

**Health-Related Boards  
Emergency Medical Services Board**

**March 1999**

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March 11, 1999

The Honorable John S. Wilder  
Speaker of the Senate  
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-Related Boards and the Emergency Medical Services Board. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

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

Sincerely,

John G. Morgan  
Comptroller of the Treasury

JGM/dw  
97-091

State of Tennessee

# Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit  
**Health-Related Boards**  
**Emergency Medical Services Board**  
February 1999

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## AUDIT OBJECTIVES

The objectives of the audit were to review the sixteen boards' and the Department of Health's legislative mandates and the extent to which the boards and department have carried out those mandates efficiently and effectively, and to make recommendations that might result in more efficient and effective operation of the boards and department.

## FINDINGS

### **Practitioner Complaint Processing Lengthy and Disciplinary Action Lenient**

The timeliness of the complaint-handling process appeared lengthy for some of the open and closed cases reviewed. And the disciplinary action the board took appeared lenient in some cases. Most of the boards do not have guidelines specifying a range of actions to take for different types of offenses. Such disciplinary guidelines could help boards decide on appropriate and consistent penalties (page 5).

### **Access to Public Information Varies Among the Boards**

The Division of Health Related Boards' lack of a written policy on releasing information about practitioners to the public has resulted in conflicting procedures among the boards. Five boards anonymously contacted by auditors had different requirements for obtaining information on practitioners and/or provided information different from that in the practitioners' files (page 22).

### **Not All Boards Have Subpoena Powers**

The Board of Medical Examiners is the only board that can issue investigative subpoenas. This type of subpoena allows investigators to obtain patients' medical records. The other boards can issue only testimonial subpoenas (requiring a person to testify) or have no subpoena authority. Without subpoena power, investigators may not be able to obtain the information necessary to determine if a violation has occurred (page 25).

### **Boards Lack Conflict-of-Interest Policies**

Neither the Division of Health Related Boards nor the individual boards have a policy requiring employees or board members to periodically submit disclosure statements of potential personal and professional conflicts of interest. Without a means of identifying potential conflicts and discussing and resolving them

before they have an impact on decisions, board members and staff could be subject to questions concerning their impartiality and independence (page 26).

### **Only Two Boards Have Authority to Assess Costs to Disciplined Practitioners**

The Board of Medical Examiners and the Board of Osteopathic Examination have statutory authority to assess disciplinary costs, although they have not yet used this authority. All boards rely on license fees to pay operating costs. If all boards could assess costs to disciplined practitioners, the resulting funds could be used to pay board operating expenses (page 28).

### **Boards Should Consider Increasing Public Representation**

Fourteen boards have at least one public member; the Board of Medical Examiners has three public members. The Emergency Medical Services Board has no public members. Citizen representatives can bring a different perspective to the board, enhancing the board's ability to protect the public health (page 31).

### **Not All Boards Assess Continuing Competence**

Not all boards require practitioners to obtain continuing education or demonstrate continuing professional competence as a condition of license renewal. Most boards require practitioners to complete a specified number of hours of continuing education as a condition of license renewal, but five boards do not require continuing education of all the practitioners under their jurisdiction (page 33).

### **Emergency Medical Services Board Revenues Do Not Cover Operating Costs**

Revenues generated from license fees collected by the Emergency Services Board are not sufficient to cover the costs of regulating the profession and its practitioners. Regulatory boards attached to the Division of Health Related Boards are required by law to be self-supporting, but the Emergency Medical Services Board, part of the Bureau of Manpower and Facilities, is not (page 37).

## **OBSERVATIONS AND COMMENTS**

The Emergency Medical Services Board is not included in the Governmental Entity Review Law (page 4).

## **ISSUES FOR LEGISLATIVE CONSIDERATION**

The General Assembly may wish to consider (1) authorizing investigative subpoena power for all the boards, (2) granting authority to assess disciplinary costs to those boards that do not have the authority, (3) increasing the number of public members required on the health-related boards, (4) requiring public members on the Emergency Medical Services Board, (5) requiring the Emergency Medical Services Board to be self-supporting, and (6) including the Emergency Medical Services Board in the Governmental Entity Review Law (page 41).

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"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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1500 James K. Polk Building, Nashville, TN 37243-0264  
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**Performance Audit  
Health-Related Boards  
Emergency Medical Services Board**

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**Performance Audit  
Health Related Boards  
Emergency Medical Services Board**

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**INTRODUCTION**

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**PURPOSE AND AUTHORITY FOR THE AUDIT**

This performance audit of 15 health-related boards was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Seven additional health-related boards attached to the Division of Health Related Boards in the Department of Health were not reviewed in this audit because they will be reviewed in later years. Under Section 4-29-220, *Tennessee Code Annotated*, the 15 boards are scheduled to terminate June 30, 1999. The Emergency Medical Services (EMS) Board is not included in this statute, but was reviewed as a part of this audit because its functions are similar to those of the health-related boards. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the boards and to report to the Joint Government Operations Committee of the General Assembly. The audit is intended to aid the committee in determining whether the boards should be continued, restructured, or terminated. The following boards were reviewed:

1. Board of Chiropractic Examiners
2. Board of Communication Disorders and Sciences
3. Council for Licensing Hearing Instrument Specialists
4. Board of Dentistry
5. Board of Dietitian/Nutritionist Examiners
6. Board of Dispensing Opticians
7. Emergency Medical Services Board
8. Board of Medical Examiners
9. Tennessee Medical Laboratory Board
10. Board of Nursing
11. Board of Examiners for Nursing Home Administrators
12. Board of Optometry
13. Board of Osteopathic Examination
14. Board of Registration in Podiatry
15. Board of Examiners in Psychology
16. Board of Veterinary Medical Examiners

## **OBJECTIVES OF THE AUDIT**

The objectives of the audit were

1. to determine the authorities and responsibilities the General Assembly mandated to the Division of Health Related Boards and to the individual boards;
2. to determine the extent to which the boards and department have fulfilled their legislative mandates;
3. to evaluate the efficiency and effectiveness of management's organization and use of resources to accomplish the division's and boards' purposes; and
4. to develop recommendations, as needed, for administrative and legislative action which might result in more efficient and/or more effective operation of the division and boards.

## **SCOPE AND METHODOLOGY OF THE AUDIT**

The audit studied the activities of the boards and the Division of Health Related Boards for fiscal years 1996 through August 1998. The audit was conducted in accordance with generally accepted government auditing standards. The methods included

1. interviews with staff of the Department of Health, board members, and representatives of health associations;
2. review of statutes and departmental rules and regulations;
3. review of a random sample of licensing files and open and closed complaint investigation files;
4. interviews with officials from other states' health profession regulatory agencies and with Tennessee Bureau of Investigation officials.

## **ORGANIZATION AND STATUTORY DUTIES**

### Division of Health Related Boards

Under *Tennessee Code Annotated*, Section 63-1-101, the Division of Health Related Boards' purpose is to provide all administrative, fiscal, inspection, clerical, and secretarial functions to the health-related boards. Under Section 63-1-115, the division is allowed to employ investigators, inspectors, or agents to carry out its administration and enforcement of laws regulating the health professions. The division, in conjunction with the boards, has the power and duty to enforce all laws regulating the healing arts. The division can petition circuit or chancery court to forbid persons practicing without a license from continuing to practice. The director of the division is appointed by the Commissioner of Health from a list of three nominees provided by a committee of board chairs.

### Health-Related Boards

The boards perform regulatory functions which include giving examinations, issuing licenses, making rules and regulations governing the standards of professional practice, setting fees, approving continuing education requirements, and conducting disciplinary hearings. (See Appendix 1 for a description of each board.)

Section 4-29-121, *Tennessee Code Annotated*, requires health-related boards to collect fees sufficient to pay operating costs. See Appendix 2 for the boards' balances for fiscal years 1996 and 1997.

### Emergency Medical Services Board

The Emergency Medical Services Board regulates emergency medical personnel and ambulance services. (See Appendix 1 for a description.) It is administratively attached to the Division of Emergency Medical Services. Division staff perform administrative and investigatory functions for the board.

### Minority and Senior Representation

According to state law, the Governor shall strive to appoint at least one member of a racial minority and one member over 60 years of age to each board, including the Emergency Medical Services Board. Seven of 16 boards have a minority representative; nine boards do not. Thirteen boards have a member at least 60 years of age; three boards do not.

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## **OBSERVATIONS AND COMMENTS**

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The issue discussed below did not warrant a finding but is included in this report because of its effect or potential effect on the operations of the Department of Health and the Emergency Medical Services Board.

### **EMERGENCY MEDICAL SERVICES BOARD NOT IN THE SUNSET LAW**

The Emergency Medical Services Board (EMS) is not included in the sunset audit legislation—the Governmental Entity Review Law. Thus, it is not mandated to have performance reviews conducted prior to a termination date, as are the other health-related boards. As a result, the General Assembly may be limited in its ability to determine whether the board is complying with statutes and regulations, and whether it is operating efficiently and effectively.

All Division of Health Related Boards regulatory entities are included in the sunset cycle and must be audited by the Comptroller of the Treasury prior to their termination dates. The Emergency Medical Services Board was included in the scope of this audit because it is a health regulatory board whose functions and responsibilities are similar to those of the health-related boards in functions and responsibilities. Management with the Department of Health believes that since the EMS profession is similar to those regulated by the health related boards, there is no reason the EMS board should not be included in the sunset cycle. The General Assembly may wish to consider adding this requirement to the Emergency Medical Services Board.

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## FINDINGS AND RECOMMENDATIONS

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### 1. Practitioner complaint processing is often lengthy and disciplinary action lenient

#### Finding

Problems in the complaint-handling process may delay the sanctioning of some practitioners and may allow unqualified practitioners to continue to practice. The complaint process was lengthy in some cases. Neither the Division of Health Related Boards nor the department's Investigations Section have time guidelines for processing cases to determine if complaints are investigated and processed timely. Also, the disciplinary action in some of the lengthy cases appeared lenient.

#### History of Complaint Investigations

Since March 1996, the investigation of practitioner complaints has been the responsibility of the Department of Health's Internal Audit and Investigations Division. Prior to that date, the Division of Health Related Boards investigated complaints. According to department management, the move was made because of supervision problems within the division and inadequate monitoring of the investigation process.

Upon taking responsibility for the investigations, the Internal Audit and Investigations Division took several steps to improve the process: it hired an investigations manager, developed a policy and procedures manual, and implemented a review process so that management reviews field investigations. In the past, investigations were sent from the field investigator directly to the board consultants.

According to management, the Investigations Section (of the Internal Audit Division) receives approximately 100 new cases per month and in August 1998 was actively investigating 705 cases. (Because the Emergency Medical Services Board is not under the direction of the Division of Health Related Boards, its cases are not included in this total. It receives approximately 80 to 90 complaints per year.)

#### Complaints

Complaints can be made by mail, by telephone, or in person. Complainants are asked to submit their complaints in writing, but are not required to do so. In July 1997, the Internal Audit Division proposed requiring all complaints to be submitted using a standardized, written form to reduce the number of frivolous complaints. The department later put this proposal on hold because the boards believed that they were not included in developing the policy, that the policy might discourage the filing of some legitimate complaints, that some complainants might not know how to write, and that some complainants wished to remain anonymous.

According to Internal Audit Division management, the department plans to eventually implement a system that allows the public to file an automated complaint over the telephone. Management estimated the system would be implemented in two years.

### Complaint-Handling Process

The boards immediately forward the complaints they receive to the Investigations Section of the department's Internal Audit and Investigations Division. Those complaints not within the jurisdiction of the board may be referred to the appropriate agency. For example, a billing complaint would be referred to the Division of Consumer Affairs. A complaint within a board's jurisdiction is forwarded to the board consultant for review to determine if a violation of the practice act has occurred. (If a complaint concerns an immediate risk of harm, the section may begin an investigation without the consultant's review.) If there is no apparent violation, the case is closed and the complainant is notified by a form letter. If the practitioner apparently violated the practice act, the case is assigned to one of 14 field investigators. Before assigning the case, the board consultant ranks the case as a high, medium, or low priority. No guideline or policy exists for assigning priority, but according to Internal Audit management, assessments are based on the seriousness of the case and the potential harm to the public. (See Exhibit 1 for a flowchart of the complaint-handling process.)

The investigations director reviews the results of the investigation and forwards the case to the board consultant and, if necessary, litigating attorney for review. The board decides whether to drop the case, write a warning letter or letter of reprimand, or bring charges. If charges are brought, the board notifies the Investigations Section, which submits the case to the Office of General Counsel (OGC), which is responsible for prosecuting the case before the board. Cases can also be settled informally—the licensee usually agrees to certain stipulations, such as counseling. If the stipulations are not met, the board can take further action.

Neither the Division of Health Related Boards nor the department's Investigations Section has developed guidelines on the appropriate time for processing complaints. The section tracks the number of investigative hours—an average of 25.7 hours per case from January 1, 1998, to December 31, 1998. The average time to complete a case is 15 to 17 months. According to the department, shortening the average time to complete an investigation will likely require additional staff. The section is analyzing the data to develop time goals for processing complaints, but the department does not know when these goals will be completed. The Emergency Medical Services Board is considering establishing one year as a guideline.

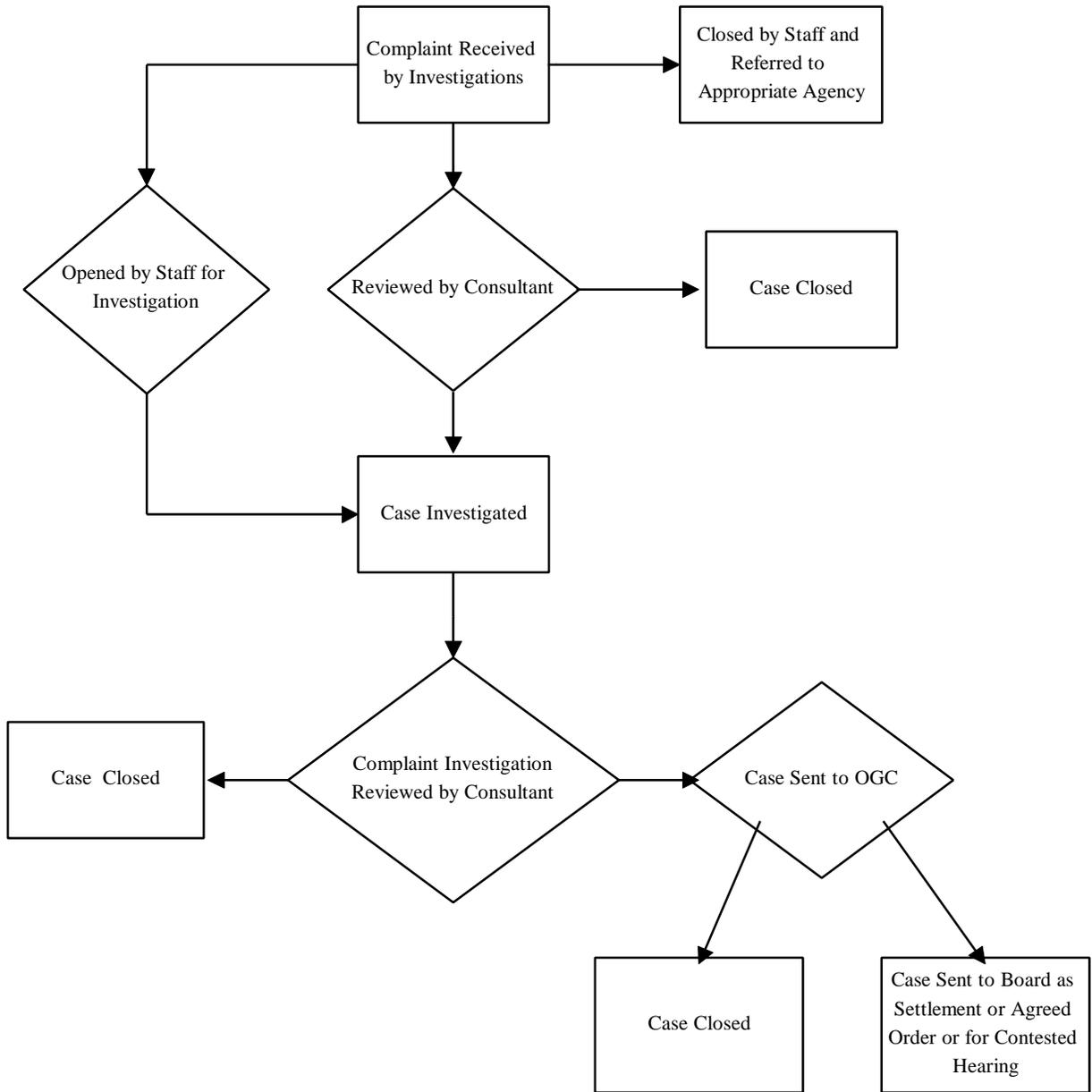
### File Reviews

The following random sample of 40 open and 154 closed investigation files and 15 EMS files was reviewed to determine the average time it took to investigate and process complaints:

- Fifty-three files closed in calendar year 1996, 55 files closed in calendar year 1997, and 46 files closed in fiscal year 1998.
- Fifty files that were open as of June 30, 1998.

- Five EMS files closed between January 1, 1996, and October 15, 1997; five files closed between July 1, 1997, and August 10, 1998; and five files that were open as of August 10, 1998.

Exhibit 1  
Health-Related Boards  
Investigations Complaint Process



Source: Department of Health.

Open Files. The average number of days cases were open appears excessive (see Exhibit 2 for open file review averages by board). Eighteen had been open over a year and seven had been open over two years. Four of these seven had been assigned a high priority.

Closed Files. The average number of days to close a file increased from 457 days in 1996 to 546 days in 1997. Case closure took 545 days in 1998. (See Exhibits 3, 4, and 5.) Although the number of days between completion of investigations to assignment to the OGC was reduced from 305 in 1996 to 150 in 1997, the averages for all other periods increased. The most significant increase was from the date the consultant review commenced to the date the case was assigned to an investigator, which more than doubled from 56 days in 1996 to over three months (105 days) in 1997. Between 1997 and 1998, the average time from receipt of complaint to first review decreased by 12 days, from first review to the date the investigator received the file, by nine days, and to completion of investigation, by nine days.

<b>Exhibit 2</b>	
<b>Complaint Files Open as of June 30, 1998</b>	
<b>Averages in Number of Days</b>	
<b>Board (number of files reviewed)</b>	<b>Received to June 1, 1998</b>
Chiropractic (1)	586
Communication Disorders (0)	No Open Cases
Dentistry (7)	520
Dietitians & Nutritionists (1)	393
Dispensing Opticians (1)	939
Hearing Instrument (1)	512
Medical (19)	305
Physician Assistants (1)	505
Respiratory Care (1)	807
Medical Laboratory (1)	539
Nursing (14)	377
Nursing Home Administrators (1)	470
Optometry (1)	388
Osteopathic (1)	537
Podiatry (1)	270
Psychology (1)	56
Veterinary (1)	854
<b>Averages (53)</b>	<b>401</b>

**Exhibit 3**  
**Complaint Files Closed in 1996**  
**Average Number of Days for Case Processing\***

<b>Board (number of files reviewed)</b>	<b>Received to First Review</b>	<b>First Review to Investigator</b>	<b>Investigator to Complete</b>	<b>Investigation Complete to OGC</b>	<b>OGC to Boards</b>	<b>Boards to Closed</b>	<b>Received to Closed</b>
Chiropractic (1)	56	6					161
Dentistry (4)	60	19	495				527
Dietitians & Nutritionists (1)	7	154	11				455
Dispensing Opticians (1)	111	51	223				524
Hearing Instrument (1)	158						158
Medical (22)	64	51	224	387	110	7	544
Athletic Trainers (1)	86	383	107				639
Physician Assistants (1)							29
Respiratory Care (1)	160	35	86				491
X-Ray Technicians (1)							29
Medical Laboratory (1)	3						68
Nursing (11)	15	14	219	36	229	4	321
Nursing Home Administrators (1)	159	1	48				371
Optometry (1)	0	83	883				1,015
Osteopathic (1)	8						764
Podiatry (1)	146	43	53				503
Psychology (2)	61	140	606	105			672
Veterinary (1)	11		35				52
<b>Averages (53)</b>	<b>55</b>	<b>56</b>	<b>252</b>	<b>305</b>	<b>149</b>	<b>6</b>	<b>457</b>

\*Note: The numbers in each column are the averages of the cases for which the number of days in that phase could be calculated. Not all cases went through each phase. Also, some dates were missing from the files, so the number of days for some phases could not be determined. All cases are reflected in the Received to Closed column.

**Exhibit 4**  
**Complaint Files Closed in 1997**  
**Averages Number of Days for Case Processing\***

<b>Board (number of files reviewed)</b>	<b>Received to First Review</b>	<b>First Review to Investigator</b>	<b>Investigator to Complete</b>	<b>Investigation Complete to OGC</b>	<b>OGC to Boards</b>	<b>Boards to Closed</b>	<b>Received to Closed</b>
Chiropractic (1)	56	1	525	34			616
Dentistry (6)	63	114	436				339
Dietitians & Nutritionists (1)	185	32	722				1,394
Dispensing Opticians (1)	8	43	131				205
Hearing Instrument (1)	55						55
Medical (22)	72	100	385	265	650	7	479
Physician Assistants (1)	146	4	183	568			1,151
Respiratory Care (1)	18	118	17				322
X-Ray Technicians (1)	4			77			414
Medical Laboratory (1)	75	7	251	225			813
Nursing (12)	13	154	391	53	195	135	752
Nursing Home Administrators (1)	5						996
Optometry (1)	199						199
Osteopathic (1)	0						0
Podiatry (1)							225
Psychology (2)	450						464
Veterinary (1)	4						1,085
<b>Averages (55)</b>	<b>70</b>	<b>105</b>	<b>371</b>	<b>150</b>	<b>252</b>	<b>119</b>	<b>546</b>

\*Note: The numbers in each column are the averages of the cases for which the number of days in that phase could be calculated. Not all cases went through each phase. Also, some dates were missing from the files, so the number of days for some phases could not be determined. All cases are reflected in the Received to Closed column.

<b>Exhibit 5</b>							
<b>Complaint Files Closed as of August 18, 1998</b>							
<b>Average Number of Days for Case Processing*</b>							
<b>Board (number of files reviewed)</b>	<b>Received to First Review</b>	<b>First Review to Investigator</b>	<b>Investigator to Complete</b>	<b>Investigation Complete to OGC</b>	<b>OGC to Boards</b>	<b>Boards to Closed</b>	<b>Received to Closed</b>
Chiropractic (1)	75						75
Communication Disorders & Sciences (1)							1,218
Dentistry (7)	71	164	206	76			278
Dietitians & Nutritionists (1)	185	32	722				1,394
Dispensing Opticians (2)	11	9	623				731
Hearing Instrument (1)	30	354	37				610
Medical (17)	40	47	379	38			517
Physician Assistants (1)	0						1,341
Medical Laboratory (1)	143						1,318
Nursing (7)	22	86	452	41	318	0	505
Nursing Home Administrators (1)	188						369
Optometry (1)	146	200	9	5			489
Osteopathic (1)	89						343
Podiatry (1)							889
Psychology (2)	83	96	13	20			330
Veterinary (1)	124	274	222	29			649
<b>Averages (46)</b>	<b>58</b>	<b>96</b>	<b>362</b>	<b>40</b>	<b>318</b>	<b>0</b>	<b>545</b>

\*Note: The numbers in each column are the averages of the cases for which the number of days in that phase could be calculated. Not all cases went through each phase. Also, some dates were missing from the files, so the number of days for some phases could not be determined. All cases are reflected in the Received to Closed column.

Five of 53 cases closed in 1996 took at least 1,000 days to resolve; two Medical board cases took over four years (1,617 days). For cases closed in 1997, 11 of 55 files reviewed took at least 1,000 days to close; a Medical board case took over four years (1,722 days). The Medical board file was an overprescribing case that resulted in disciplinary action against the practitioner. According to Internal Audit management, the OGC kept requesting further information after the initial drug audit was completed.

And for cases closed in 1998, eight of 46 cases reviewed took at least 1,000 days to close. According to Internal Audit management, some of these eight cases involved legal rather than medical questions, and patient care was not at risk. One of the cases involved the legal question of doctors' owning medical facilities; another involved inadequate monitoring of pharmacy records; and another involved a physician assistant's seeing patients he was not legally qualified to see. According to management, the law has since been changed, and the practice by the physician assistant would be legal under current law.

One effect of the slowness in processing complaints is a backlog of cases. At August 11, 1998, 1,087 cases were in the Investigations Section and 445 cases were in the Office of General Counsel.

Emergency Medical Services Board (EMS) files. All 15 of the EMS files lacked documentation of significant dates in the complaint-handling process. For the 1996-97 review, three of the ten closed files did not contain a complaint form, and none of the files included documentation that would indicate significant dates of the investigation. For open files, the average length of time files were open was 671 days. For closed files, the average time between receipt date and closure was 390 days (ranging from 13 days to 1,126 days) for the files closed between January 1996 and October 1997. The average time was 576 days (ranging from 113 days to 1,002 days) for the files closed between July 1997 and August 1998.

The cases listed below are the most serious examples of lengthy complaint processing and/or lenient disciplinary action:

### **Case 1**

November 1996 Four former employees filed suit against a chiropractor claiming multiple instances of gross sexual harassment. The chiropractor had received probation for a similar offense in 1990. The 1996 case was still being investigated in August 1998. According to the department, the complainant's legal counsel refused to let the complainant talk to investigators because of the complainant's civil suit against the chiropractor.

The following sexual harassment and unprofessional conduct complaints had previously been filed against this chiropractor:

1987-88 Three employees filed complaints accusing the chiropractor of gross sexual misconduct.

- 1989            The chiropractor initially denied the charges, but after being presented with the evidence against him, agreed to a settlement requiring him to seek therapy. The investigator believed there was sufficient evidence to file charges of immoral and unprofessional conduct.
  
- 1990            The department appealed the settlement to Chancery Court, and the chiropractor accepted an agreed order of a formal reprimand and a one-year probation.
  
- 1991            A patient filed a complaint alleging multiple rapes. The case was closed in 1992 when the complainant refused to cooperate.
  
- 1992            A complaint regarding billing for services resulted in a letter of warning from the board.
  
- 1993            Multiple complaints alleged the chiropractor used a false business name in calling individuals injured in accidents. The cases were closed in 1993 because the board had no rules prohibiting this type of advertising.

**Case 2**

A case before the Medical board involved a doctor who had a lengthy history of overprescribing Schedule II drugs. Disciplinary action took four years from the first overprescribing complaint. The doctor had entered a substance abuse treatment program; his prescribing privileges had been suspended in another state; and his working privileges had been revoked at two local hospitals.

- February 1976    After an investigation indicated cases of overprescribing Dilaudid, the board instructed the doctor to stop writing prescriptions for this medication “unless medication is for persons he knows to be legitimate patients.”
  
- December 1976    A state Attorney General’s audit of Schedule II prescription records of local pharmacies identified the doctor as prescribing unusually large quantities to patients, some of whom were reputed drug dealers.
  
- 1990            In an out-of-state case, the doctor agreed to enter a substance abuse program in Alabama.
  
- 1993            The doctor surrendered his Alabama license to prescribe controlled substances.
  
- January 1993     The board received an overprescribing complaint.
  
- April 1993        The board received an overprescribing complaint.
  
- May 1993         The board received an overprescribing complaint.

January 1994	The board received an overprescribing complaint.
January 1994	An investigator asked the OGC how to proceed with a summary suspension of the doctor's license. The OGC responded that the investigator needed to audit the doctor's records and then the OGC would review the case again.
March 1994	The board received an overprescribing complaint.
May 1994	Investigations requested legal action from the OGC.
June 1995	The OGC temporarily closed the case while a follow-up investigation was conducted. The OGC would take no action until it received additional information from investigations.
July 1995	Investigator instructed by the OGC to do a follow-up report.
July 1995	Investigations sent a request for legal action to the OGC, over two years after the original complaint.
October 1995	A pharmacist filed an overprescribing complaint.
February 1996	A mother of two patients filed an overprescribing complaint.
February 1996	The board notified the OGC of the additional complaints and informed them that there would be no investigation until it received a response from the OGC. The board received no response.
April 1996	A fraud and overprescribing complaint was filed against the doctor.
January 1997	The board received an overprescribing and billing complaint.
January 1997	The board submitted new complaints to the OGC and again sent a letter stating that no investigation would be started unless requested by the OGC.
May 1997	The board suspended his DEA privileges for 30 days, put him on probation for two years, required him to complete a mini-residency program, and assessed a \$2,000 civil penalty.

### **Case 3**

A doctor who had had several overprescribing complaints made against him, had a long history of substance abuse, and had been convicted of drunk driving received an agreed order with no suspension or revocation of his license.

May 1992	The medical board received an overprescribing complaint about the doctor.
August 1993	A complaint for Medicaid fraud was included with the original complaint.
February 1994	The investigation was completed 17 months after the investigator received the complaint.
April 1995	The second consultant review was conducted 14 months after the investigation was completed. The case was submitted to the OGC.
January 1996	The board received a second overprescribing complaint.
January 1997	An agreed order covering the complaints since 1992 was reached requiring the doctor to attend a three-day prescribing course and to have his practice monitored. The charges were to be dismissed when the conditions of the agreed order were met.
April 1997	A complaint of unprofessional conduct was received. (A new investigation was begun.)
April 1997	The board received a third overprescribing complaint from a pharmacist.
January 1998	The board received a complaint concerning patient abandonment. As of August 1998, these complaints were still being investigated.

#### **Case 4**

A veterinarian indicated on his renewal form that he had been convicted of a crime but had not previously notified the board. (He had pled no contest to four counts of sexual battery.) The applicant had not previously notified the board in writing as required. Over two years after this violation was noted, the investigation was completed. The investigations section recommended formal disciplinary action and sent the case to the OGC. Nearly four months later the case was still with the OGC. The license had been renewed during the course of the investigation.

#### **Case 5**

The Medical board assigned a high priority to the case of a doctor accused of overprescribing controlled substances. The board had received four prior complaints about the doctor. The Board of Pharmacy initiated the complaint and provided prescription records. The case was still under investigation nearly two years later. During this time, the board received a complaint concerning unprofessional conduct. According to the department, overprescribing cases are difficult to investigate because the medical consultant must determine what prescriptions each patient has been given by analyzing the prescription records. Then the investigator must get the patient records from the doctor. If the doctor is not cooperative, obtaining a subpoena to get the patient records can take several months.

## Case 6

A registered nurse working at a psychiatric hospital admitted to diverting Demerol for his own use and expressed a desire to give up his license. The case was assigned a high priority by the Nursing board consultant. The investigation was completed five months after the complaint was opened. The case has been with the OGC for 14 months; no action has been taken.

## Case 7

The Nursing board case of a registered nurse arrested for obtaining drugs by fraudulent means was assigned a high priority and sent to the OGC for an expert opinion one day after the complaint was received. Five months later, the investigation was completed and the investigations section requested formal disciplinary action from the OGC. Nine months later, the case was still with the OGC.

### Inadequate Disciplinary Guidelines

Although disciplinary guidelines can help boards decide on appropriate and consistent penalties, only the Nursing and Medical Examiners boards have disciplinary guidelines specifying the actions to take for certain offenses. Section 63-1-120, *Tennessee Code Annotated*, provides all boards statutory authority to discipline members of the professions they regulate. Therefore, the boards may promulgate rules describing what actions constitute unprofessional, unethical, or dishonorable conduct. For most boards, however, statutes do not specify penalties for offenses. Rather, these penalties are left to the discretion of the boards.

The Board of Nursing has developed comprehensive, in-depth disciplinary guidelines that provide specific actions to take for offenses. These actions can range from a letter of reprimand to probation, civil penalties, suspension, or revocation of license. For example, the guidelines for a first-time offense of impairment when the patient was not injured is an informal settlement whereby the nurse agrees to enter a peer assistance program. The guideline for a repeat offender is a nine- to twelve-month suspension followed by probation. Revocation could occur depending on the facts of the case.

Three of the boards (the Board of Dietitians/Nutritionists, the Medical Laboratory Board and the Emergency Medical Services Board) reviewed have no disciplinary guidelines. The remaining boards reviewed have some sort of disciplinary guidelines; however, these guidelines are vague and do not provide specific disciplinary actions.

The Federation of State Medical Boards in 1996 issued *A Model for the Preparation of a Guidebook on Medical Discipline* to provide state medical boards with a framework for designing guidelines reflecting each board's relevant statutes and regulations. The federation recommends "that every state medical board or authority charged with disciplinary responsibilities have a basic guidebook about medical discipline to assist its members and staff in fulfilling their obligations to protect the health and safety of the people of their state, to promote consistency in the discipline process, and to permit accurate interpretation of its actions by similar bodies in other jurisdictions." The federation does not recommend what disciplinary actions to use; it believes each

board should develop these penalties based on information provided in each state's medical practice act and relevant operational policies.

### **Recommendation**

The department and/or individual boards should develop and implement a system to monitor the timeliness of the complaint process and to set time guidelines. Management should then identify delays in the process and develop strategies and take immediate action to improve and speed up processing.

The Emergency Medical Services Board should improve the maintenance of complaint investigation files to improve monitoring. Investigators should document significant dates in the investigation process.

The boards should develop disciplinary guidelines detailing the actions to take for certain offenses and violations. The boards should consider using the guidelines of the Board of Nursing as an example. The boards should follow these guidelines to improve consistency in disciplinary actions.

### **Management's Comment**

#### Joint Comment of the Department of Health and the Emergency Medical Services Board

We have responded to this finding in three sections: Emergency Medical Services (EMS), Office of Audit and Investigations, and Office of General Counsel (OGC).

Emergency Medical Services. We concur. A case management enhancement to the Regulatory Board System (RBS) is scheduled for implementation in December 1998. This computerized system provides for detailed tracking of cases from complaint, investigation, and case prosecution stages. Comprehensive tracking and documentation are components of this system.

The issue of disciplinary guidelines is complex. Each case is unique because of mitigating and aggravating circumstances. The EMS Division and board will study the Board of Nursing's disciplinary guidelines, as well as guidelines from EMS agencies in other states, in order to develop appropriate policies.

Audit and Investigations. We concur that the process should not take as much time as it does, but it must be pointed out that the length of time it takes to investigate a complaint is a direct result of the number of complaints, the type of complaints, and the number of people to investigate the complaints. We feel that based on an analysis of these three criteria, the investigative process is working to its capacity.

The Office of Audit and Investigations has a system that monitors the cases and tracks the progress of a case. The managers of the investigative office review the case status with the

investigators in the field each week, concentrating on the oldest case by priority. The office installed a timekeeping system for the investigators in June 1996, and as of September 1998, the system indicates that the average length of time on a case is 27.9 hours, which we feel is very reasonable and is used as a guide. The problem comes when you analyze the number of cases, time required to complete a case on the average, and the number of investigators. The analysis shows that a computation of the number of cases, 800 as of October 1998, the average time to complete a case of 28 hours, and the number of investigators confirms that the average time to complete a case is 15 to 17 months. We are working on ways to improve the speed of cases, such as more automation of the drug audit program and obtaining a release of records at the time a complaint is made. These things can make some, but no appreciable, difference. An analysis of the investigators' time records, which is monitored by management, shows that the investigators are working at 94% of the expected or budgeted time which is much better than most areas. Thus, improvements to shorten the average time that it takes to complete an investigation must include an analysis of the additional staff needed to shorten the timeframes as compared to the cost of the additional staff and the potential benefits derived from the additional cost. Further, the office is working with the Office of General Counsel in reviewing case tracking systems that will interface with that office to monitor the progress of complaints.

It was mentioned in the write-up that some of the timeframes have increased over the past two years and that is accurate. When the Investigations' responsibility was moved in 1996 to this office, one of the main concerns was the quality of cases being completed. In the early part of 1996, the OGC was returning a high number of cases for further work because the investigation did not contain enough information for the attorneys to make proper decisions. Thus, the emphasis was put on case reviews to make sure that an investigation was complete prior to being sent to OGC. This review has increased the timeframes some, but the quality of cases going to OGC is much better, and we have reduced the number of cases returned from OGC to investigations for follow-up by 50 to 60%, which in the long run will make a large difference.

Office of General Counsel. We concur with the statement in finding 1 that the complaint process was lengthy in some cases. However, the amount of time spent in resolving these cases was required based on the types of cases, the volume of cases in the office, and the number of staff available to process the cases. The length of time from opening a case to imposition of sanction is not the critical measurement. The cases vary in complexity based on subject matter, proof required to make the case, number of violations, availability of proof, and witnesses. Many of the cases do not involve patient care; therefore, there is no hazard to the public.

Although some cases processed during fiscal year 1996 through August 1998 have fallen outside OGC's time limit guidelines, the average as outlined in the audit draft report has fallen well within the closure guidelines. This is true in spite of the fact that during this time period, two different General Counsels supervised the office; the office was moved three times; three of the most experienced litigating attorneys who prepared cases for the Medical and Nursing Boards left and new attorneys had to be trained. Additionally, the office has attempted to streamline and facilitate handling of cases. In the past 12 months, OGC has spent considerable effort upgrading computer equipment and strengthening the skills and type of support staff. The upgrade in computer equipment facilitates communication with program staff who reside in a different building. E-mail

and scanner capabilities have reduced the amount of time previously needed to send documents through state mail. Further, OGC participated in petitioning the Department of Personnel to create/upgrade a legal assistant prototype position. The division has filled two such legal assistant positions; these individuals assist the lawyers in organizing case files, drafting pleadings, and coordinating deposition/interview/hearing schedules. Further, OGC is reviewing case tracking systems and anticipates making changes which will better monitor case progress and provide more detailed information.

Concerning the allegation regarding leniency of disciplinary actions, the length of the case has nothing to do with the severity of the violation. Further, the discipline administered is not the province of OGC; it is totally in the discretion and control of the relevant board.

Boards have been reluctant to adopt specific rigid guidelines for meting out discipline. Cases often have numerous variables and multiple offenses which make it difficult to construct useful guidelines. Most boards have guidelines used in the settlement phase of the case. Similarly, other states use such guidelines for settlement (as opposed to disciplinary) purposes.

In regard to the cases mentioned in the report, OGC submits the following information on the cases in which OGC could identify the case:

Case 4—OGC received this case on June 5, 1998. Note that while the veterinarian pleaded guilty to a crime, the sentence for this crime was probation with the possibility of expungement. While the complaint alleges that the veterinarian violated the practice act, there is no allegation that the veterinarian had endangered patients. This factor made this case less important than four other cases being prepared for hearing. It is anticipated that this case will be resolved at the December meeting of the Veterinary Board which means that the case will be closed well within the OGC guidelines.

Case 7—This case is set for the December meeting of the Board of Nursing. While the Notice of Charges issued slightly outside OGC guidelines, the litigating attorney for this board is new. Because of the complexity of the case, the General Counsel determined that the litigating attorney required experience presenting cases to the board prior to litigating this particular case. The case will be closed well within OGC guidelines.

The following boards agree with the department's response: Board of Examiners for Nursing Home Administrators, Council for Hearing Instrument Specialists, and Medical Laboratory Board.

#### Board of Chiropractic Examiners

I concur in part with the finding. We have made many attempts to speed up the processing of complaints. They are as follows:

- We have added a consultant to the board who has experience in chiropractic and law to ensure there is no impediment by the consultant in pressing forward with the prosecution of complaints.

- The board asked the Tennessee Chiropractic Association to sponsor legislation to grant the examining board subpoena power. The state legislature passed legislation this year granting the Chiropractic Board this power, and we have begun the process of rule making to further delineate how subpoena power will be used.
- One of our major concerns is that we have not prosecuted a case within the past ten years. The board does not understand why, at the rate of receiving 28 complaints per year, that no complaints ever came to prosecution in the past ten years. To that end, we have sent one of our board members, Dr. Lou Obersteadt, to the Department of Investigations to review the closed files. Upon review of the closed files, five by the consultant and five by the attorney, there appeared to be appropriate handling of those particular claims. Dr. Obersteadt felt as though the ten files that he looked at were “sanitized” and would not reflect the body of cases that remain unprosecuted. If we attempt this review again, we will require a random sampling of closed files.

We do not concur that disciplinary action is lenient because we have not had an opportunity to discipline a practitioner since this particular board has been set; however, we have obtained a copy of the model disciplinary code from the Federation of Chiropractic Licensing Boards and plan to use this model in the evaluation of future complaints.

I concur with your recommendation to implement a system to monitor the timeliness of the complaint process. We plan to have this performed by our consultant.

#### Board of Communication Disorders and Sciences

We concur with the recommendations to develop and implement a system to monitor the timeliness of the complaint process and set time guidelines. Management will have to identify delays in the process and develop strategies to improve and speed up processing.

The Board of Communication Disorders and Sciences will review our current rules and regulations for all disciplinary guidelines for specific offenses and violations. We will use the Board of Nursing as an example. This action can be implemented at our next board meeting.

#### Board of Dentistry

We concur in part with the recommendation in that “the department should develop and implement a system to monitor the timeliness of the complaint process and set time guidelines. Management should then identify delays in the process and develop strategies and take immediate action to improve and speed up processing.” It appears after talking with our consultant that additional investigators assigned for dental complaints would improve the complaint process for our board. Again, “the boards should develop disciplinary guidelines detailing actions to take for certain offenses and violations.” “The boards should follow these guidelines to improve consistency in disciplinary actions” yet be broad enough to allow latitude for individual case action. The Board of Dentistry looks at our caseload as warranting firm but fair decisions.

### Board of Medical Examiners

The process of investigations and file review by the board's medical consultant sometimes overwhelms the system. Efforts are being made to ensure that investigations are done on a timely basis. The response from Health Related Boards on the Office of Audit and Investigations seems appropriate. We have seen the number of complaints from citizens from the state rise slowly over the past few years, and I am not sure that the number of investigators serving these complaints has increased commensurately. I do think that the monitoring process and the investigative process have become more efficient although full efficiency has not yet been realized. Certainly drug audits take a very long period of time. On the whole the board would agree with the Health Related Boards comment on the Office of Audit and Investigations.

In the area of General Counsel, the board would note that there has been a considerable amount of turnover in the attorneys handling cases for the Board of Medical Examiners. That notwithstanding the number of attorneys servicing cases for the Board of Medical Examiners has diminished considerably. You have to understand that cases may be carried to a full contested case hearing up to the minute that the board would hear the case. The case may then be settled between the Office of General Counsel and the physician whose license is being acted upon. The board is required to approve these settlements. The number of attorneys, however, makes this process slow when you realize that almost every case is contested to some greater or lesser degree. This process of contesting cases appears to be inherent in the legal system. More attorneys, however, might make the process go faster simply from a numbers standpoint.

In response to the finding that disciplinary actions are lenient, I do not know how specifically to address this. Certainly in each case, the board members feel that the action they are taking is appropriate to fit the complaint. I know that every board member has in mind the purpose of the board, which is to protect the patients of Tennessee when those disciplinary actions are made. In summary, most board members feel that disciplinary action is appropriate in each case.

### Board of Nursing

The Board of Nursing concurs that complaint processing is often lengthy and supports the recommendation. The board welcomes the opportunity to work with Investigations to develop time frame guidelines for the complaint process. The Board of Nursing does not concur that nursing board disciplinary action is lenient and credits the board-approved disciplinary guidelines referred to in the report.

### Board of Optometry

The department should consider whether the excess funds some boards have in their accounts could be used to hire additional investigators to speed up complaint processing.

### Board of Osteopathic Examination

We concur with the finding and will be monitoring the timeliness of the complaint process over the next year. At our next meeting, we will discuss ways in which we can adequately set time guidelines and disciplinary guidelines, including a review of those currently used by the Board of Nursing.

### Board of Registration in Podiatry

Our board has been as strict as the evidence has warranted. We have had several contested cases in the past several years where the legal prosecution was very weak.

### Board of Examiners in Psychology

We concur in part. The board will increase the number of board consultants who must be a former board member. The board has attempted to obtain reimbursement for expenses and compensation for board consultants.

The board is not opposed to the development of general disciplinary guidelines, especially to assist the OGC and the board consultant. The development of detailed guidelines which could be seen as restricting the board's ability to protect the public is highly prohibitive.

### Board of Veterinary Medical Examiners

The complaint process does appear to be lengthy at times. Perhaps a timeline should be set to shorten the time from when the complaint is initially filed and when the board hears the case, if deemed worthy of being heard by the investigative team, which includes our board consultants. My limited experience concerning disciplinary action finds it to be fair and equitable.

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## **2. Access to public information varies among the boards**

### **Finding**

The Division of Health Related Boards does not have a written policy for releasing public information. Instead, division staff rely on internal communications, a practice which has resulted in conflicting descriptions of proper procedure. A formal policy could help ensure that the public has easy access to information about practitioners.

Section 63-1-117(b)(1), *Tennessee Code Annotated*, states that “allegations against a practitioner of the healing arts and the various branches thereof, compiled pursuant to an investigation conducted by the division, are public information upon the filing of notice of charges.” The Health Related Boards Disciplinary Manual lists agreed orders, final orders, notice of charges, and reprimands as public information, while informal settlements and letters of warning are not. Other information such as current investigations and college transcripts is also confidential.

Although statute specifies what is public information, the division has not established a formal policy for releasing such information to concerned citizens. Based on interviews of division management and board administrators, two conflicting descriptions of the procedure have emerged. According to division management, citizens can call a board and obtain any public information in a practitioner's file including licensure status, derogatory information, and details

of disciplinary actions. Citizens are transferred to the Disciplinary Coordinator to discuss the details of a disciplinary action. The division requires businesses, such as hospitals and insurance companies, to submit a request in writing or visit the office to obtain details of a file and charges them one dollar per page to photocopy. These procedures apply to all health-related boards.

Other members of management, as well as board administrators, describe the procedure differently. Citizens can call the board and obtain licensure information and any derogatory information that is public record. However, the staff will not give out details of disciplinary actions over the telephone. Any citizen wanting to know details must make a written request, and staff will either send copies of all public information in a licensee's disciplinary file or allow public viewing at the board's offices.

To determine how boards' staff respond to citizen requests, auditors anonymously contacted the Boards of Dentistry, Chiropractic Examiners, Nursing, Optometry, and Osteopathy to obtain information regarding practitioners who have been disciplined and are still practicing. The purpose of the calls was to assess the accuracy of information board staff provided and to determine the ease or difficulty of obtaining the information. Staff from the Boards of Dentistry, Chiropractic Examiners, and Osteopathy required a written request for details of disciplinary actions. These three boards charged one dollar per page to copy a file and did not ask the auditors if they were citizens or if they represented a business. The Board of Optometry attempted to charge the auditor \$25 before learning the auditor was not representing a business. Staff from the Boards of Dentistry and Osteopathic Examination provided accurate information on the practitioners' licensure status and types of disciplinary action. However, information provided by staff from the Boards of Chiropractic Examiners and Optometry did not reflect the information in the practitioners' files. Staff from the Board of Nursing asked for the license number of the practitioner, then transferred the auditor to another division which said it was not allowed to release the information.

Because there is no formal, written policy, staff have no standard to follow. The current practice hinders citizens' access to public information. Citizens need public information easily and quickly so that they can make informed decisions.

### **Recommendation**

The Division of Health Related Boards should establish a written standard for releasing public information to provide citizens' optimum access to such information. The policy should be included in the Health Related Boards Administrator Manual, and all administrators and support staff should be trained in how to answer citizens' requests for information on licensed practitioners. Staff of all the boards should consistently adhere to this standard to ensure the public of its right to information.

## Management's Comment

### Department of Health

We concur and accept the recommendation. The division will take immediate steps to develop a policy for communicating with the public to ensure consistency and uniformity for all boards and administrators. The policy will be inclusive of all forms of communications including mail, telephone conversations, Internet, and person to person. All staff members will be trained accordingly. The policy will be placed in the training manuals and the administrator operating manuals. The department is in the process of adding some enhancements to the regulatory licensing system that will provide a public information screen for each board's administrator and staff.

The following boards agree with the department's response: Council for Hearing Instrument Specialists, Board of Dietitian/Nutritionist Examiners, Board of Dispensing Opticians, Board of Medical Examiners, Tennessee Medical Laboratory Board, Board of Nursing, Board of Examiners for Nursing Home Administrators, Board of Optometry, and Board of Veterinary Medical Examiners.

### Board of Chiropractic Examiners

We concur with the finding and recommendation by the Division of State Audit.

### Board of Communication Disorders and Sciences

We concur with the recommendation for the Division of Health Related Boards to establish a written standard for releasing public information to provide citizens optimum access to such information. Consultative services for implementing this recommendation will be offered at the next meeting of the board.

### Board of Dentistry

We concur with the finding only in the knowledge that we have with the Board of Dentistry, but accept the recommendation in the report.

### Board of Osteopathic Examination

We concur with the finding and will review our current policy, which appears to be working well. We agree that the policy for release of information regarding licensure status and types of disciplinary action of healthcare practitioners from the health-related boards should be standardized and placed in the manuals of all board administrators.

### Board of Registration in Podiatry

Should be uniform for all boards.

### Board of Examiners in Psychology

We concur.

### **3. Not all boards have subpoena powers**

#### **Finding**

Not all boards have the statutory authority to issue subpoenas. For those boards with the authority, the process for issuing and obtaining a subpoena is vague. As a result, investigators may have difficulty obtaining information to complete investigations.

There are two types of subpoenas—investigative and testimonial. Investigative subpoenas allow the boards to subpoena documents such as medical records, patient files, and prescription records. Testimonial ones can only require a person to testify. Four boards can issue testimonial subpoenas: the Boards of Communications Disorders and Sciences, Nursing, Nursing Home Administrators, and Veterinary Medical Examiners. The Board of Medical Examiners can issue investigative and testimonial subpoenas. The other boards' power is limited to requiring witnesses to testify at hearings.

Investigators need access to all information necessary to complete an investigation. Authorizing all the boards to issue subpoenas helps investigators overcome obstacles in an investigation.

#### **Recommendation**

The General Assembly may wish to consider amending relevant statutes to authorize investigative subpoena powers for all the boards. Subpoena power for the Emergency Medical Services Board should be given to the department's commissioner who by statute has disciplinary authority. If granted subpoena authority, the boards should establish rules and procedures for issuing subpoenas.

#### **Management's Comment**

##### Joint Comment of the Department of Health and the Emergency Medical Services Board

We concur and agree that subpoena power for the boards would enhance the investigative processes. The department would defer to the will of the General Assembly on legislation that would grant subpoena power to the boards. It should be pointed out that the department proposed legislation to give subpoena power to the investigative unit to cover all boards and the General Assembly rejected the proposal.

The following boards agree with the department's response: Council for Hearing Instrument Specialists, Board of Dietitian/Nutritionist Examiners, Board of Dispensing Opticians, Board of Medical Examiners, Tennessee Medical Laboratory Board, Board of Nursing, Board of Examiners for Nursing Home Administrators, Board of Optometry, and Board of Veterinary Medical Examiners.

#### Board of Chiropractic Examiners

We concur as stated in our response to finding one. Our board has obtained subpoena power and is pressing forward with rules to define how that subpoena power may be used.

#### Board of Communication Disorders and Sciences

We concur with the recommendation for the General Assembly to consider amending relevant statutes to authorize investigative powers for all the boards. If granted subpoena authority, the Board of Communication Disorders and Sciences will establish rules and procedures for issuing a subpoena.

#### Board of Dentistry

We concur with the recommendation that “the General Assembly may wish to consider amending relevant statutes to authorize investigative subpoena powers for all boards. If granted subpoena authority, the boards should establish rules and procedures for issuing a subpoena” with OGC help.

#### Board of Osteopathic Examination

We concur with the finding and believe all health-related boards should have the authority to issue both investigative and testimonial subpoenas. Consideration for proposing legislation to the General Assembly to accomplish these ends will be reviewed by the board in the near future.

#### Board of Registration in Podiatry

This is a necessary power to ensure that necessary information can be obtained to evaluate the case in question.

#### Board of Examiners in Psychology

We concur.

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#### **4. The boards do not have a conflict-of-interest policy**

##### **Finding**

Neither the Division of Health Related Boards nor the individual boards have a conflict-of-interest policy that requires employees or board members to periodically submit disclosure statements of potential personal and professional conflicts of interest.

Board members make licensure and disciplinary decisions intended to protect the public from practitioners who do not meet the qualifications of their profession or whose actions have harmed and endangered the public. These board members must therefore be impartial and independent.

Division staff review license applicant files and recommend applicants to the board for approval. Thus, these employees need to disclose personal interests that could potentially affect their recommendations. Although staff are required to sign a statement when they begin employment, acknowledging their understanding of a general conflict policy, they are not required to disclose potential conflicts.

The division's *Board Member Handbook* recommends that board members recuse themselves from participating in a hearing if they have gained too much knowledge of the case prior to the hearing, or if they believe they may be prejudiced in the matter. The handbook further recommends that board members use caution under these circumstances and seek to avoid even the appearance of bias. In addition, according to attorneys with the department's Office of General Counsel, board members in contested cases must abide by the same Administrative Procedures Act standards as judges in criminal proceedings. In such cases, board members are to recuse themselves from cases when they have a bias, when their independence may be questioned, or when there is an appearance of impropriety.

Conflict-of-interest disclosures are intended to protect the public interest and to ensure independent decisions regarding the licensure of and disciplinary action against regulated practitioners.

No statute requires written disclosure, and nothing came to our attention during this audit to indicate that board members were influenced by personal or professional conflicts of interest. However, without a means of identifying potential personal and financial conflicts of interest and discussing and resolving them before they have an impact on decisions, board members and employees could be subject to questions concerning their impartiality and independence.

### **Recommendation**

The Division of Health Related Boards and the Emergency Medical Services Board should develop and implement a formal, written policy requiring board members and employees to disclose potential conflicts of interest. The policy should specify the types of situations that would be considered a conflict and the process for documenting such a conflict. Board members should be required to periodically update disclosure statements or notify the division whenever a relevant change in a financial or personal interest occurs.

### **Management's Comment**

#### Joint Comment of the Department of Health and the Emergency Medical Services Board

We concur and agree with the recommendation. The divisions of Health Related Boards and Emergency Medical Services will develop and implement policies which define conflict of interest and explain procedures necessary to prevent conflicts of interest for board members and staff.

The following boards agree with the department’s response: Council for Hearing Instrument Specialists, Board of Dietitian/Nutritionist Examiners, Board of Dispensing Opticians, Board of Medical Examiners, Tennessee Medical Laboratory Board, Board of Nursing, Board of Examiners for Nursing Home Administrators, Board of Optometry, and Board of Veterinary Medical Examiners.

Board of Chiropractic Examiners

We concur. The Chiropractic Board would appreciate a uniform conflict of interest policy that would be drafted by HRB and adopted by all boards.

Board of Communication Disorders and Sciences

We concur with the recommendation to develop and implement a formal, written policy requiring board members and employees to disclose potential conflicts of interest. Discussion of this implementation and specific procedures to meet this requirement will occur at the next board meeting.

Board of Dentistry

We concur with the recommendation of the audit draft: “the Division of Health Related Boards should develop and implement a formal, written policy requiring board members and employees to disclose potential conflicts on interest,” etc...if they exist.

Board of Osteopathic Examination

We concur with the finding and agree that the Division of Health Related Boards and EMS Board should develop and implement a formal, written policy requiring board members and employees to disclose potential conflicts of interest.

Board of Registration in Podiatry

Said policy should be in force for all boards.

Board of Examiners in Psychology

We concur.

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**5. Only two boards have authority to assess costs to disciplined practitioners**

**Finding**

Only two of the 16 boards reviewed for this audit can assess costs to disciplined practitioners—the Medical Examiners board and Osteopathic Examiners board, and the Physician Assistants Committee within the Medical board. However, these boards have not used this power. Thus, all the boards currently rely on license fees to pay for operating costs. The majority

of practitioners who comply with laws and regulations should not be required to pay the costs of disciplining those who fail to comply.

The Physician Assistants Committee was granted the authority to assess both investigation and prosecution costs in 1995 [Section 63-19-104(a)(7) (a)(1), *Tennessee Code Annotated*]. According to the Office of General Counsel (OGC) attorney for the Medical Examiners board, the committee has yet to assess costs because it has not had a contested case since receiving authorization.

Section 63-9-111, *Tennessee Code Annotated*, was amended in April 1997 to authorize the Board of Osteopathic Examination to assess the prosecution costs of a disciplinary action against the practitioner. According to management of the Division of Health Related Boards, the bill was passed to address the excessive costs the board was amassing as the result of the many continuances in some cases. As of August 1998, the board had yet to use this authority because it had not heard a case since the authorization was granted.

The Board of Medical Examiners received statutory authorization to assess costs early in 1997. However, as of August 1998, the board had not used this authority because no applicable cases had been closed since the authorization had been granted. The Medical board and the OGC voiced concern about who will receive the recouped costs. Section 63-6-104(b)(2), *Tennessee Code Annotated*, requires that all money the board receives be paid into the state treasury. (Money from license fees is allotted back to each board for operating costs.) According to a Medical board member, the board would probably not use the practice very often if it were not allowed to retain the money. This matter will need to be addressed before actual cost assessment or before other boards are granted the authorization.

### **Recommendation**

The two boards with power to assess disciplinary costs should pursue through the department's Office of General Counsel an answer as to who will retain the recouped costs. If other boards are granted authority by the General Assembly to assess disciplinary costs, these boards should develop and implement procedures to assess and collect costs. The procedures should address determining under what circumstances costs will be assessed and how the amount will be computed.

The General Assembly may wish to consider giving the authority to assess disciplinary costs to the boards that do not have such authority.

### **Management's Comment**

#### Joint Comment of the Department of Health and the Emergency Medical Services Board

We concur and agree that all boards should have the authority to recoup disciplinary costs from the disciplined practitioner. The department would defer to the will of the General Assembly

on legislation that would assess the investigation and prosecution expenses to the respondent. The division is in the process of developing policies and procedures for identifying and collecting disciplinary costs for the two boards that have the authority to assess disciplinary costs (Medical Board and the Osteopathic Board).

The following boards agree with department's response: Council for Hearing Instrument Specialists, Board of Dietitian/Nutritionist Examiners, Board of Dispensing Opticians, Board of Medical Examiners, Tennessee Medical Laboratory Board, Board of Nursing, Board of Examiners for Nursing Home Administrators, Board of Optometry, and Board of Veterinary Medical Examiners.

#### Board of Chiropractic Examiners

We concur in part. The Board of Chiropractic Examiners has the ability to levy fines and has seen this as a way to recoup a portion of the investigative costs. The board would be interested in legislation that would give authority to assess investigation and prosecution costs to disciplined practitioners.

#### Board of Communication Disorders and Sciences

We concur with the recommendation for the Health Related Boards Division to propose legislation to obtain necessary authority to assess both investigation and prosecution costs to discipline practitioners. Once this legislation is passed, the Board of Communication Disorders and Sciences will develop rules and regulations dealing with procedures to assess and collect costs and determine under what circumstances costs will be assessed and how the amount will be computed.

#### Board of Dentistry

We concur with the audit recommendation in full "the Health Related Boards Division and/or individual boards should consider proposing legislation to obtain the necessary authority to assess both investigative and prosecution costs to disciplined practitioners...then develop procedures to assess and collect costs. The procedures should address determining under what circumstances costs will be assessed and how the amount will be computed."

#### Board of Osteopathic Examination

We concur with the finding. It is noted that the Board of Osteopathic Examination does have the authority to assess a prosecution cost of a disciplinary action against the practitioner and will carry out such authority when appropriate. It would seem proper for the board to retain these recouped costs, and this will be clarified with the OGC. Further legislation to grant the board authority to assess investigative costs, as well as prosecution costs, will be considered.

#### Board of Registration in Podiatry

All boards should have this power.

## Board of Examiners in Psychology

We concur in part. It is vital that assessed costs can be applied against expenses charged to the board for lengthy investigations and cases protracted secondary to extensive delays.

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### **6. Boards should consider increasing public representation**

#### **Finding**

The Health Related Boards may want to consider proposing legislation to increase the number of citizen representatives on their boards. Citizen representatives can bring a different perspective to a board, enhancing the board's ability to protect the public health.

Section 63-1-124, *Tennessee Code Annotated*, states that the Governor shall appoint one citizen member to each health-related board. Fourteen boards have at least one public member; the Board of Medical Examiners has three public members. The Emergency Medical Services Board, which is not required to do so, does not have a public member.

According to the *Board Member Handbook*, "a public member brings a special sensitivity to the well-being of persons not in the regulated profession because of an added perspective to the practitioner's interest in preserving high standards for the profession." Many health-related board managers, administrators, and chairmen believe there are advantages to increasing the number of public members. Creating a balance of public and private interests helps to ensure the public's concerns are addressed. Most board administrators believe public members bring objective and insightful views to the boards and provide a check on the profession. Several board chairmen agree that public members can help reduce the biases generated by practitioners in a profession.

Professional organizations such as the Pew Health Professions Commission and the Citizen Advocacy Center (CAC) endorse increasing public representation on health-related boards. Pew reports that in a majority of states, public members are now the rule rather than the exception, and that the presence of public membership on boards can help ease potential conflicts. The CAC also favors efforts to increase public representation on boards and believes public members strengthen the credibility and accountability of boards because public members are committed to protect the public health, safety, and welfare. The CAC suggests that boards consist of at least one-third public membership.

There are disadvantages because public members may not be familiar with the professional regulatory process or have as much time as the professionals, but these factors can be minimized by proper recruitment and training. Increasing the number of public members on the boards could enable the boards to be more responsive to public interest and ensure that public protection is a top priority in all board functions from licensing to disciplining practitioners. Public members not only represent the consumer side of a profession, but also possess a point of view different from that of the practitioners.

## **Recommendation**

The General Assembly may wish to consider increasing citizen membership on the health-related boards. Boards should assess the advantages and disadvantages of increasing the number of public members to determine if such action would enhance the boards' responsibility of protecting the public. Also, boards should thoroughly train public members, so they can be effective and knowledgeable participants.

The General Assembly may wish to consider requiring the Emergency Medical Services Board to have at least one citizen member on its board.

## **Management's Comment**

### Joint Comment of the Department of Health and the Emergency Medical Services Board

We concur and agree that citizen members on the boards add a public viewpoint to the decision-making processes. The department would defer to the will of the General Assembly on legislation that would increase the citizen membership on the boards.

The following boards agree with department's response: Council for Hearing Instrument Specialists, Board of Dietitian/Nutritionist Examiners, Board of Dispensing Opticians, Board of Medical Examiners, Tennessee Medical Laboratory Board, Board of Nursing, Board of Examiners for Nursing Home Administrators, Board of Optometry, and Board of Veterinary Medical Examiners.

### Board of Chiropractic Examiners

We concur. One problem we had over the past two years is finding volunteers who would spend time working with the examining board. We had one consumer that attended 80% of the meetings. We had another consumer member that did not attend any meetings. Efforts to try to contact that consumer member fell on deaf ears. I recently asked the absent consumer member to resign so that we could find someone to represent the consumers on our board. Our board has the power to appoint members to fill in unexpired terms, and we have appointed two consumer members who have committed to attend the board meetings. We have sent those names to the Governor for his information and for his approval.

### Board of Communication Disorders and Sciences

We concur in part with the recommendation to increase citizen membership on the health-related boards. Advantages of this have been established. Citizens member should, however, have specific requirements which better equip them to appropriately protect the public. Assessment of specific citizen member characteristics should be determined. Once these characteristics have been established, the board can determine the advantages and disadvantages of increasing the number of public members. The quality of the public member is more important than how many will serve.

### Board of Dentistry

We concur with the audit recommendation in part. Public representation on boards is a good concept; however, public representation should be individuals who are interested in service on the board. We have had experience with interested and very noninterested public appointees. The one public representative on the dental board does give balance to perspective.

### Board of Osteopathic Examination

We concur that public representation may need to be increased on some of the health-related boards. The Board of Osteopathic Examination consists of six members, one of whom is a citizen representative. This ratio seems appropriate for the size of our board at the present time.

### Board of Registration in Podiatry

No. This is political and political concerns typically compromise an individual's right to a fair hearing.

### Board of Examiners in Psychology

We do not concur. One public member is on the board. The lack of national standards of certification of masters programs requires extensive review of educational qualifications of files of psychological examiner applicants which cannot be delegated to administrators or public members. The primary and most efficient method of training new board members is the biannual meetings of the Association of State and Provincial Psychology Boards which the chair and vice chair must attend. Public members and new professional board members need to be educated to national licensing issues such as reciprocity. Due to their lack of familiarity with standards, public members would require more frequent attendance in order to become more knowledgeable. This would require increased financial support for attendance at these meetings.

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## **7. Not all boards assess continuing competence**

### **Finding**

Not all boards require practitioners to obtain continuing education or demonstrate continuing professional competence as a condition of license renewal. The absence of such a requirement could hinder the boards' ability to help practitioners maintain competency.

Required continuing education is the primary method the boards use to ensure continuing competence. Most boards require practitioners to complete a specified number of hours of continuing education as a condition of license renewal. (These boards' statutes require them to set continuing education standards.) Five of the 16 boards, however, do not require continuing education for all the practitioners under their jurisdiction. (See Exhibit 6.)

- The Boards of Dietitian/Nutrition Examiners and Nursing do not have continuing education requirements for any of their licensees.
- The Board of Dentistry requires continuing education of dentists and dental hygienists, and of dental assistants who perform coronal polishing, but does not require it of all other dental assistants.
- The Medical Laboratory Board only requires continuing education for medical laboratory supervisors who are not qualified as medical laboratory directors.
- The Board of Medical Examiners requires physician assistants, respiratory care practitioners, and x-ray operators to complete continuing education; however, medical doctors and athletic trainers do not have such requirements.

**Exhibit 6**  
**Continuing Education Requirements**

Board	Statutory Authority	Associated Rule	Number Of hours
Chiropractic Examiners Chiropractors	63-4-112	0260-2-.12	12 hours annually
X-ray Operators in Chiropractic Offices	63-4-119	0260-3-.12	6 hours annually
Communication Disorders & Sciences	63-17-124	1370-1-.10	10 hours annually
Council for Hearing Instrument Specialists	63-17-214	0760-1-.12	20 hours biennially
Dentistry Dentists	63-5-107	0460-1-.05	15 hours annually
Dental Hygienists	63-5-107	0460-1-.05	15 hours annually
Dental Assistants (1)	n/a	n/a	n/a
Dietitian/Nutritionist Examiners	n/a	n/a	n/a
Dispensing Opticians	63-14-106	0480-1-.12	Hours set annually
Emergency Medical Services (2) Emergency Medical Technicians	68-140-504	1200-12-1-.04	20 hours biennially
Emergency Medical Technicians – Paramedics	68-140-504	1200-12-1-.04	30 hours biennially
Emergency Medical Dispatchers	68-140-504	1200-12-1-.18	10 hours biennially
First Responders	68-140-504	1200-12-1-.16	16 hours biennially
Medical Examiners Medical Doctors	n/a	n/a	n/a
Athletic Trainers (3)	63-24-102	n/a	n/a

<b>Board</b>	<b>Statutory Authority</b>	<b>Associated Rule</b>	<b>Number Of hours</b>
Physician Assistants	63-19-104	0880-3-.12	100 hours biennially
Respiratory Care Practitioners	63-6-409	0880-7-.12	12 hours annually
X-ray Operators in Physicians' Offices	63-6-224	0880-5-.09	20 hours annually
Medical Laboratory (4)	n/a	n/a	n/a
Nursing	n/a	n/a	n/a
Nursing Home Administrators	63-16-107	1020-1-.12	18 hours annually
Optometry	63-8-119	1045-2-.05	15 hours annually
Osteopathic Examination Osteopathic Physicians	63-9-107	1050-2-.05	50 hours biennially
X-Ray Operators in Osteopathic Physician's Office	63-9-112	1050-3-.12	20 hours biennially
Podiatry	63-3-116	1155-2-.04	15 hours annually
Psychology	63-11-218	1180-2-.25	40 hours biennially
Veterinary Medical Examiners Veterinarians	63-12-120	1730-1-.12	20 hours annually
Veterinary Animal Technicians	63-12-135	1730-3-.12	12 hours annually

Notes:

1. Dental assistants who are certified to perform coronal polishing are required to have at least seven hours of continuing education.
2. Emergency medical technicians may complete a renewal exam or two college credit hours of EMT-related studies instead of the continuing education hours. Paramedics may instead complete a renewal exam or complete three college credit hours. Emergency medical dispatchers may take an exam instead of the continuing education hours. First responders must take a 16-hour refresher course or an exam.
3. Statute authorizes the board to establish rules for continuing education as a condition of renewal, but the board has not established such rules.
4. Sixty hours of continuing education are required only for medical laboratory supervisors who are not qualified as medical laboratory directors.

The issue of using continuing education to evaluate continuing competence is controversial, and board administrators are divided on the issue. For example, one administrator believes continuing education requirements measure competence because practitioners are introduced to new ideas and technologies, while another administrator believes continuing education requirements do not measure continuing competence because a person cannot be forced to learn. The President of the International Council of Nurses and the American Nurses Credentialing Center addressed the debate regarding continuing education at a conference hosted by the Citizen Advo-

cacy Center (CAC) and reached the following conclusions: “When the continuing education requirement is minimal in hours, essentially unrestricted as to the content, and unregulated as to quality, it is a useless means of assuring continuing competence. However, when continuing education is substantial in quantity, specific and personalized in content, and high in caliber, it is of great value.”

Continuing education is not the only approach for evaluating competence. Professional organizations such as the CAC and Pew Health Professions Commission (Pew) offer a number of approaches for ensuring competence. The CAC suggests that regulatory systems develop sophisticated approaches instead of endorsing a single method to fulfill mandatory recertification and relicensure requirements. Such approaches may include peer review through professional standards review organizations, reexamination, self-assessment techniques, and supervisory assessment. Pew asserts that states should require regulated health professionals to demonstrate competence periodically through testing mechanisms, which can be random or targeted. More important, Pew recognizes that emerging information technologies and the information super-highway offer states opportunities to use innovative means of assessing both initial and continuing competence. According to Pew, state boards face the challenge of defining and developing standardized, effective, and feasible continuing competence methods.

These practitioners’ competence is essential to the public’s health, safety, and welfare. Requiring continuing education as a condition of license renewal does not prevent poor performance, but it can limit the potential.

### **Recommendation**

Boards without such requirements should evaluate whether continuing education or other means of helping their licensees maintain competence is necessary. If these boards determine that continuing education will be beneficial, they should (if authorization is not already granted through statute) request that the General Assembly consider amending relevant statutes to grant the boards power to establish continuing education requirements.

### **Management’s Comment**

#### Joint Comment of the Department of Health and the Emergency Medical Services Board

We concur. The Division of Health Related Boards will recommend to the boards who currently do not require continuing education that discussions on this topic be held at upcoming board meetings.

The following boards agree with department’s response: Council for Hearing Instrument Specialists, Board of Dietitian/Nutritionist Examiners, Board of Dispensing Opticians, Board of Medical Examiners, Tennessee Medical Laboratory Board, Board of Nursing, Board of Examiners for Nursing Home Administrators, Board of Optometry, Board of Examiners in Psychology, and Board of Veterinary Medical Examiners.

### Board of Chiropractic Examiners

We concur. The Chiropractic Board currently requires 12 hours of mandatory continuing education for its chiropractic physicians and six hours of continuing education for its chiropractic x-ray technologists. The board evaluates the content to ensure it remains of high caliber. Furthermore, this year the Board of Chiropractic Examiners will be requiring that three of the hours for 1999 include a sexual/professional boundaries training. The board is investigating the possibility of requiring boundaries training, risk management, and jurisprudence training after the first year of licensure for all new licensees.

### Board of Communication Disorders and Sciences

We concur. We have license area continuing education requirements. Discussion of other options for assessing competence maintenance will occur at the next board meeting.

### Board of Dentistry

We concur with the audit recommendation in part. Our board has mixed feelings. We want competent assistants in our profession; continuing education is a measure of that, but the supply of dental assistants, some members say, is lower than office need and additional requirements may hinder assistant availability even more.

### Board of Osteopathic Examination

We concur with the finding and believe all boards of licensed healthcare practitioners should require continuing education as a condition for licensure renewal. We believe the quantity and quality of the continuing education should be appropriate to ensure the continued competence of the licensed practitioner. The Board of Osteopathic Examination currently requires 50 hours of continuing medical education every two years.

### Board of Registration in Podiatry

This is difficult at best. A mechanism for determining competence is beyond the scope of what most boards can provide because of the time required and lack of instruments for assessing competence. The boards already move too slowly in disciplinary matters.

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## **8. Emergency Medical Services Board revenues do not cover operating costs**

### **Finding**

Revenues generated from license fees collected by the Emergency Medical Services (EMS) Board are not sufficient to cover the costs of regulating the profession and its practitioners. (The board regulates emergency medical services and their staff.) The board had revenue shortfalls \$619,758 in fiscal year 1995, \$615,271 in fiscal year 1996, and \$590,175 in fiscal year 1997.

Section 4-29-121, *Tennessee Code Annotated*, requires all regulatory boards administratively attached to the Division of Health Related Boards to be self-supporting. The EMS board, however, is structured as its own division under the Bureau of Manpower and Facilities and the board's enabling statute (Section 68-140-503) does not require self-sufficiency.

Board and Department of Health management believe that EMS license fees are low and that the board should consider initiating actions to make the board more self-sufficient. Board management estimated that only 30% of the board's operating budget comes from license fees. The remaining percentage consists of state appropriations (\$649,245 in fiscal year 1997) and federal grant funds which are used to purchase training equipment. The board received \$145,000 in federal funds in fiscal year 1997 but is scheduled to receive only \$125,000 in fiscal year 1998. Management believes the amount will continue to decrease each year.

From 1983 until 1995, fees for board-regulated practitioners and services remained constant. Board management attributes the significant revenue shortfalls to its inability to raise license fees. Legislation creating the board in 1983 included a cap that prevented the board from increasing license fees. The cap on fees was removed in 1992, but according to management, the General Assembly did not allow fee increases until 1995 because of the administration's commitment to no new tax increases. The board raised fees in October 1996, increasing most practitioner fees \$2 to \$5. Preliminary data show the board generated \$191,028 in license fee revenues in fiscal year 1997, a \$27,967 increase from fiscal year 1996.

Despite the recent fee increase, EMS license fees, in comparison with other health regulatory boards, appear to be low. The license fee for emergency medical technicians (EMTs) is only \$15 for initial license and \$12 for renewal; and the fee for paramedics is \$25 for initial license and \$12 for renewal. (Licenses are valid for two years.) In addition, the license fees charged for ambulance services are only \$80 per year for initial license and renewal. A proposal to increase fees was made to the board in August 1997, but as of August 1998 had yet to be approved.

Board management and the board chairman believe that requiring the board to be more self-sufficient may be necessary to counter revenue shortfalls, possible budget cuts, and a potential decrease in federal grant funds.

#### First Responders Do Not Have to Pay Fees

The board could increase revenues by better identifying license applicants who are truly volunteers and thus eligible for fee waivers. Instead, the board has provided a blanket waiver for the first responders category—the category the board believes consists primarily of volunteers. This blanket waiver may result in lost license fee revenues from applicants who fail to meet the state's definition of volunteers.

Section 68-140-517(a), *Tennessee Code Annotated*, requires the board to waive license fees for emergency medical technicians who are "volunteer personnel associated with nonprofit corporations or associations providing emergency medical services, and otherwise non-salaried

for their provision of emergency care.” Such volunteers, however, are required to pay for testing, training, and other costs incurred by the board.

First responder is not a specific job title like paramedic or emergency medical technician (EMT). Rather, it is an adjunct category comprised of individuals who provide pre-hospital emergency care and have job titles such as fire fighters, policemen, rescue squad personnel, and park rangers.

Board management bases its blanket fee waiver on two primary factors. First, because of the adjunct nature of the first responder category, many practitioners may claim volunteer status even though they do not meet the statutory criteria. Although many of these individuals may be professionals in their line of work (e.g., police officers, fire fighters), they may also volunteer their services as first responders and thus claim volunteer status. By statute, however, these individuals would not meet true volunteer status criteria. Management estimated that as many as 98% of applicants would identify themselves as volunteers on the license application if it were amended to require this information. Second, management believes that any additional revenue generated from the non-volunteers would not cover the cost of hiring the personnel needed to make that distinction.

The board has not conducted an analysis to determine the percentage of first responders who are actually volunteers and was unable to estimate the percentage. The application for first responder licenses does not ask applicants to indicate whether or not they are volunteers. Thus, the board cannot determine or even estimate the amount of revenue it is not collecting as a result of the total fee waiver for first responders. As of June 1998, there were 2,718 licensed first responders in Tennessee.

### **Recommendation**

The General Assembly may wish to consider statutory changes that would require the Emergency Medical Services Board to be self-supporting.

The Emergency Medical Services Division should conduct an analysis to determine appropriate fee levels needed for self-sufficiency. The board should use these results to consider increasing license fees to a level that would support operating costs.

The Emergency Medical Services Board should conduct an analysis to identify the number of first responders that meet the statutory requirements for volunteer status. This could be done by adding a question to the first responder license application to determine whether applicants are volunteers. Based on the results of this analysis, the board can determine whether the generated revenues would justify the costs of personnel needed to periodically make this determination.

## **Management's Comment**

### Joint Comment of the Department of Health and the Emergency Medical Services Board

We concur. The EMS Board approved significant fee increases, which include first responders, in its March 12, 1998, meeting. The fee rules are now in the Attorney General's Office. The EMS board and staff conducted an extensive analysis and consulted with providers and licensees prior to setting the fees. This was done with the knowledge that the EMS Division has statewide emergency management responsibilities under Executive Order Number 15 and the Tennessee Emergency Management Plan (TEMP). The board feels that EMS licensees should not pay for these mandated state government responsibilities. The board believes the state appropriation from the general fund should be retained to cover these identified costs.

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## **RECOMMENDATIONS**

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### **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 boards' and the Department of Health's operations.

1. The General Assembly may wish to consider amending relevant statutes to authorize investigative subpoena powers for all the boards. Subpoena power for the Emergency Medical Services Board should be given to the department's commissioner who by statute has disciplinary authority.
2. The General Assembly may wish to consider giving the authority to assess disciplinary costs to the boards that do not have such authority.
3. The General Assembly may wish to consider increasing citizen membership on the health-related boards.
4. The General Assembly may wish to consider requiring the Emergency Medical Services Board to have at least one citizen member on its board.
5. The General Assembly may wish to consider statutory changes that would require the Emergency Medical Services Board to be self-supporting.

### **ADMINISTRATIVE**

The boards and the Department of Health should address the following areas to improve the efficiency and effectiveness of its operations.

1. The department and/or individual boards should develop and implement a system to monitor the timeliness of the complaint process and set time guidelines. Management should then identify delays in the process and develop strategies and take immediate action to improve and speed up processing.

The Emergency Medical Services Board should improve the maintenance of complaint investigation files to improve monitoring. Investigators should document significant dates in the investigation process.

2. The boards should develop disciplinary guidelines detailing the actions to take for certain offenses and violations. The boards should consider using the guidelines of the

Board of Nursing as an example. The boards should follow these guidelines to improve consistency in disciplinary actions.

3. The Division of Health Related Boards should establish a written standard for releasing public information to provide citizens' optimum access to such information. The policy should be included in the Health Related Boards Administrator Manual, and all administrators and support staff should be trained in how to answer citizens' requests for information on licensed practitioners. Staff of all the boards should consistently adhere to this standard to ensure the public of its right to information.
4. The boards, if granted subpoena authority by the General Assembly, should establish rules and procedures for issuing subpoenas.
5. The Division of Health Related Boards and the Emergency Medical Services Board should develop and implement a formal, written policy requiring board members and employees to disclose potential conflicts of interest. The policy should specify the types of situations that would be considered a conflict and the process for documenting such a conflict. Board members should be required to periodically update disclosure statements or notify the division whenever a relevant change in a financial or personal interest occurs.
6. The two boards with power to assess disciplinary costs (Medical Examiners and Osteopathic Examination) should pursue through the department's Office of General Counsel an answer as to who will retain the recouped costs. If other boards are granted authority by the General Assembly to assess disciplinary costs, they should develop and implement procedures to assess and collect costs. The procedures should address determining under what circumstances costs will be assessed and how the amount will be computed.
7. The boards should assess the advantages and disadvantages of increasing the number of public members to determine if such action would enhance the boards' responsibility of protecting the public. Also, boards should thoroughly train public members so they can be effective and knowledgeable participants.
8. Boards without continuing education requirements should evaluate whether continuing education or other means of helping their licensees maintain competence is necessary. If these boards determine that continuing education will be beneficial, they should (if authorization is not already granted through statute) request that the General Assembly consider amending relevant statutes to grant the boards power to establish continuing education requirements.
9. The Emergency Medical Services Division should conduct an analysis to determine appropriate fee levels needed for self-sufficiency. The board should use these results to consider increasing license fees to a level that would support operating costs.

10. The Emergency Medical Services Board should conduct an analysis to identify the number of first responders that meet the statutory requirements for volunteer status. This could be done by adding a question to the first responder license application to determine whether applicants are volunteers. Based on the results of this analysis, the board can determine whether the generated revenues would justify the costs of personnel needed to periodically make this determination.

## APPENDIX 1

### **Description of the Health Related Boards and The Emergency Medical Services Board**

#### Board of Chiropractor Examiners

The Board of Chiropractic Examiners was created by Section 63-4-102, *Tennessee Code Annotated*, to regulate chiropractors and operators of x-ray equipment in chiropractic offices. The board is composed of seven members—five chiropractors and two members of the public. Members are appointed by the Governor to four-year terms.

#### Board of Communication Disorders and Sciences

The Board of Communication Disorders and Sciences was created by Section 63-17-104, *Tennessee Code Annotated*, to regulate speech language pathologists, speech language pathology aids, and audiologists.

The board is appointed by the Governor and consists of five practicing speech pathologists or audiologists, one consumer member, and one licensed physician whose medical specialty is otolaryngology (ear, nose, and throat specialty). The physician member is to be selected from a list of three nominees submitted from the Tennessee Academy of Otolaryngology. Of the six nonphysician members, at least two are to be audiologists and at least two are to be speech language pathologists. The fifth member can either be a speech language pathologist and audiologist. Each member serves a three-year term.

#### Council for Licensing Hearing Instrument Specialists

Section 63-17-202, *Tennessee Code Annotated*, created the council within the Board of Communication Disorders and Sciences to license those who dispense and fit hearing instruments. Its duties also include requiring an annual calibration of audiometric equipment and establishing minimum requirements for test procedure and test equipment to be used in the fitting of hearing instruments.

The Governor appoints five members for five-year terms. Three are licensed hearing instrument specialists and fitters of hearing instruments who are certified by the National Board for Certification of Hearing Instrument Sciences. (Members can be nominated from a list submitted by the Tennessee Hearing Aid Society.) One member is a licensed physician who has been certified by the American Council of Otolaryngology. (The member can be appointed from a list of nominees submitted by the Tennessee Medical Association.) One member is a user of hearing instruments for five years preceding the appointment.

#### Board of Dentistry

The Board of Dentistry was created by Section 63-5-101, *Tennessee Code Annotated*, to regulate dentists, dental hygienists, and dental assistants.

The Governor appoints nine members to three-year terms. The board consists of six practicing dentists (two from each grand division of the state), one practicing dental hygienist, one practicing registered dental assistant, and one public member. The dentist members may be appointed by the Governor from a list submitted from the Tennessee Dental Association. The dental hygienist member may be appointed by the Governor from a list recommended by the Tennessee Dental Hygienists' Association. The dental assistant member may be appointed from a list recommended from the Tennessee Dental Assistants' Association.

#### Board of Dietitian/Nutritionist Examiners

Section 63-25-106, *Tennessee Code Annotated*, created the Board of Dietitian/Nutritionist Examiners to ensure that persons practicing the profession of dietetics and nutrition meet minimum standards of proficiency and competency acquired through training and experience.

Six members are appointed by the Governor to three-year terms. Five members are required to have at least five years' experience in the practice or teaching of dietetics and/or nutrition. One member is a public member. Appointments may be made from lists of nominees submitted by the Tennessee Dietetic Association, Tennessee Hospital Association, and the Tennessee Medical Association.

#### Board of Dispensing Opticians

The Board of Dispensing Opticians was created by Section 63-14-101, *Tennessee Code Annotated*. The board is composed of six members. Five members must have been engaged in the practice as dispensing opticians for at least five years. One is a public member. Terms are for four years.

#### Emergency Medical Services Board

The Emergency Medical Services Board was created by Section 68-140-503, *Tennessee Code Annotated*, to regulate providers of ambulance services, emergency medical technicians, paramedics, first responders, and emergency medical dispatchers. The board certifies training programs in the professions regulated by the board. It also regulates the development and operation of emergency medical telecommunication systems and set standards for emergency vehicles and equipment.

The Governor appoints 13 members to four-year terms:

- Two licensed physicians, who may be from a list of nominees submitted by the Tennessee Medical Association.
- One registered nurse, who may be from a list of nominees submitted by the Tennessee Nurses Association.
- One hospital administrator, who may be from a list of nominees presented by the Tennessee Hospital Association.

- One member affiliated with a volunteer, nonprofit ambulance service who is either an emergency medical technician (EMT), emergency medical technician-paramedic (EMT-P), registered nurse, or physician.
- Two operators of ambulance services who are certified as an EMT or EMT-P. Members may be from a list of nominees by the Tennessee Ambulance Services Association.
- One rescue squad member who is certified as an EMT or EMT-P and who may be from a list of nominees submitted by the Tennessee Association of Rescue Squads.
- One member who is certified as an EMT-P and may be from a list of nominees submitted by the Tennessee Professional Fire Fighters Association.
- One member who is certified as an EMT or EMT-P and may be from a list of nominees submitted by the Tennessee Civil Defense Association.
- Two officials of county, municipal, or metropolitan governments which operate ambulance services.
- One paramedic instructor from an accredited paramedic program.

#### Board of Medical Examiners

Section 63-6-101, *Tennessee Code Annotated*, created the Board of Medical Examiners to regulate medical doctors, physician assistants, athletic trainers, respiratory care practitioners, and x-ray equipment operators. The twelve members are appointed by the Governor for five-year terms. Nine members are licensed physicians and three are consumer members. The Governor has the discretion to seek recommendations from the Tennessee Medical Association in making appointments to the board.

Within the board is the Council of Respiratory Care (Section 63-6-403) which regulates respiratory therapists, respiratory care technicians, and respiratory care assistants. The board also has a Committee on Physician Assistants (Section 63-19-103) to aid in its regulation of this profession. Physician assistant licenses are issued in the board's name.

#### Tennessee Medical Laboratory Board

Section 68-29-109, *Tennessee Code Annotated*, created the Tennessee Medical Laboratory Board to regulate medical laboratory personnel (directors, supervisors, technologists, technicians, trainees, and special analysts). The board also licenses medical laboratories and medical laboratory training facilities.

The board is composed of 13 members appointed by the Governor to four-year terms:

- Three pathologists who are licensed physicians and certified in clinical and anatomical pathology. (One must be associated with a medical laboratory personnel education program.)
- One hospital administrator.

- One independent laboratory management/administration representative.
- One licensed medical technologist generalist.
- One licensed physician who is not a pathologist.
- One educator in a medical technology or medical laboratory technician program who is licensed as a medical laboratory technologist or as a licensed nonphysician medical laboratory supervisor.
- One licensed nonphysician medical laboratory supervisor.
- One licensed medical technologist generalist.
- One licensed medical technologist.
- One licensed cytotechnologist.
- One citizen to represent the public interest.

### Board of Nursing

The Board of Nursing was created by Section 63-7-201, *Tennessee Code Annotated*, to regulate registered nurses and licensed practical nurses. It issues certificates of fitness to prescribe drugs to nurse practitioners. Nurse practitioners must be registered nurses and meet other board standards. The board also approves schools of nursing.

The board has nine members appointed by the Governor to four-year terms. Five members are registered nurses, three members are licensed practical nurses, and one is a public member. The registered nurse and licensed practical nurse members must have at least five years of experience in their professions. Members may be appointed from lists of nominees submitted by their respective organizations. The board has the duty to employ, with the approval of the Governor, an executive director who is not a member of the board.

### Board of Examiners for Nursing Home Administrators

The Board of Examiners for Nursing Home Administrators was created by Section 63-16-102, *Tennessee Code Annotated*, to regulate nursing home administrators. It consists of eight members appointed by the Governor to three-year terms:

- Three members are representatives of the nursing home industry nominated by the Tennessee Health Care Association.
- One member is a nursing home administrator appointed by the Tennessee Hospital Association.
- One member is a hospital administrator nominated by the Tennessee Hospital Association.
- One member is a physician nominated by the Tennessee Medical Association.
- One member is a nurse nominated by the Tennessee Nurses' Association.
- One member is a consumer representative.

### Board of Optometry

The Board of Optometry was created by Section 63-8-103, *Tennessee Code Annotated*, to regulate optometrists. The board has six members appointed by the Governor for five-year terms. Five members are practicing optometrists and one is a public member. The Governor may appoint the optometrist members from a list of nominees from the Tennessee Optometric Association.

### Board of Osteopathic Examination

The Board of Osteopathic Examination was created by Section 63-9-101, *Tennessee Code Annotated*, to regulate osteopathic physicians. The board also sets standards for persons operating x-ray equipment in osteopathic physicians' offices. The board has six members appointed by the Governor to five-year terms. Five are practicing osteopathic physicians; one is a citizen member.

### Board of Registration in Podiatry

The Board of Registration in Podiatry was created by Section 63-3-103, *Tennessee Code Annotated*, to regulate the practice of podiatry. Five members are appointed by the Governor for three year-terms. Four members must have been licensed podiatrists for at least two years. At least one of these members must be from a school of podiatry. One member is a public member.

### Board of Examiners in Psychology

Section 63-11-101, *Tennessee Code Annotated*, created the Board of Examiners in Psychology to regulate psychologists and psychological examiners. The board has seven members appointed by the Governor. It is composed of three practicing psychologists, two academic psychologists, one licensed psychological examiner, and one public member. The psychologist members must be appointed from a list provided by the Tennessee Psychological Association. The psychological examiner member may be appointed from a list provided by the Tennessee Association of Psychological Examiners.

### Board of Veterinary Medical Examiners

The Board of Veterinary Medical Examiners was created by Section 63-12-104, *Tennessee Code Annotated*, to regulate veterinarians and animal technicians. Six members are appointed by the Governor to five-year terms. Five are licensed doctors of veterinary medicine. The Tennessee State Veterinary Medical Association may recommend doctors of veterinary medicine for appointment.

## APPENDIX 2

### BOARD BALANCES

<u>Board</u>	<u>FY 1995-96 Balance</u>	<u>FY 1996-97 Balance</u>
Chiropractic Examiners	\$ (1,644)	\$ 830
Communication Disorders and Sciences	21,447	29,663
Dentistry	(176,335)	(47,140)
Dietitian/Nutritionist Examiners	24,578	19,670
Dispensing Opticians	6,440	(3,272)
Hearing Instrument Specialists	4,639	(7,326)
Medical Examiners	217,311	(14,068)
Athletic Trainers	1,579	2,628
Physician Assistants	32,934	31,496
Respiratory Care	53,682	63,904
Medical Laboratory	43,148	44,392
Nursing	274,270	217,926
Nursing Home Administrators	31,235	42,017
Optometry	38,802	58,975
Osteopathic Examination	1,142	6,582
Podiatry	(264)	6,704
Psychology	13,262	1,822
Veterinary Medical Examiners	28,733	73,143

### APPENDIX 3

#### NUMBER OF LICENSES CALENDAR YEAR 1997\*

<u>Board</u>	<u>Profession</u>	<u>Number of Licenses</u>	<u>Licenses under Board</u>
Nursing	Registered Nurses	51,937	77,792
	Licensed Practical Nurses	25,855	
Medical Examiner	Medical Doctors	16,081	20,817
	X-Ray Operators	1,931	
	Respiratory Care Therapists	1,168	
	Respiratory Care Technicians	1,012	
	Physician Assistants	358	
	Athletic Trainers	267	
	Respiratory Care Assistants	76	
Emergency Med Services	Emergency Medical Personnel	13,380	13,380
Dentistry	Dental Assistants	3,364	9,327
	Dentists	3,244	
	Dental Hygienists	2,719	
	Medical Laboratory Personnel	7,355	
Medical Laboratory	Medical Laboratory Personnel	7,355	7,355
	Psychology	Psychologists	1,263
Veterinary	Psychological Examiners	929	1,478
	Veterinarians	1,305	
Communication Disorders and Sciences	Veterinary Medical Technicians	173	1,412
	Audiologists	224	
	Speech Pathologists	1,132	
Optometry	Speech Pathologist Aids	56	918
	Optometrists	918	
Chiropractic Examiners	Chiropractors	782	917
	Chiropractic X-Ray Operators	135	
	Dispensing Opticians	775	
Dietitian/Nutritionist	Dispensing Opticians	775	775
Nursing Home Admin	Dietitians and Nutritionists	720	720
Osteopathic Examination	Nursing Home Administrators	713	713
	Osteopaths	511	
	Osteopathic X-Ray Operators	3	
Podiatry	Podiatrists	180	116
Hearing Instrument Specialists	Hearing Instrument Specialists	116	

\* Number of licenses for the Emergency Medical Services Board is for June 1998.