6. Tennessee Site Visit Summary Report

I. Background

The State WIC agency in Nashville, TN, was visited the week of August 28, 2000. The local agencies visited were Tennessee Department of Health, Mid-Cumberland Regional Office in Nashville and Williamson County Health Department in Franklin.

WIC Program Organization
The Tennessee WIC Program serves approximately 150,000 participants per year; children and infants account for approximately 100,000 of this population. TDH has integrated the WIC Program with its network of comprehensive primary care clinics administered through county health departments. Six of these county health departments operate as contractors to TDH; these counties include the three largest metropolitan areas-Nashville (Davidson County), Knoxville (Knox County) and Memphis (Shelby County).

TDH directly administers the rest of the county health departments, which serve mostly rural areas, through eight regional offices. WIC Program administration in the contract counties is in large part the same as in the State-run county health departments, because all counties operate under the same policy manual and use the same management information system (MIS). Although a large majority of the 140 WIC service sites offer a broad array of primary healthcare services, several sites serve more specialized populations, such as pregnant teenagers.

The fundamental integration of WIC services with healthcare delivery at the local level aids certain aspects of program administration. The integration of patient registration makes it easier to secure Social Security numbers for data processing. Staff are usually quite familiar with clients and their health histories since participants consistently receive health services at the same location. This level of familiarity promotes high-quality service and enhances program security.

The WIC Program in Tennessee is administered as part of the Tennessee Department of Health (TDH), Nutrition Services Division. WIC Program management is overseen by the WIC director who has responsibility to the director of nutrition services. The director of nutrition services also supervises community nutrition programs and a special projects division. The State WIC director maintains a small staff that handles vendor relations, clinic nutrition education, program review and data management.

Local clinic staff include both clerical personnel and health professionals. Typically, at least one clerk is assigned exclusively to the production of food instruments and at least one clerk handles the reception area. The usual staffing of a local clinic also includes a nutritionist who assesses and documents nutritional risk, prescribes food packages and provides nutrition education. Other professional staff at the local clinics, such as physicians and nurses, are usually less involved with WIC services but provided related healthcare, including prenatal care, well-child care and immunizations.

Each of the eight TDH regional offices has a specific geographic area to serve and a regional director to oversee operations. Each region has a WIC director who oversees local program operations, one or more vendor representatives (charged with handling all aspects of local vendor relations), and one or more nutritionists who oversee the nutritional assessments, education and other services provided by clinic nutrition staff.

In addition to WIC, TDH also administers the Commodity Supplemental Food Program (CSFP). This program operates on a small scale in three locations: Nashville, Memphis and a small rural county. A small number of pregnant/postpartum women and children receive CSFP benefits. At the State level, CSFP administration is housed within the WIC division.

Management Information System

Complementary to the integration of public health service delivery, the data systems for the various client services are also integrated. All WIC patient data is entered into the Patient Tracking Billing and Management Information System (PTBMIS), a statewide database combined for all services provided by the TDH. The PTBMIS has modules for patient registration, collection of financial information, tracking of services, and maintaining medical records. The WIC module supports all program functions, including certification, nutritional assessment, food prescriptions, nutrition education, and check issuance.

The PTBMIS operates on a network of AS400 servers, with one server for each TDH region and one for each contracting county agency. Each clinic has one or more terminals with access to all of the data for the clinic's region or contracting county agency. The statewide PTBMIS host exchanges data on a daily basis with the regional servers and with other TDH data systems.

The Tennessee PTBMIS was developed following the decision in the 1980s to integrate WIC with other local public health operations. The system was developed by QSTechnologies, Greenville, SC, and the pilot was installed in Tennessee in 1989. Implementation was arduous because so many agencies had to be brought on board. Tennessee is currently alone in its statewide use of this software. Numerous county health departments in other States utilize the application.

The WIC Program uses a separate vendor MIS, known as SAMIS, for vendor management. SAMIS is a PC-based Microsoft Access application that maintains all data needed to meet WIC Program requirements for The Integrity Profile (TIP) database. Each regional office has a run-time version of SAMIS for use in adding and updating vendor records.

Quality Management

Quality Management of WIC Program operations is a centralized, State-mandated function. Within the WIC Program, there are local, regional and State levels of operational review. WIC Program administration is also subject to reviews from the quality management (QM) unit of TDH's Bureau of Health Services Administration (BSA) and from TDH internal auditors.

The BSA QM reviews are conducted once a year per clinic, with criteria based upon the quality management standards that were developed by the state in 1998 and later revised in 1999. Quality management focuses on customer service, quality of care and standard medical practices.

The TDH internal auditors focus on compliance with Federal requirements, fiscal management and appropriate administrative procedures.

TennCare

In an effort to better meet the health needs of its citizens and maintain financial solvency, Tennessee opted not to be a part of the conventional Medicaid program, and to offer a reform plan called TennCare. On January 1, 1994, the State extended health insurance to its Medicaid population and to all others who were uninsured or considered uninsurable due to a denial by a health insurance provider. By January 1995, TennCare reached 90 percent of its target population and closed its rolls to additional uninsured participants.

Currently, enrollment is open to persons who are Medicaid-eligible, deemed uninsurable by virtue of denial from a health plan or are under the age of 19 and not covered by a family health plan. Participants with income above the means test for Medicaid pay premiums, copayments and deductibles on a sliding scale based on income. TennCare enrollees may choose from managed care plans in their geographic area. They can also obtain services from the system of county health clinics. As of May 2000, the TennCare system provided insurance to approximately 1.3 million residents of Tennessee, of whom approximately 800,000 qualified for Medicaid.

The TennCare system has been an important advance for the level of healthcare in Tennessee. Since TennCare has brought healthcare coverage to a previously uninsured population, Tennessee citizens now have access to primary care physicians in their community and a decreased reliance on county health departments. This has translated to a greater prominence of the WIC Program in the county health department administration since patient rolls for other services have waned. At the same time, WIC program administration has become more complex since a simple means test does not govern eligibility for TennCare coverage. WIC staff must determine whether TennCare participants are Medicaid-eligible, a more complex confirmation than in other States where a current Medicaid card is sufficient proof of categorical eligibility for WIC.

II. WIC Program Operations and Processes

A. Certification

Integrated Registration/Appointment System

The PTBMIS uses a standard sequence of registration screens for all services. These screens capture identifying and demographic information on the patient, parent/care giver information, insurance coverage, FSP and TANF participation status, and household composition and income. This information is then carried through to screens used to schedule appointments, check patients in for visits, record WIC-specific certification data, and issue checks. This standardization avoids multiple entry, promotes accuracy on the part of the registration clerk, facilitates the sharing of staff and equipment across programs, and simplifies patients' access to services. An abbreviated registration screen is available to record information necessary for scheduling a patient's first appointment and to track the initial data of contact for compliance with WIC standards. For each child, the mother's Social Security number is used to link records to the mother's records and to other children in the same family.

The PTBMIS also manages appointments and service tracking. All appointments within the clinic's region are shown to the clerk making an appointment, thus facilitating coordination of appointments for different services. Provision of services, including WIC visits, is tracked through the creation and completion of encounter records, with each encounter having a unique identifier and one or more codes indicating the services provided. Patient transfers between clinics are easier because of the history of encounters available on the PTBMIS. In addition, all PTBMIS client service records also have an accompanying paper trail from the encounter form upon which WIC staff initially record information. These are used for data entry into the PTBMIS and are retained and filed at the local clinic.

Verification of Participant Identity, Income, and Residence

As of July 1, 2000, all WIC clients must be present at clinic at time of certification to meet the physical presence requirement. Exceptions are made for health conditions if they are certified by a nurse or physician. Mothers can present a birth certificate, crib card, or hospital bracelet as forms of identification and proof of age for their infant. Women must present suitable proof of identity, such as a driver's license or birth certificate.

WIC staff members are trained not to accept a post office box address as proof of residency. Instead, a prospective client must prove that she has an address at which she resides. Most often the client provides a utility bill. The disaster clause in the State agency's policy delineates that if a fire destroys the home and is the cause for having no record of residence, the client will receive 1 month of checks and be asked to bring a report from the Fire Department to validate this missing documentation.

A WIC client who lacks an independent residence can produce a utility bill for the person with whom they live. No third party verification is needed in this situation. If the client has access to a utility bill, it is assumed that she actually resides at the stated address. The PTBMIS registration screen is used to record the type of identification and residence documentation presented through a coding system.

The financial information (FI) screen guides the income determination process for all TDH clinic users, including WIC participants. This screen is completed after registration, with identifying information carried over from the initial registration screen. Past versions of the FI screen are saved in case they are needed for investigations.

If documentation of income eligibility entered into the PTBMIS is based upon reported income in the form of a pay stub, the financial information screen allows entry of income for individuals with name, dollar amounts and period of time over which income was earned. The system calculates annual household income. If income changes, the user can input new income for one member and the system recalculates the total. The user looks up the WIC guideline for the household on a hard-copy table. (This information is on the system in a sliding scale table, but it is awkward to access and users are not trained to use this table for this purpose.) The family size that is keyed in is checked against the count of members entered.

For each type of documentation, PTBMIS has a table of acceptable codes; the user can pop up the table to select a code or enter a valid code from memory. Examples of acceptable income

documentation include last W2 statement and most recent pay stub. For the exception codes that apply when documentation is unavailable, the pop-up table indicates when a signed statement is required. The system vendor added these fields at no charge to the State agency when the WIC Program regulations were changed, as provided for by the State agency's contract with the vendor. These upgrades to the system were implemented in July 2000.

All WIC applicants must provide documentation of income eligibility, although those who can prove that they are adjunctively eligible need not provide other income documentation. DHS retains income information for services provided on a sliding fee scale. This requirement was implemented in 1998, before the Federal income documentation requirement was established.

Clerks are trained to ensure that income documentation presented is no more than 3 months old and that gross income is presented. If the client has been unemployed for more than 3 months, additional information is typically required, e.g. a bank statement or any other last income record. The client must sign an informed consent form that States that all information presented is true. Income information is only required at certification visits; the previously existing policy called for information (but not documentation) at every visit to the clinic.

In general, clerks are trained to probe for additional information in situations where a client's lifestyle does not appear to match with income that is reported; often family history information available in a small community aids this pursuit. If a client reports that she has no cash income and is living with a relative, she must provide a statement of support from the relative indicating the cash value of the support. One particular challenge is delineating the number of household members who are counted as a WIC household compared with the family economic unit used for Medicaid and TANF eligibility.

Online Access to Verify TennCare Status and Medicaid Eligibility

When a client presents a TennCare card or indicates that she participates in TennCare, WIC staff look up the status code on the Medicaid system, which is available via the terminals used to access the PTBMIS. Specified TennCare status codes indicate Medicaid-eligible (presumptive or determined by the Department of Human Services). The codes are in the table of accepted income proof codes. The TennCare code is entered into the PTBMIS as the code for income documentation. WIC will accept presumptive Medicaid eligibility status to authorize 1 month's worth of checks. The participant must then present proof of full Medicaid certification by the Tennessee DHS at the next visit to complete the WIC certification process.

Linkage of Infant and Child Records to Immunization and Birth Records

For infants, the WIC record is matched to the TDH immunization registry, which records by birth and death records. The immunization registry is not directly accessed via PTBMIS but the databases are linked. When immunization data in PTBMIS are updated, the information in the registry is updated and sent to all regional PTBMIS databases. Conversely, when the immunization registry is updated by another source (such as input from a private physician's office), the immunization history in PTBMIS is updated.

This linkage facilitates the timely, accurate collection of Social Security numbers for WIC infants. In Tennessee, a SSN is automatically requested when a birth is registered. When the SSN is assigned, the data from the Social Security Administration are loaded to the immunization

registry and then used to fill or correct the SSN in PTBMIS. The mother's maiden name field also is populated from the immunization registry, and the PTBMIS calculates the mother's age at the child's birth from the birth dates for mother and child.

Real-time Dual Participation Check within Region with Lockout from CSFP for WIC Participants

The PTBMIS checks online for a duplicate SSN within the clinic's region during registration. (The region is the county or group of counties covered by the clinic's PTBMIS server.) If a client attempts to register with a SSN that is already in the system, staff cannot register that client.

When a prospective client signs up for the PTBMIS module, CSFP certification checks for WIC enrollment within the region and blocks the user from printing a CSFP food ticket if a duplicate benefit is noted. The WIC module does not check for CSFP benefits because the CSFP program was added after the system was implemented, but there are reasonably good controls to prevent dual participation. Clerks in the three counties with both CSFP and WIC are able to check CSFP status during enrollment. But on a practical level this check may not happen on a regular basis. If a participant enrolls in WIC after receiving CSFP benefits, the participant can only get CSFP benefits until the next CSFP visit, at which time more CSFP benefits are blocked.

Flexible Report to Detect Other Dual Participation

A flexible batch report provides TDH with the means to detect dual participation across regions. All PTBMIS WIC updates from each region are uploaded to a central server on a daily basis. CSFP participation data come from a monthly transfer from the regional sites.

The dual participation report program is run monthly to detect participants receiving WIC or CSFP benefits in more than one region. TDH can change the focus and scope of its dual participation report by adjusting the criteria for identifying a match. The monthly report identifies a match if records in a different region have the same SSN or the same combination of name, date of birth, race, and sex. Each field used for matching has an adjustable score, and the user can specify the total score required for a match. TDH had only been running the dual participation report on a quarterly basis because of a large number of false positives, but refinement of the matching criteria made monthly runs manageable. The dual participation report is highly efficient because of the high proportion of participants for whom TDH obtains SSNs.

Once or twice a year, TDH runs a check to identify all cases with multiple issuance records for the same month, including multiple records within the same region. This process produces a long list of potential duplicates, but most are justified (change of formula etc.) and do not represent fraud. Nevertheless, TDH finds that this report provides a useful check for fraud and over-issuance errors.

TDH is building a central patient index that now exists, but is not in operation. This tool could be used for dual participation, but a lot of duplicate records are produced which do not involve actual cases of dual participation. To make this index useful as a check on WIC fraud, the State would have to invest a fair amount of work to define the criteria for accurate dual participation reports.

Automatic Termination
The PTBMIS automatically calculates the due date for the next certification, based on the certification category and the date of certification. Checks cannot be issued after this date without updating the certification data. The PTBMIS notifies the check clerk when a participant is due for recertification at the next appointment, and the clerk gives the participant a form indicating the documentation that must be provided at certification. As of October 2000, the clerk will also notify the parent or caregiver of an infant or child participant of the physical presence requirement for certification.

Clinic Staff Conducts Blood Work and Measurements
In Tennessee WIC clinics, competent professional authorities (CPAs) are trained to perform their own blood work and interpret the results, and also to take accurate height and weight measurements for children, infants and pregnant women. (Participants can provide referral measures from other medical professionals if they are timely.) Providing this type of services is an added benefit to participants and also increases the personal knowledge of staff about their participants. For example, a CPA is more likely to detect signs of child neglect—a potential indicator that benefits are being abused—if the CPA has closer contact with the child during the certification process.

B. Food Instrument Issuance and Management

To begin client services, an encounter must be established in the PTBMIS, which automatically assigns a unique tracking number for the visit. The clerk issuing checks cannot open encounters at the same time. The encounter tracking process generates a label with the tracking number for the encounter form, which provides paper documentation of the patient visit. In the future, TDH will also use this label for the informed consent form completed at each certification.

The PTBMIS restricts the types of service that are allowed based upon the categorical status of the patient. In particular, a community health user will only be allowed services pertinent to that type of patient. To close the encounter, the check clerk must record the check issuance as a service provided. The system keeps an audit trail of who opened the encounter and who provided each service.

On-Demand Check and Receipt Printing with No Serialized Paper
Once the check clerk completes the WIC data screen with the required information (including updated certification data, if certification is due), the clerk issues a command to print the checks. The PTBMIS automatically assigns the next available serial number to each check. Based on the food package code entered by the clerk, the PTBMIS automatically generates the appropriate set of checks for 1 to 3 months, depending on the specifications provided by the clerk and the certification period. The clerk can reduce amounts of foods on the checks. The system also prints a receipt for the participant to sign indicating the number of checks issued and the date.

All information on the check is printed on demand. The check stock has no preprinted information, so blank checks remain worthless until a participant encounter is processed. The check stock does, however, have a watermark and other security features. A template of standard information and graphics printed on all checks is stored in a memory card in the printer, expediting the printing process.

The information that is specific to the check is provided by the PTBMIS, including the date of the check, participant name, identification number of the issuing clerk, and the components of the food package. To support this method of check printing, TDH uses laser printers with special toner cartridges containing magnetic ink that can be read by the magnetic ink character recognition (MICR) devices used by the State's bank. TDH implemented this system in July 1997 to eliminate the central printing of checks and the many logistical and security problems they created, especially the need to produce checks manually under a variety of circumstances.

Automated Proration

If a client comes to a clinic after the beginning of the service month, checks will be prorated to reflect the actual date of pick up. When an encounter is opened and the date of service recorded, an automatic proration to the food instrument will occur. The proration system allows for four levels available for infant formula based upon date of pick-up of check, each level relating to 1 week of a calendar month. All other food packages, which are lower in value, are prorated upon a two-level system. If a client is issued sample formula from clinic stock, the clerk will also prorate the food instrument that is distributed with the formula.

Controls Over Check Printing

Checks can only be printed at a designated terminal—typically two per clinic, usually with only one in use at a time. Each clinic has its own ID and can print only within specified hours. The check clerk has a separate function from the check-in clerk to minimize opportunity for fraud. Clerks must be certified to issue checks and have password/system identity to do so as provided by the regional system administrator. Clerks are automatically signed off a terminal after 30 minutes of inactivity, and they must sign off a terminal whenever leaving for a significant period of time. This is done as a form of protection against the production of fraudulent checks in a staff member's name.

Controls on Special Formula Issuance

Tennessee maintains tighter controls on special formula issuance due to cost factors involved. The nutrition coordinator must approve all special formula requests. The State purchases formula and it is shipped to the health department. Usually, one pharmacy per county distributes noncontract formula. This acts as a check on the purchase given the advance notice. Special checks are printed for formula based upon two codes in the system, one for special formula and another for the remainder of the food package. On the check print detail screen, the clerk can reduce quantities. This is done to split checks for special formula because of supply constraints or for use on a trial basis.

Automatic Check to Prevent Duplicate Issuance of Food Package without Voids

The PTBMIS will not allow the same food package to be issued twice within the same 3-month period unless the first set of checks have been voided via the check history screen. Checks may be voided and replaced if medical reasons exist (i.e., allergy, change of prescription). For a voided check, a comment and accompanying reason must be recorded. This information is used as justification when the double issuance shows up on a dual participation report.

The system retains the cause of void, the date, the user ID of the clerk completing the void, and the face value of check. Returned checks must be physically stamped as "VOID" to prevent

fraudulent transaction and redemption. If formula is returned, the staff issues prorated checks for the current month. Formula that is returned is logged and can be reissued to another recipient who will sign for it, as any other food instrument. If a check is accidentally voided, a designated regional WIC staff member can reverse the void.

Automated Check Replacement Process

TDH allows replacement of stolen and damaged checks; lost checks can be replaced after a five-day wait if a CPA certifies that the participant would otherwise be at nutritional risk. The check clerk voids the checks to be replaced with the appropriate code and comments, and the PTBMIS produces duplicate checks. If food purchases and checks are destroyed in a household disaster, the clinic issues checks to replace the food under a different food package code, because the system will not let the same food package code to be printed again. Designated regional WIC staff have the special right to replace checks on behalf of merchants so that they can be redeemed (e.g., if a check is damaged after the merchant accepts it).

C. Food Instrument Transaction and Redemption

Participants may transact their WIC checks at any authorized food store (vendor). At the time of checkout, the cashier enters the total on the check, the participant signs the check, and the cashier stamps and dates the check. Cashiers are expected to verify that the check is presented within the valid dates and that the foods are authorized for purchase with the check. The vendor submits the check to its bank for redemption, and the vendor's bank submits the check to the bank under contract with the state.

The State agency's bank performs a physical review of the checks before accepting them for redemption. About 1,500 checks are rejected by the bank each month. In the physical review, checks are rejected if they are missing the vendor stamp or date (the most common reason for rejection), or if they show evidence of tampering or other damage. If the vendor stamp is missing but the vendor information is printed on the back of the check, the bank will process the check but flag it as fixed. This step cuts the number of rejections in half. To prevent rejections and the accompanying fees, the State agency encourages vendors to review their checks before depositing them. The bank sends the State agency a monthly report listing all returned and fixed checks.

The State agency will review checks upon the request of the retailer before they are submitted to the bank. The vendor representatives in the regional offices are authorized to validate or replace legitimate checks that have been rejected so that they can be processed by the bank. For example, a clerk may record the total with tax (which does not apply to a WIC purchase) and then scratch it out to enter the correct total. If the store submits this check to the bank, it will be rejected; instead, the store can have the State agency validate the check. There is a special function on the PTBMIS that allows authorized State agency staff to replace damaged vouchers so that they can be paid. Stores have started to present more checks for validation before submission to a bank.

Automated Check Reconciliation

Tennessee's check reconciliation process identifies checks that meet one of four exception criteria: checks that are transacted yet voided in the system; checks that are transacted without a valid record of issuance; checks that are transacted, but a duplicate check number has also been

transacted; and checks presented for payment past their expiration date. In all of these cases, the check has been transacted by the participant, but payment is denied by the bank, based on the file of valid checks provided daily by the State agency.

Checks that are transacted without a valid record of issuance and checks which have been transacted under 2, seemingly identical, serial numbers are researched by the State agency. This process entails retrieving the check's image from files maintained on CD-ROM. Virtually all of these cases are misreads of the MICR encoding at the bottom of the check. Checks that are transacted yet coded as a void in the PTBMIS are sent to the regional WIC directors for research in the field. Most often, these checks have been voided in error, and payment will be made to the vendor.

For checks that have been transacted past their expiration date, the bank confirms that the food instrument was used past the expiration date and returns them to the vendor, if this is the case. Once a year, usually at the close of the State government's fiscal year, a report is run that automatically voids checks in the PTBMIS that have passed their expiration date.

D. Quality Management and Staff Oversight

WIC clinic operations are subject to several layers of review oversight to ensure quality of service, compliance with regulations and policies, and program integrity. Check clerks are required to perform daily quality control checks. Local clinic supervisors review records, specifically the check issuance process, monthly.

The regional WIC office administers an ongoing review, which examines each clinic once a quarter. In addition, there are state-level review functions. TDH's Quality Management (QM) group reviews each clinic once a year. The Bureau of Internal Audits (BIA) conducts a review of each region once a year, including visits to a sample of clinics. (In the counties that contract with TDH to operate their own WIC clinics, independent audits take the place of BIA's reviews.) The State auditor also reviews the WIC Program once per fiscal year.

Quality Control Checks of Food Instrument Issuance

Check accountability is ensured through the daily printing of the check receipt report, which compares all checks printed that day against the number of receipts printed with each check issuance and signed by the participant. The clerk who runs the report looks for gaps in the sequence of check serial numbers.

The clerk also prints the void check report, which lists all checks that have been voided on the PTBMIS that day, and performs a match by serial number against the checks that have been physically voided. Voided checks are sent periodically to the State agency, where they are imaged for ease of retrieval and spot-checked against the void check report. Clerks who issue checks and those who run the reports must initial and date their work, to establish an initial line of accountability for the checks.

Local clinic supervisors review the check accountability reports once a month. This review helps ensure that the daily quality controls are maintained and any problems are detected promptly. A more informal but equally important control is the fact that the check clerk operates in the

reception area of the clinic, a high-visibility location where supervisors can readily observe the clerks at work.

Integrated Quality Management Reviews by Regional Offices

Each TDH regional WIC staff conducts a review of every clinic in its region at least once a year. This quality control function is conducted by the regional WIC director to review 3 months of checks at a time. The process entails confirming the work of the local clinic supervisor and check clerks, including data entry, signed receipts, and daily issuance report review. A reconciliation process is conducted by both the regional and central staff.

TDH has a system of comprehensive QM reviews of all clinic operations, including WIC. Each region has its own QM team, led by a QM coordinator, which goes to each county site twice or more each year for various reviews. Most QM reviews are done by nurses, but the regional accountant does fiscal standards. Either the WIC regional director or a QM staff member may do the WIC review. The State QM coordinator prefers to have QM personnel to conduct WIC reviews because they tend to document problems instead of just fixing them.

TDH has an integrated QM manual with standards for all grants. Topics of QM reviews include: administration, health maintenance standards, encounter/medical records standards, fiscal review, risk minimization and WIC operations. The administration review deals with personnel records, patient satisfaction surveys, appointment schedules, posters, policy and procedures manuals, etc. The review of health maintenance standards uses a sample of records from PTBMIS. This includes correct plotting of growth, plans of care present and followed, referrals and follow up as appropriate. The encounter/medical records standards review includes checks that charges match medical records and key information on each encounter is filled in. The fiscal review deals with receipts, cash boxes, shortages and refers problems to internal audits. The risk minimization review looks at following proper safety procedures according to the clinic manual.

WIC reviews are based on standards provided by the State's WIC director and WIC quality assurance supervisor. These standards were first used in 1998 and have been updated each year. They cover certification, health histories, nutritional assessment, growth measures, blood tests, assignment of risk codes, nutrition education plans, food prescriptions, check issuance, immunizations, patient responsibility, and completeness of records. When income documentation requirements were implemented in July 2000, the review guide was revised to cover these requirements.

For each clinic, the annual review includes a variety of inspections, observation of procedures, and record reviews. The WIC reviewer pulls 10 or more WIC records to verify compliance with all program requirements, including certification and food package issuance rules. The reviewer also examines the check accountability reports for a 3-month period. Current clinic oversight visits include the observation of nutritionist with client, ensuring that the assessments made and instructions and advice given are appropriate.

The audit tool is on a laptop, which is used to enter findings into the database. The software application allows the reviewer to produce a report of preliminary findings for the exit conference with clinic management.

Typical problem areas identified in WIC reviews are medical history, growth measures, development, and behavioral screens. Initial measures are adequate, but there are common problems in plotting trend data versus expectations for growth. These problems might affect the quality of care, but not the integrity of WIC certification. The most common security problem is that staff members do not sign off when they leave their computer terminals, a requirement that is sometimes difficult to meet in the busy clinic environment.

The TDH regional office sends findings from QM reviews to the local director for response in 30 days. When problems are found, an automatic 3-month followup is pursued. Often peer review is utilized to discuss problems and assess causes. Patterns are discussed at regional QM committees and the State quality committee's annual meeting. Summary reports on the results of QM reviews are provided to State WIC management and other program managers. The State QM office oversees regional plans for focus on areas needing improvement, and meets annually with reviewers to assure consistency by reviewing the standards and addressing problems with applying them. QM nurses meet 4 times a year regarding medical records review standards.

Internal Audits of State-Operated Clinics

In addition to the reviews conducted by QM, the TDH Bureau of Internal Audits (BIA) also looks at various aspects of the county health department including WIC. These audits analyze reported income and ensure that income is documented at every certification. The BIA review also looks at a random sample of charts, screens and other documentation. The review criteria include: documentation of certification consistent with reason for nutrition care, proper time between certification and recertification, timely notice of ineligibility for termination, and proper nutrition education per nurse's notes. Audits also cover personnel records: applications, employee qualifications, and payrolls. The review of check records includes check receipt reports and receipts, void reports, and voids.

Fewer problems have been observed in the internal audits process since the advent of the QM program. BIA reports that it is now less common to see undocumented income or a client reporting no income. The most common problems observed involve missing or improper documentation of dietary recalls, growth charts, or nutrition education.

Participant Sanctions

TDH has a very specific sanction system, defining the actions taken against the participant when program abuse is detected. Upon a first violation of fraud, a participant is usually given a warning by the local clinic staff. The local clinic can also require that a participant pick up checks on a monthly basis. It is feasible to require a participant to transact checks at a specific vendor by prestamping checks, but TDH does not currently use this strategy. The most common sanction taken upon a second offense is program suspension for a specific period of time.

Employee Fraud

In the counties where TDH directly manages the clinics, all employees who will work for the WIC Program are State employees and subject to State personnel procedures. All new hires must go through a standardized Civil Service procedure to be hired. This is a preventive step against any opportunity for collusion among staff members-it is a check against any favoritism in hiring. The Civil Service application requires the applicant to state whether he or she has a criminal record, but no actual criminal background check is performed.

State WIC officials question the usefulness of a background check of this type, since employees who have been caught abusing the WIC Program and subsequently were sanctioned did not have a previous criminal record. The metropolitan counties that operate their own WIC clinics follow their own personnel procedures to ensure employee integrity. The two known cases of employee fraud in the history of the Tennessee WIC Program involved the theft of preprinted checks under the previous issuance system.

III. Summary of Site Visit Results

The key practices that promote participant and staff integrity in the Tennessee WIC Program are the following:

- The integration of WIC services as part of the public health clinic system
- A single process for making appointments, registering customers, screening for income eligibility, and tracking encounters for all services
- The integrated design of the PTBMIS to support integrated local operations and enhance information linkages between WIC and other programs, notably immunization and TennCare/Medicaid
- The separation of duties between registration and check issuance
- The highly effective dual participation checks based on real-time information for the clinic's region, a high rate of success in obtaining SSNs, and a flexible system for statewide dual participation checks
- An on-demand check printing system that eliminates serialized blank checks and controls when, where, and by whom checks can be produced
- Strong daily reconciliation processes for check issuance and voids, coupled with monthly supervisory reviews
- Multiple layers of regional and State review, including both WIC and non-WIC staff

The ability to check in "real time" for duplicate registration on a regional basis represents a mid-level of security compared to other State agencies' fraud prevention systems that have been analyzed in this study. Specifically, WIC facilities in California are able to perform a real-time match of pending participants against the entire State's WIC rolls at initial registration. Texas, on the other hand, does its dual participation check through a nightly batch process, and thus must follow up after dual participation has occurred.

Tennessee has chosen to incur the cost of online data communications between the clinic and a central host computer. By using an existing infrastructure for these communications, Tennessee substantially reduced the cost of providing online capability for WIC. According to TDH, the

amount of dual participation that is detected outside the real-time system is too small to justify the added expense of expanding online access to the entire WIC participant database.

The Tennessee certification system has a small window of vulnerability because it relies on the current presumptive eligibility process for Medicaid. WIC staff ask pregnant clients to self-declare their income and household size. A preliminary certification including, the issuance of 1 month's checks, is performed. After this is completed, WIC staff contact the Tennessee Department of Human Services to confirm the information provided by the client. Even if the participant does not meet eligibility requirements, the month's checks have already been issued. Although there is a low incidence of abuse, this situation represents an avenue through which fraud might occur.

Despite the statewide use of the WIC policy manual and the PTBMIS, there are some reasons to question whether program integrity is as strong in the county-operated clinics as it is in those operated directly by TDH. The State WIC management team has less control over the county-operated clinics. For example, the State WIC director prefers for all WIC clinics to provide scheduled appointments for all participants, as the State-run WIC clinics are required to do, but the county-run clinics often operate on a walk-in basis.

The county-run clinics are not reviewed by the TDH's internal auditors. Instead, TDH relies on the counties' own auditors and their direct accountability for program integrity. It is true, nevertheless, that the Tennessee WIC Program has exercised a significant amount of control through the contracts it has established with the metropolitan counties and the checks built into the PTBMIS. Moreover, TDH maintains strong lines of communications and a shared vision with the WIC directors in these counties. We are left with some uncertainty about how well these more indirect management tools take the place of TDH's internal management systems for its own clinics.

Finally, the quality management structure that has been developed is characterized by creation of quality control standards for the WIC Program by non-WIC personnel. In addition, it is very typical for quality management personnel to perform annual reviews rather than a regional WIC director. Some of the expectations for performance may be somewhat misfit to WIC operations. The entire quality management program has only been in existence since 1998, so it is natural that there is room for improvement.

This situation begs the question of whether the additional layer of oversight, although valid, makes a difference in actual quality control terms, given the layers of internal WIC Program reviews that exist. Essentially, if accountability processes work, quality management merely confirms the procedural priorities of the program. Other States' Agencies have chosen less frequent State reviews, but have implemented much more of an arm's length distance between oversight and the clinic operations that are being reviewed.