



OFFICE OF INSPECTOR GENERAL INTERNAL AUDIT UNIT

ANALYSIS OF TUBERCULOSIS PROGRAMMATIC AND FISCAL ISSUES

Report # O-1213DOH-004
January 10, 2013

EXECUTIVE SUMMARY

What was reviewed:

The Department of Health's (DOH) Tuberculosis (TB) Program. Specifically, whether funding sources were used appropriately, select medical experts were paid by the appropriate funding source, isolation practices conformed to recommended protocols and guidelines, TB clinical studies and research were reported to the DOH Institutional Review Board (IRB) appropriately and to review roles and responsibilities of the TB Program's various components.

What was found:

- ❖ Funding sources were used in accordance with legislative intent and grant terms;
- ❖ Clinical studies and research were generally reported to the IRB appropriately;
- ❖ Isolation practices conformed to recommended protocols and guidelines but further documentation of environmental control compliance in non-traditional healthcare facilities is needed;
- ❖ Roles of the TB Program Office were not clearly defined and staff within the TB Program Office were generally uninformed regarding critical operational functions statewide;
- ❖ Roles and responsibilities of the TB Managers/Coordinators were not clearly defined and not all played equally critical roles in the process;
- ❖ Confusion exists as to who has oversight and responsibility for the TB Medical Director;
- ❖ Areas of concern were noted regarding DOH's contract with the TB Physicians Consultation Network;
- ❖ Inconsistencies existed in reporting data to the TB Program Office; and
- ❖ The use of redundant systems to document and share X-ray review and consultation was inefficient and counterproductive.

We were unable to determine whether a DOH medical expert was paid from appropriate funding sources due to a lack of documentation maintained by a DOH contracted entity.

What is being recommended:

We recommend the TB Program Office:

- ❖ Update guidelines to require additional documentation for the existence of and compliance with environmental controls prior to using temporary housing for TB clients;
- ❖ Establish clearly defined roles and responsibilities of the Office, both within the greater Department-wide DOH TB *System of Care* and through communication with Program Office staff;
- ❖ Be better informed as to critical operational functions within the TB Program statewide;
- ❖ Along with the team assembled to develop DOH's *System of Care*, evaluate need and identify the fewest number of TB Managers/Coordinators required and clearly define their roles and responsibilities;
- ❖ Review its plan for the supervision of and communication with its TB Medical Director to ensure accountability and clearly-defined expectations among all parties;
- ❖ Require the University of Florida (UF) to provide consistent documentation for the services of the TB Physicians Consultation Network (TB Physicians Network);
- ❖ Provide direction for all county health departments (CHDs) to use the TB Physicians Network for the reviewing of X-rays, consultations and clinics;
- ❖ Find ways to more efficiently verify data being reported across the state; and
- ❖ Encourage and train TB nurses to make original entry of Form 167 data into the Health Management System TB Module and request from DOH management the redundant TB X-ray Database be discontinued.

Details supporting the statements listed in this Executive Summary can be found in the remainder of this report. DOH management agreed with all findings and has submitted corrective action plans, which have been included in this report. The Office of Inspector General will conduct a follow-up six months from the publication date of this report to assess the status of management's corrective actions.

OBJECTIVES AND SCOPE

DOH Executive Management requested the Office of Inspector General review documentation sufficient to determine whether:

- ❖ The funding sources for the TB Program were being used appropriately (including consistency with legislative intent, grant terms, etc.);
- ❖ Selected medical experts were being paid for by the appropriate funding source;
- ❖ TB isolation practices conform to DOH and Centers for Disease Control and Prevention (CDC) protocols; and
- ❖ Clinical studies and research for TB were reported to the DOH Institutional Review Board (IRB) in accordance with established policies.

Once into our review, we determined that it was also necessary to document the roles of and interaction between the various components of DOH's TB Program. We reviewed the following components of DOH's TB Program:

- ❖ Bureau of Communicable Diseases' TB Section;
- ❖ The Bureau of Communicable Diseases' TB Section's Medical Director and his staff;
- ❖ Eight Area TB Regional Program Coordinators;
- ❖ Contracted Providers;
- ❖ Florida TB Physicians Network; and
- ❖ any additional component that came to our attention during the project.

This project was not an audit, as industry-established auditing standards were not applied. Internal Audit Unit procedures for the performance of reviews were followed and used during this project.

BACKGROUND

TB is a communicable disease spread from person to person through the air, usually affecting the lungs, but can also affect parts of the body, such as the brain, kidneys and spine.

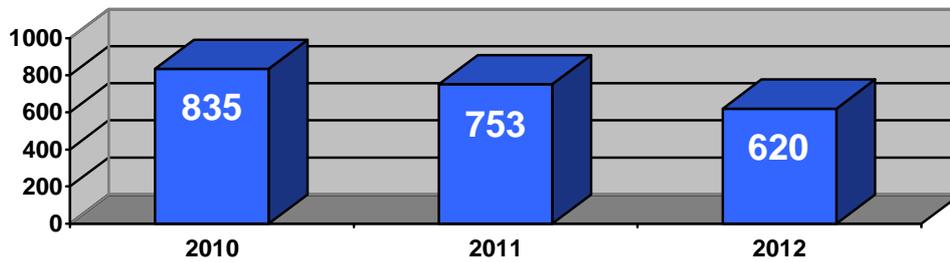
The DOH TB Section, located within the Division of Disease Control & Health Protection, Bureau of Communicable Diseases, has been established to administer an overall TB Program that:¹

- Provides leadership, policy development and technical assistance to contribute to the prevention of TB;
- Supports the provision of targeted testing, contact investigation, treatment for latent TB infection and treatment for TB disease services;
- Provides training and technical assistance related to TB control;
- Coordinates morbidity reporting;
- Serves as liaison to laboratories, pharmacies and the CDC; and
- Provides surveillance and monitoring services, epidemiological investigation and program evaluation.

Over the last several years, there has been a decline in the number of reported TB cases in the State of Florida, as represented in **Exhibit 1** below.

¹ Source: DOH TB Program intranet site

Exhibit 1: Reported TB Cases in Florida per Year



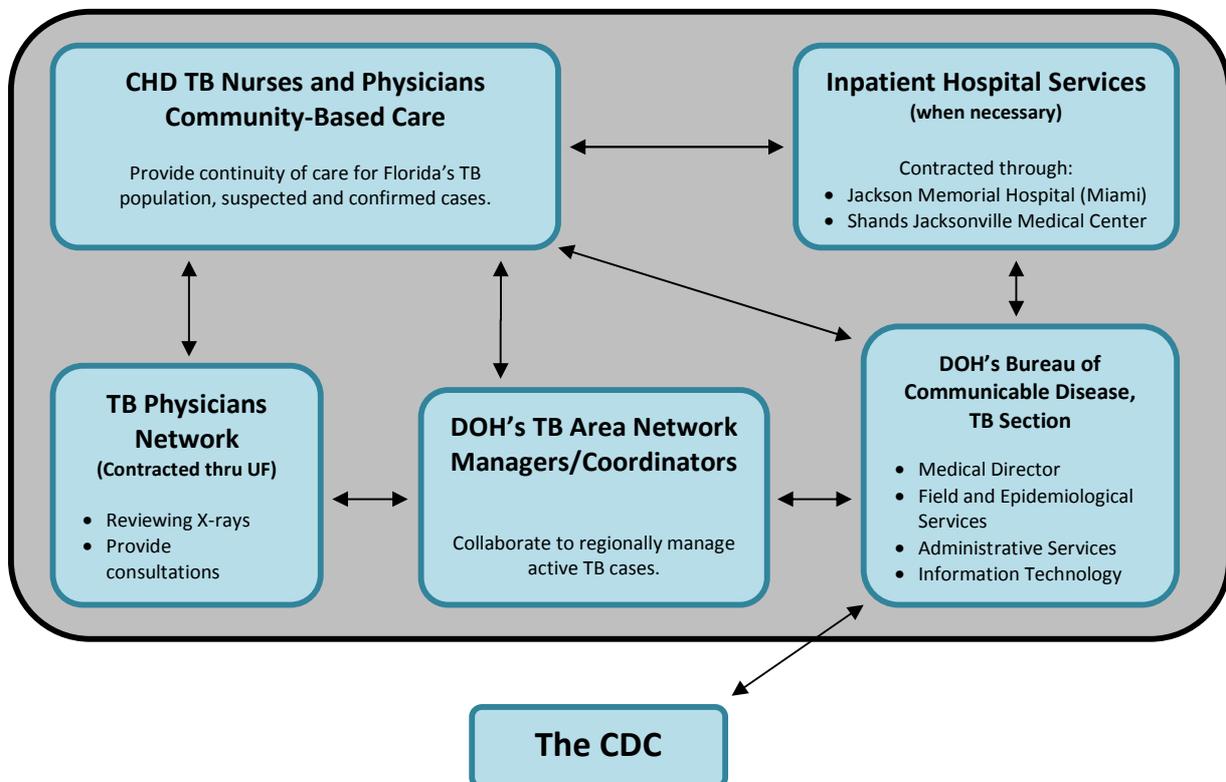
Source: DOH TB Program Office

Current Changes to the TB Program

Following passage of legislation by the Florida Legislature to effectively close the nation’s lone remaining hospital dedicated to TB clients, A.G. Holley State Hospital (A.G. Holley) in Lantana, DOH executive management in early 2012 established an Incident Command Team (Team) to coordinate the closure of A.G. Holley and develop a new model to manage Florida’s statewide TB Program. The result was a re-defined *System of Care* that continues to evolve, the goal of which is to provide a seamless system of care for Florida’s TB population.

There are several components that comprise the Florida TB *System of Care*. Each component performs its role and interacts with the other functions. Based upon our analysis and the information gathered during this project, the program currently is structured as follows (See **Exhibit 2** below):

Exhibit 2: Components of Florida’s TB System of Care



Protocols and the CDC

Protocols and recommendations for TB management and treatment are promulgated through the CDC. The CDC publishes “What the Clinicians Should Know”, which covers criteria for infectiousness and non-infectiousness clients; separating and isolating persons with TB signs/symptoms; administrative control criteria for clinicians; environmental control criteria for preventing the spread and reducing concentration of infectious droplet nuclei; treatment of the disease; and numerous additional recommendations on the treatment and management of TB.

The CDC also publishes Morbidity and Mortality Weekly Reports (MMWR) which serve as the CDC’s primary vehicle for their public health information and recommendations. We examined MMWR reports related to the treatment of TB, the essential components of TB prevention and control program; and guidelines for preventing the transmission of TB in healthcare facilities.

To maintain conformity with these CDC guidelines, DOH created TB Technical Assistance Guidelines (guidelines) for use by all CHDs. These guidelines cover numerous areas related to TB including administrative and environmental controls; infection control; usage, eligibility and restrictions of enablers, such as temporary housing to encourage completion of TB treatment; allowance for local CHD guidelines on incentives and enablers; evaluating and managing homeless clients being considered for temporary housing assistance; the need for the client to be placed in Direct Observed Therapy (DOT) and carefully monitored for full compliance with the treatment plan; and guidelines on how to conduct DOT.

Institutional Review Board

An IRB, also known as an independent ethics committee or ethical review board, is a committee that has been formally designated to approve, monitor and review biomedical and behavioral research involving humans. They often conduct some form of risk-benefit analysis in an attempt to determine whether or not research should be done. In the United States, the Food and Drug Administration (FDA) and Department of Health and Human Services (specifically Office for Human Research Protections) regulations have empowered IRBs to approve, require modifications or disapprove planned research projects. IRBs are also responsible for critical oversight functions for research conducted on human subjects to ensure they are scientific, ethical and regulated.

The DOH IRB is located within the Bureau of Chronic Disease Prevention and is responsible for overseeing all DOH related human subject research and when obtaining data about research participants through intervention or interaction with them or through obtaining identifiable private information.

There are two DOH IRB committees comprised entirely of volunteers and consisting of both medical and non-medical personnel as well as DOH and non-DOH employees. Each committee meets once a month. The DOH IRB is also involved in research related to TB program agreements and TB data use agreements.

The DOH IRB is the only public health organization to receive accreditation from the Association for Accreditation of Human Research Protection Programs in 2008 and re-accredited in 2011.

FINDINGS AND RECOMMENDATIONS

During our review, we were able to determine the following related to the objectives of this project:

- ❖ ***The funding sources for the TB Program were being used in accordance with legislative intent and grant terms.***

We reviewed the requirements and restrictions on spending the TB program's federal grant from the CDC, as well as related expenditures. We also reviewed the General Appropriations Act pertaining to the General Revenue received by the TB program and related expenditures. Funding sources for the TB Program were consistent with legislative intent and grant terms.

- ❖ ***Clinical studies and research for TB were generally reported to the DOH IRB in accordance with established policies.***

We interviewed the IRB Administrator along with the State TB Medical Director and his Program Administrator. We also reviewed IRB policies and procedures, email communications and IRB authoritative sources to determine if TB related research projects are being reported to the DOH IRB in accordance with established policies.

While we did note some communication issues between the State TB Medical Director and the DOH IRB during the time of the A.G. Holley closure, those issues have been rectified and overall, we found that established policies were being followed.

- ❖ ***TB isolation practices conformed to CDC protocols and DOH guidelines.***

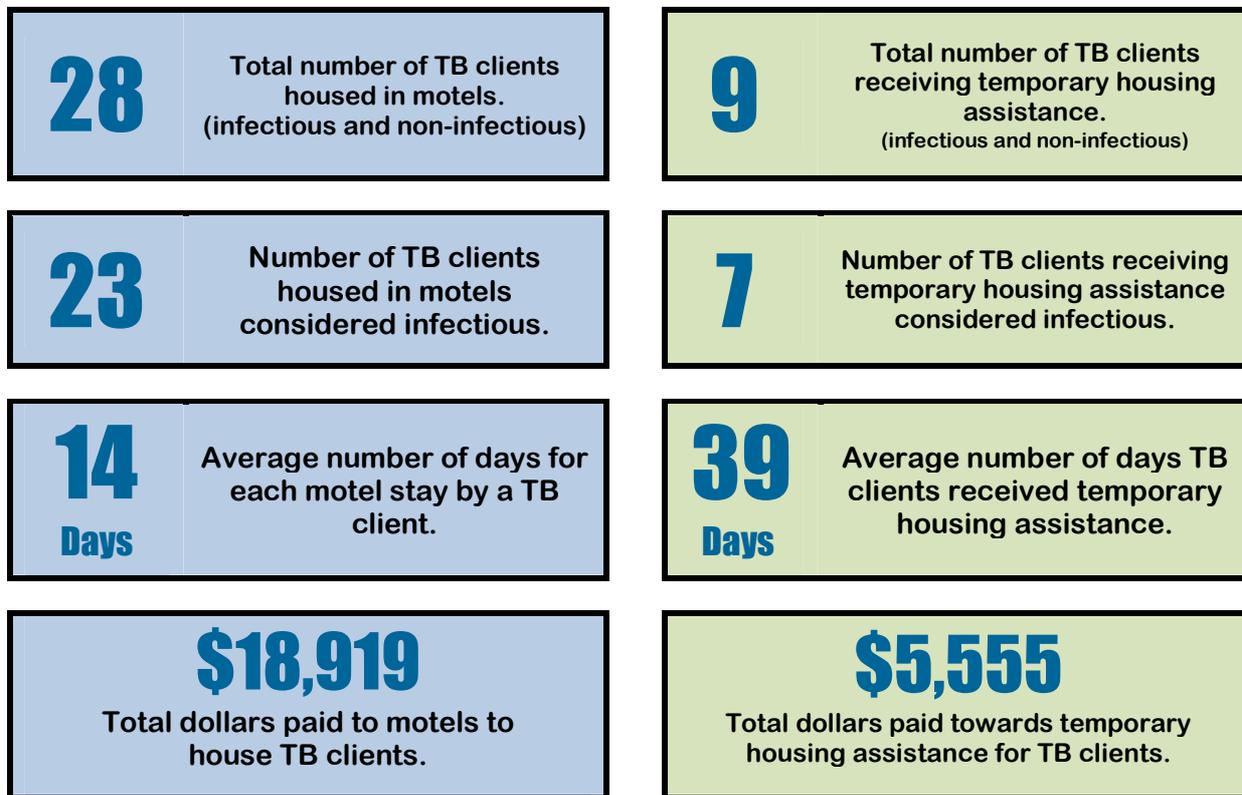
Once diagnosed with TB, some clients are placed in DOT that is geared towards ensuring the client meets all required treatments. Incentives and enablers are products or services used to help motivate clients' adherence to treatments, take medications, keep appointments or cooperate in other ways necessary to complete treatment. Studies have historically shown that DOT, in combination with incentives and enablers, produce the highest treatment completion rate. Both CDC protocols and DOH guidelines allow for the use of incentives and enablers where warranted to help ensure proper treatment is obtained by an at-risk client. As such, temporary housing is sometimes utilized as an enabler to ensure full treatment is achieved.

During our review, we looked at the use of housing enablers for at-risk TB clients. Two forms of housing enablers were utilized by the DOH TB Program Office during our review period. In some instances, a client may have lost their job or may feel the threat of eviction due to loss of income as a result of TB isolation and/or treatment. In these instances, the caseworker had the option to offer the client temporary payment of the individual's rent or other housing payments in order to keep them isolated during their recovery period. In other cases, motels were utilized as an enabler for clients to complete their TB treatment plan and no other suitable housing arrangements could be found.

We reviewed invoice submissions on incentive/enabler request forms from July 2011 to July 2012 throughout Florida, specifically related to motel use, to determine conformity with established guidelines. We also examined payments made to temporarily cover an individual's rent payments. Furthermore, enabler requests for motels and rental payments were reconciled with Florida Accounting Information Resource system (FLAIR) data to assess the appropriateness of these payments. While we found no issues with the guidelines themselves, we did note an issue related to documenting the compliance with guidelines (See **Finding #1**, Page 7 below).

Highlights of our data review can be found in **Exhibit 3** below. Full results of our data analysis can be found in **Appendix A** at the end of this report.

Exhibit 3: Use of Motels and Temporary Housing Assistance from July 2011 through July 2012: **



** Data Source: TB Program Office

Although there was a limited utilization of motels, their use was within CDC guidelines, environmental controls were considered prior to use and there were no documented instances of other guests becoming infected as a result of motel utilization, DOH management made the decision in July 2012 to end the practice of using motels to house TB clients during their recovery. Instead, other housing alternatives, such as obtaining apartments or specialty housing specifically designed for such clients, will be utilized in the future.

❖ ***We were unable to determine whether a DOH medical expert was paid from appropriate funding sources due to a lack of documentation maintained by a DOH contracted entity.***

One medical expert worked directly for DOH and through a contract with UF as it relates to TB matters. We had hoped to compare detailed timesheets from both DOH and UF to ensure proper segregation of responsibilities and billings for time worked were appropriate. However, UF was found to maintain timesheets on an “exception basis” (meaning only leave time and time NOT worked is reported) without detailed support for the days and hours actually worked on a given project. Thus, we were unable to draw any conclusions on this particular objective.

Most of the remainder of this report focuses on our attempts to document the roles of and interaction between the various components of DOH's TB *System of Care* (with the exception of Finding #1). There are several components that comprise the Florida TB *System of Care* (See **Exhibit 2**, Page 3). While these different components all interact with one another, it was difficult to find a true leadership element to the entire program. The following findings and recommendations address issues related to the objectives of our review that should receive attention by management during their continued effort to develop a comprehensive *System of Care* in addressing Florida's TB population.

FINDING 1

While DOH's TB isolation practices were found to conform to DOH guidelines and CDC protocols, further documentation related to environmental control compliance when utilizing non-traditional healthcare facilities are needed.

RECOMMENDATION:

1.1 TB Program Office management should update its guidelines to require additional documentation for the existence of and compliance with proper environmental controls prior to using temporary housing for TB clients.

SEE PAGE 14 FOR MANAGEMENT'S RESPONSE

Environmental controls are established to prevent the spread and reduce the concentration of TB infectious contaminants within an area and exhaust the air from that area. They include:

- **Natural ventilation** which relies on cross ventilation in a building designed for good air exchanges; for example the use of open doors and windows to bring in air from outside. Fans can be used to help distribute the air; and
- **Mechanical ventilation** which relies on equipment to circulate and move air in a building consisting of local exhaust ventilation and general ventilation. Local exhaust ventilation stops airborne contaminants before they spread into the general environment. General ventilation systems maintain air quality in health-care settings by the dilution of contaminated air; removal of contaminated air and control of airflow in the patient's procedure room or setting.

Rooms should have adequate negative pressure ventilation, (i.e., a minimum of six air changes per hour in existing facilities and 12 per hour for new facilities). In rooms which re-circulate air, this can occur through the use of high energy particulate air (HEPA) filters.

Alternatively, appropriate ultraviolet germicidal irradiation (UVGI) may be used in rooms as a supplement to other environmental controls.

Our review determined that DOH guidelines are established for ensuring that CDC protocols for environmental controls are met when other temporary housing facilities are used to accommodate TB clients during their recovery.

However, while no evidence came to our attention that these protocols were not being met, we noted that documentation was not required to be maintained to validate that environmental protocols were being considered and addressed prior to the use of these facilities.

It is important to document that these controls were both considered and addressed prior to utilizing any temporary, non-health care housing alternatives, such as apartments or other landlord based facilities. This is to protect both the client, to ensure their treatment is the most effective, and to protect other individuals from coming into contact with a contagious client.

FINDING 2

The role of the TB Program Office was not clearly defined and staff was found to be generally uninformed regarding critical operational functions within the TB Program statewide.

RECOMMENDATION:

2.1 TB Program Office management should establish clearly defined roles and responsibilities of the Office, both within the greater Department-wide DOH TB System of Care and through communication with Program Office staff.

2.2 TB Program Office staff should be better informed as to critical operational functions within the TB Program statewide.

**SEE PAGE 14 FOR
MANAGEMENT'S RESPONSE**

As of August 2, 2012, at least 12 of 31 positions (39%) on the TB Program Office's *Organizational Chart*, including the Chief of the Bureau of Communicable Diseases, were vacant during the time of our review. The Section Administrator had accepted a job in another state and an Interim Section Administrator had been assigned. A revised *Organizational Chart* was created near the end of our project showing the number of proposed positions reduced to 28 positions, with seven vacancies (25%).

We interviewed many of the available personnel in the TB Program Office. Most staff was able to clearly communicate their individual roles and responsibilities. However, staff was less clear how the statewide TB Program functions as a whole.

We were unable to obtain consistent, reliable information from any one person in upper management within the TB Program Office during our review. Multiple conversations with the same staff led to multiple answers and explanations. TB Program Office staff appeared uninformed regarding key functions of what was happening with the TB Program statewide. The TB Program Office did not have a clear knowledge of what the TB physicians and TB nurses at CHDs do.

It is important to denote that Carol Tanner, RN, accepted her assignment as Interim TB Section Administrator near the end of our project. Accordingly, the remarks above do not reflect any assessment of her performance or the goals for improvement she has set for the TB Program.

We also learned from our many interviews and observations that DOH's TB nurses and physicians at the CHD level integrate and act responsibly to ensure continuity of care of Florida's suspected and confirmed TB population.

The TB Program Office provides support but was not directly involved with continuity of care. The TB Program Office staff:

- Collected and reported data to the CDC;
- Managed the federal grant it receives, and contracts with DOH providers;
- Assisted with the identification and screening of immigrants coming into Florida with previously-identified abnormal screenings;
- Assisted with tracking the movement of TB suspects, contacts, and latent TB infection clients to other states and jurisdictions within the United States for continuity of care;
- Served as liaison for Florida Department of Corrections for reporting to the CDC the TB suspected and confirmed cases inside the correctional system;
- Was available for nursing consulting to counties;
- Coordinated statewide TB geno-typing as required by the CDC;
- Allocated federal and state funds to counties; and
- Provided information technology (IT) support to itself and the CHDs.

FINDING 3

Roles and responsibilities for the TB Managers/Coordinators were not clearly defined. Additionally, while some TB Managers/Coordinators were found to play critical roles related to overall TB monitoring and care, others played only minor roles.

RECOMMENDATIONS:

3.1 TB Program Office management and the team assembled to develop DOH's System of Care should evaluate need and identify the fewest number of TB Managers/Coordinators required. This should be closely aligned with the number of Networks the team decides upon.

3.2 TB Program Office management and the team assembled to develop DOH's System of Care should clearly define the roles and responsibilities of all TB Managers/Coordinators.

SEE PAGES 14-15 FOR MANAGEMENT'S RESPONSE

DOH's *Florida Tuberculosis System of Care*, revised July 30, 2012, explains the TB Area Networks (Networks) are jointly coordinated with local CHDs. The Networks collaborate to manage the active TB cases within their boundaries. This function "supports the management of 5% of active TB cases." While networks are not required by law, Section 392.61(3), *Florida Statutes*, "does not prevent the department from operating regionally based tuberculosis control programs."

Distinction between TB Managers and TB Coordinators.

We wanted to understand the distinction between Area Managers, Area Coordinators, Area Surveillance Program Managers and Area Surveillance Coordinators. TB Program Office management explained the general distinction between Managers and Coordinators is that a TB Manager is responsible for a single county and a TB Coordinator is responsible for multiple counties. However, the same management provided us a list as of August 2012 of these personnel where that distinction was not consistent.

No defined roles and responsibilities

The role of the TB Manager, Coordinator, and Surveillance personnel was not well-defined by either DOH or the CHDs in which they are assigned. We interviewed several TB Managers/Coordinators and Surveillance personnel, as well as nurses and physicians. We found there was no common explanation of the roles and responsibilities of a TB Manager or Coordinator, or of Surveillance personnel.

Some Managers/Coordinators perform a vital, responsible function assisting in the coordination of care and assisting to ensure the integrity of data ultimately reported by the TB Program Office to the CDC.

It was not clear how some of the other Managers/Coordinators perform a role for DOH that justifies a full-time or even a half-time position.

Number of TB Managers and TB Coordinators

During our review there were TB Managers/Coordinators and Surveillance personnel encompassing 18 regional areas, each with at least one person assigned to one of these positions.

Management was unable to explain why there were 18 regional areas when DOH's *Florida Tuberculosis System of Care* explained there were eight Networks.

We found that as DOH continues to develop its new TB *System of Care* model, the team assigned to research and develop this model preliminarily divided the State of Florida into eight regionally-strategic areas. The final number and design of areas is yet to be decided.

FINDING 4

Confusion exists as to who within the TB Program has oversight and responsibility for the TB Medical Director.

RECOMMENDATION:

4.1 *TB Program Office management should review its plan for the supervision of and communication with its TB Medical Director and his staff to ensure accountability and clearly-defined expectations among all parties.*

**SEE PAGE 15 FOR
MANAGEMENT'S RESPONSE**

We determined that DOH's TB Medical Director and staff were listed as being a part of the TB Program Office but located physically at the Palm Beach CHD, Delray Beach.

The TB Medical Director (David Ashkin, MD) and his support staff are involved in the continuity of care of suspected and confirmed TB cases across the state. The TB Program Section Administrator (within the TB Program Office in Tallahassee) held direct responsibility to approve the timesheet of Dr. Ashkin. However, "direct supervision" of Dr. Ashkin was re-delegated to Alina Alonso, MD, Director, Palm Beach CHD, according to a Delegation of Authority document signed on August 23, 2012 by Jennifer Bencie, Interim Director, Division of Disease Control and Health Protection. Yet, Dr. Alonso explained during interviews she does not regularly see Dr. Ashkin and does not regularly engage with him in the work he performs.

It was difficult for internal audit staff to determine who held true responsibility and accountability for the performance of Dr. Ashkin. The audit team questioned how the TB Program Section Administrator located in Tallahassee could approve the timesheets for a person physically located in Palm Beach County. The audit team also questioned how and why the head of the Palm Beach CHD could be responsible for the performance of a person she rarely comes into contact with. Furthermore, the audit team was unable to see the value in splitting up the oversight responsibilities among two different individuals at two separate locations.

FINDING 5

Several areas of concern were noted in relation to DOH's contract with the TB Physicians Network. These concerns include:

- Inconsistent data being reporting to DOH;
- Untimely and inaccurate data reporting to DOH; and
- Lack of unified use of the TB Physicians Network by the CHDs, resulting in additional costs.

RECOMMENDATIONS:

5.1 TB Program Office management should require UF to provide consistent documentation for the services of the TB Physicians Network. In accordance with terms of the contract, salaries should not be reimbursed to UF unless work can be tied to the reviewing of X-rays, consultations or clinics.

5.2 TB Program Office management should provide direction for all CHDs to use the TB Physicians Network for the reviewing of TB X-rays, consultations and clinics, as it similarly contracts with designated hospitals for necessary inpatient services of CHD clients.

SEE PAGE 15 FOR MANAGEMENT'S RESPONSE

The TB Physicians Network was originally organized under the Bureau of Tuberculosis in 1997 at DOH, and later moved to UF. The physicians in the TB Physicians Network review X-rays sent to them by some CHDs and provide a diagnosis or consultation. Some clinics (trainings) are also provided at CHDs.

DOH contracts with UF for the services of the TB Physicians Consultation Network (TB Physicians Network). Physicians working under the contract each month are to report the number of hours worked under the cost-reimbursement contract. Beginning March 2012, DOH required UF to have the physicians attest to their hours worked. Additionally, UF is required to submit a spreadsheet of the number of X-rays reviewed for each CHD by each physician in the TB Physicians Network. The current contract ends December 31, 2012.

Inconsistent Reporting to DOH

The TB Physicians Network physicians primarily are paid based upon the number of X-rays reviewed and consultations involved with reviewing X-rays, with an occasional clinic being provided. However, during a review of UF supporting documentation, the frequency and number of X-rays reported as being reviewed was not consistent with the time reported by the physicians. As an example, according to UF documentation from July 2011 to July 2012, one physician only reviewed X-rays in December 2011 (108), January 2012 (20) and March 2012 (143). Yet UF billed DOH and was paid for the physician's salary each month of the contract. Another of the physicians reported working 59.77 hours in April 2012, but reviewed no X-rays and provided no clinics.

Untimely and inaccurate reporting to DOH

DOH's contract with UF requires that invoices be submitted so that they are received by DOH's contract manager by the 21st of each month for the preceding month. However, some invoices we reviewed were not submitted timely as required by the contract.

Additionally, the physicians' travel to clinics they provided at various CHD sites was cumulatively billed to DOH rather than submitted monthly as required by the contract. DOH was billed in August 2011 for clinics held over the five-month period of March through July 2011. Clinics held in August 2011 were not included in the invoice for August 2011.

One of the physicians provided clinics at Broward CHD from November 2011 through the time of our review. These clinic hours were not reported by UF to DOH since February 2012.

Underutilization of the TB Physicians Network

DOH's contract with UF pays for physicians' salaries, allowing all CHDs to use the physicians in the TB Physicians Network. DOH does not pay a per X-ray consultation charge. However, the TB Program Office explained that some CHDs contract with other physicians to review their X-rays and provide a consultation. This creates additional spending for services already included in the TB Physicians Network contract.

The TB Program Office explained a rationale that DOH cannot force CHDs to use this contract. However, DOH contracts with selected hospitals for Level 3 care in its System of Care. Only those hospitals would be used by CHDs for necessary inpatient services of their clients.

FINDING 6

We noted instances where inefficiencies occurred in the reporting of data to the TB Program Office.

RECOMMENDATION:

6.1 *TB Program Office management should analyze its current process for the initial reporting of accurate data to the TB Program Office and find ways to more efficiently verify the data reported across the State.*

**SEE PAGE 15 FOR
MANAGEMENT'S RESPONSE**

The Health Management System (HMS) TB Module is the system designated and required to be used by all CHDs to input and document client care coordination and case-management.

We found there to be a lot of duplication of verification of this data. TB nurses at the CHDs generally first input the data. Many personnel in different areas explained it was their chief role to verify and/or re-verify such data, including the TB Coordinators/Managers, Surveillance personnel, and several persons in the TB Program Office. It was not clear to the audit team why DOH's TB nurses, with one additional level of verification, could not be relied upon for accurate input of data into the HMS TB Module in an effort to streamline the process.

FINDING 7

The use of redundant systems to document and share X-ray review and consultation services for the TB program was inefficient and counterproductive.

RECOMMENDATIONS:

7.1 DOH should discontinue use of the TB X-ray Database, requiring all CHDs and TB physicians to use the HMS TB Module.

7.2 TB Program Office management should encourage and train TB nurses to make original entry of Form 167 data into the HMS TB Module, eliminating duplicative work of first filling out hard-copies of these forms.

**SEE PAGE 16 FOR
MANAGEMENT'S RESPONSE**

DOH uses Carestream as its teleradiology system for use with the TB Program and TB Physicians Network to upload and share X-rays for diagnosis and consultation. Seventeen (17) CHDs have used Carestream.

DOH's TB nurses use DOH Form 167, *X-ray Form*, as a document to record and transmit information to the TB physicians, including the patient's name, an assessment of symptoms and risk factors for developing TB, results of a sputum test, and what medications the patient is taking. The physician reviews the X-ray in Carestream and provides a consultation, recording his/her diagnosis and notes on Form 167, which becomes part of the patient's medical record. CHD nurses we interviewed explained Forms 167 are typically still processed via hard-copy. The information must also be recorded in the HMS TB Module. The data fields for information to be collected on Form 167 are already included in the HMS TB Module. The physicians in the TB Physicians Network have been granted access to HMS so that they can use the system.

We learned the TB X-ray Database (Database) is used by 13 CHDs and only five of the physicians in the TB Physicians Network as a companion system to Carestream. This system is an electronic version of Form 167, *X-ray Form* that was developed internally at A.G. Holley. The system was developed for the convenience of the physicians in the TB Physicians Network. The X-rays are maintained separately in Carestream.

Martin, Broward, Indian River, Monroe, Sarasota, Duval, St. Lucie, Hendry, Glades, Palm Beach, Okeechobee, Hardee, and Collier counties used the Database at the time of our project fieldwork.

However, the Database is a redundant system. Once the physician's notes are recorded in the system, the TB nurse must copy the notes into the HMS TB Module so that such notes become a permanent record in DOH's official system. There is no assurance that all notes are completely copied into the HMS TB Module so that DOH has a complete record of the patient's medical record. A TB nurse we interviewed that extensively uses the Database explained she manually writes out a Form 167. She then types the same data into the Database. After the physician reviews the X-ray and provides consult notes in the Database, the TB nurse explained she then copies the same information into the HMS TB Module.

The Database has not been appropriately approved by DOH. A proposal to seek approval of the system was submitted to DOH's Governance level Tier I in December 2006. For the project to remain at Governance Level Tier I for approval at the program-level, the presenters of the project informed the Governance process that the system would utilize DOH Standard Technology. Otherwise the project would have automatically been elevated to Governance Level Tier II for review and required approval. The project was never submitted to, reviewed, or approved by DOH's Information Technology Standards Workgroup (ITSW) and was not DOH Standard Technology. The system was not vetted by the appropriate approval level of DOH's Governance Committee which would have been Tier II.

The TB Program Office currently continues to allow the use of this second Database, transferring technical support of the system from A.G. Holley to Headquarters following the closure of A.G. Holley.

MANAGEMENT'S RESPONSE

Recommendation	Management's Response
<p>1.1 TB Program Office management should update its guidelines to require additional documentation for the existence of and compliance with proper environmental controls prior to using temporary housing for TB clients.</p>	<p>Management agrees with the recommendation. Medical Director's office shall assume the lead for the development and or review of guidelines, policy and compliance with environmental controls prior to placement of temporary housing for TB clients. This includes recommendations from the <i>System Of Care</i> (SOC) Housing Workgroup.</p> <p>ANTICIPATED COMPLETION DATE: March 1, 2013</p>
<p>2.1 TB Program Office management should establish clearly defined roles and responsibilities of the Office, both within the greater Department-wide DOH TB System of Care and through communication with Program Office staff.</p>	<p>Management agrees with the recommendation. TB Program Office staff roles and responsibilities are currently under review, update and revision by the SOC Standardization Workgroup. This workgroup consists of CHD Health Officers and Central office Leadership who are tasked to look at the key aspects of the SOC by levels of service. They will work towards defining outcomes with associated performance standards for each Level including standards of care for medical management, nursing protocols and case management. The TB Program Office is holding five vacancies at this time subject to workgroup recommendations and program restructure.</p> <p>ANTICIPATED COMPLETION DATE: March 30, 2013</p>
<p>2.2 TB Program Office staff should be better informed as to critical operational functions within the TB Program statewide.</p>	<p>Management agrees with the recommendation. April - Sept. 2012 were challenging times for the TB Program Office staff. They experienced multiple program leadership changes, the closing of A.G. Holley and the concurrent implementation of Florida's SOC. It appears program communication regarding critical program changes was very limited and minimal at best. Staff was not informed or engaged in pending program transitional operations thus, creating low employee morale. Staff meetings, both formal and informal, were not held on a scheduled basis nor were field staff engaged in program decisions and activities. Currently, staff meetings are scheduled on a regular basis. This includes field staff as well. Staff is now engaged and participates on all program-related conference calls. Nine of the 10 program staff are now actively participating on SOC Workgroups (Housing, Standardization, Finance and HMS/IT). It was also noted that many employees had not received appraisals for one to three years. All TB Program Office staff have now received updated appraisals and job performance standards to support current program operations at this point in time. Staff position descriptions will be subject to change as per the recommendations of the SOC Standardization workgroup and designation of permanent program leadership.</p> <p>ANTICIPATED COMPLETION DATE: March 30, 2013</p>
<p>3.1 TB Program Office management and the team assembled to develop DOH's System of Care should evaluate need and identify the fewest number of TB Managers/Coordinators required. This should be closely aligned with the number of Networks the team decides upon.</p>	<p>Management agrees with the recommendation. SOC Standardization Workgroup tasked to review roles and responsibilities and provide recommendations to the State Surgeon General.</p> <p>ANTICIPATED COMPLETION DATE: February 1, 2013</p>

<p>3.2 TB Program Office management and the team assembled to develop DOH's System of Care should clearly define the roles and responsibilities of all TB Managers/Coordinators.</p>	<p>Management agrees with the recommendation. SOC Standardization Workgroup tasked to review roles and responsibilities and provide recommendations to the State Surgeon General.</p> <p>ANTICIPATED COMPLETION DATE: February 1, 2013</p>
<p>4.1 TB Program Office management should review its plan for the supervision of and communication with its TB Medical Director and his staff to ensure accountability and clearly defined expectations among all parties.</p>	<p>Management agrees with the recommendation. The TB Medical Director has been provided clarification regarding supervision and oversight of his staff. He reports directly to the TB Control Section Administrator and Dr. Alina Alonso (medical consultation only) until such time permanent Division and Section leadership is established. The TB Medical Director's position description is in the process of being revised along with Telecommuting paperwork, pending signatures.</p> <p>ANTICIPATED COMPLETION DATE: March 1, 2013</p>
<p>5.1 TB Program Office management should require UF to provide consistent documentation for the services of the TB Physicians Network. In accordance with terms of the contract, salaries should not be reimbursed to UF unless work can be tied to the reviewing of X-rays, consultations or clinics.</p>	<p>Management agrees with the recommendation. The TB Physician Network (TBPN) has been provided a six-month contract extension (January-June 2013) until SOC Standardization Workgroup can provide recommendations and direction to CHDs. Goal of the workgroup will be to maximize resources. Contract extension contains specific measurable deliverables and subject to financial remedies. Appropriate CHD utilization of services related to concentration of cases is a key component of the SOC Standardization Workgroup tasks. Proposed new contractual agreement should provide clarity, expectations and accountability of the TBPN.</p> <p>ANTICIPATED COMPLETION DATE: January 30, 2013</p> <p>Response from UF (dated December 13, 2013): UF will work with the TB Program Office and be responsive to ensure documentation for the services provided under the TB Physicians Network contract is consistent with TB Program Office expectations.</p>
<p>5.2 TB Program Office management should provide direction for all CHDs to use the TB Physicians Network for the reviewing of TB X-rays, consultations and clinics, as it similarly contracts with designated hospitals for necessary inpatient services of CHD clients.</p>	<p>Management agrees with the recommendation. The TBPN has been provided a six-month contract extension (January-June 2013) until SOC Standardization Workgroup can provide recommendations and direction to CHDs. Goal of the workgroup will be to maximize resources. Contract extension contains specific measurable deliverables and subject to financial remedies. Appropriate CHD utilization of services related to concentration of cases is a key component of the SOC Standardization Workgroup tasks. Proposed new contractual agreement should provide clarity, expectations and accountability of the TBPN.</p> <p>ANTICIPATED COMPLETION DATE: January 30, 2013</p>
<p>6.1 TB Program Office management should analyze its current process for the initial reporting of accurate data to the TB Program Office and find ways to more efficiently verify the data reported across the State.</p>	<p>Management agrees with the recommendation. The SOC HMS/IT Workgroup has been tasked to review current in-house systems and recommend an efficient and timely integrated data collection system that meets the needs across the State. This includes integrated client surveillance capabilities with other similar programs (i.e. HIV/AIDS and STD) to maximize client services within the CHDs.</p> <p>ANTICIPATED COMPLETION DATE: March 30, 2013</p>

<p>7.1 DOH should discontinue use of the TB X-ray Database, requiring all CHDs and TB physicians to use the HMS TB Module.</p>	<p>Management agrees with the recommendation. The TB Program Office will phase out and eventually discontinue use of TB X-ray database and promote the use of Carestream (digital image on a CD) with contracted local providers. Carestream is available to any CHD at no additional cost and capable of downloading the image into a DOH server for access to read the X-ray.</p> <p>ANTICIPATED COMPLETION DATE: April 30, 2013</p>
<p>7.2 TB Program Office management should encourage and train TB nurses to make original entry of Form 167 data into the HMS TB Module, eliminating duplicative work of first filling out hard-copies of these forms.</p>	<p>Management agrees with the recommendation. The SOC HMS/IT Workgroup currently reviewing the process. This workgroup will provide clarification and direction for Statewide training and implementation.</p> <p>ANTICIPATED COMPLETION DATE: March 30, 2013</p>

APPENDIX A

TB Program Temporary Housing Use from July 2011 through July 2012: ***

Motels		Temporary Housing Assistance
23	# of Infectious Clients	7
4	# of Non-Infectious Clients	2
1	# of Unknown Infectious Clients	0
28	TOTAL TB CLIENTS	9
30	# of Unique Stays/Coverage ****	11
14 days	Average Length of Stay/Coverage	39 days
12 days	Median Stay/Coverage	30 days
417 days	Total Days Covered by DOH	427 days
\$18,918.63	Total \$ Spent by DOH	\$5,555.00

*** Calculated by Internal Audit staff based upon source data provided by the TB Program Office.

**** Some clients needed more than one isolation period. Each unique, separate stay or covered period was counted.

NOTE:

See page 5 of this report, under the heading "TB isolation practices conformed to CDC protocols and DOH guidelines" for more information on housing options utilized by DOH to isolate and/or provide Direct Observed Therapy (DOT) to TB clients.

SUPPLEMENTAL INFO

Section 20.055, *Florida Statutes*, charges DOH's Office of the Inspector General responsibility to provide a central point for coordination of activities that promote accountability, integrity and efficiency in government. Reviews are conducted to review and evaluate internal controls necessary to ensure the fiscal accountability of DOH.

The review was conducted by Mark Boehmer, C.P.A., Senior Management Analyst II; and Tony Hernandez, C.I.A., Senior Management Analyst II; under the supervision of Michael J. Bennett, C.I.A., Director of Auditing.

Our methodology included observations and interviews with management and staff and the use of analytical procedures in the review and testing of records regarding compliance with governing laws, policies and procedures.

CLOSING COMMENTS

We want to thank management and staff of the Bureau of Communicable Disease, Tuberculosis Section, as well as the TB nurses and physicians statewide for providing their cooperation and assistance to us during the course of this review.

Copies of this report can be found on our website at: www.doh.state.fl.us/ig/Audit.htm

Questions or comments related to the information provided in this report should be addressed to the Director of Auditing, Florida Department of Health by the following means:

Address: 4052 Bald Cypress Way, Bin A03,
Tallahassee, FL 32399

Email: InspectorGeneral@doh.state.fl.us

Phone: (850) 245-4141