 9/26/12

Close Date	Number of Complaints
9/22/2011	1
10/15/2011	1
12/21/2011	1
2/6/2012	1
9/13/2012	1
10/3/2012	1
10/10/2012	15
10/16/2012	2
10/17/2012	2
10/22/2012	16
Total	41

The department does have policies and procedures for investigating complaints, but they appear to be incomplete. Policy L 98-2 states that all complaints must be entered into the Centralized Complaint Database upon receipt. This database should be used to prioritize and monitor complaint investigations. Complaint investigations that do not require immediate attention are to be investigated within five business days. There is nothing in the policy related to the length of time in which a complaint should be investigated and closed so a complaint could remain open indefinitely. Also, with a number of cases remaining open in the system that

should have been closed, it appears more specific procedures are needed for monitoring the progress of complaints.

Inconsistencies and Data Reliability

There were many inconsistencies in how complaints are documented and entered into the database. The department does have edit checks for the system, but these checks only prevent individuals from entering a future date. The system does not prevent individuals from entering an incorrect date.

Auditors randomly sampled 105 complaints from across the state and found many differences in how they are handled. Some complaints had complete paper files that matched all information that was entered into the database. Some complaints had paper files that partially matched the information in the database. Some complaints had either handwritten notes in the file or other documentation that was scanned into the system. Others had no paper file at all other than a report that was generated from the database itself, which provided no method for auditors to validate data reliability. Because all of the data could not be verified, largely due to the closed date being unreliable, auditors could not perform calculations on the entire sample in regard to case duration. Of the 105 complaints that were randomly sampled, only 75 were able to be used.

Of these 75 complaints, some cases took only a few days to investigate and close while others took over a year. Based on the sampled files that appeared to be complete, auditors determined that it takes the Middle Tennessee regional office an average of 103 days; East Tennessee, 78 days; and West Tennessee, 78 days to close a complaint. The average time to close a complaint from the date it is assigned for all three regional offices was 83 days.

Without sufficient policies and procedures for investigation closure and consistent documentation, management cannot effectively supervise the quality of the investigation or the inspector. The lack of clear policies and procedures also contributes to confusion of which complaint record management deems the official record, database or paper file. The current database information does not allow for auditors or management to gain a full understanding of a complaint without also consulting documentation in a paper file. Additionally, while the database does contain edit checks, the reliability of closure dates is low, and data needed for supervision and decision making is inaccurate.

Recommendation

Management should review policies and procedures related to complaints to determine the best way to direct staff in what elements should constitute the official record and enter those into the database to improve consistency, timeliness, and data reliability. Management should also review complaint data and determine an appropriate time period for complaints to be investigated and closed. In addition, management should determine the proper database changes needed, such as edit checks and required fields, in order to improve data reliability and reduce the number of errors.

Management's Comment

We concur. Our new Complaint Compliance Module for the Office of Licensure's database is currently under development. It will go live by June 30, 2013. This module, along with policies, procedures, and training requiring consistent use of this system, will facilitate better tracking of surveys, violations, repeat violators, penalties, and managerial oversight. The Office of Licensure will conduct another review of their practices, policies, and procedures. Changes will be made to standardize practices across the three regional state offices by September 30, 2013. Emphasis will be placed on improving timeliness, record keeping, and data reliability. What constitutes the "official" record will be made clear as will minimum expectations regarding the contents of that record. Staff will be retrained on the use of the computer system by September 30, 2013, in order to reduce errors and improve timeliness of data entry.

2. The department still has not established the statutorily required schedule for civil penalties, and improvements are needed in the process for identifying repeat violators and collecting civil penalties

Finding

Auditors identified several areas in the civil penalty process requiring improvement, including identification of repeat violators and the collection of civil penalties. Also, the department still has not established the required schedule of civil penalties in its rules and regulations.

The 2006 performance audit found that the Licensure Division was not using its statutory authority to impose civil penalties on facilities for violations of rules. Also, the division had not established the required schedule of penalties, increasing the risk of noncompliance with rules, including repeat violations.

Pursuant to Section 33-2-407(b), *Tennessee Code Annotated*, "the department may impose a civil penalty on a licensee for a violation of this title or a department rule. Each day of a violation constitutes a separate violation." Per Section 33-2-410, these civil penalty collections should be deposited into the Service Recipient Protection Trust Fund. The division has implemented a written policy and procedure, effective July 2006, for imposing civil penalties but still has not established the required penalty schedule in its rules. Per 33-2-407(b), because the department has not established this schedule in rules, the maximum civil penalty that can be imposed is the lowest figure set in the appropriate subsection of Section 33-2-409 that applies to the violation, which is \$250 for a first violation and \$500 for a second or subsequent violation of the same kind within 12 months of the first penalty imposition. Therefore, not having a schedule in rules limits the department's enforcement ability to sanction violators, especially repeat violators.

We found that violations noted during annual inspections and complaint investigations are not in the licensure database. As a result, civil penalties are not in the database for our review. We obtained information from the Licensure Director regarding penalties imposed from January 2011 through June 2012 and determined that seven entities were assessed a combined \$6,500 in penalties. Of those, 39% have been collected as of June 2012. As a result of suspension of admissions to a facility due to licensure violations, the department used some funds (approximately \$2,004) to place service recipients in other housing. Overall, the Service Recipient Protection Trust Fund has a current balance of approximately \$9,200.

Another issue with the civil penalty process is there is no policy and procedure for notifying the Fiscal Division when penalties have been issued and should be noted as receivables. Per the Licensure Director, each region generates its own invoices for penalty amounts due. However, there is no mechanism to notify the Fiscal Division, and as a result, the only way fiscal staff know a penalty was issued is when they receive a payment included with the invoice.

Overall, the major issues of having no information in the licensure database on violations and civil penalties, which impedes the identification of repeat violators, and having no mechanism for alerting the Fiscal Division that penalties are due, hinder the department's ability to enforce the rules and laws associated with serving and protecting this vulnerable population.

Recommendation

The Licensure Division, in conjunction with Information Systems staff, should determine what is needed to fully document survey and complaint violations in the database as well as corresponding penalties to aid in identifying repeat violators. The Licensure Division should also develop and implement written policies and procedures for notifying the Fiscal Division when penalties have been issued so a receivable will be expected and/or recorded in the accounting system. Lastly, the division should promulgate a schedule for civil penalties as required by state law to enhance its ability to sanction repeat offenders.

Management's Comment

We concur. The Office of Licensure's ability to document surveys, complaints, violations, repeat offenders, and civil penalties can be improved upon by fully developing and utilizing the Licensure database. To that end, the Office of Licensure and Information Systems staff are developing the new Complaint Compliance Module, which will go live by June 30, 2013. Additionally, the Office of Licensure will review its policies and procedures, and make changes necessary to ensure information regarding violations and civil penalties are accurately reflected in the database and that the database is fully utilized by July 31, 2013. The Office of Licensure now ensures that the Fiscal Division is put on notice of any civil penalties and will require that this continues to be done. The Office of Licensure relies on the default schedule of penalties provided in Section 33-2-407, *Tennessee Code Annotated*. By November 30, 2013, the

Office of Licensure will, in consultation with the Governor's Office, decide whether rulemaking or legislative action should be taken to increase civil penalties.

3. The department has partially met the requirements of subcontract monitoring specified in Policy 22, yet inconsistent documentation practices and record keeping issues prevented auditors from conclusively verifying compliance with certain measures

Finding

In 2004, the Department of Finance and Administration (F&A) implemented Policy 22, which created a decentralized and uniform contract monitoring approach for state agencies to attempt to ensure subrecipient compliance with state and/or federal programs, applicable laws and regulations, and stipulated results and outcomes. Policy 22 requires all state agencies that fund subrecipients to submit annual monitoring plans for F&A approval by October 1. The September 2011 Comptroller's audit *Review of Tennessee's Contract Monitoring and Management Systems* raised concerns that the state relies completely on management at the individual state entities to comply with Policy 22 and does not have an effective oversight mechanism to ensure that state entities are, in fact, complying with Policy 22. When choosing the population of contracts to be monitored each year, agencies must

1. annually monitor a minimum of one-third of the total number of all subrecipient contracts executed by their agency; and
2. ensure that the current-year maximum liability value of the contracts selected is equal to or greater than two-thirds of the aggregate current-year maximum liability value of the agency's entire subrecipient grant population.

The policy requires agencies to assess all subrecipients and assign a risk level of high, medium, or low. While the scope of a review may vary based on the perceived risk to the state agency, it must include, at a minimum, the program-specific monitoring requirements as well as the applicable core monitoring areas outlined in the *Policy 22 Monitoring Manual*. Based on the department's annual monitoring plan, recurring low-risk grants would be monitored at minimum every three years, medium-risk grants would be monitored at minimum every two years, and high-risk grants would be monitored every year.

According to Policy 22, when choosing the population of contracts to be monitored, consideration should be given to contracts that

1. based on their state agency assigned risk assessment, pose a greater risk to the state (programmatically and/or financially);
2. have not recently been monitored; and
3. have prior review findings that indicate serious deficiencies.

Contract Sample Selection

Auditors examined the department's fiscal year 2012 sample of contracts selected for monitoring and attempted to verify evidence of programmatic reviews which satisfied Policy 22 requirements. The department selected a total of 308 contracts as part of the sample to be reviewed in fiscal year 2012. The sample represented 59.75% of the department's total contract population and had a value of \$79,587,496—which accounted for 67.6% of the total value for the entire subrecipient grant population. Based on discussion with management, inspection of program review documentation, and analysis of the contract management database, auditors concluded that the department partially satisfied the sampling threshold and fully met the core reporting requirements promulgated in Policy 22.

Division of Alcohol and Drug Abuse Services

All 97 Alcohol and Drug Division file folders were located on the department shared drive. According to Policy 22, departments are to notify subrecipients of any findings within 30 days of any visits or audits. Auditors found that reviewers would inform subrecipients of any findings the same day or the following day after completion of the monitoring visit. All contracts had the required risk assessment. Documentation for monitoring visits, subrecipient corrective action plans, and letters containing desk audits were documented on the department shared drive.

Division of Mental Health

Auditors verified that the Division of Mental Health reviewed 187 contracts, which met the requirement that one-third of the total contract population be reviewed. However, because the sample contained approximately 24 contracts that were outside the purview of the Division of Mental Health (e.g., the contract was not renewed, was from the wrong fiscal year, or was a federal contract) and subsequently not reviewable, the contracts that were reviewed (and that auditors could verify documentation for) just totaled \$76,772,966, which was \$1,719,163.33 short of the Policy 22 two-thirds dollar value requirement of \$78,492,129.33. Auditors were unable to determine whether the department notified subcontract grant recipients of program review outcomes within the required 30-day window—due to lack of documentation. Per management, not all documentation was uploaded to the shared drive. It is possible recipients received verbal notification, but there was no documentation to confirm. Auditors also confirmed that monitoring reports are being generated and disseminated to subcontract grant recipients and that the department is receiving corrective action plans, as required from noncompliant grant recipients.

Overall Results

In the process of ascertaining Policy 22 compliance, auditors discovered documentation problems such as inconsistent and incorrect usage of contract numbers on review documents and erroneous information contained in the master contract sample for fiscal year 2012—including incorrect program names, contract numbers, and program codes; duplicate entries, the wrong fiscal year, or a combination thereof; and cases where the responsibility for monitoring oversight

was not the responsibility of the Division of Mental Health. The immediate effect of these issues made it difficult for auditors to match and locate documents and ultimately undermined the integrity and reliability of the data being reviewed.

Recommendation

The department should adopt more uniform and consistent documentation procedures related to subcontract monitoring specified in Policy 22. By creating more standardized practices, the department may reduce errors and inconsistencies, produce more accurate samples, improve the ability to track documentation and monitor progress, and enhance effectiveness and efficiency of both internal and external reviews. The department should consider any additional changes related to increasing data reliability that would strengthen monitoring oversight and better ensure that grant recipients are complying with program-specific obligations.

Management's Comment

We concur. As part of the department's top to bottom review in the spring of 2011, the department was reorganized, resulting in the combining of two divisions (Division of Recovery Services and Division of Special Populations) to form what is now the Division of Mental Health Services. It was then recognized by management that there were inconsistencies in the documentation processes for subcontract monitoring specified by Policy 22. Division management initiated steps to standardize the documentation process for FY13 within the division and will continue to do so. However, since this time, the department has identified the entire Policy 22 Monitoring process to be addressed in a LEAN event across divisions and throughout the department. The LEAN event will standardize and streamline the process across the department resulting in more efficient and effective internal and external reviews. The event will also focus on the documentation process resulting in more clear and concise documentation of the reviews and corrective action plans. The department also recognizes the subcontract monitoring process to be time and labor intensive for our grant recipients. The LEAN event will also take this into account resulting in changes consistent with a more customer focused government. The LEAN event is scheduled for May 2013 with plans for implementation to occur in FY14.

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 Department of Mental Health and Substance Abuse Services and on the citizens of Tennessee.

A Majority of Licensure Inspections Occur, on Average, Between 12 and 14 Months After the Previous Inspection Date

Auditors determined that a large percentage of licensure inspections, on average, occurred between one and two years after the previous inspection.

Section 33-2-413, *Tennessee Code Annotated*, requires the department to “...make at least one (1) unannounced life safety and environmental inspection of each licensed service or facility yearly.” Department rule 0940-5-4-.01 states that for the purposes of life safety, facilities must meet appropriate standards of the Fire Protection Association Life Safety Code enforced by the State Fire Marshal’s office. Department rule 0940-5-5-.02 stipulates general environmental requirements for all facilities such as maintaining the cleanliness of the facility, safe stairs and steps equipped with hand rails, a heating system and a cooling system, operable windows, a telephone system, a first aid kit, a drinking water source approved by the Tennessee Department of Health, a system of sewage disposal, and natural or artificial lighting. There are additional requirements specific to each facility type that go beyond the general requirements.

Based on discussions with staff, inspection data is maintained in a department developed database. Auditors obtained access to the database and queried for all facilities active between January 1, 2012, and December 31, 2012. Using information in the database, auditors populated a spreadsheet detailing all inspection dates for license expiration dates for 2010 through 2013.

Prior to analyzing the full dataset, auditors needed to assess data reliability. Auditors randomly selected 125 entities and reviewed 32 files for both the East and West regions and 61 for Middle.

Based on files we were able to review, we determined that 92% of inspection dates matched information in the paper file. For the purposes of our review, we considered this reliable. See Table 3.

**Table 3
Comparison of Database to Paper Files
Inspection Date**

	East	Middle	West	Overall	
Accurate	74	106	49	229	92%
Inaccurate*	4	14	2	20	8%
Total Available for Review	78	120	51	249	100%

Other Notations

No File Provided	1	26	0	27	11%
Survey completed but not entered into database	7	9	15	31	13%
Not Applicable	42	85	62	189	76%
Total Without Review	50	120	77	247	100%

*Ranges from 2 days to 5 months difference in dates between paper file and electronic

We attempted to determine the average number of days between inspections for all 463 facilities. However, there were 161 (35%) facilities for which we could not calculate an average as they lacked multiple inspections over the period reviewed. Of the remaining 302 facilities, we found that only 37% (110 of 302) were inspected within one year. An additional 57% (173 of 302) were inspected between one year and 14 months. Overall, 94% (283 of 302) were inspected within 14 months. See Table 4.

Table 4
Average Inspection Time Frames

Days	East		Middle		West		Total	
0-180	1	1%	1	1%	3	4%	5	2%
181-360	18	19%	59	42%	28	42%	105	35%
361-421	71	76%	70	50%	32	48%	173	57%
422-462	2	2%	3	2%	1	1%	6	2%
463-523	1	1%	0	0%	2	3%	3	1%
524-584	0	0%	7	5%	0	0%	7	2%
585-708	1	1%	1	1%	1	1%	3	1%
Totals	94	100%	141	100%	67	100%	302	100%

While there should be time variances for keeping unannounced inspections as unpredictable as possible, the current law requires yearly inspections. The commissioner may wish to consider consulting with the General Assembly on modifying the current law to allow for a window that better allows for keeping inspections unpredictable, but still timely.

Update on the Regional Mental Health Institutes' Pharmacy Database

The Tennessee Department of Mental Health and Substance Abuse Services currently operates four Regional Mental Health Institutes (RMHIs)—recently reduced from five with the closing of Lakeshore Mental Health Institute on June 30, 2012. The RMHIs provide in-patient psychiatric services for adults, and the majority of RMHI admissions are made on an emergency, involuntary basis. The provision of psychiatric services is based upon the demonstrated and emerging best practices of each clinical discipline, and services are fully accredited, certified, and licensed.

In the fall of 2011, the department started transitioning to a new pharmacy database called Prime Care at all RHMI locations across the state. The new database replaces the previous one called “CRX” and has been implemented in Chattanooga, Nashville, and Memphis. Prime Care went “live” at the Bolivar location on November 16, 2012. The decision to change database systems was primarily driven by the loss of both technical support and information updates associated with the old platform. The new system will allow medication to be tracked throughout the dispensing process, and orders can now be flagged with greater detail, which will enhance auditing and billing reports. Additional advantages offered include a more dynamic

reporting tool, which will allow the pharmacy and central office staff to create customizable reports based on the needs of the department or pharmacy, as well as the capability to interface with hospital databases that host patient information.

The previous CRX system had limited capabilities for tracking inventory movement and reporting and was hampered by antiquated hardware that caused increased delays—especially when printing out required hospital forms. The Prime Care system uses vastly improved laser printers so documents will be faster and easier to read, and the risk of medication errors will be reduced. Drug names that look alike or sound alike will be printed in special lettering in accordance with recommendations by the FDA and the Institute for Safe Medication Practices. This special lettering will be used for patient medication labels, medication administration records, and physician order forms. While the new database is lauded as an improvement, it is more labor intensive than the previous system, and new information from the software vendor has created the need to retrain staff. The old CRX system has been in use since 1995, and issues related to the transition have created frustration within the pharmacy department.

Standardized Practices at the Regional Mental Health Institutes

As a result of the department's Top to Bottom Review, staff have begun attempting to standardize operations at all RMHIs related to documentation, treatment, and planning. The review noted that standardized practices will increase the efficiency and effectiveness of the institutes. The changes are also needed to aid in complying with changes to the mental health laws as well as to improve efficiency and consistency of operations.

The main change in law, Section 33-1-101, *Tennessee Code Annotated*, makes all admissions to the RMHIs subject to the availability of suitable accommodations, which means admission will be delayed if the facility does not have an appropriate bed. Therefore, transportation to an RMHI should not occur without written verification that an appropriate bed is available. One of the barriers to assuring bed availability was a lack of weekend discharges. If a patient was able to leave the facility on a Saturday, the patient would have to wait until Monday for discharge; thus, a bed that could have been available on Sunday is filled. The department identified barriers to weekend discharges and has now implemented changes, but this will be an ongoing process as situations change.

A second major initiative is the standardization of forms, such as admission forms; medical records, including electronic records; and policies, such as seclusion and restraint between the RMHIs. Getting all of the forms standardized and determining what information should constitute a medical file is important for transitioning patients among RMHIs if necessary. Implementing standardized policies ensures that all clients are treated in the same manner. Furthermore, consistency of documentation and policies should allow for better comparison of performance among the hospitals. In fact, the department has instituted standard of quality performance measures for the hospitals based on patient questionnaires.

A third major initiative was adopting a standard psychiatric medication formulary among the RMHIs and centralizing the process for changes and/or exceptions to the formulary. Per the

Medical Director, because approximately 90% of clients are uninsured, the department wants to ensure that these clients can access their medications in the community when they are discharged from the hospital and is taking steps such as looking at what medications are included in pharmacy assistance programs.

An ongoing initiative included in the department's Three Year Plan is the use of Telehealth services to aid in accessing behavioral health services and enhancing the efficiency of the crisis service delivery system. Telehealth is the use of electronic information and telecommunication technologies, such as audio-video communication or videoconferencing, to support clinical care between an individual with mental illness and/or substance abuse issues and a healthcare practitioner. The department concluded that the continued development of the Internet and recent cost reductions of technology have made Telehealth a viable option for delivering services to individuals in rural and underserved geographic regions. This technology is also being used to remotely assess emergency admission clients to determine eligibility for admission.

The department has also implemented the Severe Outcome Questionnaire (SOQ), another initiative listed as Goal 3 in the department's Three-Year Plan. This questionnaire encourages clients to think about the last week and answer a survey of 45 questions to help the department to understand how they have been feeling.

Lastly, the department has implemented a new Pharmacy database to aid in tracking inventory and reducing medication errors. (See page 17 for more discussion on this issue.)

Some initiatives that are currently in progress or planned for the future include

1. *Department Dashboard* – An online data book to make mental health data and substance abuse data more accessible.
2. *Department Centralization* – The consolidation of all mental health programs under the Division of Mental Health Services; moving research staff from across the department into a new Division of Planning, Research and Forensics; and moving all hospital-related services under a new Assistant Commissioner for Hospital Services.
3. *RMHI Treatment Mall* – A program based on principles of psychiatric and psychosocial rehabilitation that is in a separate and distinct space where patients and their staff spend most of the day. The goal is to provide group-oriented opportunities for patients to acquire the information and skills they need to function more successfully in the community.

Closure of Lakeshore Regional Mental Health Institute

The department closed Lakeshore Mental Health Institute on June 30, 2012. Regional Mental Health Institutes (RMHIs) provide in-patient psychiatric services for adults, mostly on an emergency involuntary basis. The RMHIs provide psychiatric services based upon the

demonstrated and emerging best practices of each clinical discipline and are fully accredited, certified, and licensed. Lakeshore was a Regional Mental Health Institute located in Knoxville that served individuals from 24 counties. There are four remaining RMHI's located across the state (Moccasin Bend in Chattanooga, Middle Tennessee in Nashville, Western in Bolivar, and Memphis).

The department reallocated Lakeshore's funding to community programs and three privately operated acute health care facilities: Peninsula Hospital in Louisville (Blount County), Ridgeview Psychiatric Hospital and Center in Oak Ridge, and Woodridge Psychiatric Hospital in Johnson City. The goal is to serve more people and to accommodate patients who would previously have been admitted to Lakeshore. Most individuals in the affected counties should be able to access inpatient psychiatric services in their community, and the three private hospitals can provide services to the uninsured. In addition, Moccasin Bend RMHI is the facility designated to serve the counties previously served by Lakeshore. To compensate for the closure, 25 beds were added to Moccasin Bend. If there is no room at Moccasin Bend, patients will go to Middle Tennessee RMHI in Nashville.

Department staff informed auditors that the closing of Lakeshore has resulted in an increase of community mental health resources and services for individuals residing in the regions that it primarily served and allowed the department to have a greater impact with its current funding. Services and programs include Intensive Long-Term Support, Crisis Stabilization Units and Staffing, Crisis Services Continuum, Respite Services, Behavioral Health Safety Net, Peer Support Centers, Assisted Outpatient Treatment, and Inpatient Targeted Transitional. Also, contracting with three private in-patient psychiatric units provides in-patient treatment to individuals that is closer to their communities and puts them in a less institutionalized setting. According to department staff, the closure of Lakeshore has allowed individuals to still receive the essential services and treatment they need.

RECOMMENDATIONS

ADMINISTRATIVE

The Department of Mental Health and Substance Abuse Services should address the following areas to improve the efficiency and effectiveness of its operations.

1. Management should review policies and procedures related to complaints to determine the best way to direct staff in what elements should constitute the official record and enter those into the database to improve consistency, timeliness, and data reliability. Management should also review complaint data and determine an appropriate time period for complaints to be investigated and closed. In addition, management should determine the proper database changes needed, such as edit checks and required fields, in order to improve data reliability and reduce the number of errors.
2. The Licensure Division, in conjunction with Information Systems staff, should determine what is needed to fully document survey and complaint violations in the database as well as corresponding penalties to aid in identifying repeat violators. The Licensure Division should also develop and implement written policies and procedures for notifying the Fiscal Division when penalties have been issued so a receivable will be expected and/or recorded in the accounting system. Lastly, the division should promulgate a schedule for civil penalties as required by state law to enhance its ability to sanction repeat offenders.
3. The department should adopt more uniform and consistent documentation procedures related to subcontract monitoring specified in Policy 22. By creating more standardized practices, the department may reduce errors and inconsistencies, produce more accurate samples, improve the ability to track documentation and monitor progress, and enhance effectiveness and efficiency of both internal and external reviews. The department should consider any additional changes related to increasing data reliability that would strengthen monitoring oversight and better ensure that grant recipients are complying with program-specific obligations.

**Appendix 1
Title VI and Other Information**

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

For fiscal year 2012, the department received \$35,364,804 in federal funds for Substance Abuse Services and \$18,303,092 for Community Mental Health Services.

The Human Rights Commission is responsible for reviewing plans submitted by agencies and determining areas that need improvement or that are noncompliant. The results of the commission's review covering fiscal years 2010 and 2011, submitted to the Governor and General Assembly on September 22, 2011, found that the department met all requirements. The department had three complaints filed and closed during the period.

**Department of Mental Health and Substance Abuse Services
Staff Ethnicity and Gender by Job Position
November 2012**

<i>Title</i>	<i>Gender</i>		<i>Ethnicity</i>					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Account Clerk	1	4	0	0	0	0	5	0
Accountant 3	10	2	1	2	0	0	9	0
Accounting Manager	2	2	0	0	0	0	4	0
Accounting Technician 1	3	14	0	3	0	0	13	1
Accounting Technician 2	0	2	0	0	0	0	2	0
Adjunctive Therapy Director	2	1	0	2	0	0	1	0
Administrative Assistant 1	0	5	0	2	0	0	3	0
Administrative Secretary	0	16	0	3	0	0	13	0
Administrative Services Assistant 2	3	14	0	2	0	0	15	0
Administrative Services Assistant 3	3	13	0	3	0	0	13	0
Administrative Services Assistant 4	1	11	0	2	0	0	10	0
Administrative Services Assistant 5	2	5	0	1	0	0	6	0
Administrative Services Assistant Superintendent	2	1	0	1	0	0	2	0
Administrative Services Manager	1	0	0	0	0	0	1	0
Application Architect	1	0	1	0	0	0	0	0

<i>Title</i>	<i>Gender</i>		<i>Ethnicity</i>					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Attorney 3	4	2	0	0	0	0	6	0
Boiler Operator 1	5	0	0	1	0	0	4	0
Boiler Operator Supervisor	1	0	0	0	0	0	1	0
Budget Analysis Director 1	1	0	0	0	0	0	1	0
Budget Analyst 2	0	1	0	0	0	0	1	0
Building Maintenance Worker 1	5	0	0	2	0	0	3	0
Building Maintenance Worker 2	10	0	0	6	0	0	4	0
Building Maintenance Worker 3	6	0	0	1	0	0	5	0
Clerk 2	2	18	0	15	0	0	5	0
Clerk 3	0	12	0	8	0	0	4	0
Commissioner 2	1	0	0	0	0	0	1	0
Computer Operations Manager 3	1	0	0	0	0	0	1	0
Computer Operations Supervisor	0	1	0	1	0	0	0	0
Cook 1	0	5	0	5	0	0	0	0
Cook 2	0	2	0	1	0	0	1	0
Counseling Associate 2	1	5	0	5	0	0	1	0
Custodial Worker 1	34	41	1	66	0	0	7	1
Custodial Worker 2	4	5	0	7	0	0	2	0
Custodial Worker Supervisor 1	3	3	0	4	0	0	2	0
Custodial Worker Supervisor 2	3	0	0	3	0	0	0	0
Deputy Commissioner 2	0	1	0	0	0	0	1	0
DHS Program Coordinator	1	0	0	1	0	0	0	0
DHS Program Manager	1	0	0	0	0	0	1	0
Dietitian	0	2	1	0	0	0	1	0
Dietitian Supervisor	0	1	0	1	0	0	0	0
Equipment Mechanic 2	2	0	0	0	0	0	2	0
Executive Administrative Assistant 1	0	1	0	0	0	0	1	0
Executive Administrative Assistant 2	2	1	0	0	0	0	3	0
Executive Administrative Assistant 3	3	1	0	0	0	0	4	0
Executive Housekeeper 1	0	1	0	1	0	0	0	0
Executive Housekeeper 2	1	0	0	1	0	0	0	0
Executive Secretary 1	0	1	0	0	0	0	1	0
Facilities Construction Specialist 3	1	0	0	0	0	0	1	0
Facilities Manager 3	2	0	0	0	0	0	2	0
Facilities Safety Officer 3	3	0	0	0	0	0	3	0
Facilities Supervisor	6	0	0	1	0	0	5	0
Fiscal Director 1	2	1	0	0	0	0	3	0
Fiscal Director 3	1	0	0	0	0	0	1	0

<i>Title</i>	<i>Gender</i>		<i>Ethnicity</i>					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Food Service Assistant Manager 2	0	1	0	1	0	0	0	0
Food Service Director 3	0	1	0	0	0	0	1	0
Food Service Manager 2	2	0	0	1	0	0	1	0
Food Service Supervisor 2	0	3	0	3	0	0	0	0
Food Service Supervisor 3	0	1	0	1	0	0	0	0
Food Service Worker	9	10	0	17	0	0	2	0
General Counsel 3	1	0	0	0	0	0	1	0
Grounds Worker 2	2	0	0	0	0	0	2	0
Health Information Manager	0	4	0	1	0	0	3	0
Heating & Refrigeration Mechanic 2	1	0	0	0	0	0	1	0
Heating & Refrigeration Mechanic 3	2	0	0	0	0	0	2	0
Human Resources Analyst 1	0	1	0	0	0	0	1	0
Human Resources Analyst 2	0	6	0	3	0	0	3	0
Human Resources Analyst 3	1	3	0	1	0	0	3	0
Human Resources Director 1	0	2	0	1	0	0	1	0
Human Resources Director 2	1	1	0	0	0	0	2	0
Human Resources Director 3	0	1	0	0	0	0	1	0
Human Resources Manager 1	0	2	0	0	0	0	2	0
Human Resources Manager 2	1	0	0	0	0	0	1	0
Human Resources Technician 1	2	2	0	1	0	0	2	1
Human Resources Technician 2	2	9	0	2	0	0	9	0
Human Resources Technician 3	1	3	0	3	0	0	1	0
Human Resources Transactions Supervisor	0	1	0	1	0	0	0	0
IDD Program Specialist 2	1	4	0	2	0	0	3	0
Information Resource Support Specialist 2	2	1	0	0	0	0	3	0
Information Resource Support Specialist 3	3	0	0	1	0	0	2	0
Information Resource Support Specialist 4	4	2	0	1	0	0	5	0
Information Resource Support Specialist 5	1	0	0	0	0	0	1	0
Information Systems Analyst 2	0	1	0	0	0	0	1	0
Information Systems Analyst 4	1	1	0	1	0	0	1	0
Information Systems Consultant	1	0	0	0	0	0	1	0
Information Systems Director 2	1	0	0	0	0	0	1	0
Information Systems Director 3	1	0	1	0	0	0	0	0
Information Systems Manager 1	3	1	0	0	0	0	4	0
Information Systems Manager 2	1	0	0	0	0	0	1	0

<i>Title</i>	<i>Gender</i>		<i>Ethnicity</i>					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Information Systems Manager 3	2	0	0	0	0	0	2	0
Institutional Services Manager	1	0	0	0	0	0	1	0
Laboratory Technician 1	0	2	0	1	0	0	1	0
Lead Psychiatric Technician	16	15	0	27	0	0	4	0
Legal Assistant	1	0	0	1	0	0	0	0
Licensed Practical Nurse 2	2	40	0	20	0	0	22	0
Licensed Practical Nurse 3	0	7	0	7	0	0	0	0
Mail Clerk	1	0	0	1	0	0	0	0
Mail Technician 1	1	0	0	0	0	0	1	0
Mail Technician 2	1	0	0	1	0	0	0	0
Maintenance Carpenter 2	1	0	0	0	0	0	1	0
Maintenance Electrician 1	1	0	0	0	0	0	1	0
Maintenance Electrician 2	1	0	0	0	0	0	1	0
Maintenance Mechanic 2	2	0	0	0	0	0	2	0
Maintenance Mechanic 3	1	0	0	0	0	0	1	0
Maintenance Painter 1	1	0	0	1	0	0	0	0
Maintenance Painter 2	1	0	0	0	0	0	1	0
Maintenance Plumber 1	1	0	0	0	0	0	1	0
Maintenance Plumber 2	1	0	0	0	0	0	1	0
Medical Records Assistant	0	3	0	1	0	0	2	0
Medical Records Technician 1	0	1	0	0	0	0	1	0
Medical Technologist 1	0	1	0	0	0	0	1	0
Medical Transcriber 1	0	6	0	1	0	0	5	0
Medical Transcriber 2	0	2	0	0	0	0	2	0
MH Executive Director	2	3	0	0	1	0	3	1
MH Hospital Services Director	1	0	0	0	0	0	1	0
MH Program Specialist 2	4	8	0	9	0	0	3	0
MH Program Specialist 3	8	9	1	4	0	0	12	0
MH Transportation Specialist	6	7	0	4	0	0	9	0
MH/IDD Institutional Program Coordinator	6	12	0	6	0	0	12	0
MH/IDD Institutional Program Director	1	9	0	5	0	0	5	0
MH/IDD Investigator	2	3	0	1	0	0	4	0
MH/IDD Licensure Director	0	1	0	0	0	0	1	0
MH/IDD Planner	0	4	0	1	0	0	3	0
MH/IDD Program Director	4	13	0	3	0	0	14	0
MH/IDD Standards Coordinator	1	3	0	0	0	1	3	0
Music Therapist 1	1	0	0	0	0	0	1	0

<i>Title</i>	<i>Gender</i>		<i>Ethnicity</i>					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Nurse Practitioner	3	13	0	4	0	0	12	0
Occupational Therapy Assistant (Certified)	0	2	0	2	0	0	0	0
Patient Accounts Specialist 1	3	7	0	4	0	0	6	0
Patient Accounts Specialist 2	0	8	0	2	0	0	5	1
Patient Accounts Specialist 3	1	3	0	2	0	0	2	0
Pharmacist 1	3	6	0	1	1	0	7	0
Pharmacist 2	4	0	0	0	0	0	4	0
Pharmacy Technician	0	9	0	1	0	0	8	0
Physician	1	1	0	0	0	0	1	1
Physician Assistant	0	1	0	0	0	0	1	0
Physician-Internal Medicine	2	2	0	1	0	0	3	0
Physician-Psychiatric Institute Clinical Director	3	0	1	0	0	0	2	0
Physician-Psychiatrist	19	10	5	5	0	0	13	6
Physician-Specialty	1	0	0	0	0	0	1	0
Planning Analyst 4	0	1	0	1	0	0	0	0
Procurement Officer 1	2	2	0	1	0	0	3	0
Procurement Officer 2	1	2	0	0	0	0	3	0
Programmer/Analyst 4	2	0	0	1	0	0	1	0
Programmer/Analyst Supervisor	0	1	0	0	0	0	1	0
Property Officer 1	1	0	0	1	0	0	0	0
Psychiatric Chaplain 2	1	0	0	1	0	0	0	0
Psychiatric Chaplain 3	1	0	0	1	0	0	0	0
Psychiatric Hospital Assistant Superintendent	3	4	0	3	0	0	4	0
Psychiatric Hospital Superintendent	2	2	0	0	0	0	4	0
Psychiatric Nurse	0	2	0	1	0	0	1	0
Psychiatric Social Worker 1	5	17	0	9	0	0	13	0
Psychiatric Social Worker 2	3	10	0	4	0	0	9	0
Psychiatric Teacher Counselor	0	4	0	2	0	0	2	0
Psychiatric Teacher Counselor Supervisor	0	1	0	0	0	0	1	0
Psychiatric Technician	316	287	2	477	3	1	110	10
Psychological Examiner 1	2	0	0	0	0	0	2	0
Psychological Examiner 2	1	0	0	1	0	0	0	0
Psychologist	5	3	0	0	0	0	8	0
Psychology Director	1	1	0	0	0	0	2	0
Public Health Administrator 1	0	1	0	1	0	0	0	0
Publications Editor 1	0	1	0	0	0	0	1	0

<i>Title</i>	<i>Gender</i>		<i>Ethnicity</i>					
	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Recreation Therapist 2	17	18	0	27	0	0	8	0
Recreation Therapist 3	1	1	0	1	0	0	1	0
Registered Nurse 1	2	6	0	2	0	0	4	2
Registered Nurse 2	31	143	14	48	2	0	98	12
Registered Nurse 3	12	62	5	32	0	0	37	0
Registered Nurse 4	3	15	0	7	0	0	11	0
Registered Nurse 5	0	4	0	1	0	0	3	0
Rehabilitation Therapist	2	0	0	2	0	0	0	0
Rehabilitation Therapist Supervisor	0	1	0	1	0	0	0	0
Secretary	1	14	0	5	0	0	10	0
Security Chief	3	1	0	2	0	0	2	0
Security Guard 1	27	7	0	20	0	0	13	1
Security Guard 2	8	2	0	5	0	0	4	1
Social Services Director	0	3	0	1	0	0	2	0
Social Services Specialist 2	0	9	0	5	0	0	4	0
Social Worker 2	1	3	0	1	0	0	3	0
Statistical Research Specialist	0	2	1	1	0	0	0	0
Storekeeper 2	4	2	0	1	0	0	5	0
Stores Clerk	1	0	0	0	0	0	1	0
Stores Manager	1	0	0	0	0	0	1	0
Telephone Operator 1	1	10	0	8	0	0	3	0
Telephone Operations Supervisor	0	1	0	1	0	0	0	0
Training Officer 2	1	0	0	0	0	0	1	0
Training Specialist 2	1	0	0	1	0	0	0	0
Vehicle Operator	5	0	0	4	0	0	1	0
Totals	760	1,110	34	988	7	2	801	38

Appendix 2 Performance Measures Information

As stated in the Tennessee Governmental Accountability Act of 2002, “accountability in program performance is vital to effective and efficient delivery of governmental services, and to maintain public confidence and trust in government.” In accordance with this act, all executive branch agencies are required to submit annually to the Department of Finance and Administration a strategic plan and program performance measures. The department publishes the resulting information in two volumes of *Agency Strategic Plans: Volume 1 - Five-Year Strategic Plans* and *Volume 2 - Program Performance Measures*. Agencies were required to begin submitting performance-based budget requests according to a schedule developed by the department, beginning with three agencies in fiscal year 2005, with all executive-branch agencies included no later than fiscal year 2012. The Department of Mental Health and Substance Abuse Services began submitting performance-based budget requests effective for fiscal year 2009.

Detailed below are the department’s performance standards and performance measures, as reported in the September 2012 *Volume 2 - Program Performance Measures*. Also reported below is a description of the agency’s processes for (1) identifying/developing the standards and measures; (2) collecting the data used in the measures; and (3) ensuring that the standards and measures reported are appropriate and that the data is accurate.

Performance Standards and Measures

Administrative Services

Performance Standard:

The costs of administrative services as a percentage of total department costs will not exceed 6.50%.

Performance Measure:

The costs of administrative services as a percentage of total department costs.

Actual (FY 2011-2012)	Estimate (FY 2012-2013)	Target (FY 2013-2014)
5.82%	6.5%	6.5%

This measure seeks to assess the efficiency and economy of administrative services. The smaller the percentage of administrative services expenditures to total department expenditures, the more departmental funding available for mental health and substance abuse services. The data for this measure is obtained from accounting reports on an annual basis, once actual expenditures are completed. This measure is calculated by dividing the actual expenditures for Administrative Services by the Total actual departmental expenditures. Both the budget director and planning section of the department review this measure. This measure appears appropriate and the data used originates from an audited data set and therefore should be accurate. The 2011 Strategic Plan listed an actual measure of 5.75% for 2010-11 and an estimated goal of 7% for 2011-12. The department met this goal.

Community Substance Abuse Services

Performance Standard 1:

Increase the percentage of individuals receiving treatment with a primary substance of abuse as opioids or benzodiazepines

Performance Measure 1:

Percent of individuals who at admission listed their primary substance of abuse as opioids or benzodiazepines

Actual (FY 2011-2012)	Estimate (FY 2012-2013)	Target (FY 2013-2014)
33%	34%	34%

This measure determines the primary substance of abuse for clients entering treatment through the Division of Substance Abuse Services (DSAS) funded programs. The data for this measure is collected from the Tennessee Web-based Information Technology System (TN WITS), in which contracted providers input the data during the intake process. This measure is calculated by using the number of clients at admission who indicate their primary substance of abuse is opioids/benzodiazepines divided by the total number of clients at admissions. The DSAS uploads admission data to the Substance Abuse and Mental Health Services Administration (SAMHSA) quarterly. SAMHSA verifies and compiles the data and submits reports to DSAS. The Substance Abuse Prevention and Treatment Block Grant Coordinator and department research team review the SAMHSA reports and provide feedback if needed. This measure appears appropriate. This is a new measure since the 2011 Strategic Plan.

Performance Standard 2:

Reduce the criminal justice involvement of persons treated in the state's substance abuse treatment system.

Performance Measure 2:

Percent reduction of persons arrested after receiving substance abuse treatment services as compared to persons arrested prior to receiving treatment services.

Actual (FY 2011-2012)	Estimate (FY 2012-2013)	Target (FY 2013-2014)
95%	94%	93%

The goal for this measure is to improve the arrest-free status of persons treated in the substance abuse services funded treatment system. According to the *Healthy People 2010* report, for drug abuse, approximately 56% of the estimated productivity losses were associated with crime, including incarcerated perpetrators (26%) of drug-related crime. The *Crime in Tennessee 2011 Report* states that 47,066 (32%) of the adults arrested for crimes against society were arrested for drug-related offenses. The data for this measure is collected from TN WITS, in which contracted providers input the data during the intake process. The performance measure is calculated by using the number of clients without arrests at admission versus discharge [numerator] and the total number of admission and discharge clients with non-missing values on arrests [denominator] to get the percentage of clients without arrests at admission versus

discharge. Finally, each discharge percentage at each treatment level of care is averaged to get the result. As for data reliability, the DSAS uploads admission and discharge data to SAMHSA quarterly. SAMHSA verifies and compiles the data and submits reports to the division. The Substance Abuse Prevention and Treatment Block Grant Coordinator and the department research team review the reports provided by SAMHSA and provide feedback as needed. This measure appears appropriate. This is a new measure since the 2011 Strategic Plan.

Community Mental Health Services

Performance Standard 1:

Increase the percentage of grantees meeting all program criteria on first review.

Performance Measure 1:

The percent of grantees achieving contract compliance on initial review.

Actual (FY 2011-2012)	Estimate (FY 2012-2013)	Target (FY 2013-2014)
90%	92%	92%

This measure seeks to assess whether the community mental health agencies are in contract compliance with fiscal operations related to the grants they receive through the department. Information for this measure is provided to the Fiscal Division, which sends a report listing the community mental health agencies that were reviewed for grant/contract monitoring purposes and whether they were in compliance with fiscal operations. The measure is calculated by dividing the number of community mental health agencies in compliance by the total number of community mental health agencies monitored during the year. This measure appears appropriate. In the 2011 Strategic Plan, the department reported an actual measure of 100% for 2010-11 and an estimate of 92% for 2011-12. The actual result did not meet the estimate from the prior year.

Performance Standard 2:

Reduce hospitalization length of stay for persons receiving services in the Community Supportive Housing programs.

Performance Measure 2:

Percent reduction of the average number of days hospitalized for mental health treatment after receiving services through the Community Supportive Housing programs as compared to the average number of days hospitalized before receiving these services.

Actual (FY 2011-2012)	Estimate (FY 2012-2013)	Target (FY 2013-2014)
86%	85%	86.5%

This measure is meant to determine whether people who receive Community Supportive Housing services are helped sufficiently by participating in the program to reduce the need for much more costly psychiatric hospitalization. Reduced hospital stays strongly imply increased quality of life and length of positive recovery from mental illness for the individual and cost saving in public funding. All contracted providers are asked to report this data annually as part

of their April quarterly report. They research client records at the agency and at psychiatric hospitals where the residents had been treated to determine the number of days in psychiatric hospitals for the year prior to entering supportive housing. They research their own agency records to determine the number of psychiatric hospital days in the last year. The Administrative Assistant in the central office verifies the reports are received and transfers the reported data to the database for this program, which automatically populates and computes the report on this indicator. The Director of Housing, Homeless, and Suicide Prevention Services will also review data after it is in the database. After all data has been reported for all 78 locations, the data is checked to assure numbers included in the calculations are accurate and complete. Only data on residents where both the pre- and post-data are known are included in the calculations. The statewide total number of psychiatric hospital days before entering supportive housing for all locations (Pre) is totaled as is the number of psychiatric hospital days in the last year for these same residents (Post). The calculation is (Pre minus Post) divided by Pre, which is expressed as a percentage. This measure appears appropriate. The 2011 Strategic Plan reported 84.6% for 2010-11 and an estimate of 81% for 2011-12. The department exceeded the estimate, and therefore the goal was met for residents where both pre and post data were known.

The department expressed concerns about this measure because contracted agencies, after two years of gathering and reporting this data, still struggle to find accurate data on hospitalizations for the majority of their residents for the year prior to entering supportive housing. Often this has occurred 10-20 years ago and records are no longer available. Therefore, although the reduction of hospitalization days is the strongest indicator of success of this program, a complete data set of pre- and post-data is currently not available for the majority of people served by this program. The department believes the data available is an accurate sample of the total population but currently cannot verify that. It will continue to work on improving the data and therefore the number of residents included in this calculation. It will also continue conversations with evaluators of similar programs and with providers on how to improve outcome evaluation of this program. While no changes are planned for the upcoming budget or strategic plan, future changes are being considered.

Regional Mental Health Institutes

Performance Standard 1:

Manage patient census capacity through effective clinical practices relative to admission and discharge decisions.

Performance Measure 1:

Percent of beds occupied.

RMHI	Actual (FY 2011-2012)	Estimate (FY 2012-2013)	Target (FY 2013-2014)
Middle Tennessee	85.55%	85%	85%
Western	73.94%	85%	85%
Moccasin Bend	82%	85%	85%
Memphis	82.63%	85%	85%

This measure is the percent of occupancy for each RMHI. The measure is set to ensure each facility will have room for the next patient to be admitted and yet operate with an economy of scale. Data for this measure is entered by RMHI staff into the AVATAR database. Division of Hospital Services staff access occupancy reports quarterly. The calculation is made by dividing the number of operating beds for each facility by the average daily census. The Division of Hospital Services staff reviews the data. This appears to be an appropriate measure. The 2011 Strategic Plan lists the following:

RMHI	Actual (FY 2010-2011)	Estimate. (FY 2011-2012)
Middle Tennessee	83.48%	90%
Western	79.20%	85%
Moccasin Bend	80.59%	85%
Memphis	75.17%	85%

Based on these figures, the department did not meet the prior year estimate. However, the closure of Lakeshore RMHI may have skewed the results.

Performance Standard 2:

Decrease the percentage of persons readmitted to an RMHI within seven days of discharge.

Performance Measure 2:

Percent of persons readmitted to an RMHI within seven days of discharge.

RMHI	Actual (FY 2011-2012)	Estimate (FY 2012-2013)	Target (FY 2013-2014)
Middle Tennessee	2.91%	2.35%	2.50%
Western*	1.61%	2.00%	2.00%
Moccasin Bend	2.43%	2.30%	2.00%
Memphis	2.85%	2.75%	2.50%

* Western's census has recently increased (with the transfer of sub-acute patients to Western from Lakeshore Mental Health Institute, Moccasin Bend, and Middle Tennessee) and their admission rate is likely to go up over the next year or so.

This measure, which focuses on patients readmitted within seven days, may indicate an inadequate discharge plan or premature discharge, thereby requiring readmission in a brief period of time. The data is entered by RMHI staff into the division database, AVATAR, and the Division of Hospital Services staff access the occupancy reports quarterly. The measure calculating the percentage of patients being discharged during a specific period of time being readmitted to the same RMHI within seven days of discharge does not address readmittance to other department or contracted facilities. The 2011 Strategic Plan lists the following:

RMHI	Actual (FY 2010-2011)	Estimate (FY 2011-2012)
Middle Tennessee	2.67%	2.90%
Western	2.11%	2.75%
Moccasin Bend	2.86%	2.10%
Memphis	4.61%	4.40%

Based on these figures, the department did not meet the prior-year estimate for Western and Memphis. However, the closure of Lakeshore RMHI may have skewed the results.

Major Maintenance

Performance Standard:

Cost of major maintenance will be no more than \$0.45 per square foot.

Performance Measure:

Major maintenance cost per square foot.

Actual (FY 2011-2012)	Estimate (FY 2012-2013)	Target (FY 2013-2014)
\$0.43	\$0.45	\$0.45

This measure, the maintenance cost per square foot, is calculated by using the actual expenditures for major maintenance from accounting reports and dividing it by the total of facility square feet, which originates from construction and engineering records for facilities. This measure may be inappropriate because avoidance of maintenance can lower the cost in one year but significantly raise it in future years. The 2011 Strategic Plan lists the 2010-11 cost at \$0.16 and an estimate for 2011-12 of \$0.33. The department did not meet the prior-year estimate but did meet the current-year goal.

Appendix 3
Statewide Planning and Policy Council Attendance
August 2011 through August 2012

Current Membership	Term	Meetings Absent	Meetings Present	Attendance Rate
Becky Morris	7/1/12 - 6/30/15	1	0	0%
Brian Buuck	7/1/12 - 6/30/15	1	0	0%
Candace Allen	7/1/12 - 6/30/15	1	0	0%
Carmencita Espada	7/1/11 - 6/30/14	5	0	0%
Danae Briggs	7/1/12 - 6/30/15	5	0	0%
Ed Rothstein	7/1/12 - 6/30/15	1	0	0%
Evelyn Yeargin	7/1/12 - 6/30/15	1	0	0%
John York	7/1/12 - 6/30/15	1	0	0%
Martha Padgett	7/1/12 - 6/30/15	5	0	0%
Richard Barber	7/1/12 - 6/30/15	1	0	0%
Sen. Doug Overby	7/1/11 - 6/30/13	5	0	0%
Suzette Webster	7/1/09 - 6/30/12	5	0	0%
Rep. Jeanne Richardson	8/27/10 - 6/30/12	4	1	20%
Brennan Francois	7/1/11 - 6/30/14	3	2	40%
Emma Long	7/1/12 - 6/30/15	3	2	40%
Linda Lewis	7/1/12 - 6/30/15	3	2	40%
Walter Williams	7/1/10 - 6/30/13	3	2	40%
Albert Richardson	7/1/10 - 6/30/13	2	3	60%
David Bowers	7/1/10 - 6/30/13	2	3	60%
Mary Moran	7/19/10 - 6/30/13	2	3	60%
Charlotte Bryson	7/1/12 - 7/1/15	1	3	75%
Jack Stewart	8/12/11 - 6/30/13	1	3	75%
Carol Westlake	7/1/10 - 6/30/13	1	4	80%
Debbie Hillin	7/1/12 - 6/30/15	1	4	80%
Robert Benning	7/1/11 - 6/30/14	1	4	80%
Vonda Gray	7/1/10 - 6/30/13	1	4	80%
Ben Harrington	7/1/10 - 6/30/13	0	5	100%
Ginger Naseri	7/1/12 - 6/30/15	0	1	100%
Jennifer Dedrick	7/1/12 - 6/30/15	0	1	100%
Joe Page	7/1/10 - 6/30/13	0	5	100%
Kim Parker	7/1/09 - 6/30/12	0	5	100%
Laura Berlind	7/1/12 - 6/30/15	0	1	100%
Luisa Hough	7/1/11 - 6/30/14	0	5	100%
Pastor Diane Young	7/1/12 - 6/30/15	0	1	100%
Paul Fuchar	7/1/11 - 6/30/13	0	5	100%
Tim Tatum	7/1/12 - 6/30/15	0	1	100%
Wendy Sullivan	7/1/12 - 6/30/15	0	1	100%

Current Membership	Term	Meetings Absent	Meetings Present	Attendance Rate
Linda Copas*	Ex Officio	4	0	0%
Bettie Teasley-Sulmers	Ex Officio	0	2	100%
Cheryl Campbell-Street	Ex Officio	0	2	100%
Commissioner Doug Varney	Ex Officio	0	5	100%
Debbie Miller	Ex Officio	0	3	100%
Linda O'Neal	Ex Officio	0	5	100%
Lynne O'Neal	Ex Officio	0	5	100%
Marthagem Whitlock	Ex Officio	0	5	100%
Michael Myszka	Ex Officio	0	5	100%
Renee Bouchillon	Ex Officio	0	4	100%
Wanda Willis	Ex Officio	0	5	100%

*Tennessee Department of Education Representative