Tennessee Department of Health
Division of Health Licensure and Regulation
Office of Health Care Facilities, Civil Rights Compliance
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243
www.state.tn.us/health

CIVIL RIGHTS COMPLIANCE REPORT

The Office for Civil Rights Compliance (OCRC), Office of Health Care Facilities, has responsibility for enforcing the following:

Title VI of the Civil Rights Act of 1964, as amended, prohibits discrimination on the basis of race, color, or national origin.

Section 504 of the Rehabilitation Act of 1973, as amended, prohibits discrimination on the basis of physical or mental handicap.

Public Chapter 977 of the 1988 public laws, TCA 68-1-113, prohibits racial discrimination in healthcare facilities licensed by the Department of Health.

Tennessee Department of Health, Board for Licensing Health Care Facilities, Civil Rights Compliance Rules and Regulations, 1200-8-16, January 1991.

In order to determine your compliance status under the above regulations, we are requesting that you complete the enclosed Civil Rights Compliance Report and **keep this report at the facility/agency.** The report will be reviewed by the OCRC Surveyors during their on-site visits. This report should be completed within thirty (30) days of receipt by the facility/agency.

The Office for Civil Rights Compliance (OCRC) has technical assistance staff available to assist you in preparing this report. If you have questions regarding information requested herein, please contact the Regional Civil Rights Administrator or central office:

East Tennessee
(865) 594-0728

West Tennessee
(731) 984-9731

Office of Health Care Facilities, Civil Rights Compliance
665 Mainstream Drive, Second Floor
Nashville, TN 37243
Phone: (615) 532-6595
Fax: (615) 253-8798

CIVIL RIGHTS COMPLIANCE REPORT

SECTION I

SELF-EVALUATION

Medicaid Number: _____ Medicare Number: _____

Person Completing Report: _____ Date Completed _____

A. IDENTIFICATION

Facility/Agency Name: _____

Former Name: _____

Address: _____

_____

Phone Number: (_____) _____

Administrator: _____

B. DESCRIPTION

1. Type of Facility/Agency (Check All Applicable)

General Hospital _____ Home Health Agency _____

Specialty Hospital _____ Ambulatory Surgical Center _____

2. Type of Ownership/Control

A. Governmental ( ) City ( ) County ( ) State ( )
Other ( ) If other, Specify _____

B. Non-Governmental, Not For Profit ( )

C. Investor Owned, For Profit ( )

3. Is your facility/agency owned or managed by a person or group which owns/manages other health agencies/facilities? Yes ( ) No ( )

If yes, provide the following:

Name of Person or Group: _____

Address: _____

_____

City: _____ Zip _____

Phone Number: (____) _____ Fax: (____) _____

How many other facilities/agencies are owned by this person or group? _____

4. Is your facility/agency affiliated or related in any way with another health or social service agency such as a hospital, retirement village, physical therapy center, etc.? Yes ( ) No ( )

If yes, specify name and address of each. _____

_____

_____

5. Does your facility/agency have any transfer agreements with other health or social service agencies for the acceptance or referral of patients? Yes ( ) No ( )

If yes, identify each name and address. _____

_____

_____

6. Do you offer priority admission consideration to patients/clients who are being served by any other health or social service agency?
Yes ( ) No ( ) If yes, please explain. _____

_____

_____

7. Is your facility/agency owned or operated by any religious organization?
Yes ( ) No ( ) If yes, identify. _____

_____

_____

8. Are admissions restricted or limited based on fraternal, religious or other group membership?
Yes ( ) No ( ) If yes, Identify. _____

_____

_____

9. List all <u>MEDICAL</u> and <u>SOCIAL</u> services provided. _____

_____

_____

10. List all major referral sources. _____

_____

_____

11. Number of beds/capacity: _____

12. Cost of accommodations: (Highest-Lowest)

A. Private _____
B. Semi-Private _____
C. Wards

13. Number of Floors: _____

14. Number of Wings: _____

15. Number of Employees: _____

A. Total Minorities: _____
B. Total Non-Minorities: _____
C. Other: _____

C. PRIMARY GEOGRAPHIC SERVICE AREA

1. What is your facility/agency's primary geographic service area (i.e. List County (ies), city (ies), etc.)

_____

_____

2. Describe the racial/ethnic composition of the above:

	Total Pop.	White	Black	Other
Number:	_____	_____	_____	_____
Percent of Total:		_____	_____	_____

Please use the most current population data prepared by the Center for Health Statistic, TDH.

3. Is there a sub-section of the primary geographic service area from which over 50% of your Patients/clients are drawn? If so, please describe and identify racial/ethnic population statistics.

	Total Pop.	White	Black	Other
Number:	_____	_____	_____	_____
Percent of Total:		_____	_____	_____

D. PATIENT CONTACT STAFF (HHA and ASC only)

Provide the following:

1. A list of physicians by race/ethnicity. (Ambulatory Care Centers Only.) If additional space is needed please use a separate sheet.

2. A list of patient, contact staff by name, race/ethnicity, and position (e.g., R.N., L.P.N., Therapists) (HHA and ASRC only). If additional space is needed please use a separate page.

3. Please state the criteria used to assign patient contact personnel. Indicate if race, color, national origin or handicapping conditions are factors considered when making staff assignments. If additional space is needed please use a separate page.

SELF-EVALUATION TITLE VI OF THE
CIVIL RIGHTS ACT OF 1964

TITLE VI COMPLIANCE CHECKLIST

1. Has your facility/agency signed copies of the Title VI and Section 504 Assurance of Compliance Agreements with the Department of Health and Human Services?
   Yes _____ No _____ (DHHS forms 441 and 641)

2. Do you have an acceptable nondiscriminatory policy statement in or near the lobby/entrance of your facility/agency for compliance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.
   Yes _____ No _____

3. Do you have a Title VI and Section 504 compliant poster and forms available to staff, patients and visitors to the facility/agency?
   Yes _____ No _____

4. Do you have a copy of your annual public notification of your admission policy and your advertisement for recruitment of employees which provides the facility's nondiscriminatory policies with regard to race, color, national origin or handicapping condition.
   Yes _____ No _____ (If yes, please attach a copy of these notifications).

5. Are there written policies of nondiscrimination that provides for admissions, services, and room assignments (if applicable) without regard to race, color, national origin or handicapping conditions in the following:

A.	Admission policy?	Yes__	No____	
B.	Employee's handbook and/or bulletins?	Yes__	No____	
C.	Room assignment policy?	Yes__	No____	N/A____
D.	Emergency room policy?	Yes__	No____	N/A____

6. Is any part of the facility/agency services used on the basis of race, color, national origin or Handicapping condition? Yes _____ No _____

   If yes, please explain. _____
   _____

7. Are rules of courtesy uniformly applied throughout the facility/agency without regard to race, color, national origin or handicapping condition? Yes _____ No _____

   If yes, please attach copies of the facility's written Courtesy Title policy, (see sample policy).

8. Have employees been instructed about their obligation under Title VI?
Yes ____ No ____

(If yes, please provide us with materials on how the policy is distributed to employees, or explain your method of informing employees of their obligations under Title VI in regard to rendering direct or indirect services to patients/clients.)

9. How is room assignments made? (If applicable) _____
_____
_____
_____
_____

Please attach a copy of your written policy.

10. How is room transfers made? (If applicable) _____
_____
_____
_____
_____

11. Do you maintain copies of discrimination complaints filed against your facility/agency?
Yes _____ No _____

12. Do you maintain a file for employees and patient complaints against your facility/agency?
Yes _____ No _____

13. Do all contracts with physicians, vendors, or other health care providers contain a nondiscriminatory clause? Yes _____ No _____

(Please attach examples of your contracts with physicians, vendors, etc.)

14. How are your physicians and other referral sources informed of the facility's nondiscriminatory policy? _____
_____
_____

15. Do you have a Planning or Advisory Board that plays a significant role in the management of the facility/agency?
Yes _____ No _____

(If your facility/agency has a planning or advisory board, please complete the following).

A. Members of your Planning/Advisory Board.

Name	Telephone Number	Race/Ethnicity
	( )	
	( )	
	( )	
	( )	
	( )	

B. A list of your handicapped members.

Name	Telephone Number	Race/Ethnicity
	( )	
	( )	
	( )	
	( )	
	( )	

C. How are members of the Planning/Advisory Board selected?

D. What efforts have been made to recruit handicapped persons?

16. Do you have a Board of Directors or a Medical Board in your facility/agency?
Yes _____ No _____ (If yes, please complete the following information).

A. Total minority members _____
B. Total non-minority members _____
C. Total handicapped members _____
D. How are members recruited _____
_____
E. How long is their term of membership _____
_____
F. Does the Board of Directors or Medical Board have by laws?
Yes _____ No _____ (If yes, please attach a copy).

SELF-EVALUATION SECTION 504 OF THE
REHABILITATION ACT OF 1973

SECTION 504 COMPLIANCE CHECKLISTS

1. Do you have a Section 504 Coordinator? Yes _____ No _____

2. Identify the facility/agency's Section 504 Coordinator.

   Name _____

   Title _____

   Telephone # (____) _____

   Duties _____

   _____

   _____

3. Do you have a Section 504 "Task Force" or Self-Evaluation Committee to examine and make decisions on the facility's policies and procedures for Section 504?
   Yes ___ No ___

4. What consultants or organizations are represented on the Self-Evaluation Committee to represent handicapped persons with impaired sensory or speaking skills?

Name	Organization	Race/Ethnicity

5. Is there a written policy of nondiscrimination for the following that complies with Section 504? (Provide copies of written materials.)

A.	Admission policy	Yes___	No___
B.	Services and benefits	Yes___	No___
C.	Public Notice	Yes___	No___
D.	Employment Practices	Yes___	No___
E.	Pre-Employment Criteria	Yes___	No___
F.	Job Descriptions	Yes___	No___
G.	Application Forms	Yes ___	No ___

6. Do you have a Section 504 Grievance Procedure meeting Section 504 standards (45 CFR 84.7(b))? Yes ___ No ___ (Provide a copy of your Grievance Procedures for Section 504).

7. Does your facility/agency provide reasonable accommodations as required under Section 504 (45 CFR 84.12)? Yes _____ No _____

Reasonable accommodation may include but are too limited to:

A.	Handicapped ramps	Yes___	No___
B.	Special equipment	Yes___	No___
C.	Modified work schedules	Yes___	No___
D.	Parking Lots	Yes___	No___
E.	Restrooms	Yes ___	No ___

8. Does your facility/agency conform to the American National Standards Institute (ANSTI) for access and use by physically handicapped persons?
Yes _____ No _____

9. Does your facility/agency provide telecommunication devices for the deaf (TTY/TDD)?
Yes _____ No _____ (If no, please explain what procedure is in place for providing access to services for the hearing impaired client/patient).

_____

_____

_____

10. Has your facility/agency conducted a self-evaluation? If you have, please provide us with a copy or description of the self-evaluation including, at least:

A. A list of the handicapped persons, or organizations representing handicapped persons, or other interested persons consulted; and

B. A brief description of the areas examined, any identified problems, and modifications made or remedial steps taken.

If your facility/agency has not conducted a self-evaluation, OCRC will require immediate action to conduct this self-evaluation within thirty (30) days upon receipt of this package.

11. Does your facility/agency have formal arrangements with individuals or organizations to provide translation services when needed? Yes _____ No _____

(Please check the arrangement that is applicable to your facility/agency). Formal arrangements include:

_____ Contracts
_____ Formal written arrangement
_____ Memorandum of understanding

A. What method is used to contact interpreters for persons with limited English proficiency or persons with impaired hearing when those services are needed?

_____

_____

_____

B. What method is used to obtain written consent to treatment or waivers of rights from qualified handicapped persons including those with impaired sensory or speaking skills?

_____

_____

_____

C. Who is the responsible staff person for contacting the appropriate interpreter for emergency room situations for the limited English proficiency person or persons with impaired hearing?

_____

_____

_____

12. Does your facility/agency provide auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons the services needed? Yes ___ No ___ (Please list all auxiliary aides available in your facility/agency). Example: TTY equipment, brailed materials, wheelchairs, etc.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Other: _____

_____

13. Identify the facility/agency's qualified sign language interpreters and bilingual interpreters.

Name	Education	Telephone Number
_____	_____	(___) _____
_____	_____	(___) _____
_____	_____	(___) _____
_____	_____	(___) _____
_____	_____	(___) _____

14. Are the facility/agency's qualified interpreters available 24 hours a day? Yes __ No ___

15. Do you have an Infectious Disease Control policy? Yes ___ No ___
(If yes, please provide a copy of the following policies and procedures).

A. Isolation policies and procedures
B. AIDS policy and procedures

CIVIL RIGHTS COMPLIANCE REPORT

SECTION II
STATISTICAL REPORT

The Office on Civil Rights Compliance is requiring all health care facilities to maintain specific racial data required under Title VI of the Civil Rights Act of 1964 and implementing regulations at (45 CFR 80.6(b)) which states:

> . . . federally assisted recipients should have available for the Department racial and ethnic data showing the extent to which members of minority groups are beneficiaries of and participants in federally-assisted programs . . .

Facilities should begin immediately maintaining this data and should make this data available to OCRC surveyors upon request.

Instructions For Completing Hospital Bed Census

1. Insert the name and address of your hospital in the upper left corner of the census form.

2. Indicate in the upper right hand corner the period for which the census is being completed. "Beginning Date" refers to the date on which you began recording the census. "Ending Date" refers to the date on which the census was completed.

3. Name/Coded Identifier - refers to the name or Medicaid/Medicare identification number of each patient. If private insurance indicate "P" by name or coded identifier.

4. Race.

5. If Limited English Proficiency indicate (LEP). This will indicate patient's national origin other than Black, not of Hispanic origin or white, not of Hispanic origin.

6. Age - refers to patient's age.

7. Sex - refers to sex of the patient, male or female.

8. Room Number - refers to the number of the room to which the patient is assigned.

9. Number of Beds in Room - refers to the number of beds in the room. If there are two or more beds per room, use a separate line to indicate information pertaining to each person; (e.g., each patient's race, sex, age, and bed number).

10. Type of Patient - refers to the section of the hospital to which the patient is assigned; (e.g., Medical, Surgical, Pediatric, Obstetrics and Gynecology or Orthopedic).

11. Method (Source) of Payment - refers to the method of payment that the patient is using to reimburse the hospital for services received, [e.g., PP (Private Paying), MD (Medicare), MC (Medicaid), INS (Insurance, and S (Services)].

12. Room Rate - refers to the cost of the room per day.

13. Admission Date - refers to the date the patient was admitted to the hospital.

14. Length of Stay - refers to the actual number of days the patient is in the hospital.

15. Discharge Date - refers to the date the patient was discharged from the hospital.

Note: To illustrate new admissions, please circle all New admissions in red. To illustrate room transfers, please circle all transfers in blue.

PATIENT CENSUS

Provider Name _____

Address _____

_____

Date(s) of Census Survey
From ______ to ______

Hospitals: Please provide patient census for 14 consecutive days.

Name/Coded Identifier	Race	*LEP	Age	Sex	Room Number	No. Beds per room	Type of Patient	Method (Source) of Payment	Room Rate	Admission Date	Length of Stay	Discharge Date

*LEP (Limited English Proficiency)

Racial Composition of Medical and Hospital Staff

Table No. 1

Present status of facility's medical and dental staff - Indicate in each category the number of persons who are either on the staff or attending patients in this facility.							
Categories	Total (All)	White	Black	American Indian	Hispanic	Asian/Pacific Islander	Other
PHYSICIANS							
Active							
Associate							
Courtesy							
Consulting							
Other							
DENTISTS							
Staff							
Others							
Total							

Table No. 1(a)

Indicate the number and status of applications for medical and dental positions received by your facility during the last two years.							
Categories	Total (All)	White	Black	American Indian	Hispanic	Asian/Pacific Islander	Other
Pending (2 yr.)							
Received							
Denied							
Approved							
Pending (now)							
TOTAL							

Table No. 2

Hospital Employees	Total (All)	White	Black	American Indian	Hispanic	Asian/Pacific	Other
R.N.'s							
L.P.N.'s							
Aides							
Orderlies							
Housekeeping							
TOTAL							

Table No. 3

Do you have a training program? ( ) Yes ( ) No. If "yes" indicate the number of persons currently in training in each category by race of the participant. (If this reporting period is between training sessions, give training data for last training classes.)

Categories	Total (All)	White	Black	American Indian	Hispanic	Asian/Pacific Islander	Other
Interns							
Residents							
Student Nurse							
LPNs/Training							
Medical Tech.							
Therapists							
Social Worker							
Other							
Total							

	Answer		Corrective Action Necessary	
	Yes	No	Yes	No
1. Are all trainees (nursing students, interns and/or residents) selected without regard to race, color, or national origin?	____	____	____	____
2. Are residence facilities assigned to nursing students, interns, residents, other trainees, or personnel on a nondiscriminatory basis?	____	____	____	____
3. To the best of your knowledge, do you conduct affiliated training programs for institutions which discriminate?	____	____	____	____

What specific recruitment efforts have been made in order to encourage minority participation in training programs sponsored by the facility? _____

_____

_____

Racial Composition of Volunteers

Table No. 4

Is membership in the hospital volunteer service groups open to all persons without regard to race, color, or national origin? Yes ____ No ____
If yes, what is the racial breakdown of volunteers?

Categories	Total (All)	White	Black	American Indian	Hispanic	Asian/Pacific Islander	Other
Adult							
Youth							
Total							

Have all personnel in the social services department been instructed to make referrals to other activities (e.g., nursing homes and other services) with regard to race, color, or national origin?
Yes _____ No _____

The following page is a form to be completed on the last 25 patients discharged who required continuing care.

Complete for the last 25 patients discharged who required continuing care.

Patient name or number	Race	Date of Discharge	Name of continuing care facility or agency where patient was placed or name of service providing care if patient was discharged to home

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