

**DEPARTMENT OF HEALTH
HEALTH ADVISORY ENTITIES**

JULY 1997

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July 2, 1997

The Honorable John S. Wilder
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The Honorable Jimmy Naifeh
Speaker of the House of Representatives
The Honorable Kenneth N. (Pete) Springer, Chair
Senate Committee on Government Operations
The Honorable Mike Kernell, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Health Advisory Entities. 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 entities should be continued, abolished, or restructured.

Very truly yours,

W. R. Snodgrass
Comptroller of the Treasury

WRS/tp
96/053

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit
Department of Health
Health Advisory Entities
July 1997

AUDIT OBJECTIVES

The objectives of the audit were to review the eleven health advisory entities' legislative mandates and the extent to which the entities and the associated Department of Health programs have met those mandates and to make recommendations that might result in more efficient and effective operation of the entities and/or programs.

FINDINGS

The Primary Health Care Centers Advisory Board No Longer Has a Clearly Defined Mission

Several of the board's major responsibilities have been removed by the General Assembly in recent years, and several other responsibilities are performed, at least in part, by other entities. As a result, the role of, and continued need for, the board is unclear (page 5).

The Public Health Council's Role Has Diminished

Although the council is mandated to formulate the rules, regulations, and policies of the Department of Health, interviews with department staff and a review of meeting minutes indicate that the council makes few independent recommendations and has little involvement in the department's day-to-day activities. Factors limiting the council's usefulness to the department include the lack of special medical expertise on the council and the infrequency of council meetings (page 6).

Program Funds That Were Allocated to Meet Designated Public Needs Were Not Always Used

The General Assembly has specifically allocated the Renal Disease Program over \$1 million annually in recent years. However, despite a waiting list of up to 120 patients, the program has instituted an enrollment cap and cut back on types and amount of assistance, spending as little as 22 percent of dollars appropriated for the program. In addition, as of June 1996, the Traumatic

Brain Injury Fund had a balance of over \$1 million, even though some mandated services, such as case management, had not yet been provided (page 9).

Monitoring of Some Program Grantees Has Been Limited

The Department of Health contracts with both private and public agencies/facilities to provide services to clients of the various programs associated with the health advisory entities. However, department monitoring of some grantees, especially those of the hemophilia, epilepsy, genetics, and traumatic brain injury programs, has been limited or inconsistent (e.g., few or no on-site inspections, no receipt or review of quarterly or annual reports) (page 12).

Reporting Problems Lessen the Effectiveness of the Traumatic Brain Injury Registry

The intent of the 1993 legislation establishing the Traumatic Brain Injury Registry was to provide information about patients with brain injuries so that services could be appropriately planned, provided, and evaluated. However, the usefulness of the information in the registry has been limited thus far because of problems in the reporting of data. The reports routinely provided by hospitals do not contain the quality and type of information needed to make the registry an effective tool, and some hospitals have refused to submit the additional information requested by department staff. Although legislation was passed in 1996 in an attempt to increase reporting of this additional information, the actual impact of the legislation is not yet known (page 16).

Statutory Meeting and Reporting Requirements Have Not Been Met

Five of the entities did not meet as required in calendar year 1995; one other entity did not meet in either 1994 or 1995. In addition, two entities did not meet reporting requirements. Failure to meet and report as prescribed by law not only indicates noncompliance with statute, but also deprives department and state leadership of the entities' advice and professional expertise regarding program activities. The failure to meet could mean a loss of information the department would not acquire by other means. Additionally, the lack of meetings may also signify that the entity is no longer beneficial to the department. Reporting provides one way to determine if the entities' activities have been beneficial (page 18).

Entity Membership Requirements Are Not Currently Met

As of May 1996, several of the health advisory entities were not in compliance with membership requirements specified in statute. In some cases, positions designated for a particular expertise or organizational affiliation were vacant; in other cases, minorities or certain geographic regions appeared to be underrepresented. As a result, entities (and the department) may be deprived of needed technical advice or varying perspectives on issues, clients' needs, etc. (page 23).

Entities Do Not Have a Formal Conflict-of-Interest Policy

Although some entities have an inherent conflict of interest because of the statutory membership requirements, there is no formal policy or procedure to provide guidance when possible conflicts arise (page 27).

OBSERVATIONS AND COMMENTS

The audit also discusses the following issues that may affect the operations of the entities and the Department of Health, as well as the citizens of Tennessee: the effect of TennCare on the entities and their associated programs and the focus of the state epilepsy program on education and support rather than direct medical treatment (page 3).

ISSUES FOR LEGISLATIVE CONSIDERATION

The General Assembly may wish to consider whether there is a continued need for the Primary Health Care Centers Advisory Board. If the board is not continued, the General Assembly may wish to consider reassigning the board's duties. For example, publication of an annual directory of primary health care centers could be reassigned to the Office of Rural Health and Health Access, and monitoring activities could be reassigned to the Board of Nursing and the Board of Medical Examiners or its Committee on Physician Assistants (page 6).

If the Department of Health's evaluation of the Public Health Council indicates that there is no benefit to retaining the council, the General Assembly may wish to consider terminating the council. If the council is continued, the General Assembly may wish to consider (a) revising the council's composition to provide the types of specialized medical expertise the department needs, or (b) revising the statute to allow the Commissioner of Health to appoint the council members and expand the council (or appoint temporary and standing committees) as needed to add additional types of expertise as new health issues arise (page 7).

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

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PERFORMANCE AUDIT
DEPARTMENT OF HEALTH
HEALTH ADVISORY ENTITIES

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PERFORMANCE AUDIT
DEPARTMENT OF HEALTH
HEALTH ADVISORY ENTITIES

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Tennessee Department of Health's 11 health advisory entities was conducted pursuant to the Tennessee Governmental Entity Review Law, Title 4, Chapter 29 of *Tennessee Code Annotated*. Under Section 4-29-218, six of the entities are scheduled to terminate June 30, 1997; the Public Health Council is scheduled to terminate June 30, 1999, under Section 4-29-220. Four of the entities, although not specifically listed in the Governmental Entity Review Law, are being reviewed under the general authority of Section 4-29-119. The Comptroller of the Treasury is authorized under *Tennessee Code Annotated*, Section 4-29-111, to conduct a limited program review audit of the entities and to report to the Joint Government Operations Committee of the General Assembly. This audit is intended to aid the committee in determining whether the entities should be abolished, continued, or restructured. A performance audit of the Department of Health is also being conducted and will be issued separately.

The following entities were reviewed:

1. Advisory Committee for Children's Special Services
2. Interagency Council and Advisory Panel on Osteoporosis
3. Hemophilia Advisory Committee
4. Renal Disease Advisory Committee
5. Epilepsy Advisory Committee
6. Traumatic Brain Injury Advisory Council
7. Public Health Council
8. Genetics Advisory Committee
9. Perinatal Advisory Committee
10. Primary Health Care Centers Advisory Board
11. Cancer Reporting Advisory Committee

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to determine the authority and responsibility mandated to the entities by the General Assembly;
2. to determine the extent to which the entities and the associated departmental programs have met their legislative mandate; and
3. to recommend possible alternatives for legislative or administrative action that may improve the entities' and/or programs' effectiveness.

SCOPE AND METHODOLOGY

The entities' activities and procedures were reviewed, with the focus on activities during calendar years 1994 and 1995 and on procedures in effect at the time of field work, March to June 1996. The audit was conducted in accordance with generally accepted government auditing standards and included

1. a review of applicable legislation and department rules and regulations;
2. an examination of the department's records, reports, and internal reviews;
3. interviews with department staff, staff of state and federal agencies who interact with the health advisory entities, staff of outside advocacy groups, and chairpersons of the various entities;
4. a review of contracts and grantee files; and
5. a review of health advisory entity meeting minutes.

ORGANIZATION, STATUTORY DUTIES, AND ENTITY ACTIVITIES

The Appendix contains a description of each of the health advisory entities (e.g., general information about the entity, activities, membership, meeting frequency, statutory charge, and expenses) and a description of the affiliated program, where applicable. According to the Commissioner of Health, these health advisory entities are generally considered beneficial to the Department of Health. (See Findings 1 and 2 for possible exceptions.) The members of the health advisory entities do not receive compensation for their service but may receive reimbursement for travel expenses incurred to attend meetings. (The extent to which these entities complied with meeting, reporting, and membership mandates is discussed in Findings 6 and 7).

OBSERVATIONS AND COMMENTS

The issues discussed below did not warrant findings but are included in this report because of their effect or potential effect on the operations of the health advisory entities, their related programs, and the health, safety, and welfare of the people of Tennessee.

Effect of TennCare

TennCare has had a major impact on the Department of Health and many of its programs. Three programs associated with health advisory entities have been particularly affected—Children’s Special Services, the Perinatal Program, and the Traumatic Brain Injury Program.

Children’s Special Services. TennCare has changed the Department of Health’s role as a health provider. Approximately 5,000 children are currently enrolled in the Children’s Special Services program, and TennCare covers almost 88 percent of the children. Because the majority of participants no longer rely on the department for health care, program staff now focus on providing support services and ensuring that TennCare, through its managed care organizations, provides and pays for all the services the children need. Thus far, according to Children’s Special Services staff, it has been difficult to get some managed care organizations to provide all needed services.

As a result of the department’s shift away from providing direct health care, the need for the Advisory Committee for Children’s Special Services to recommend health care providers for the program has also decreased. In order for the committee to continue to be effective, it may need to refocus its advice and recommendations toward cooperation with the managed care organizations. Including one or more representatives from such organizations on the committee would be one way to foster communication and cooperation.

Perinatal Program. Regionalization of perinatal health care in the state was motivated by a need to ease access to care for as large a segment of the population as was feasible. Among the goals of regionalization was to ensure availability of all levels of care within a perinatal region through a coordinated system to transfer patients, as needed, to hospitals designated for specific types and levels of care. Department staff fear that TennCare may be detrimental to this established referral system, for example, that managed care organizations may attempt to save money by sending the patient to a secondary hospital.

Traumatic Brain Injury Program. According to department staff, although TennCare has not had a major effect on the Traumatic Brain Injury Program, it has had some negative effects on the state’s traumatic brain injury population. Traumatic brain injury victims require a continuum of care, especially rehabilitation, and TennCare provides limited coverage for rehabilitation. Staff

stated that TennCare meets the acute health care needs of Tennesseans suffering from traumatic brain injury but falls short of providing adequate rehabilitation services for some of its clients. Therefore, it is important that the Traumatic Brain Injury Program staff develop a case management system, as mandated by *Tennessee Code Annotated*, Section 68-55-202 (b)(1), and work with TennCare to ensure needed rehabilitation services are provided.

Epilepsy Program Not Meeting Statutory Charge

The state epilepsy program does not fund any form of direct medical treatment for people suffering from epilepsy, although *Tennessee Code Annotated*, Section 68-49-103(a)(3), states that one of the Department of Health's duties is to "extend financial assistance to persons suffering from epilepsy and other seizure disorders in obtaining the medical, nursing, pharmaceutical, and technical services necessary in caring for such diseases." The department's epilepsy program is carried out through contracts with four epilepsy foundations in Tennessee. These foundations do not use the state funds to finance any form of medical treatment, but instead use the money to conduct a variety of educational and support programs, including providing preventive intervention information to the general public, training seminars for health care workers, epilepsy alert programs, counseling and referral information, and liaison services.

Other duties of the department, as listed in *Tennessee Code Annotated*, Section 68-49-103, include developing standards for determining eligibility for care and treatment under the Epilepsy Program and assisting in the development and expansion of programs for the care and treatment of persons suffering from epilepsy and other seizure disorders. The statute also states that subject to such additional funds as may be made available by the General Assembly, the department will provide community epilepsy education and needed support services to the rural areas of Tennessee through contract with the Epilepsy Foundation of America. Currently, the Epilepsy Program is not assisting in the development and expansion of programs for care and treatment of epilepsy, nor extending financial assistance to persons suffering from epilepsy. The Epilepsy Program received an allotment of \$205,200 from the General Assembly in fiscal year 1996 and divided the money among the four epilepsy foundations.

By focusing on information and education programs rather than direct assistance, the department may not be meeting its statutory mandate. However, because funds for the program are limited and TennCare may have made it easier for epileptics to obtain insurance, education and support may now be the most cost-effective and most needed services the department can provide. The Department of Health should assess the needs of Tennesseans suffering from epilepsy, and shift resources, if necessary, to meet those needs.

FINDINGS AND RECOMMENDATIONS

THE PRIMARY HEALTH CARE CENTERS ADVISORY BOARD NO LONGER HAS A CLEARLY DEFINED MISSION

1. FINDING:

Several of the Primary Health Care Centers Advisory Board's major responsibilities have been removed by the General Assembly in recent years, and several other responsibilities are performed, at least in part, by other entities. (See the Appendix for a listing of the board's current duties.) As a result, the role of, and continued need for, the board is unclear.

The board's initial focus was on the primary health care needs of medically underserved areas and the use of nurse practitioners and physician assistants in those areas. However, several of the board's related responsibilities were removed in 1994 with the lifting of the site restriction requirement, which required nurse practitioners and physician assistants to limit their practice to priority areas of need (such as areas designated as medically underserved). The board still publishes an annual directory of primary health care centers in Tennessee, but all other access-related duties appear to be performed by the Office of Rural Health and Health Access in the department's Health Promotion and Disease Control Division. This program surveys the state to identify and designate those communities that are underserved for primary care, obstetrics, and pediatrics and then helps recruit physicians, nurse practitioners, nurse midwives, and physician assistants to those areas. Program staff also operate a clearinghouse for data about rural health care issues and publish the Annual Health Access Plan Update.

The board's most recent focus has been on monitoring the activities of nurse practitioners and physician assistants. However, since March 1996 (when the requirement for nurse practitioners and physician assistants to submit a protocol, or detailed explanation of their duties and responsibilities, was repealed), the board's oversight has been limited to reviewing the formulary applications of nurse practitioners and physician assistants. (Formularies describe and define the drugs they are permitted to prescribe, since nurse practitioners and physician assistants are not allowed to prescribe controlled substances.) The board also has the responsibility to monitor physicians' supervision of physician assistants and nurse practitioners. The board does no direct, on-site monitoring of this supervision; however, during 1996 the board issued a survey requesting information about supervision to all physicians employing nurse practitioners and/or physician assistants. If the survey responses indicated a lack of compliance with statutes or rules, a follow-up letter was sent to educate the physician about supervision requirements.

Although the board has the above-mentioned monitoring responsibilities, all other oversight functions for physicians, nurse practitioners, and physician assistants are handled by the Board of Medical Examiners, the Board of Nursing, the Committee on Physician Assistants, and the department's Division of Health Related Boards. Therefore, it is not clear that the Primary Health Care Centers Advisory Board is the appropriate entity to carry out this monitoring activity.

RECOMMENDATION:

The General Assembly may wish to consider whether there is a continued need for the Primary Health Care Centers Advisory Board. If the board is not continued, the General Assembly may wish to consider reassigning the board's duties. For example, publication of an annual directory of primary health care centers could be reassigned to the Office of Rural Health and Health Access, and monitoring activities could be reassigned to the Board of Nursing and the Board of Medical Examiners or its Committee on Physician Assistants.

If the Primary Health Care Centers Advisory Board is continued, board members and department staff should examine the board's mission and activities to ensure that the board provides a useful function and does not duplicate the activities of departmental boards or programs.

MANAGEMENT'S COMMENTS:

Joint Comment of the Department of Health and the Chairman of the Primary Health Care Centers Advisory Board:

We concur with the finding and with the recommendation that board members and departmental staff must develop a mission that clearly defines the role of the board.

THE PUBLIC HEALTH COUNCIL'S ROLE HAS DIMINISHED

2. FINDING:

Although mandated to formulate the rules, regulations, and policies of the Department of Health, the Public Health Council has played an ever diminishing role in advising and supporting the administration of the Department of Health.

Historically, the Public Health Council (created in 1935) has been seen as the voice of the health department, according to the council chairman. But department staff view the council's purpose as advisory and stated that the overall growth in the department and its increased responsibilities have led to less involvement by the Public Health Council in the day-to-day activities of the department.

Based on a review of meeting minutes and interviews with department staff, it appears that instead of formulating rules, regulations, and policies, the Public Health Council endorses the department's recommendations, basically "rubber stamping" whatever the Department of Health places before it. A similar concern was raised at the council's 1989 sunset hearing—that instead of making independent recommendations, the Public Health Council acted as a reactive rather than a proactive board. However, according to a council member, the health department does not ask or expect advice on the issues it presents to the council.

One factor limiting the council's usefulness to the department is the lack of special medical expertise on the council. (Statutory membership requirements, which have changed little since the council's creation in 1935, do not specify particular medical specialties for the physicians on the council.) For example, the commissioner mentioned a lack of persons on the council to specifically address HIV/AIDS and some children's health issues. At a November 1994 council meeting, department staff suggested the use of ad hoc committees as a more effective way to provide the needed expertise and specialization.

Another factor limiting the council's role is the infrequency of council meetings. The council is required by law to meet twice a year, which allows for only minimal involvement in department operations. In fact, the council did not meet at all in 1995.

Despite the council's infrequent meetings and lack of expertise in some areas, department staff stated that the council does serve a function in that members provide feedback from the professional groups and associations they represent and serve as disseminators of information to those groups. By serving as an intermediary with important professional organizations, members can provide the Department of Health vital information about the effectiveness of various programs and act as advocates for Department of Health policies.

RECOMMENDATION:

The department needs to formally evaluate the role of and need for the Public Health Council and communicate these findings and recommendations to the General Assembly. If there is no benefit to retaining the council, the General Assembly may wish to consider terminating the council. If the council is continued, the General Assembly may wish to consider revising the council's composition to provide the types of specialized medical expertise the department needs.

As an alternative, the General Assembly may wish to consider revising the statute to allow the Commissioner of Health to appoint the council members and expand the council (or appoint temporary and standing committees) as needed, which would give the department more flexibility in obtaining specific types of expertise as new health issues arise.

MANAGEMENT'S COMMENTS:

Joint Comment of the Department of Health and the Chairman of the Public Health Council:

In order for the Public Health Council to be adequately informed of the complex issues facing the department so that appropriate policies and strategies can be recommended, the following would be necessary: at least monthly meetings lasting six hours or longer, additional volunteer time to review materials related to topics of the next meeting, telephone conferences between meetings, and revision of council membership to reflect expertise needed today.

And while it is widely recognized that the role of the Public Health Council has changed since 1935, most also recognize that there is still an important role to be played: (1) providing input and perspective from health professionals outside the department, and (2) acting as liaisons and advocates for public health activities with professional groups.

The General Assembly could revise the statute to better reflect the expertise needed today. However, in a few years, there might be new issues and different needs. The statute could be revised to (1) allow the commissioner to name the members who have the expertise needed for the issues facing the department and (2) allow the commissioner and the council to appoint temporary and standing committees (including non-council members) to advise on issues requiring special expertise and to replace several of the existing advisory committees required by state statute or federal guidelines for various programs. This approach could decrease the number of advisory committees required, increase the involvement of the Public Health Council, and improve the awareness and recommendations of our advisory health professionals.

PROGRAM FUNDS THAT WERE ALLOCATED TO MEET DESIGNATED PUBLIC
NEEDS WERE NOT ALWAYS USED

3. FINDING:

Despite a need for the services the programs provide, direct allocations from the legislature for some entities have not been used.

Renal Disease Program

Although there is a waiting list for patients in the Renal Disease Program, the program is not spending all its allocated funds. *Tennessee Code Annotated*, Section 68-35-103, requires the department to extend financial assistance to persons suffering from chronic renal diseases so that they can obtain needed medical, nursing, pharmaceutical, and technical services. An enrollment cap of 1,475 was imposed as a result of an anticipated \$500,000 budget shortfall during fiscal year 1991. At the end of 1993, the program had 1,388 active patients; the dialysis center at the University Medical Group in Memphis, the largest clinic, had 194 active patients. In addition to the enrollment cap, the department also imposed monthly caps on the purchase of pharmaceuticals, discontinued payment of premiums for patients who require private co-insurance, and canceled contracts with local chapters of the Kidney Foundation for transportation services. Since the enrollment cap was initiated in February 1991, the Renal Disease Program has maintained a waiting list of up to 120 patients. As of June 1996, there were 83 patients on the waiting list.

The General Assembly has allotted the Renal Disease Program roughly \$1.2 million per year for the past five fiscal years. However, since the initiation of the enrollment cap, the program has spent far less money than appropriated, resulting in the following unencumbered budget balances:

- Fiscal Year 1993 \$989,925
- Fiscal Year 1994 \$1,001,111
- Fiscal Year 1995 \$861,290

According to department staff, end-stage renal disease patients on the program's waiting list must rely on dialysis centers to absorb the cost of the treatment until the center can bill the state (i.e., until an opening in the program becomes available through attrition or death of patients).

Traumatic Brain Injury Program

As of June 1996, there was a substantial balance of uncommitted money in the Traumatic Brain Injury Fund.

Instead of providing its participants direct medical treatment or rehabilitation, the Traumatic Brain Injury Program uses its resources to assist traumatic brain injury victims with services and to administer grants to programs that give traumatic brain injury victims direct assistance with rehabilitation and housing. The coordinator of the program, with the advisory council's assistance, is mandated by statute to develop a coordinated case management system; also included in the goals of the advisory council is developing a statewide case management plan.

The program is funded through fines on four types of traffic violations; revenues are deposited directly into the Traumatic Brain Injury Fund. (As of May 1993, the fines for reckless driving, driving with an invalid license, driving under the influence, and driving in excess of ten miles over the speed limit were increased; the revenue from those additional fines is deposited into the fund.) Because revenues exceeded expenditures in the early months of the program, as of June 30, 1996, the fund had a balance of \$1,081,000. Pursuant to *Tennessee Code Annotated*, Section 68-55-401, this balance does not revert to the general fund, but remains available for the program.

In a November 1995 memorandum, department staff stated that they anticipated funding some part of a case management system. As of June 1996, no case management had been provided, but the Traumatic Brain Injury Program funded two \$36,000 contracts for case management in fiscal year 1997, as well as several contracts for education-related activities and a \$108,000 contract with the Tennessee Rehabilitation Center. As of April 1997, the department has requested approval from the Department of Finance and Administration to access \$200,000 from the trust fund for fiscal year 1998; \$100,000 would be used to provide one-time grants for the development of home- and community-based programs to serve traumatic brain injury survivors and their families, and the other \$100,000 would be used as matching funds in a proposal to secure federal funds for one-year state demonstration grants.

RECOMMENDATION:

Renal Disease Program staff should reassess the needs of Tennessee's renal disease population to determine the level of services needed. The department should then use the funds the General Assembly allocates, as needed, to increase the enrollment cap to accommodate more patients and/or increase services to program participants.

The Traumatic Brain Injury Program should continue to work with the advisory council and the Department of Finance and Administration to develop a plan for spending trust funds to provide mandated services.

MANAGEMENT'S COMMENTS:

Department of Health:

Renal Disease Program. We concur. With the implementation of TennCare in January 1994, services and supplies which were previously covered by the Renal Disease Program are now covered by TennCare. As a result, the program has experienced a budget surplus over the past few years. Program staff are currently reassessing the needs of individuals with renal disease to identify services which are not covered by other third-party payers, such as Medicare and TennCare. It is anticipated that by July 1997 this assessment will be complete and program services will be modified to meet the needs of Renal Disease Program participants.

Traumatic Brain Injury Program. We concur. The program should continue to work with the advisory council and the Department of Finance and Administration to develop a plan for spending trust funds to provide mandated services.

Chairman of the Renal Disease Advisory Committee:

As chairman of the Renal Disease Advisory Committee, I am very concerned that the budget has decreased from \$1.2 million in 1991 to \$450,000 this year. This program has not expended the allocated funds in an attempt to save money; unfortunately, this has been done at the expense of the end-stage renal disease patients who need that money. Money was saved through an enrollment cap that resulted in as many as 120 patients being maintained on a waiting list. The number needing help may be even greater, because the dialysis facilities have stopped sending applications. Each year the program has demonstrated an excess of funds, leading to progressive losses in appropriations. All this has been done at the expense of patients who have an added economic stress. This was unnecessary because the money was available and the patients qualify for the program. These decisions were taken without consulting the committee. When the committee met in May 1997, our recommendation was to open the enrollment and increase the number of patients in the program to 1,500.

Chair of the Traumatic Brain Injury Advisory Council:

We concur in part. The council and staff spent many months investigating different programs on which to allocate the one-time funds left from unspent revenues in the early stages of the program. The case management services and personal care attendants are both intended as demonstration projects.

MONITORING OF SOME PROGRAM GRANTEEES HAS BEEN LIMITED

4. FINDING:

Grantees of several departmental programs associated with the health advisory entities have received limited or inconsistent monitoring, especially grantees of the hemophilia, epilepsy, genetics, and traumatic brain injury programs. Based on a review of grantee files, contract maintenance and monitoring of grantees appear sporadic, and those programs that do monitor their grantees appear to have only recently started the process.

Hemophilia

The hemophilia program contracts with five comprehensive medical clinics to provide services to patients with blood diseases. These clinics are Vanderbilt University Medical Center in Nashville, University of Tennessee Medical Center in Knoxville, University of Tennessee Medical Center in Memphis, Erlanger Medical Center in Chattanooga, and the East Tennessee State University College of Medicine in Johnson City. According to department staff, the total \$325,000 provided mainly covers salaries for nurses and social workers, who handle referrals and seek approval from the department for program services requiring authorization.

The contracts require the clinics to provide the department quarterly reports detailing the number of patients who visited the clinic, the number of patient visits, the number of patient infusions, the number of patients on home-based therapy, the number of known emergency visits, the number of physical examinations administered, and the number of consultations social workers administered. (However, the contracts contained no specific performance goals.) The contracts also include a provision enabling the department to conduct on-site visits at the clinics to ensure contract compliance. According to department staff, the contracts are monitored through a review of the clinics' quarterly reports and an audit of those reports during site visits. However, the department's grantee files contained no documentation of any on-site inspections of the clinics during the past six fiscal years and no evidence until 1995 that grantees had submitted quarterly reports.

The department's contracts with these clinics are awarded annually, but the renewal is almost guaranteed. Therefore, it is important that the department set performance goals and obtain and review performance data to ensure (1) that the clinics are providing the services described in the contract and (2) that program funds are allocated appropriately among the clinics, based on the number of patients served.

Epilepsy

The Epilepsy Program assists persons suffering from epilepsy and other seizure disorders by providing the four Epilepsy Foundations in the state financial support for educational and counseling activities. The foundations must achieve certain program goals; these involve objectives such as producing a given number of media kits and making a certain number of epilepsy alert presentations.

Monitoring of the foundations appeared to focus more on financial than program activities. Each foundation submits an annual report (including audited financial statements) and quarterly expenditure reports. In addition, the contract requires "brief periodic progress reports" to detail achievement of program goals. (These reports, according to staff, were to be submitted quarterly.) The program's grantee files contained quarterly progress reports for fiscal years 1994 and 1995, but not for fiscal year 1996. In addition, although some foundation directors stated that the department had made on-site visits in the past, there was no documentation of such visits in the files. Finally, there was no evidence that staff compared activities with goals to ensure contract terms were met.

Genetics

The Genetics Program provides funding to six regional genetics centers and four sickle-cell anemia centers for genetic screening tests and other services. Genetics Program personnel in the department evaluate these grants by conducting site visits. The site visit reports include recommendations for improvement and comments on the following areas: fiscal, personnel, clinical observation, chart evaluation, laboratory, and data collection. However, based on a review of the contract files for the regional genetics and sickle-cell centers, the department's monitoring has been limited and inconsistent.

There were no site visit reports for 1994; reports from 1995 were available for all the regional genetics screening centers and all the sickle-cell centers except Meharry College Hospital. The department has no prescribed time frame for site visits, but staff stated that they try to visit the centers every one to two years. In addition, the available site visit reports appeared inconsistent in their ratings of the centers. For example, several reports described a center's performance as "excellent," but concluded with a lengthy list of recommendations, some of which reflected noncompliance with federal laws and contract provisions. Other centers with basically the same list of recommended improvements received only "good" or "satisfactory" evaluations. Additionally, although each center also received an overall numerical score, the basis of the score was not clear, and centers with similar problems received widely varying scores.

Traumatic Brain Injury

The Traumatic Brain Injury Program is authorized to provide grants to nonprofit organizations and government agencies that focus on helping traumatic brain injury victims. The program approved two three-year grants (totaling \$120,000) in fiscal year 1995: one to the Crumley House Head Injury Rehabilitation Center, a day treatment rehabilitation center for persons with traumatic brain injury, and one to the Mid-South Head Injury Association to match housing and urban development funds for housing projects for people with physical and mental disabilities. The Traumatic Brain Injury Program also awarded a \$108,100 per year contract (for three years) to the Tennessee Department of Human Services for a vocational rehabilitation program for persons with traumatic brain injury and a one-year \$5,000 contract to the Bill Wilkerson Hearing and Speech Center. Two health department offices were issued grants (one for \$10,000, one for \$5,000) for educational programs on traumatic brain injury.

As of May 1996, the files contained no evidence of any site visits by department staff or any progress reports from the grantees. According to program staff, the grantees were scheduled to report on their activities at the June 1996 Traumatic Brain Injury Advisory Council meeting. Contracts do not specifically mention site visits by the department, and only require the grantee to submit "brief, periodic progress reports, as requested." However, the newness of the program and lack of precedence seem to require that program staff stay as informed as possible on the grantees' activities.

RECOMMENDATION:

Department staff should carefully monitor program grantees through periodic site visits and review of progress reports/performance data. Staff should establish specific performance goals for all grantees, include those goals in the contracts, and evaluate the grantees' compliance with contract terms before grantees receive funding for future years.

MANAGEMENT'S COMMENTS:

Department of Health:

Hemophilia Program. We concur. In 1996 the quarterly reports submitted by the hemophilia clinics were revised to more accurately reflect contract activities. These new reports allow staff to identify the patients served by each clinic and the type of service each patient received. The information from the quarterly reports will be verified during on-site visits scheduled during the fourth quarter of the fiscal year. Additionally, the data obtained from the quarterly reports and on-site visits will be used to set performance goals for each clinic and to develop a methodology for distributing contract funds based on the number of patients served.

Epilepsy Program. We partially concur. Because of staff shortages, no formal site visits were made. However, a surrogate visit was held at each annual meeting of the Epilepsy Advisory Committee whereby department staff received in-depth reviews of annual operations from directors of the four foundations. A comparative analysis of operations vs. expectations was included. In 1997 it is anticipated that department staff will conduct on-site visits at each of the four foundations.

Genetics Program (Joint Comment of the Department of Health and the Chair of the Genetics Advisory Committee). We concur. No reports were done in 1994 because of staff vacancies in the program. In 1995 all agencies contracted for genetic and sickle cell services were scheduled for site visits and all visits were made except for the Meharry Sickle Cell Center. The Director of the Meharry Sickle Cell Center requested cancellation of two of the scheduled visits in 1995 because of extensive construction/renovation and moving. Those requests were honored and a site visit was made in April 1996.

The department's Genetics staff does carefully monitor program grantees through periodic site visits and review of progress reports. Visits are made every 1-3 years based on staff information, including findings from a previous visit, and whether or not the entity is a state agency and subject to regular review by the State Comptroller. Staff are currently working with the contracted agencies, where appropriate, to review the "1991 Comprehensive Genetics Program Review" procedures that are used to monitor and evaluate all contracted agencies. The monitoring/evaluation tool will be compared to and reconciled with the current scope of services in their contracts. Needed revisions in performance standards including revised and/or new formulas for allocating funds to both the Genetic and Sickle Cell Centers are targeted to be in place by calendar year 1998.

Traumatic Brain Injury Program. We concur. It should be noted that program staff have made several visits to grantees and are in close contact via telephone. The three major grantees have attended most, if not all, quarterly advisory council meetings. The Department of Human Services grantee at the Tennessee Rehabilitation Center reports at every council meeting. Program staff are currently developing standard monitoring tools and will conduct site visits to every grantee yearly.

Chair of the Hemophilia Advisory Committee:

We concur in part that monitoring has been limited. Although the files may have contained no evidence prior to 1995 of grantees' submitting quarterly reports, I was personally involved in seeing that quarterly reports were submitted by the East Tennessee Comprehensive Hemophilia Treatment Center in Knoxville in 1993-94 when I was the center's coordinator and social worker. The nurse coordinator and myself submitted these reports in a timely manner. The finding goes on to state that the files contained no documentation of site visits of the clinics during the past six years. Prior to 1992, the State Hemophilia Program Coordinator made on-site visits to the comprehensive hemophilia treatment clinics. The clinics found his on-site visits to be extremely beneficial as he

offered technical assistance to the staff and communicated the department's interest in the program and overall service delivery. The coordinator took an advocacy role and took the time to establish a cooperative, working relationship with the clinics, which gained him the respect of the hemophilia community across the state. The clinics were very disappointed when the on-site visits were discontinued. To my knowledge, no site visits have been conducted since 1992, when the department staff's responsibilities were revised.

Chair of the Traumatic Brain Injury Advisory Council:

We concur in part. The staff and some council members have visited all grantee sites at least once in each year and, in most cases, much more frequently. In order to assure that goals are being met, the staff is in monthly and often weekly contact with grantees and update reports are given to the council at least every six months. However, the files may contain no evidence of site visits by department staff or progress reports from the grantees. We will begin to require written verification of site visits by staff and progress reports from grantees.

REPORTING PROBLEMS LESSEN THE EFFECTIVENESS OF THE
TRAUMATIC BRAIN INJURY REGISTRY

5. FINDING:

The intent of the 1993 legislation establishing the Traumatic Brain Injury Registry was to provide information about patients with brain injuries so that services could be appropriately planned, provided, and evaluated. However, the usefulness of the information in the registry has been limited thus far because of problems in the reporting of data. The reports routinely provided by hospitals do not contain the quality and type of information needed to make the registry an effective tool, and some hospitals have refused to submit the additional information requested by department staff. Although legislation was passed in 1996 in an attempt to increase reporting of this additional information, the actual impact of the legislation is not yet known.

By federal law, all hospitals are required to submit discharge forms (known as UB-92 forms) to the department. (Hospitals in Tennessee send approximately 700,000 UB-92 records to the department each year.) The department's Hospital Discharge and Data Retrieval section sorts and directs to Traumatic Brain Injury staff all records whose principal diagnostic code section (nature of the injury codes) indicates a brain injury. Individual names identified in this manner are automatically entered into the registry.

There are several problems with the information obtained from the UB-92 forms. Because the discharge forms for in-patients are the only ones used by the registry to determine traumatic brain injury survivors, it appears that even an overnight stay in the hospital (e.g., for a concussion) could qualify someone for the registry if the form indicates a brain injury. Additionally, registry staff stated that information obtained from the UB-92s is sometimes incomplete. For example, all hospitals are supposed to include information on external causes on their UB-92 forms; however, many reporting hospitals do not. This omission limits the usefulness of the registry as a diagnostic tool in traumatic brain injury assessment. One goal of the state registry is to centralize information, thereby facilitating research on the causes, effects, and treatment of head trauma injuries. However, the research and analysis will be limited if information on the cause of the injury is not available.

Information for the registry is also inherently dated, since the health care provider has 60 days to report the data after the end of the previous quarter. However, there appears to be an even further delay in the department's obtaining the data. Insurance companies used to send in the UB-92 information, but a change in state law now requires hospitals to send the data in themselves. According to Hospital Discharge and Data Retrieval staff, the transition from having insurance companies report UB-92 information to having hospitals report the data is causing a delay in the record collection process. As of June 1996, the Traumatic Brain Injury Registry consisted of 2,413 records, based on data from the UB-92 hospital discharge forms for the third and fourth quarters of 1994.

Because of the limitations in the UB-92 information, Traumatic Brain Injury Registry staff then send follow-up surveys to the hospitals requesting verification and additional information about the victims (e.g., cause of injury). However, some hospitals have refused to submit information to the Traumatic Brain Injury Registry because of concerns over patient confidentiality. Approximately 49 of the 76 hospitals (64%) identified as having treated a traumatic brain injury patient during the third quarter of 1994 had submitted the additional information to the registry. Department staff believe reporting will improve as a result of 1996 legislation that mandates the reporting of traumatic brain injury information and includes a civil penalty of up to \$100 for those agencies failing to report. A second or subsequent violation could result in a penalty of up to \$5,000. *Tennessee Code Annotated*, Section 68-55-204, states that the commissioner shall establish a reporting system which requires the treating hospital to report to the department within a reasonable period after identifying a person with traumatic brain injury. Consent of the injured person is not required. The law requires hospitals to submit name, age, and residence of the injured person as well as other information requested by the department "that is currently available and collected by computer in the medical records department of the treating hospital." Department staff are, however, concerned that hospitals may circumvent the statute (whether intentionally or not) by not having the information "currently available and collected by computer."

RECOMMENDATION:

Traumatic Brain Injury Program staff should continue to work with hospitals to encourage reporting of traumatic brain injury information. When necessary, program staff should use the penalties in the new legislation to ensure compliance with reporting requirements.

MANAGEMENT'S COMMENTS:

Department of Health:

We concur. Program staff should continue to work with hospitals to encourage reporting of traumatic brain injury information. When necessary, program staff should use the penalties in the new legislation to ensure compliance with reporting requirements.

Chair of the Traumatic Brain Injury Advisory Council:

We concur in part. Reporting problems have lessened the effectiveness of the Traumatic Brain Injury Registry. The Traumatic Brain Injury Program staff, council, and registry personnel have continued to work on rectifying these problems and great strides have been made since this audit. Numerous correspondences with hospitals and trauma centers have taken place and are continuing. We concur that non-compliance penalties should be used.

STATUTORY MEETING AND REPORTING REQUIREMENTS
HAVE NOT BEEN MET

6. FINDING:

Five of the ten entities did not meet as required in calendar year 1995. Additionally, one entity did not meet in calendar years 1994 or 1995. (This analysis excludes the Interagency Council and Advisory Panel on Osteoporosis which was created effective July 1, 1995.) Failure to meet and report as prescribed by law not only indicates non-compliance with statute, but also deprives department and state leadership of the entities' advice and professional expertise regarding program activities. The failure to meet could mean a loss of information the department would not acquire from other means. Additionally, the lack of meetings may also signify that the entity is no longer beneficial to the department. Reporting provides one way to determine if the entities' activities have been

beneficial. If the program has functioned effectively and the entities' assistance has not been necessary, perhaps there is no longer a need for that particular entity.

Meeting Requirements

Advisory Committee for Children's Special Services. The Advisory Committee for Children's Special Services did not meet in either 1994 or 1995. No meeting requirements are mandated by statute.

Cancer Reporting Advisory Committee. Although the Cancer Reporting Advisory Committee is charged with meeting quarterly, department staff stated that in recent years the committee has canceled every other meeting. As a result, the committee held two meetings per year in 1994 and 1995, instead of the required four.

Public Health Council. Although statute charges the council with biannual meetings, the Public Health Council did not meet in 1995.

Hemophilia Advisory Committee. Although statute specifies annual meetings for the Hemophilia Advisory Committee, the committee failed to meet in 1995.

Epilepsy Advisory Committee. The Epilepsy Advisory Committee is required to meet annually, yet the committee failed to meet in 1995.

Renal Disease Advisory Committee. Although mandated to meet annually, the committee did not meet in 1995.

Several entities complied with their mandated meeting requirements. The Traumatic Brain Injury Advisory Council, the Perinatal Advisory Committee, the Genetics Advisory Committee, and the Primary Health Care Centers Advisory Board complied with the meeting requirements in 1994 and 1995. Additionally, as of June 1996, the following health advisory entities had already met in 1996: the Traumatic Brain Injury Advisory Council, the Primary Health Care Centers Advisory Board, the Perinatal Advisory Committee, the Epilepsy Advisory Committee, the Genetics Advisory Committee, and the Cancer Reporting Advisory Committee.

Reporting Requirements

Some of the entities did not meet reporting requirements. First, the Primary Health Care Centers Advisory Board is required to report annually to the General Assembly and the Commissioner of Health the board's findings on the delivery of primary health care in Tennessee and to annually publish a directory of primary health care centers. Department staff stated that other than the directory of primary care centers, no reports were issued by the board in 1994 or 1995. The mandate to publish a directory and report on the

delivery of primary health care may be better placed with the Office of Rural Health and Health Access in the Division of Health Promotion and Disease Control (see Finding 1).

Second, following each meeting, the Public Health Council is required to submit a copy of suggestions and recommendations to the Commissioner of Health and the Governor. No suggestions or recommendations were reported in 1994, and the council did not meet in 1995.

In addition, as of December 1996, the Interagency Council on Osteoporosis had only met once and had not yet prepared a report for the General Assembly describing educational initiatives on osteoporosis and making recommendations for new educational initiatives on osteoporosis. (Statute does not specify a report due date.)

Entities in compliance with their reporting requirements included the Traumatic Brain Injury Advisory Council, which is required to report annually to the House Health and Human Resources Committee and the Senate General Welfare, Health and Human Resources Committee. The council submitted reports in 1994 and 1995. The Hemophilia Advisory Committee, the Epilepsy Advisory Committee, the Renal Disease Advisory Committee, the Genetics Advisory Committee, the Advisory Committee for Children's Special Services, and the Cancer Reporting Advisory Committee are not required to produce written reports.

RECOMMENDATION:

The health advisory entities should work with department staff to schedule meetings as required by statute. Every attempt should be made to comply with mandated meeting requirements.

The health advisory entities, with assistance from department staff, should fulfill the mandated reporting requirements in order to keep the General Assembly and the public as informed as possible.

The Commissioner of Health should work with department staff to assess each entity's usefulness to the particular program to which the entity is attached. If the duties provided in statute are no longer applicable, the continued need for the entity should be evaluated.

MANAGEMENT'S COMMENTS:

Department of Health:

Meeting Requirements

Advisory Committee for Children's Special Services. We concur. Although there were no formal committee meetings during 1994 and 1995, the committee chair served on a task force to address possible program restructuring to complement the implementation of managed care by TennCare. The "System of Care for Children with Special Health Care Needs Committee" was established to address this issue. The committee met in April and June 1995; in May 1995 committee members were sent correspondence advising them of the development of the special committee as requested by the Commissioner of Health. Subsequent reports were also sent to committee members.

A second task force met to develop a proposal for the restructuring of the Advisory Committee for Children's Special Services. This task force included a regional health department administrator, a nursing director, a Children's Special Services regional nurse, the Children's Special Services Program Director, and the section director.

The Advisory Committee for Children's Special Services continued to review and approve physician applications to the program during 1994 and 1995. This committee serves in an important consultant role for developing standards and for assuring the quality of services provided by the Children's Special Services Program. We recommend this committee be continued.

Cancer Reporting Advisory Committee (Joint Comment of the Department of Health and the Committee Chairman). We concur. During 1994 and 1995, staff were working on several large projects. It was the opinion of staff and committee that the cost of the quarterly meeting would exceed benefits since these large projects were not yet completed. Also, although meetings are not held, telephone communication (i.e., conference calls) between department staff and committee members is maintained on an "as needed" basis to review requests received for access to confidential data. In reality, these telephone discussions are sometimes needed on a monthly basis rather than quarterly.

In the future, the Cancer Reporting Advisory Committee will convene on-site meetings or conference calls during each calendar quarter. A conference call was scheduled for March 18, 1997, to address the meeting requirement for the first quarter of 1997.

Hemophilia Advisory Committee and Renal Disease Advisory Committee. Meetings of these committees were postponed until sufficient information was available to assess the impact of TennCare on each of the program's operations. Meetings of the committees will be scheduled by the end of fiscal year 1997 to discuss possible policy and rule changes necessitated by the implementation of TennCare.

Epilepsy Advisory Committee. The committee met in June 1994 to discuss additional funding allocations. The next meeting would have been in June 1995; but because of the retirement of the program director and the fact that he was not replaced until March 1996, no meeting was held. The committee met in April 1996 to put the group back on schedule and another meeting is planned for June 1997.

Reporting Requirements

Primary Health Care Centers Advisory Board. We partially concur. The board did not report to the General Assembly and the Commissioner of Health on the delivery of primary care in Tennessee in 1994 or 1995. Because of the issuance of the survey (on practice and supervision of nurse practitioners and physician assistants) in 1996 and the compilation of this data, the board is now in a position to report to the General Assembly and the Commissioner of Health.

Interagency Council on Osteoporosis. We concur. The council is planning to meet again during late fiscal year 1997. A needs assessment of current initiatives, research conducted in the state, and level of public and professional awareness of osteoporosis is necessary to make recommendations to the General Assembly. It is anticipated that this needs assessment will be completed by December 1997. After this assessment is completed, the council will prepare a report for the General Assembly. A due date for this report was not mandated by the legislation.

Chair of the Hemophilia Advisory Committee:

We concur. The committee did not meet in 1995. In July 1995, I began working as Program Coordinator for Hemophilia Health Services. I was hired to coordinate the non-profit educational component of the agency known as H.O.P.E.—Hemophilia Opportunities for Personal Empowerment. At that time, a concern was raised about a possible conflict of interest because of my role as a member and Chair of the Hemophilia Advisory Committee. Our meeting was placed on hold until the issue could be resolved. It was my hope that the committee could have been given approval to conduct a meeting, at which time the issue could and should have been addressed in the open. I am a social worker/counselor who also happens to be a person with hemophilia. I look forward to seeing this issue of a “conflict” addressed openly and honestly. It should not interfere with annual meetings being conducted, as required by the statute.

In July 1996, we were again told that the committee meetings had been placed on hold and that there was no information to report to the hemophilia community. The issue involving TennCare is reason enough to meet. For the hemophilia community, prompt care is crucial. TennCare has interfered with care being prompt, as well as care being accessible. The referral process required has inhibited some physicians from making the necessary referrals to the comprehensive hemophilia treatment centers, resulting in unnec-

cessary delays in care. The hemophilia community was told it had to transfer from the Tennessee Comprehensive Health Insurance Program (TCHIP) to TennCare. However, there is no comparison to the coverage and care received under TCHIP and the coverage and care under TennCare. The coverage and care was far superior under TCHIP.

Finally, some persons with hemophilia have been terminated from the State Hemophilia Program without the advice or involvement of the committee, and the committee was not involved in the development of new eligibility standards.

Chairman of the Renal Disease Advisory Committee:

The Department of Health decided that it was not necessary for us to meet because there was nothing to report. Therefore, we did not meet in 1995 or 1996. As a matter of fact, there was a lot to report because the program's budget was being cut because of underutilization. The committee did meet in May 1997 and recommended increasing the number of patients in the program to 1,500.

ENTITY MEMBERSHIP REQUIREMENTS ARE NOT CURRENTLY MET

7. FINDING:

Several of the health advisory entities do not meet the membership requirements specified in statute. As of May 1996, the following entities were not in compliance:

Membership Composition

Hemophilia Advisory Committee. The position for a representative from a blood bank had not been filled.

Primary Health Care Centers Advisory Board. A dentist position and a citizen position were vacant.

Public Health Council. The position to be filled from a list of names submitted by the Tennessee Congress of Parents and Teachers and the Tennessee Federation of Women's Clubs was vacant.

Advisory Committee for Children's Special Services. One position was vacant. Although the statute does not require that a particular profession be represented, the position has previously been designated for an orthodontist representing East Tennessee.

Vacancies in the health advisory entities' membership composition, especially for positions designated for a particular expertise, could be detrimental to the department, signifying a lack of available expertise. The department and the commissioner could be deprived of the technical advice and support they cited in interviews as one of the most valuable benefits of the health advisory entities.

Racial Composition

The statute creating the Public Health Council provides that the Governor when appointing the council should strive to ensure that at least one person serving on the council is a member of a racial minority. Additionally, Section 68-1-701, *Tennessee Code Annotated*, states that in making appointments of members to the Primary Health Care Centers Advisory Board, every effort should be made to include an equitable number of qualified black and other minority citizens. As of May 1996, there were no minorities on the Public Health Council and no minority members on the Primary Health Care Centers Advisory Board.

The Renal Disease Advisory Committee is mandated to have at least one person serving on the council who is a member of a racial minority; there are presently three minority members.

The following information lists the racial composition (as of May 1996) of the health advisory entities not mandated to have minority members:

	<u>Minority</u>	<u>Non-Minority</u>
Advisory Committee for Children's Special Services	0	6
Cancer Reporting Advisory Committee	1	11
Epilepsy Advisory Committee	3	8
Genetics Advisory Committee	5	7
Hemophilia Advisory Committee	0	6
Perinatal Advisory Committee	6	15
Traumatic Brain Injury Advisory Council	1	8

Information on age and geographic and racial composition for the Interagency Council and Advisory Panel on Osteoporosis was not available as of June 1996.

Minority representation on a health advisory entity helps ensure varied points of view on decisions affecting all citizens of the state. By not including minority members, the entity is deprived of advice from important segments of the state's population.

Age Requirements

Statutes creating the Public Health Council and the Renal Disease Advisory Committee state that the Governor shall strive to ensure that at least one person serving on the council is 60 years of age or older. Both entities currently meet the age requirements.

Geographic Representations

The Public Health Council requires that six members be physicians, two from each grand division of the state. These requirements are currently met. The Advisory Committee for Children's Special Services is mandated to have general geographic distribution, and "due consideration" is to be given to the geographic distribution of the members of the Primary Health Care Centers Advisory Board. The Advisory Committee for Children's Special Services appears to meet its geographic requirements; however, 13 of the 19 members of the Primary Health Care Centers Advisory Board are from the Middle Tennessee area.

The absence of representation of a certain geographic region could detract from the overall value of the entity, since the needs and requirements of different areas of the state vary widely.

RECOMMENDATION:

Program staff of the department should work with the Commissioner and the Governor's office to help ensure that all vacant positions are filled in a timely manner and that minorities and the state's geographic regions are represented as required.

MANAGEMENT'S COMMENTS:

Department of Health:

We concur with the recommendation. Nine of the entities are appointed by the Commissioner of Health; two are appointed by the Governor. As vacancies occur, board administrators are informed and/or letters are written to the various associations in order to obtain at least three nominees. This information is submitted to the Governor or the Commissioner of Health for consideration in making appointments. After receiving appointment letters from the Governor's office, the department is responsible for submitting memos to the board administrator along with copies to the administrative office and payroll. Notice of Appointment forms are also completed and sent to the Secretary of State's Open Appointments Office.

Membership Composition

Hemophilia Advisory Committee. We concur. On July 22, 1996, a new member was appointed to serve and his term will expire June 30, 2000.

Primary Health Care Centers Advisory Board. We concur. On June 30, 1996, a member was appointed to serve for the Tennessee Dental Association. His term will expire June 30, 1998. There are three citizen positions on this advisory board. On July 22, 1996, two were appointed to serve on the board. On October 17, 1996, another was appointed.

Public Health Council. We concur. Recommendations for the Tennessee Congress of Parents and Teachers and the Tennessee Federation of Women's Clubs representatives were submitted for appointment and later returned with a request for additional recommendations.

Advisory Committee for Children's Special Services. We concur. A letter was written to the Tennessee Dental Association requesting nominees for the orthodontist position on the committee; nominees were received. Because Section 68-12-106, *Tennessee Code Annotated*, does not stipulate any particular profession, another list of nominees was received from the advisory committee's administrator on September 9, 1996, and submitted to the Commissioner for approval. The Commissioner's approval was sent to the Governor's office on January 10, 1997, and the Governor's approval was received February 21, 1997. Appointment letters were sent out immediately.

Racial Composition

Public Health Council. We concur. Every effort is made to comply with the statute regarding racial composition. Letters requesting nominations always refer to that provision in the statute.

Primary Health Care Centers Advisory Board. We concur. As future vacancies occur, every effort will be made to comply with the racial composition statute.

Interagency Council and Advisory Panel on Osteoporosis. We concur. Information on age, geographic, and racial composition was not available as of June 1996.

Geographic Representation

Primary Health Care Centers Advisory Board. Currently, 13 board members are from Middle Tennessee, four are from East Tennessee, and one is from West Tennessee. As vacancies occur, we will comply with the geographic requirements.

Chair of the Hemophilia Advisory Committee:

We concur. However, the position for a representative from a blood bank has now been filled.

THE ENTITIES DO NOT HAVE A FORMAL CONFLICT-OF-INTEREST POLICY

8. FINDING:

None of the 11 health advisory entities have a conflict-of-interest policy or procedure in place. Although some entities have an inherent conflict of interest because of the statutory membership requirements, there is no formal policy or procedure to provide guidance when possible conflicts arise.

Examples of potential conflicts of interest are cited below.

- The Epilepsy Advisory Committee includes representatives from the four epilepsy foundations. The committee's responsibilities include offering guidance to the commissioner regarding how money allocated for the treatment of epilepsy is to be spent. However, because all the epilepsy program's money is dispensed to the epilepsy foundations through grants, the foundation representatives are affected by how funds are allocated. In fiscal year 1995, the General Assembly allotted an additional \$50,000 for the Epilepsy Program. The four epilepsy foundation representatives suggested that the money be divided by prorating the sum based on past allotments to the four groups, but department staff and the commissioner agreed that the money should be divided based on the populations they serve. This issue may arise again, since an additional \$50,000 has been appropriated for fiscal year 1997.
- At the October 1994 Traumatic Brain Injury Advisory Council meeting, the Vocational Rehabilitation Services Director of the Department of Human Services requested that money from the program's trust fund be used to implement a Traumatic Brain Injury program at the Tennessee Rehabilitation Center. Because the chair of the council was also the superintendent of the Tennessee Rehabilitation Center, he declared a conflict of interest and asked another member to assume the chair for that agenda item. The council endorsed the proposal at that meeting. However, the June 1995 meeting minutes noted that legal counsel had determined that the superintendent's serving as chair presented a conflict of interest since the Tennessee Rehabilitation Center had received the funding. A new chair was elected at that meeting.

- Some of the physicians who serve on the Advisory Committee for Children’s Special Services also serve as health care providers for the program. In 1991, committee members were asked to recommend how much money doctors providing health care services to Children’s Special Services should be paid.
- The Perinatal Advisory Committee faced a potential case of conflict of interest in 1994 when there was a vacant consumer representative position. The committee rejected the nomination of a prospective member because the nominee’s pending consultant contract with TennCare was viewed as a potential conflict of interest. Additionally, there is an inherent conflict in the committee’s membership, since the statute creating the advisory committee provides for the automatic appointment of the directors of the obstetrical and newborn units for each regional perinatal center within the state. As members of the committee, these directors will be asked to make recommendations that directly affect their centers.

There are also inherent conflicts of interest in the membership of some of the other health advisory entities. The statute creating the Genetics Advisory Committee calls for all screening center directors to serve as members of the committee. However, it creates the appearance of a conflict when these directors, as members of the advisory committee, exercise influence over the allocation of funds to the centers they operate.

Department staff and upper management have stated that conflicts of interest are not really an issue since the entities do not make the final funding decisions—this is ultimately handled by the Commissioner of Health. However, because members of the entities have varied and vested interests and almost every health advisory entity has a responsibility to advise the department on how program dollars are allocated, it appears reasonable that conflicts of interest may arise. By establishing a formal policy or procedure on how these particular situations may be handled, the entities acknowledge and address concerns of partiality before a problem arises and avoid the appearance of impropriety when decisions are made.

RECOMMENDATION:

The health advisory entities should work with the department’s Office of General Counsel to implement a formal conflict-of-interest policy or procedure to ensure potential conflicts are handled appropriately. The department may wish to confer with the Office of the Attorney General to ensure policies comply with the state’s conflict of interest statutes.

MANAGEMENT'S COMMENTS:

Department of Health:

We concur with the recommendation. The department will work with each advisory group to adopt a policy on conflicts of interest. Since the majority of conflicts involve funding, it will be recommended that in the event the group is considering a grant to an entity with which an advisory member has a financial or professional relationship and could be declared to benefit from the grant, the member would declare that interest and abstain from voting on the issuance of the grant.

Chairman of the Cancer Reporting Advisory Committee:

We concur with the finding. The staff of the Cancer Reporting System and the members of the Cancer Reporting Advisory Committee will work with the department's general counsel to implement a formal conflict-of-interest policy or procedures to ensure potential conflicts are handled appropriately. It should be noted, however, that even without a formal policy in place, it is standard practice that a committee member not participate in the decision of whether to approve or deny a request for access to confidential data if they or any of their associates (i.e., other researchers at their institution) are involved in the study.

Chair of the Genetics Advisory Committee:

We concur. This finding has been referred to the department's legal staff who will work with the Office of General Counsel to consider alternatives.

Chair of the Perinatal Advisory Committee:

We concur in part. This finding has been referred to the department's legal staff who will work with the Office of General Counsel to consider alternatives. The Perinatal Advisory Committee has never had a formal conflict-of-interest policy in place. The decisions regarding the amount of funds available for the five regional centers are from TennCare which handles the contracts with the centers. The membership of the advisory committee is mandated in statute. The duties of the Perinatal Advisory Committee require the expertise of persons trained in maternal-fetal medicine and neonatology. These experts direct and/or work at the regional perinatal centers. However, the membership does include other representatives from the medical community across the state. The members advise the department and the Commissioner on policies and issues related to perinatal health and the regionalization system. They make recommendations; they do not make final decisions.

Chair of the Traumatic Brain Injury Advisory Council:

We concur in part. The legislatively mandated membership of this council can produce some inherent conflicts of interest, and a formal conflict-of-interest policy or procedure should be implemented. The council and staff did request money to implement a program at the Tennessee Rehabilitation Center. (The council cannot make any final decision on funding; this decision comes from the Commissioner of Health and the Department of Finance and Administration.) During the vote to request appropriations to the Tennessee Rehabilitation Center, a conflict of interest did not actually occur because the chair excused himself from the vote and from the chair during the process. The council voted to fund this project to ensure implementation of a program that the brain-injured community had anticipated for a year prior to this date. We understood that, originally, funding was to come from the Department of Health. When department funding failed to materialize, the council evaluated the program and the legislation and found that the program met every criteria for funding mandated in the legislation. The council (with the chair not participating) voted unanimously to request funding so that this program would not be lost to the brain-injured population of Tennessee.

Chair of the Hemophilia Advisory Committee:

We concur. Because of the mandated requirements of the make-up of the committee, there are inherent conflicts of interest. These conflicts should be discussed openly and honestly, as mentioned in my response to Finding 6. A policy should be established, as soon as we get word that the committee is no longer “on hold” and are able to meet as required by statute. (Note: The Hemophilia Advisory Committee was scheduled to meet on June 18, 1997.)

RECOMMENDATIONS

LEGISLATIVE

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

1. The General Assembly may wish to consider whether there is a continued need for the Primary Health Care Centers Advisory Board. If the board is not continued, the General Assembly may wish to consider reassigning the board's duties. For example, publication of an annual directory of primary health care centers could be reassigned to the Office of Rural Health and Health Access, and monitoring activities could be reassigned to the Board of Nursing and the Board of Medical Examiners or its Committee on Physician Assistants.
2. If the department's evaluation (see 2. below) indicates that there is no benefit to retaining the Public Health Council, the General Assembly may wish to consider terminating the council. If the council is continued, the General Assembly may wish to consider (a) revising the council's composition to provide the types of specialized medical expertise the department needs, or (b) revising the statute to allow the Commissioner of Health to appoint the council members and expand the council (or appoint temporary and standing committees) as needed to add additional types of expertise as new health issues arise.

ADMINISTRATIVE

The health advisory entities and the Department of Health should address the following areas to improve the efficiency and effectiveness of their operations.

1. If the Primary Health Care Centers Advisory Board is continued, board members and department staff should examine the board's mission and activities to ensure that the board provides a useful function and does not duplicate the activities of departmental boards or programs.
2. The department needs to formally evaluate the role of and need for the Public Health Council and communicate these findings and recommendations to the General Assembly.
3. Renal Disease Program staff should reassess the needs of Tennessee's renal disease population to determine the level of services needed. The department should then use

the funds the General Assembly allocates, as needed, to increase the enrollment cap to accommodate more patients and/or increase services to program participants.

4. The Traumatic Brain Injury Program should continue to work with the advisory council and the Department of Finance and Administration to develop a plan for spending trust funds to provide mandated services.
5. Department staff should carefully monitor program grantees through periodic site visits and review of progress reports/performance data. Staff should establish specific performance goals for all grantees, include those goals in the contracts, and evaluate the grantees' compliance with contract terms before grantees receive funding for future years.
6. Traumatic Brain Injury Program staff should continue to work with hospitals to encourage reporting of traumatic brain injury information. When necessary, program staff should use the penalties in the new legislation to ensure compliance with reporting requirements.
7. The health advisory entities should work with department staff to schedule meetings as required by statute.
8. The health advisory entities, with assistance from department staff, should fulfill the mandated reporting requirements in order to keep the General Assembly and the public as informed as possible.
9. The Commissioner of Health should work with department staff to assess each entity's usefulness to the particular program to which the entity is attached. If the duties provided in statute are no longer applicable, the continued need for the entity should be evaluated.
10. Program staff of the department should work with the Commissioner and the Governor's office to help ensure that all vacant positions are filled in a timely manner and that minorities and the state's geographic regions are represented as required.
11. The health advisory entities should work with the department's Office of General Counsel to implement a formal conflict-of-interest policy or procedure to ensure potential conflicts are handled appropriately. The department may wish to confer with the Office of the Attorney General to ensure policies comply with the state's conflict of interest policy.

APPENDIX DESCRIPTION OF HEALTH ADVISORY ENTITIES

Advisory Committee for Children's Special Services

The Department of Health is mandated to organize and conduct local public diagnostic and operative clinics for physically handicapped and crippled children. Statute further empowers the department to carry on a state program of convalescent care and follow-up work, providing after-care as part of its general program of health work. The Advisory Committee for Children's Special Services, created by Section 68-12-106, *Tennessee Code Annotated*, advises the department on issues related to children with special health care needs (chronic disease), establishes criteria for determining which handicapped children are eligible for treatment from Children's Special Services, and approves all physicians who are appointed to serve as health care providers for Children's Special Services. Physicians must be approved before they are qualified to provide services and be reimbursed under Children's Special Services; approval is granted by the member of the committee with the same expertise as the applying physician. The Advisory Committee for Children's Special Services consists of seven members appointed to four-year terms by the Commissioner of Health.

The Advisory Committee for Children's Special Services met once in 1991 and once in 1993, but has not met since. Five committee members attended each of the last two meetings. Activities at these meetings included a discussion of TennCare (before the program was implemented), a recommendation for physician reimbursement, and an endorsement of the clinic concept for Children's Special Services.

Children's Special Services is funded in part by the Maternal and Child Health block grant in the Bureau of Health Services and consists of four components:

- Clinical care
- Coordinated Care program
- Parents Encouraging Parents program
- TEACH (Together Educating and Coordinating Health)

The Children's Special Services Program had a total budget of \$9,746,500 in fiscal year 1995, with expenditures of \$6,646,748. The program was budgeted \$10,296,981 in fiscal year 1994, and actual expenditures totaled \$8,065,282.

Children's Special Services divides the state into seven regions and has established a pediatric health clinic in the main office of each region, as well as clinics in Nashville and Memphis. The program currently serves approximately 5,000 children, providing evaluation, diagnosis, education, counseling, comprehensive medical care, and case management services for physically

handicapped children from birth to age 21. Roughly half the children who participate in the clinical component are served at the regional clinics; the others go to private providers whom the state reimburses. Children's Special Services manages its caseload through a network of care coordinators stationed in the regional and metropolitan service centers. There are metropolitan centers in Davidson, Hamilton, Knox, Shelby, and Sullivan Counties. The remaining 90 counties administer the program through community services agencies.

Interagency Council and Advisory Panel on Osteoporosis

The Interagency Council and Advisory Panel on Osteoporosis and an Osteoporosis Prevention and Treatment Education Program were created by *Tennessee Code Annotated*, Section 68-1-1503, effective July 1, 1995. As of June 1996, the council's five members had met (in May 1996); sixteen persons had been appointed to the panel; and the program was still being established.

The Interagency Council on Osteoporosis consists of representatives from the Commission on Aging, the Bureau of TennCare, the Department of Education, and the Department of Human Services. The Commissioner of Health serves as chair. No funds are allocated to the council, since it is viewed mainly as a way to educate people, by appointing council members who will increase awareness of osteoporosis among the medical community and other health professionals. The council is charged with coordinating the osteoporosis programs conducted by the Department of Health and establishing and coordinating an advisory panel of nongovernmental members to provide assistance with the osteoporosis prevention and treatment education program. Membership on the advisory panel is to include persons with osteoporosis, public health educators, osteoporosis experts, providers of osteoporosis health care, persons knowledgeable in health promotion and education, and representatives of women's health organizations and national osteoporosis organizations or their state/regional affiliates.

The State Osteoporosis Prevention and Treatment Education Program was created to improve awareness (among the general public and health care providers in the state) of the causes and nature of osteoporosis (a bone-thinning disease), the value of prevention and early detection, and the options for diagnosing and treating the disease. According to Department of Health staff, the Interagency Council has planned two initial projects: assembling a resource guide for the treatment of osteoporosis, and addressing issues of insurance coverage for the affected population. The council also plans to further develop the advisory panel, create a newsletter, develop a resource library, activate a toll-free consumer information hotline, create rural initiatives, and develop more patient-education tools.

Pursuant to *Tennessee Code Annotated*, Section 68-1-1503(b)(5)(B), the council is to

- coordinate osteoporosis programs conducted by or through the department;
- establish a mechanism for sharing information on osteoporosis among all officials and employees involved in carrying out osteoporosis-related programs;

- establish mechanisms to use the results of research concerning osteoporosis in the development of relevant policies and programs; and
- prepare a report that describes the state's educational initiatives on osteoporosis and makes recommendations for new educational initiatives, and transmit the report to the General Assembly and make the report available to the public.

Hemophilia Advisory Committee

The Hemophilia Advisory Committee, created by Section 68-41-103, *Tennessee Code Annotated*, is composed of seven persons: one representative each from hospitals, medical schools, blood banks, voluntary agencies interested in hemophilia, local public health agencies, medical specialists in hemophilia, and the general public. Each member serves a four-year term. Although the committee is required to meet annually, it did not meet in 1995 and met once in 1994. The committee has two primary areas of responsibility—advising the department on the most effective way to treat people suffering from hemophilia (an inherited disorder causing prolonged bleeding) or other genetic blood disorders and determining and establishing medical and financial guidelines for the admission of new patients. According to the 1994 meeting minutes, the committee added products to the Hemophilia Program formulary (i.e., the list of covered drugs), approved the purchase of TennCare premiums for certain patients, and heard clinic reports about patient participation.

The department, with the advice of the committee, is mandated to develop standards for determining eligibility for care and treatment under the program, assist in the development and expansion of programs for the care and treatment of persons suffering from hemophilia, and extend financial assistance to provide diagnosis of and treatment for persons suffering from hemophilia. The Hemophilia Program provides in-patient and out-patient care for program participants through five comprehensive clinics located across the state:

- East Tennessee State University College of Medicine in Johnson City
- University of Tennessee Medical Center in Knoxville
- Erlanger Medical Center in Chattanooga
- University of Tennessee Medical Center in Memphis
- Vanderbilt University Medical Center in Nashville

Other program services include allowances for blood products, emergency room visits, infusion supplies, drugs, orthopedic appliances, and preventive medical and dental treatment. There is no cap on enrollment in the Hemophilia Program; 558 patients were provided direct assistance in fiscal year 1995, and 455 patients were served in fiscal year 1994. Expenditures for the program totaled \$634,915 in fiscal year 1995 and \$588,594 in fiscal year 1994.

Renal Disease Advisory Committee

The Renal Disease Advisory Committee, appointed by the Commissioner of Health pursuant to Section 68-35-102, *Tennessee Code Annotated*, consists of eleven persons representing hospitals and medical schools that establish dialysis centers, voluntary agencies interested in kidney diseases, local public health agencies, physicians licensed to practice medicine in all its branches, and the general public. Each member's term is four years. The committee is mandated to meet annually, but did not meet in 1995 and met once in 1994.

The Renal Disease Advisory Committee is to counsel the Department of Health on the best way to finance and direct the treatment of people suffering from end-stage renal disease, those who need dialysis or a kidney transplant to survive. The committee has three primary areas of responsibility: establishing guidelines for participants in the Renal Disease Program (i.e., determining the appropriate medical and financial criteria for allowing a person to enter the program); advising the department on developments in the treatment and prevention of renal disease; and recommending patients for the program. According to the meeting minutes, the committee's activities included approval of an exclusive renal drug formulary and consent to continue utilization of the Crisis Intervention Fund and continue coverage of transplant patients.

The Renal Disease Program assists persons suffering from chronic renal diseases who require lifesaving care and treatment, but who are unable to pay for such services. With the advice of the committee, the department is required to develop standards for determining eligibility for care and treatment under the program, assist in the development and expansion of programs for the care and treatment of persons suffering from chronic renal diseases, assist in the development of prevention programs, extend financial assistance to persons suffering from chronic renal diseases so that they can obtain necessary services, assist in equipping dialysis centers, and institute an educational program. The Renal Disease Program had expenditures of \$388,510 in fiscal year 1995 and \$290,419 in fiscal year 1994.

Epilepsy Advisory Committee

The Epilepsy Advisory Committee, appointed by the Commissioner of Health pursuant to Section 68-49-102, *Tennessee Code Annotated*, is composed of 11 persons representing hospitals and medical schools, voluntary agencies interested in seizure disorders such as epilepsy, local public health agencies, physicians licensed to practice medicine in all its branches, and the general public. Each member's term is four years. The Epilepsy Advisory Committee is responsible for advising the department on the medical needs of people suffering from epilepsy in Tennessee and on the dispensation of monetary support to Tennessee's four epilepsy foundations, and advocating public health education on epilepsy. Required to meet annually, the committee met once in 1994, with six members in attendance, and did not meet in 1995. Activities of the Epilepsy Advisory Committee included listening to quarterly presentations of the epilepsy foundations, recommending how funds are dispensed among the foundations, and discussing actions to take in reducing epileptic-related deaths.

Pursuant to Section 68-49-103, *Tennessee Code Annotated*, the Department of Health has the following duties to care for persons suffering from epilepsy and other seizure disorders:

- Develop standards for determining eligibility for care and treatment under the program, with the advice of the epilepsy advisory committee.
- Assist in the development and expansion of programs for the care and treatment of persons suffering from epilepsy and other seizure disorders.
- Extend financial assistance to persons suffering from epilepsy and other seizure disorders so that they can obtain necessary services.
- Institute and carry on an educational program.

According to department staff, the Epilepsy Program assists persons suffering from epilepsy and other seizure disorders by providing the four epilepsy foundations in the state financial support for educational and counseling activities. These activities are designed to educate persons with epilepsy and their families, professional and paraprofessional groups, and the general public concerning the physical, psychosocial, and vocational needs of the patient with a seizure disorder. The Epilepsy Program had expenditures of \$255,393 in fiscal year 1995 and \$204,254 in fiscal year 1994.

Traumatic Brain Injury Advisory Council

The Traumatic Brain Injury Advisory Council is composed of nine members appointed by the Governor to serve two-year terms. According to *Tennessee Code Annotated*, Section 68-55-102, of the nine members,

- five members shall be family members, survivors or primary care givers;
- one member who is knowledgeable on traumatic brain injury shall represent the Department of Mental Health and Mental Retardation;
- one member who has experience in providing special education services or therapy to persons with traumatic brain injury shall represent the Department of Education;
- one member knowledgeable on traumatic brain injury shall represent the Department of Human Services; and
- one member shall be a health care professional who spends at least 50 percent of his or her time providing direct care to head-injured individuals.

The council is charged with advising the coordinator of the department's traumatic brain injury program on needed program policies and procedures, making recommendations, and performing other such duties as necessary for implementation of a statewide plan to assist traumatic brain injury persons and their families. Pursuant to *Tennessee Code Annotated*, Section 68-55-103(b), the council is also to provide assistance to the traumatic brain injury coordinator in the development of a state brain trauma registry and a state plan for a comprehensive system of services for persons with traumatic brain injuries, including short-term and long-term goals and objectives for implementing the plan and developing a statewide case management plan. The Traumatic Brain Injury Advisory Council met once in fiscal year 1994 and five times in fiscal year 1995. Council activities have included organizational duties, recommendations on funding grants and contracts, and reviews of Traumatic Brain Injury program staff activities.

Pursuant to *Tennessee Code Annotated*, Section 68-55-202, the Traumatic Brain Injury coordinator is charged with seeking and obtaining funding to implement state plans and services, compiling a directory of available programs, providing technical assistance and defining gaps in service delivery, evaluating data from the Traumatic Brain Injury Registry, promoting research on head injuries, and developing a case management system. The Traumatic Brain Injury Program, which was established in 1993, operates an information clearinghouse designed to distribute health care information to people suffering from traumatic brain injury. The program also operates a toll-free telephone line that traumatic brain injury victims and other interested persons can call to get information about available health care services. Additionally, the program provides grants to and contracts with programs that provide direct assistance with rehabilitation and housing to traumatic brain injury survivors.

Funding for the Traumatic Brain Injury Program is provided through a general fund reserve (the Traumatic Brain Injury fund) created by statute specifically for the program through increased fines on four traffic violations. Fiscal year 1995 collections totaled \$626,707, with expenditures of \$146,405. Fund revenues in fiscal year 1994 were \$381,018, while expenditures totaled \$36,043. (See Finding 3 about the balance of uncommitted funds.) Council expenditures were \$787 for fiscal year 1994 and \$6,505 for fiscal year 1995.

Public Health Council

The Public Health Council, created by Section 68-1-501, *Tennessee Code Annotated*, consists of 12 members appointed by the Governor:

- Six licensed practitioners of medicine
- One licensed practitioner of dentistry
- One licensed pharmacist
- One member of the Tennessee Congress of Parents and Teachers and the Tennessee Federation of Women's Clubs

- One licensed veterinarian
- One person learned in the prevention and treatment of mental retardation
- One hospital administrator

Each member serves a three-year term. The Public Health Council is charged with formulating the rules, regulations and policies of the Department of Health. The council is required to meet semiannually and to select annually a chairperson, vice-chairperson, and secretary from its own membership. The Commissioner of Health serves *ex officio* as a member of the council. The Public Health Council met twice in 1994, with an average attendance of eight. The council did not meet in 1995. Council expenditures totaled \$2,678 in 1994. Public Health Council meeting minutes indicated that the council listened to reports from various Department of Health staff members, approved rules for Children's Special Services, and approved departmental budget improvement requests.

Genetics Advisory Committee

The Genetics Advisory Committee, appointed by the Commissioner of Health pursuant to Section 68-5-503, *Tennessee Code Annotated*, is composed of 12 members: one representative from each of the six regional genetic centers and the three regional sickle-cell centers, two members at large, and the chief medical officer for the state. The chief medical officer serves as the chairperson. Each member's term is four years. The Genetics Advisory Committee advises the department on matters concerning the development and operation of a statewide genetics program. The Genetics Program provides access to genetic screening, diagnostic testing, and counseling services to individuals and families who have or who are at risk for genetic disorders. The committee is required to meet annually. The committee met the annual meeting requirement in 1994 and 1995, and averaged eight members at each meeting. Genetics Advisory Committee activities included listening to reports from the genetic screening and sickle-cell centers, approving a change in a departmental rule governing genetic centers' personnel requirements, and discussing funding allocations for the centers.

Pursuant to *Tennessee Code Annotated*, Section 68-5-504(b), the department is mandated to develop and administer statewide genetic and metabolic screening programs to prevent, detect, and ensure follow-up for birth defects and genetic disorders. A goal of the department is to provide all children with genetic screening within 24 hours of birth, since most genetic errors can be corrected and treated simply if discovered immediately after birth. Another major goal of the program is to decrease the incidence of and deaths associated with genetic disorders. The Laboratory Services division of the Department of Health conducted about 1.5 million tests last year, with the largest volume involving genetic screening to detect genetic newborn errors. Every newborn in the state (approximately 77,000 per year) is checked by the Laboratory Services division for phenylketonuria, hypothyroidism, galactosemia, and hemoglobinopathies (such as sickle-cell anemia). The Genetic Screening Program had expenditures of \$1,987,929 in fiscal year 1995 and \$2,001,116 in fiscal year 1994.

Center-based genetic programs are also funded by Maternal and Child Health. Six centers in the state provide newborn screening—Knoxville, Memphis, Chattanooga, Nashville (two centers), and Johnson City. Additionally, Maternal and Child Health contracts for sickle-cell anemia services with MeHarry College Hospital in Nashville, the Mid-South Sickle-Cell Center in Memphis, the T.C. Thompson Children’s Medical Center in Chattanooga, and the University of Tennessee Medical Center in Knoxville.

Perinatal Advisory Committee

The Perinatal Advisory Committee was created by Section 68-1-803, *Tennessee Code Annotated*, to advise the department on its perinatal programs, specifically the development of the following: regional newborn centers, a transportation and referral system, a communication and consultation system, education and training activities, and eligibility standards. The Perinatal Advisory Committee is appointed by the Commissioner of Health, and is composed of the director of each obstetrical and each newborn unit of each regional perinatal center within the state, in addition to at least one representative from each of the following categories: medical schools, health and environment agencies, hospital administrators, medical specialists in obstetrical and newborn conditions, family physicians, obstetrical and neonatal intensive care nurses, and the general public. Total membership of the committee is not to exceed 21. Each member serves a four-year term, and the committee is required to meet annually. The Perinatal Advisory Committee met six times during 1994 and 1995, and averaged an attendance of 12 board members. Expenses for the 1995 meetings totaled \$7,738; according to department staff, committee members met at their own expense during 1994—no travel was charged to the state.

The Perinatal Advisory Committee has produced four publications since 1990:

- *Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities* (March 1990)
- *Educational Objectives for Nurses* (March 1993)
- *Educational Objectives in Medicine for Perinatal Social Workers* (June 1994)
- *Guidelines for Transportation* (July 1995)

Department staff stated that these practice guidelines for all health care providers involved in the perinatal care system may eventually be adopted as TennCare standards. Perinatal Advisory Committee meeting minutes indicated that much committee time was devoted to a discussion of TennCare, and resolutions were passed concerning the impact of TennCare on adherence to the perinatal guidelines and on the distribution of the perinatal guidelines to the TennCare managed care organizations.

There are five perinatal care regions, each with a perinatal center: University of Tennessee Medical Center in Knoxville, Vanderbilt University Medical Center in Nashville, East Tennessee

State University College of Medicine in Johnson City, Erlanger Hospital in Chattanooga, and the Regional Medical Center in Memphis. The Perinatal Program was funded in the past by department funds; however, the program (i.e., the network of transportation, hotline, education, and consulting services) is now funded through TennCare administrative dollars, at a continuing rate of \$4,546,600, for the last three fiscal years. Direct patient care is covered by TennCare or other insurance coverage.

Primary Health Care Centers Advisory Board

The Primary Health Care Centers Advisory Board, appointed by the Commissioner, consists of 19 members, including the Commissioner of Health or her designee, who serves as executive secretary for the board. Membership includes the following:

- One individual assigned by the National Health Service Corps to Tennessee
- One rural health initiative program grantee in Tennessee
- One representative of the department's Primary Care Division
- One representative of the Bureau of TennCare
- One physician appointed from a list of three nominees submitted by the Tennessee chapter of the American Academy of Pediatrics, the Tennessee Pediatrics Society
- One physician appointed from a list of three nominees submitted by the Tennessee Society of Internal Medicine
- One physician appointed from a list of three nominees submitted by the Tennessee Academy of Family Physicians
- One physician appointed from a list of three nominees submitted by the Tennessee Medical Association
- One representative of the Tennessee Association of Primary Health Care Centers
- Two nurse practitioners appointed from a list of six nominees submitted by the Tennessee Nurses Association
- One representative of the Tennessee Pharmaceuticals Association
- Three prominent citizens who are not providers of direct or indirect health care services

- One physician appointed from a list of three nominees submitted by the Tennessee Association of Osteopathic Physicians and Surgeons
- One dentist appointed from a list of three nominees submitted by the Tennessee Dental Association
- One physician assistant appointed from a list of three nominees submitted by the Tennessee Academy of Physician Assistants

Members serve four-year terms. The board is required to meet quarterly. The Primary Health Care Centers Advisory Board met a total of eight times in 1994 and 1995, with attendance averaging nine members per meeting. Board members' travel expenses for 1994 and 1995 totaled \$4,574. The board's activities are described in Finding 1.

Tennessee Code Annotated, Section 68-1-701, enumerates the board's duties:

- Defining and categorizing the various types of primary health care centers currently existing or proposed in the state
- Prioritizing areas of need within each health service area in the state
- Establishing standards for evaluation of primary care centers and programs in the state
- Recommending to the commissioner the need to provide primary care services at any given site
- Publishing annually a directory of primary health care centers
- Monitoring the prescriptive practices of nurse practitioners and the supervision by physicians under whom such nurse practitioners are rendering services
- Reporting any complaints against such nurse practitioners to the director of the Division of Health Related Boards
- Assisting in investigations of improper prescriptive practices
- Reporting annually to the General Assembly and the Commissioner of Health the board's findings regarding the delivery of health care in this state

Additionally, the prescriptive practices of physician assistants, and the supervision by physicians under whom such physician assistants are rendering service, shall be monitored by the Primary Health Care Centers Advisory Board. (Monitoring of the physicians' supervision of physician assistants is also discussed in the September 1996 performance audit of the Board of Medical Examiners' Committee on Physician Assistants.)

Cancer Reporting Advisory Committee

The Cancer Reporting Advisory Committee, appointed by the commissioner pursuant to Section 68-1-1005, *Tennessee Code Annotated*, is composed of at least nine, but no more than 12 members, including, but not limited to

- one biostatistician,
- one cancer registrar,
- one epidemiologist,
- one oncologist,
- one pathologist,
- one radiologist,
- the commissioner or her designee, and
- at least two additional members to be appointed by the commissioner.

The committee advises the commissioner on all matters reasonably related to the administration of the cancer reporting system including the development of the reporting form, the design of the data system, the types of controls needed to preserve patient confidentiality, the training requirements for participants in the system, and the uses to be made of the data the system generates. Members serve three-year terms. The Cancer Reporting Advisory Committee is to meet at least quarterly; however, the committee held only two meetings in 1994 and two meetings in 1995 (see Finding 6). Attendance at the meetings averaged seven members. The committee's cumulative expenditures for 1994 and 1995 totaled \$4,457. The Cancer Reporting Advisory Committee's meeting minutes showed that the committee mainly considered requests (e.g., from cancer researchers) for confidential data from the Cancer Registry and either granted or denied the requests after a committee discussion.

The Cancer Registry was implemented in 1989 and requires fairly extensive reporting on the part of the hospitals. The department processes approximately 30,000 records per year for the Cancer Registry. The program is designed to further knowledge about the causes and types of various kinds of cancer by providing appropriate data to members of the medical, scientific, and academic research communities for authorized institutional research. The registry estimates spending \$262,900 in fiscal year 1996; estimated expenditures in fiscal year 1995 were \$184,775. (The Cancer Registry does not have a separate cost center but is included within the Health Statistics and Information budget, so expenditures are estimates only.)