The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BUDGET SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS
Senator Negron, Chair
Senator Rich, Vice Chair

MEETING DATE: Friday, March 11, 2011
TIME: 8:00 —10:00 a.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Negron, Chair; Senator Rich, Vice Chair; Senators Gaetz, Garcia, Oelrich, Richter, and Sobel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Budget Workshop		Discussed
2	Alternative Low Income Pool Model		Discussed
3	Public Testimony on HHS Budget		Discussed
4	Public Testimony on Medicaid Reform		Discussed

Senate Budget Committee
Span of Control - Health and Human Services Agency Ratios

	Agency/Budget Entity	Current Ratio	Revised Ratio	Comments	
1	**Veteran's Affairs**	**1:9.2**	**1:9.2**		1
2	Total Supervisors	119.0	119.0		2
3	Total Positions	1,089.0	1,089.0		3
4	Veteran's Homes	1:10.0	1:10.0		4
5	Executive Direction and Support Services	1:4.5	1:4.5		5
6	Veteran's Benefits and Assistance	1:6.6	1:6.6		6
7					7
8	**Agency for Healthcare Administration**	**1:5.3**	**1:8.0**		8
9	Total Supervisors	317.0	229.0	Agency proposes to restructure bureaus and reduce 8 supervisory positions.	9
10	Total Positions	1,669.0	1,828.0	Adjusted for OPS and contracted staff.	10
11	Administration and Support	1:3.7	1:9.1		11
12	Executive Direction and Support Services	1:5.1	1:7.3		12
13	Health Fac and Prac Reg	1:6.9	1:8.6		13
14					14
15	**Agency for Persons with Disabilities**	**1:5.1**		Not Received to Date	15
16	Total Supervisors	589.0			16
17	Total Positions	2,995.0			17
18	Home and Community Services	1:5.3			18
19	Program Management and Compliance	1:4.5			19
20	Developmental Services Public Facilities	1:5.2			20
21					21
22	**Department of Children and Families**	**1:6.3**	**1 : 8.3**	Adjusted for Governor's reductions in administrative and vacant positions.	22
23	Total Supervisors	2,098.0	1,112.0		23
24	Total Positions	13,263.0	9,283.5	Does not include mental health treatment facility staff.	24
25	Executive Direction and Support Services	1:4.9	1:9.8		25
26	Information Technology	1:5.2	1:10.5	Includes 135 contracted employees supervised by the department.	26
27	Northwood Shared Resource Center	1:5.2	-		27
28	Family Safety and Preservation Services	1:6.4	1:7.5	For Adult Protective Investigators and Child Protective Investigators, the department follows the Child Welfare League of America's ratio of 1:5.	28
29	Mental Health Services	1:5.0	1:7.6	Does not include mental health treatment facility staff.	29
30	Substance Abuse Services	1:3.6	1:7.7		30
31	Economic Self Sufficiency Services	1:9.1	1:8.6		31
32					32

Senate Budget Committee
Span of Control - Health and Human Services Agency Ratios

	Agency/Budget Entity	Current Ratio	Revised Ratio	Comments	
33	**Department of Elder Affairs**	1:5.8	1:11.24		33
34	Total Supervisors	79.0	79.0		34
35	Total Positions	457.0	888.0	Adjusted for 260 volunteers; and 171 OPS	35
36	Comprehensive Eligible Services	1:9.7	1:11.57		36
37	Home and Community Services	1:4.1	1:5.70		37
38	Executive Direction and Support Services	1:3.5	1:7.39		38
39	Consumer Advocate Services	1:3.1	1:27		39
40					40
41	**Department of Health**	**1:5.3**		DOH was allowed to use the mandated agency Evaluation and Justification Review report in place of this assigmnemt. See letter from DOH	41
42	Total Supervisors	3,197.0			42
43	Total Positions	17,004.0			43
44	Executive Direction and Support Services	1:4.6			44
45	Information Technology	1:5.0			45
46	Family Health Services	1:4.9			46
47	Infectious Disease Prevention Control	1:3.9			47
48	Environmental Health Services	1:3.6			48
49	County Health Location Health Need	1:5.3			49
50	Statewide Health Support Services	1:5.3			50
51	Child Specialized Health Care	1:5.6			51
52	Medical Quality Insurance	1:5.2			52
53	Community Health Resources	1:5.3			53
54	Disability Benefits Determination	1:6.9			54
55	Other	1:3.7			55

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2 March 2011

Senator Joe Negron, Chair
Budget Subcommittee on Health and Human Services Appropriations
201 The Capitol
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Negron,

This letter represents the Florida Department of Veterans' Affairs (FDVA) response to your request dated February 18, 2011, asking for a review of our department's supervisor to employee ratio.

We have examined the data maintained within our department as well as the attachment you provided to us. We are pleased that, Agency wide, FDVA exceeds your target goal of one supervisor to eight employees by a full fifteen percent. At this time, we do not have any proposed reductions to our current structure.

We understand the current budget constraints and appreciate your efforts during these difficult times. If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,

Christina R. Porter, CPA
Director, Division of Administration

FLORIDA DEPARTMENT OF HEALTH

Rick Scott
Governor

March 8, 2011

The Honorable Joe Negron
Chairman, Budget SubCommittee
Health and Human Services Appropriations
201 The Capitol
404 South Monroe Street
Tallahassee, Florida 32399-1100

Dear Senator Negron:

Thank you for the opportunity to provide information to the Budget subcommittee in response to the span of control assignment. The Florida Department of Health Evaluation and Justification Review, Report Findings and Recommendations (in response to HB 5311, Section 34) has been submitted to the Governor and the Legislature, and we have enclosed a copy for your convenience.

The report reflects a comprehensive evaluation and justification review of each division established under s. 20.43, *Florida Statutes*, within the department. The report includes a rationale for each division, the return on investment for each division, identifies funding associated with each division, and provides alternative course of action based on outcomes from the report. The department is proposing that our divisions be reduced from 11 to 6 and our bureaus reduced from 50 to 18. One of the cornerstones of our plan is for all managers to focus on improving their supervisory to employee staffing ratios. Other specific information is outlined in the report.

We hope that this report meets the intent of your request and look forward to working with you to identify all opportunities to increase efficiencies and reduce costs at the Department of Health. If you have questions or concerns, please contact one of us by calling (850) 245-4321.

Sincerely,

Kimberly A. Berfield
Deputy Secretary

Shairi R. Turner, M.D., M.P.H.
Deputy Secretary for Health

Enclosures

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FLORIDA DEPARTMENT OF HEALTH

Florida Department of Health Evaluation and Justification Review

Report on Findings & Recommendations

In Response to
Ch. 2010-161, § 34, Laws of Florida

Submitted March 1, 2011

Rick Scott
Governor

Acknowledgements

The department gratefully acknowledges the contribution of numerous staff – both in and outside the department's central office. Their collective efforts, along with those of the department's external (public and private sector) stakeholders, made this report possible.

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I. EXECUTIVE SUMMARY

In 2010, the Florida Legislature passed HB 5311 – now Ch. 2010-161, Laws of Florida. Section 34 of this law requires the Department of Health (the department) to conduct a comprehensive evaluation and justification review of its divisions established in section 20.43, F.S., and programs within these divisions. This law also requires that, "No later than March 1, 2011, the department shall submit a report of its evaluation and justification review findings and recommendations to the President of the Senate, the Speaker of the House of Representatives, the chairs of appropriate substantive committees, the Legislative Auditing Committee, the Governor, and the State Surgeon General," (Ch. 2010-161 § 34(1) at 44, Laws of Fla.).

The scope of this evaluation and justification review included the department's divisions established in section 20.43, F.S., and programs within these divisions. County health departments (CHDs) were reviewed only to the extent that recommended changes to central office programs could affect local (county) operations.

The department's divisions have statewide responsibilities to protect and promote health, and to provide administrative and technical support to the CHDs. The divisions and associated field operations, and the CHDs throughout Florida represent only part of Florida's overall public health *system.* Partnerships – both public and private – within the system build the state's capacity to protect and improve the health of the population. Through a focused approach to population health and health priorities, the department can better direct the state's limited resources toward more effective prevention of the major causes of death and disease in Florida.

Staff in the department planned and implemented a systematic review process with a timeline for associated deliverables. Fundamental to the evaluation and justification review process is a complete accounting (inventory) of central office divisions and programs, and their associated resources.

A rigorous and participatory process by design, the review included input from stakeholders both internal and external to the department. Evidence considered during the process was provided through multiple means, including numerous and frequent face-to-face meetings, analysis of written documentation and testimony from public health experts.

In addition to the recommendations regarding the department's divisions and programs (and dedicated state and federal resources for each) are recommendations for the department's statutorily defined purpose and responsibilities, and its organizational structure. In order to best support the division's, bureaus and county health departments in carrying out the responsibilities of the department, alternative management structures were also considered, and recommendations made.

Throughout the review process, the department was mindful of the importance of its responsibilities. Implementation of recommendations outlined in this report is not intended to diminish the capability of the department to prevent the occurrence and spread of serious and emerging diseases and respond to disasters and other major threats to health.

This report documents the department's review process, analytical criteria, and resulting recommendations. Using the results of this review, the department is improving the accountability and efficiency of the organization.

RECOMMENDATIONS

Recommendation 1: The Legislature amend section 20.43(1), F.S., to revise the department's purpose: "To protect and promote the health of all residents and visitors in the state through organized state and community efforts, including cooperative agreements with counties." Further, the department adopt the revised purpose as its operational mission.

Recommendation 2: The Legislature amend the department's responsibilities as assigned in section 20.43(1)(a)-(m), F.S., to:

- **(a) Identify, diagnose, and conduct surveillance of diseases and health conditions in the state, accumulating health statistics necessary to establish trends.**
- **(b) Implement interventions that prevent or limit the impact or spread of diseases and health conditions.**
- **(c) Collect, manage, and analyze vital statistics and other health data to inform and formulate public health policy and planning.**
- **(d) Maintain and coordinate preparedness for and responses to public health emergencies in the state.**
- **(e) Provide or assure the provision of quality health and related services to identified populations in the state.**
- **(f) Regulate environmental activities that have a direct impact on public health in the state.**
- **(g) Regulate health practitioners, to the extent authorized by the legislature, as necessary for the preservation of the health, safety, and welfare of the public.**

Recommendation 3: The Legislature discontinue allocation of the state's general revenue to fund the provision of Primary Care/Adult and Primary Care/Child health care services. Continued provision of primary health care services, treatment, programs and activities by a county health department would be in collaboration with the county and local community public health partners. The department's assurance function is not affected by this recommendation.

Recommendation 4: The Legislature approve a transition plan for the closure of A.G. Holley State Hospital set forth in the department's "*Report on A.G. Holley State Hospital: Transition Planning for Closure."* The department recommends relocating the patients to a smaller and more cost-efficient facility. Further, the department should retain oversight to maintain the standards of care recommended by the U.S. Centers for Disease Control and Prevention (CDC) for inpatient treatment of tuberculosis.

Recommendation 5: The department develop and implement a state health improvement plan with priorities for statewide health improvement.

Recommendation 6: The Legislature amend the following statutes:

Section 20.43, F.S.

- **Revise the designation of the agency head from "State Surgeon General and State Health Officer" to "Secretary of Health."**
- **Replace "…must be a physician licensed under chapter 458 or chapter 459…" with "…may be a physician licensed under chapter 458 or chapter 459…"**
- **Add language stipulating that if the Secretary of Health is a physician licensed under chapter 458, F.S., or chapter 459, F.S., he or she must also be designated "State Health Officer." In addition, if the Secretary for Health is not a physician, either of the department's deputy secretaries may be designated "State Health Officer," *provided* they are a physician licensed under chapter 458, F.S., or chapter 459, F.S.**
- **Add language to require that at least one deputy secretary be a physician licensed under chapter 458, F.S., or chapter 459, F.S.**

PROPOSED AMENDMENT:

20.43 Department of Health.—There is created a Department of Health.
(1) No change.
(2)(a) The head of the Department of Health is the Secretary of Health~~State Surgeon General and State Health Officer~~. The Secretary of Health shall have ~~State Surgeon General must be a physician licensed under chapter 458 or chapter 459 who has~~ advanced training or extensive experience in public health administration and may be a physician licensed under chapter 458 or chapter 459. The Secretary of Health ~~State Surgeon General~~ is appointed by the Governor subject to confirmation by the Senate. The Secretary of Health ~~State Surgeon General~~ serves at the pleasure of the Governor. ~~The State Surgeon General shall serve as the leading voice on wellness and disease prevention efforts, including the promotion of healthful lifestyles, immunization practices, health literacy, and the assessment and promotion of the physician and health care workforce in order to meet the health care needs of the state. The State Surgeon General shall focus on advocating healthy lifestyles, developing public health policy, and building collaborative partnerships with schools, businesses, health care practitioners, community-based organizations, and public and private institutions in order to promote health literacy and optimum quality of life for all Floridians.~~
(b) There shall be deputy secretaries who are to be appointed by and shall serve at the pleasure of the Secretary of Health. In the event the Secretary of Health is not a physician licensed under chapter 458 or chapter 459, at least one of the deputy secretaries must be a physician licensed under chapter 458 or chapter 459.
(c) The Department of Health shall have a State Health Officer, who must be a physician licensed under chapter 458 or chapter 459. If the Secretary of Health is a physician licensed under chapter 458 or chapter 459, the Secretary of Health is the State Health Officer. If the Secretary of Health is not a physician licensed under chapter 458 or chapter 459, a deputy secretary of the Department of Health shall be designated the State Health Officer by the Secretary of Health.
(b) The Officer of Women's Health Strategy is established within the Department of Health and shall report directly to the Secretary of Health~~State Surgeon General~~.
(3) No change
(4) No change
(5) The department shall plan and administer its public health programs through its county health departments and may, for administrative purposes and efficient service delivery, establish up to 15 service areas to carry out such duties as may be prescribed by the Secretary of Health~~State Surgeon General~~. The boundaries of the service areas shall be the same as, or combinations of, the service districts of the Department of Children and Family Services established in s. 20.19 and, to the extent practicable, shall take into consideration the boundaries of the jobs and education regional boards.
(6)The Secretary of Health~~State Surgeon General~~ is authorized to appoint ad hoc advisory committees as necessary. The issue or problem that the ad hoc committee shall address, and the timeframe within which the committee is to complete its work, shall be specified at the time the committee is appointed. Ad hoc advisory committees shall include representatives of groups or entities affected by the issue or problem that the committee is

asked to examine. Members of ad hoc advisory committees shall receive no compensation, but may, within existing departmental resources, receive reimbursement for travel expenses as provided in s. 112.061.

(7) No change.
(8) No change.
(9) No change.
(10) No change.

Section 391.028(1), F.S.

- **Eliminate the position of Deputy Secretary and Deputy State Health Officer for Children's Medical Services.**

PROPOSED AMENDMENT:

391.028 Administration. –The Children's Medical Services program shall have a central office and area offices.

(1) The Director of Children's Medical Services must be a physician licensed under chapter 458 or chapter 459 who has specialized training and experience in the provision of health care to children and who has recognized skills in leadership and the promotion of children's health programs. The director ~~shall be the deputy secretary and the Deputy State Health Officer for Children's Medical Services and~~ is appointed by and reports to the secretary. The director may appoint division directors subject to the approval of the secretary.
(2) No change.
(3) No change.

Recommendation 7: The Legislature amend the following statutes:

Section 20.43(2)(b), F.S.

- **Eliminate the position of Officer of Women's Health Strategy.**

PROPOSED AMENDMENT:

20.43 Department of Health.—There is created a Department of Health.
…
~~—(b)The Officer of Women's Health Strategy is established within the Department of Health and shall report directly to the State Surgeon General.~~
…

Section 381.04015, F.S.

- **Repeal the entire section relating to the duties assigned to the Officer of Women's Health Strategy.**

Recommendation 8: The Legislature review and direct the department with regard to its recommendations to reduce and restructure the department's divisions, bureaus, and offices, from 11 to 6 divisions; 50 to 18 bureaus; 2 to 0 stand-alone bureaus; and 11 to 5 stand-alone offices.

II. INTRODUCTION

Public Health

Public Health is the science of protecting and improving the health of populations, large or small. Florida has a complementary structure; the department's divisions and programs concentrate on the health of the entire state, while county health departments work to protect and improve the health of every community. The purpose of public health is to keep communities healthy. This population-based preventive approach is an important distinction between public health practice and individual health care.

The three core functions of public health, as identified in the 1988 Institute of Medicine report, "The Future of Public Health," are: (1) Assessment, (2) Assurance, and (3) Policy Development.[i]

Assessment includes the monitoring of disease incidence and other threats and risks to the community's health in order to identify health issues, as well as investigating and diagnosing health problems and hazards affecting a community.

Assurance involves making sure that the population is protected from disease and other threats to health, and not faced with conditions that jeopardize health. Assurance includes evaluation of the effectiveness, accessibility, and the quality of the health services within a community. In addition, a key part of keeping communities healthy is assuring that laws and regulations are enforced to protect health and ensure safety.

Policy Development includes health planning, and working with governing bodies and communities to protect and improve health of people in Florida. Every public health agency must exercise its responsibility to strategically lead in the development of comprehensive, evidence-based public health policies, with an understanding and appreciation for the importance of the political process.

There is a distinction between public health and individual health (including primary health care). The latter is traditionally viewed as the domain of private health care providers. To fulfill its core public health function of assurance, the state provides primary health care services through Florida's centralized network of local county health departments. The level of service provision is based on each community's need for increased availability of basic health care services for the uninsured and underinsured. The level of service for each county is articulated in the county health department's core contract.

The scope and complexity of current health problems continue to present formidable challenges for Florida. A number of factors confront the state in meeting the health needs of its residents and visitors. These include the growth and diversity of Florida's population; the ongoing threat of infectious diseases, such as Influenza, HIV/AIDS, and Tuberculosis; the large number of substance abusers, including children and adults who use tobacco and consume alcohol; and the ever-present threat of natural or manmade disasters. Also of critical importance is the unequal burden of disease based on socio-economic status and race. The system faces wide disparities in health status, with minority populations bearing a disproportionate burden of disease.

No single entity – public or private – is solely equipped to address these challenges; it takes an organized system.

Florida's Public Health System

The Florida Legislature defines, in statute, the legislative intent for Florida's public health system. Section 381.001(1), F.S., "Legislative intent; public health system.–", states (in part): "It is the intent of the Legislature that the Department of Health be responsible for the state's public health system which shall be designed to promote, protect, and improve the health of all people in the state … The Legislature recognizes that the state's public health system must be founded on an active partnership between federal,

state, and local government and between the public and private sectors, and, therefore, assessment, policy development, and service provision must be shared by all of these entities to achieve its mission."

All entities within the public health system (including public/private partnerships at both the community and state level) share multiple duties and responsibilities that contribute to the health of the public. To achieve its aim, effective public health requires organized community efforts.

Florida's Department of Health

In 1996, the Florida legislature established the Florida Department of Health (the department) as a separate agency under the Governor. The department is comprised of a state health office (central office) in Tallahassee, with statewide responsibilities; Florida's 67 county health departments; 22 Children's Medical Services area offices; 12 Medical Quality Assurance regional offices; nine Disability Determinations regional offices; five public health laboratories; and A.G. Holley State Hospital. In addition, the Correctional Medical Authority is assigned to the department for administrative purposes only (section 945.602(1), F.S.). The department has 16,985.25 FTE (not including OPS or contracted staff). Of this number, 1,743.50 FTE are central office program staff geographically located in Tallahassee.

As Florida's governmental public health entity, the department monitors the health status of Floridians; identifies, diagnoses, investigates and treats health problems; and mobilizes local communities to address health-related issues. The department formulates policies and plans that support public health goals, enforces laws and regulations necessary to protect the public's health, links people to needed health care services, and provides services locally where necessary.

The department licenses and regulates health care practitioners, and provides medical disability determinations. In addition, the department has statewide and local responsibilities in the area of disaster preparedness and response, and provides specialized assistance to pregnant women, infants, and children with special health care needs. The department also serves as the state's official registrar for all vital records and the statewide repository for aggregate health related data accumulated by Florida's state agencies.

The department's establishing statute specifically assigns thirteen responsibilities, outlined in section 20.43(1)(a)-(m), F.S. This list includes a variety of required duties and functions the department must carry out to meet its intended purpose. In this statute, these responsibilities are:

(a) Prevent to the fullest extent possible, the occurrence and progression of communicable and noncommunicable diseases and disabilities.

(b) Maintain a constant surveillance of disease occurrence and accumulate health statistics necessary to establish disease trends and to design health programs.

(c) Conduct special studies of the causes of diseases and formulate preventive strategies.

(d) Promote the maintenance and improvement of the environment as it affects public health.

(e) Promote the maintenance and improvement of health in the residents of the state.

(f) Provide leadership, in cooperation with the public and private sectors, in establishing statewide and community public health delivery systems.

(g) Provide health care and early intervention services to infants, toddlers, children, adolescents, and high-risk perinatal patients who are at risk for disabling conditions or have chronic illnesses.

(h) Provide services to abused and neglected children through child protection teams and sexual abuse treatment programs.

(i) Develop working associations with all agencies and organizations involved and interested in health and health care delivery.

(j) Analyze trends in the evolution of health systems, and identify and promote the use of innovative, cost-effective health delivery systems.

(k) Serve as the statewide repository of all aggregate data accumulated by state agencies related to health care; analyze that data and issue periodic reports and policy statements, as appropriate; require that all aggregated data be kept in a manner that promotes easy utilization by the public, state agencies, and all other interested parties; provide technical assistance as required; and work cooperatively with the state's higher education programs to promote further study and analysis of health care systems and health care outcomes.

(l) Include in the department's strategic plan developed under section 186.021, F.S., an assessment of current health programs, systems, and costs; projections of future problems and opportunities; and recommended changes that are needed in the health care system to improve the public health.

(m) Regulate health practitioners, to the extent authorized by the Legislature, as necessary for the preservation of the health, safety, and welfare of the public.

Public-private partnerships are important in accomplishing these responsibilities. Currently, 51.78% of the department's $2.94 billion budget is outsourced through contracts; purchase orders; banking and vouchering services for WIC and Child Nutrition programs; and medical payments through client payment systems for Children's Medical Services (CMS) and the Brain and Spinal Cord Injury Program.

Evaluation and Justification Review

Scope

In 2010, the Florida Legislature passed HB 5311 – now Ch. 2010-161, Laws of Florida. Section 34 of the law requires the department to conduct a comprehensive evaluation and justification review of its divisions established in section 20.43, F.S., and programs within these divisions. These are:

- Division of Administration
- Division of Environmental Health
- Division of Disease Control
- Division of Family Health Services
- Division of Children's Medical Services Network
- Division of Emergency Medical Operations
- Division of Medical Quality Assurance
- Division of Children's Medical Services Prevention and Intervention
- Division of Information Technology
- Division of Health Access and Tobacco
- Division of Disability Determinations

The law also requires a report of findings and recommendations, resulting from the review, be submitted to the President of the Florida Senate, Speaker of the Florida House of Representatives, chairs of appropriate substantive legislative committees, the Legislative Auditing Committee, the Governor, and the State Surgeon General, no later than March 1, 2011.

To initiate the review, the department conducted an objective evaluation of its purpose (mission) and statutory responsibilities. Next, the department designed a systematic process, using a standard set of criteria, as set forth in the law, to determine efficiency and effectiveness of the divisions and programs within the divisions.

To meet the specific requirements outlined in this law, the evaluation and justification review included the department's statutorily established divisions listed above; however, to meet the intent of the law for a comprehensive review, the department also evaluated its stand-alone bureaus and offices – those not located within any division. These are:

- Bureau of Laboratory Services
- Bureau of Statewide Pharmaceutical Services
- Office of Minority Health

- Office of Public Health Nursing
- Office of Public Health Research
- Office of Health Statistics and Assessment

The Correctional Medical Authority was not reviewed or evaluated as part of the process, as it is assigned to the department for administrative purposes only in section 945.602.(1), F.S.

Planning Process

This evaluation and justification review presented the department an opportunity to evaluate the efficiency and effectiveness of its operations, and improve the organization's ability to fulfill its duties and responsibilities. The State Surgeon General appointed an internal planning workgroup of senior staff to assist the department's executive leadership in designing and facilitating the overall review. This internal planning workgroup (made up of central office staff and CHD representatives), established a charter outlining its roles and responsibilities, and developed a strategy and a plan of action, with a timeline for completing the key deliverables necessary to meet the project deadline. The workgroup was staffed with internal department experts in system design and process improvement.

The integrity of the process and methodology was critical to the credibility of the results. The department sought to guard against the bias inherent in any self-review as much as possible, by repeatedly verifying both the data collected, and the assumptions made based on the data. While stakeholders represented a variety of viewpoints, all agreed that the purpose of the department remains critical to the protection and preservation of the health, safety and welfare of those it serves.

In an effort to increase objectivity and gain perspective, the process was designed to repeatedly seek input from external stakeholders and accountable internal stakeholders. This was accomplished through a variety of means, including individual and facilitated group meetings, standardized assessment tools, and data extracted from state and national databases. Seeking to improve reliability of results, department staff performed repetitive, comparative analyses of all accumulated qualitative and quantitative data from all of the sources.

It was important for the department's internal stakeholders to actively participate in the review process. They will be responsible for implementing the resulting recommendations for improvement. This included staff at all levels of the department's central office (including division directors) and county health department representatives.

The review process began with clarifying the department's purpose (or mission) and its statutory responsibilities. Governmental public health agencies are uniquely accountable to both the public and to lawmakers. Only by carefully considering the department's proper role could staff effectively evaluate for the Legislature, and Florida's taxpayers, the efficiency and cost-effectiveness of its essential services.

Clarification of authority and responsibility – both of the department and of state government – was important throughout the evaluation and justification review process. There is no clear universal agreement on the "core responsibilities" of state government, except those set forth by the Legislature.

While multiple statutes define the department's overall duties and responsibilities, the department has thirteen responsibilities specifically assigned in its establishing statute, section 20.43(1)(a)-(m), F.S. (see above).

Beyond what is provided in Florida Statutes, a national model exists for core public health functions within state health departments. This model describes the core responsibilities of the department's business – public health. The 10 Essential Public Health Services,[ii] developed in 1994 by representatives from the U.S. Public Health Service agencies and other major public health organizations, are based on the three core public health functions (defined previously).

These “10 Essentials” are the nationally recognized public health framework of responsibilities for state and local health systems:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Methodology

The requirements set forth in Ch. 2010-161 § 34 at 43, Laws of Fla., became the standardized review criteria for the department’s review. They were arranged according to: (1) mission alignment (whether a program or activity aligned to the department’s statutory purpose); (2) cost effectiveness (with particular attention to programs generating license or regulatory associated fees); and (3) efficiency (whether a program was administered in the most efficient way possible). Both quantitative and qualitative data were considered.

As “discontinuation” was stated but not defined in this law, programs or activities recommended for department discontinuation were categorized as follows:

- **Transfer** – Discontinuation of a program or activity by the department; program or activity is transferred to another state government agency, to include the state university system.
- **Outsource** – Discontinuation of a program or activity by the department, with direct contractual oversight retained by the department.
- **Privatize** – Discontinuation of a program or activity by government; program or activity may be carried out by a private sector (for profit or not-for-profit) entity or entities; no government oversight – contractual or otherwise – by the department or any other state agency.
- **Eliminate** – Discontinuation of a program or activity by the department, not recommended for reassignment to any other state agency or private entity.

Of the programs or activities recommended for retention within the department, none are recommended to continue “as is” – every program or activity recommended for retention, in either form or function, is recommended for retention *and* improvement. Based upon the adoption of the recommendations set forth in this report, the missions, goals and objectives of the proposed and restructured divisions will be developed.

Using the review criteria, the department developed a systematic process for decision-making, and formulated recommendations for each of the programs and activities reviewed.

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i. Institute of Medicine. The Future of Public Health: Executive Summary. National Academy Press. Washington, D.C. 1988. p.8.

ii. U.S. Centers for Disease Control and Prevention, “National Public Health Performance Standards Program: Orientation to the Essential Public Health Services” http://www.cdc.gov/nphpsp/documents/EssentialServicesPresentation.pdf

HB 5311 Evaluation & Justification Review

Establish Department of Health Program Inventory

Develop Assessment Tools Using HB 5311 Review Requirements to Standardize Program Data

- ✓ Identifiable cost
- ✓ Specific purpose
- ✓ Specific public health benefit
- ✓ Progress toward achieving outputs and outcomes
- ✓ Explanation of contributing factors to achieving/not achieving progress
- ✓ Potential for improving efficiency and effectiveness
- ✓ Duplication and/or adequate coordination of activities
- ✓ Potential for another public or private sector entity to administer more efficiently or effectively
- ✓ Cost effectiveness, including whether users finance (or could finance) program costs
- ✓ Cost to administer vs. license and other fee revenues
- ✓ Consequences for elimination

Conduct Assessments of all DOH Divisions and Programs Using Standardized Tools

Gather Additional Data from Both Internal Stakeholders (division directors, central office and county health department staff) and External Stakeholders (including subject matter experts)

Analyze Data From All Sources

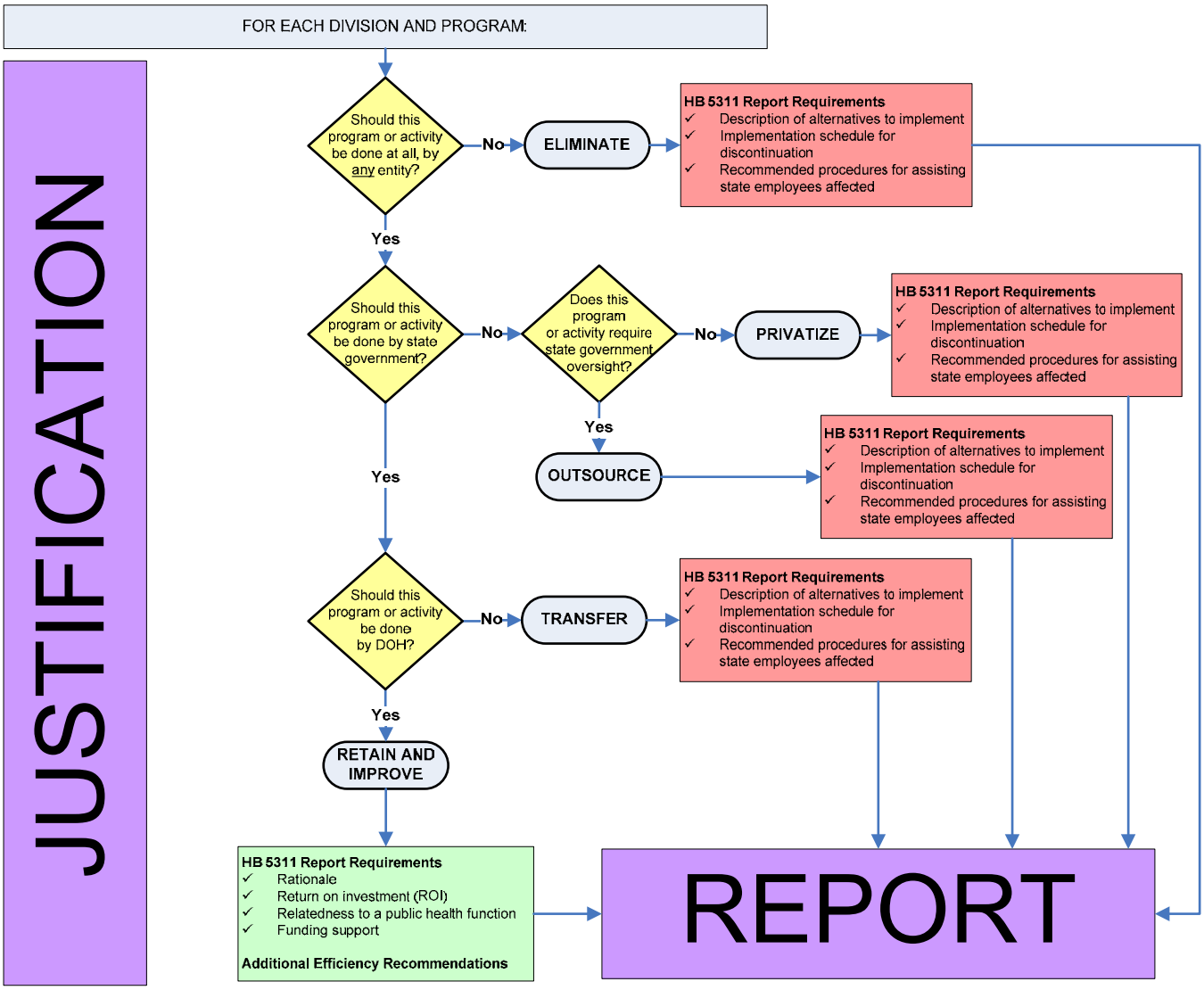
1. Mission Alignment
   - ✓ Specific purpose
   - ✓ Specific public health benefit
   - ✓ Potential for improving efficiency and effectiveness

2. Cost-Effectiveness
   - ✓ Identifiable cost
   - ✓ Duplication and/or adequate coordination of activities
   - ✓ Potential for another public or private sector entity to administer more cost-effectively
   - ✓ Cost effectiveness, including whether users finance (or could finance) program costs
   - ✓ Cost to administer vs. license and other fee revenues

3. Efficiency
   - ✓ Progress toward achieving outputs and outcomes
   - ✓ Explanation of contributing factors to achieving/not achieving progress
   - ✓ Potential for improving efficiency and effectiveness
   - ✓ Duplication and/or adequate coordination of activities
   - ✓ Potential for another public or private sector entity to administer more efficiently or effectively
   - ✓ Consequences for discontinuation

EVALUATION

HB 5311 Evaluation & Justification Review



III: EVALUATION AND JUSTIFICATION REVIEW RESULTS

FINDINGS & RECOMMENDATIONS

PURPOSE & RESPONSIBILITIES

Finding 1: The department adopted, as its operational mission, the broader statutory language that describes Florida's public health system, rather than adopting the statutory purpose of the Department of Health.

An organization's mission statement is a declaration of its core purpose and focus, and is periodically reviewed for relevance. The strategies and activities of an organization may change; however, if aligned with a clear mission, these should consistently support the organization's purpose.

The legislative purpose provided in Florida's establishing statutes should inform the mission of a state agency. According to section 20.43(1), F.S., "The purpose of the Department of Health is to *promote and protect* the health of all residents and visitors in the state through organized state and community efforts, including cooperative agreements with counties."

The department adopted, "Promote, protect and improve the health of all people in Florida" as its operational mission, in order to encompass all programs and activities located within the department. This language is found in section 381.001(1), F.S.: "Legislative intent; public health system.-" which reads (in part): "It is the intent of the Legislature that the Department of Health be responsible for the state's public health system which shall be designed to promote, protect, and improve the health of all people in the state."

Recommendation 1: The Legislature amend section 20.43(1), F.S., to revise the department's purpose: "To *protect and promote* the health of all residents and visitors in the state through organized state and community efforts, including cooperative agreements with counties." Further, the department adopt the revised statutory purpose as its operational mission.

Finding 2: The responsibilities assigned to the department in its establishing statute in section 20.43(1)(a)-(m), F.S., are inconsistent in scope and specificity.

While multiple Florida Statutes define and inform the department's overall duties and responsibilities, the thirteen responsibilities, as they are currently outlined in the department's establishing statute, section 20.43(1), F.S., lack clarity.

Recommendation 2: The Legislature amend the department's responsibilities as assigned in section 20.43(1)(a)-(m), F.S., to:

- **(a) Identify, diagnose, and conduct surveillance of diseases and health conditions in the state, accumulating health statistics necessary to establish trends.**
- **(b) Implement interventions that prevent or limit the impact or spread of diseases and health conditions.**
- **(c) Collect, manage, and analyze vital statistics and other health data to inform and formulate public health policy and planning.**

(d) Maintain and coordinate preparedness for and responses to public health emergencies in the state.

(e) Provide or assure the provision of quality health and related services to identified populations in the state.

(f) Regulate environmental activities that have a direct impact on public health in the state.

(g) Regulate health practitioners, to the extent authorized by the legislature, as necessary for the preservation of the health, safety, and welfare of the public.

PUBLIC HEALTH ROLE

Finding 3a: The department serves as Florida's primary health care "safety net provider." Allocating the state's limited health care funds for this purpose is not an effective means of improving the overall health of Florida's population.

Serving as the state's "safety net" promotes the department as a "catch-all" health organization. The department's continuing provision of individual medical (primary) care should be a local (community) decision, based on local needs, using local resources to sustain the services. The core public health function of assurance includes channeling people to needed individual health care. The department's assurance function assures there is available health care in every community.

Finding 3b: The department does not strategically distribute the state general revenue funds allocated for the delivery of primary health care services. Distribution of funds is not based upon aggregate statewide prioritization of community need.

A community's need for primary care – defined, for purposes of this report, as individual health care treatment for adults and children – is determined at the local level. Individually, CHDs identify, prioritize and address local health needs using standardized community assessments that can support the strategic distribution of funds. However, at the state level, the department distributes these general revenue (GR) funds without a comparison, or prioritization of (the aggregate) community need within the state.

Recommendation 3: The Legislature discontinue allocation of the state's general revenue to fund the provision of Primary Care/Adult and Primary Care/Child health care services. Continued provision of primary health care services, treatment, programs and activities by a county health department would be in collaboration with the county and local community public health partners. The department's assurance function is not affected by this recommendation.

<u>Finding 4</u>: The department does not have an approved transition plan to replace the critical inpatient Tuberculosis (TB) care services currently provided at A.G. Holley State Hospital.

Inpatient care for persons with complex, multiple-drug resistant TB, or those ordered by the court to receive treatment, is a public health necessity due to the potential spread of this highly communicable disease. Partnerships with academic and private sector entities will be necessary to keep the population protected during and after closure of A.G. Holley State Hospital.

In November 2010, the department set forth options for the closure of A.G. Holley State Hospital (see "*Report on A.G. Holley State Hospital: Transition Planning for Closure").*

<u>Recommendation 4</u>: The Legislature approve a transition plan for the closure of A.G. Holley State Hospital set forth in the department's "*Report on A.G. Holley State Hospital: Transition Planning for Closure."* The department recommends relocating the patients to a smaller and more cost efficient facility. Further, the department should retain oversight to maintain the standards of care recommended by the U.S. Centers for Disease Control and Prevention (CDC) for inpatient treatment of tuberculosis.

<u>Finding 5</u>: Systematic, statewide prioritization of community health needs and efficient distribution of resources requires a state health improvement plan; the department does not have a state health improvement plan.

Health improvement planning underpins accountable and effective public health outputs and outcomes, at both the state and local levels. At the local level, CHDs coordinate and work in conjunction with all of their local public and private sector public health partners to identify, evaluate, prioritize, and address community health needs. Although this is done at the local level, statewide prioritization is not done systematically.

<u>Recommendation 5</u>: The department develop and implement a state health improvement plan with priorities for statewide health improvement.

ORGANIZATIONAL REDUCTION AND RESTRUCTURE

<u>Finding 6</u>: The current executive management structure of the department does not support effective operational management, oversight, or accountability.

The department requires an agency head with strong leadership and operational management skills to plan, direct, coordinate, and execute the powers, duties, and functions vested in the department. Section 20.43(2)(a), F.S., requires the head of the department to be the State Health Officer. It is important for the State Health Officer to be a physician licensed under chapter 458, F.S., or chapter 459, F.S. Amending the statute to allow the head of the agency to be a non-physician, and requiring that one of the deputies be a physician, ensures that Florida will always have a designated State Health Officer. This flexibility will allow for the most qualified agency head to be appointed.

The agency must also have flexibility to hire and designate deputy secretaries. Currently, the position of Deputy Secretary and Deputy State Health Officer for Children's Medical Services is established in statute (section 391.028(1), F.S.). This statutorily-mandated deputy position restricts the authority of the agency head to designate or eliminate deputies as organizational needs dictate.

Recommendation 6: The Legislature amend the following statutes:

Section 20.43, F.S.

- **Revise the designation of the agency head from "State Surgeon General and State Health Officer" to "Secretary of Health."**

- **Replace "…must be a physician licensed under chapter 458 or chapter 459…" with "…may be a physician licensed under chapter 458 or chapter 459…"**

- **Add language stipulating that if the Secretary of Health is a physician licensed under chapter 458, F.S., or chapter 459, F.S., he or she must also be designated "State Health Officer." In addition, if the Secretary for Health is not a physician, either of the department's deputy secretaries may be designated "State Health Officer," *provided* they are a physician licensed under chapter 458, F.S., or chapter 459, F.S.**

- **Add language to require that at least one deputy secretary be a physician licensed under chapter 458, F.S., or chapter 459, F.S.**

PROPOSED AMENDMENT:

20.43 Department of Health.—There is created a Department of Health.

(1) No change.

(2)(a) The head of the Department of Health is the Secretary of Health~~State Surgeon General and State Health Officer~~. The Secretary of Health shall have ~~State Surgeon General must be a physician licensed under chapter 458 or chapter 459 who has~~ advanced training or extensive experience in public health administration and may be a physician licensed under chapter 458 or chapter 459. The Secretary of Health ~~State Surgeon General~~ is appointed by the Governor subject to confirmation by the Senate. The Secretary of Health ~~State Surgeon General~~ serves at the pleasure of the Governor. ~~The State Surgeon General shall serve as the leading voice on wellness and disease prevention efforts, including the promotion of healthful lifestyles, immunization practices, health literacy, and the assessment and promotion of the physician and health care workforce in order to meet the health care needs of the state. The State Surgeon General shall focus on advocating healthy lifestyles, developing public health policy, and building collaborative partnerships with schools, businesses, health care practitioners, community-based organizations, and public and private institutions in order to promote health literacy and optimum quality of life for all Floridians.~~

(b) There shall be deputy secretaries who are to be appointed by and shall serve at the pleasure of the Secretary of Health. In the event the Secretary of Health is not a physician licensed under chapter 458 or chapter 459, at least one of the deputy secretaries must be a physician licensed under chapter 458 or chapter 459.

(c) The Department of Health shall have a State Health Officer, who must be a physician licensed under chapter 458 or chapter 459. If the Secretary of Health is a physician licensed under chapter 458 or chapter 459, the Secretary of Health is the State Health Officer. If the Secretary of Health is not a physician licensed under chapter 458 or chapter 459, a deputy secretary of the Department of Health shall be designated the State Health Officer by the Secretary of Health.

(b) The Officer of Women's Health Strategy is established within the Department of Health and shall report directly to the Secretary of Health~~State Surgeon General~~.

(3) No change

(4) No change

(5) The department shall plan and administer its public health programs through its county health departments and may, for administrative purposes and efficient service delivery, establish up to 15 service areas to carry out such duties as may be prescribed by the Secretary of Health~~State Surgeon General~~. The boundaries of the service areas shall be the same as, or combinations of, the service districts of the Department of Children and Family Services established in s. 20.19 and, to the extent practicable, shall take into consideration the boundaries of the jobs and education regional boards.

(6)The Secretary of Health~~State Surgeon General~~ is authorized to appoint ad hoc advisory committees as necessary. The issue or problem that the ad hoc committee shall address, and the timeframe within which the committee is to complete its work, shall be

specified at the time the committee is appointed. Ad hoc advisory committees shall include representatives of groups or entities affected by the issue or problem that the committee is asked to examine. Members of ad hoc advisory committees shall receive no compensation, but may, within existing departmental resources, receive reimbursement for travel expenses as provided in s. 112.061.

(7) No change.
(8) No change.
(9) No change.
(10) No change.

Section 391.028(1), F.S.

- **Eliminate the position of Deputy Secretary and Deputy State Health Officer for Children's Medical Services.**

PROPOSED AMENDMENT:

391.028 Administration. –The Children's Medical Services program shall have a central office and area offices.

(1) The Director of Children's Medical Services must be a physician licensed under chapter 458 or chapter 459 who has specialized training and experience in the provision of health care to children and who has recognized skills in leadership and the promotion of children's health programs. The director ~~shall be the deputy secretary and the Deputy State Health Officer for Children's Medical Services and~~ is appointed by and reports to the secretary. The director may appoint division directors subject to the approval of the secretary.
(2) No change.
(3) No change.

Finding 7: Duties assigned to the Officer of Women's Health Strategy in section 381.04015, F.S., have been integrated into relevant department program areas; therefore, the designation of the position "Officer of Women's Health Strategy" is no longer necessary.

Recommendation 7: The Legislature amend the following statutes:

Section 20.43(2)(b), F.S.

- **Eliminate the position of Officer of Women's Health Strategy.**

PROPOSED AMENDMENT:

20.43 Department of Health.—There is created a Department of Health.
…
~~—(b) The Officer of Women's Health Strategy is established within the Department of Health and shall report directly to the State Surgeon General.~~
…

Section 381.04015, F.S.

- **Repeal this section relating to the duties assigned to the Officer of Women's Health Strategy.**

Finding 8: The department, its divisions and programs within divisions can be organized in a more efficient and effective manner, and each division's missions, goals and objectives should be redefined.

Recommendation 8: The Legislature review and direct the department with regard to its recommendations to reduce and restructure the department's divisions, bureaus, and offices, from 11 to 6 divisions; 50 to 18 bureaus; 2 to 0 stand-alone bureaus; and 11 to 5 stand-alone offices.

RECOMMENDATIONS FOR REDUCTION

Through the evaluation and justification review process, the department identified central office services, programs and activities recommended for discontinuation. As “discontinuation” was stated – but not defined – in Ch. 2010-161 § 34 at 43, Laws of Florida, programs or activities recommended for department discontinuation were categorized as follows:

- **TRANSFER** – **Discontinuation of a program or activity by the department; program or activity is transferred to another state government agency, to include the state university system.**

  Programs, services, or activities were identified as appropriate to consider for transferring to another state government agency (or to a university), if they have the potential to be more efficiently or effectively administered by another unit of government or appear to better align to the mission of another governmental entity.

- **OUTSOURCE** – **Discontinuation of a program or activity by the department, with direct contractual oversight retained by the department.**

  Programs, services, or activities were identified as appropriate to consider for outsourcing to a public or private entity if they have the potential to be more efficiently or effectively administered.

- **PRIVATIZE – Discontinuation of a program or activity by government; program or activity may be carried out by a private sector (for profit or not-for-profit) entity or entities; no government oversight – contractual or otherwise – by the department or any other state agency.**

  Programs, services, or activities were identified as appropriate to consider for privatization, if they have the potential to be more efficiently or effectively administered in the private sector, without government oversight.

- **ELIMINATE – Discontinuation of a program or activity by the department, not recommended for reassignment to <u>any</u> other state agency <u>or</u> private entity.**

  Programs, services, or activities were identified as appropriate to consider for elimination, if the public health benefit was not measurable; if efforts were duplicative of existing public or private sector entities; if they were not based on community health needs; if they were not prioritized from a statewide perspective; or if potential alternatives existed.

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR TRANSFER:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff To Transfer to Another State Government Entity		Funds To Transfer to Another State Government Entity	
Aquatic Toxins Disease Prevention	Environmental Health	Transfer this program to Florida Fish and Wildlife Research Institute; appears to better align with its duties and responsibilities.	July 1, 2011 – June 30, 2012	**FTE**	2	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	1.5	**State Trust Fund**	$0
						Federal Trust Fund	$312,000
Biomedical Waste Inspections	Environmental Health	Transfer this central office function to Department of Environmental Protection (DEP) to contract directly with the service provider(s).	July 1, 2011 – June 30, 2012	**FTE**	4	**General Revenue**	$0
				OPS	1	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$880,000
						Federal Trust Fund	$0
Brain and Spinal Cord Injury Program	Emergency Medical Services	Transfer this program to Agency for Health Care Administration (AHCA) to increase the effective use of resources.	July 1, 2011 – June 30, 2012	**FTE**	62	**General Revenue**	$2,436,105
				OPS	3	**Tobacco**	$0
				Contract	2	**State Trust Fund**	$26,349,101
						Federal Trust Fund	$0
Child Protection Teams	Children's Medical Services Intervention and Prevention	Transfer this program to Department of Children and Families (DCF); appears to better align with its mission. These teams will require physician oversight at DCF headquarters level.	July 1, 2011 – June 30, 2012	**FTE**	0	**General Revenue**	$8,800,000
				OPS	25	**Tobacco**	$0
				Contract	13	**State Trust Fund**	$0
						Federal Trust Fund	$5,700,000

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR TRANSFER:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff To Transfer to Another State Government Entity		Funds To Transfer to Another State Government Entity	
Council on the Deaf and Hard of Hearing	Children's Medical Services Network	Transfer this Council to the Florida School for the Deaf and the Blind; it appears to better align with the mission.	July 1, 2011 – June 30, 2012	**FTE**	0	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0
Florida Safe Drinking Water Act Program	Environmental Health	Transfer this program in an effort to consolidate the program's administration into the lead funding agency, DEP.	July 1, 2011 – June 30, 2012	**FTE**	2	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$800,000
						Federal Trust Fund	$0
Fund Disbursement Function to Federally Qualified Health Centers (FQHC)	Health Access and Tobacco	Transfer this service to the AHCA; it appears to better align with the mission.	July 1, 2011 – December 31, 2011	**FTE**	2	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$327,375

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR TRANSFER:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff To Transfer to Another State Government Entity		Funds To Transfer to Another State Government Entity	
Human Research Protections Program *(Including Institutional Review Board)*	Public Health Research	Transfer this program to a public or private university in Florida; other entity(ies) can provide this service.	July 1, 2011 – June 30, 2012	**FTE**	2	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$192,000
						Federal Trust Fund	$0
Limited Use Drinking Water Program	Environmental Health	Transfer this program to consolidate the program's administration into the lead funding agency, DEP.	July 1, 2011 – June 30, 2012	**FTE**	1	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$147,713
						Federal Trust Fund	$0
Local Health Councils	Health Access and Tobacco	Transfer this program to AHCA to align functions and reduce overhead costs.	July 1, 2011 – December 31, 2011	**FTE**	3	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$855,647
						Federal Trust Fund	$1,137,362
Mobile Home and RV Park Inspections	Environmental Health	Transfer this service to local building code enforcement agencies; local building code enforcement agencies can contract directly with the service provider.	July 1, 2011 – June 30, 2012	**FTE**	1	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$74,350
						Federal Trust Fund	$0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR TRANSFER:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff To Transfer to Another State Government Entity		Funds To Transfer to Another State Government Entity	
Nursing Student Loan Forgiveness Program	Public Health Nursing	Transfer this program to Department of Education (DOE); appears to better align with its mission.	July 1, 2011 – June 30, 2012	**FTE**	1	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	1	**State Trust Fund**	$1,168,259
						Federal Trust Fund	$0
Pregnancy Support Services Funding	Family Health Services	Transfer this service to DCF; appears to better align with its mission.	July 1, 2011 – August 15, 2011	**FTE**	0	**General Revenue**	$2,000,000
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0
Refugee Health	Disease Control	Transfer this program to DCF; DCF is the designated State Refugee Coordinator for Refugee Services in Florida.	July 1, 2011 – June 30, 2012	**FTE**	6	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$17,282,474
Rural Health	Health Access and Tobacco	Transfer this program to a college of medicine or school of osteopathic medicine; other entity(ies) can provide this service.	July 1, 2011 – December 31, 2011	**FTE**	0	**General Revenue**	$500,000
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR TRANSFER:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff To Transfer to Another State Government Entity		Funds To Transfer to Another State Government Entity	
Office of Trauma Program	Emergency Medical Operations	Transfer this program to AHCA; these functions align with AHCA's statutory mandate to regulate hospitals and health care facilities.	July 1, 2011 – June 30, 2012	**FTE**	8.5	**General Revenue**	$0
				OPS	2	**Tobacco**	$0
				Contract	1	**State Trust Fund**	$9,364,485
						Federal Trust Fund	$1,307,700
Traumatic Brain Injury Association Funding	Emergency Management Services	Transfer this program to AHCA along with the Brain and Spinal Cord Injury Program, the program's current service contract manager.	July 1, 2011 – June 30, 2012	**FTE**	0	**General Revenue**	$711,330
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0
Unlicensed Activity Program	Medical Quality Assurance	Transfer this program to state attorneys offices that prosecute unlicensed activity (criminal acts).	July 1, 2011 – June 30, 2012	**FTE**	19	**General Revenue**	$0
				OPS	2	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$1,100,904
						Federal Trust Fund	$0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR TRANSFER:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff To Transfer to Another State Government Entity	Funds To Transfer to Another State Government Entity
Vision Services	Family Health Services	Transfer this funding to DOE; appears to better align with its current activities related to providing screening services in schools.	July 1, 2011 – June 30, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $500,000 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Well Surveillance Program *(Includes SUPER Act, Drinking Water Toxins, and Dry Cleaning Solvents programs)*	Environmental Health	Transfer this program to consolidate the program's administration into the lead funding agency, DEP.	July 1, 2011 – June 30, 2012	**FTE** 11 **OPS** 4 **Contract** 0	**General Revenue** $144,024 **Tobacco** $0 **State Trust Fund** $842,865 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR OUTSOURCE:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funds to Transfer to Contracted Services Category
Children's Medical Services	Children's Medical Services Network / Children's Medical Services Prevention and Intervention	Pursue further outsourcing to a private vendor for cost efficiencies as referenced in the *"Children's Medical Services Privatization is Feasible; Could Save Over $18 Million, But Barriers Must Be Overcome," The Florida Legislature, Office of Program Policy Analysis and Government Accountability, Report No. 02-04, January 2002*; upon completion of outsourcing, transfer the remaining functions to Agency for Health Care Administration. **Number of staff remaining will be contingent on outsourcing bid procurement negotiation.*	July 1, 2011 – June 30, 2012	**FTE** 700.5* **OPS** 276 **Contract** 29	**General Revenue** $20,367,721 **Tobacco** $0 **State Trust Fund** $14,210,611 **Federal Trust Fund** $6,431,425
Clinical Examination for Optometry, Opticianry, and Dentistry	Medical Quality Assurance	Outsource this program to a private vendor; other entity(ies) can provide this service.	July 1, 2011 – June 30, 2012	**FTE** 2 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $93,154 **Federal Trust Fund** $0
Continuing Education Audit Section	Medical Quality Assurance	Outsource this program to a private vendor; other entity(ies) can provide this service.	July 1, 2011 – June 30, 2012	**FTE** 3.5 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $126,968 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR OUTSOURCE:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funds to Transfer to Contracted Services Category
Contractual Services for Warehouse Operations	Emergency Medical Services	Outsource these services for maintaining medical supplies and equipment for rapid response to a private vendor or other entity(ies).	July 1, 2011 – June 30, 2012	**FTE** 2 **OPS** 0 **Contract** 2	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $197,560
Emergency Medical Service Providers *Licensure, Permitting, and Inspection*	Emergency Medical Services	Outsource this service to a private accreditation company; other entity(ies) can provide the service.	July 1, 2011 – June 30, 2012	**FTE** 3 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $171,300 **Federal Trust Fund** $0
Emergency Medical Technician (EMT) and Paramedic Schools *Licensure, Inspection and Regulation of EMT Schools, Training Programs and Continuing Education*	Emergency Medical Services	Outsource this service to a private accreditation company; other entity(ies) can provide the service.	July 1, 2011 – June 30, 2012	**FTE** 2 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $114,200 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR OUTSOURCE:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funds to Transfer to Contracted Services Category
Imaging Section	Medical Quality Assurance	Outsource this program to a private vendor; other entity(ies) can provide this service.	July 1, 2011 – August 31, 2011	**FTE** 8 **OPS** 1 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $302,733 **Federal Trust Fund** $0
License Verification for Health Care Practitioners	Medical Quality Assurance	Outsource this program to a private vendor; other entity(ies) can provide this service.	July 1, 2011 – June 30, 2012	**FTE** 2 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $68,794 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR PRIVATIZATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funding Reduction
Environmental Health Professional Certification	Environmental Health	Privatize this service; other entity(ies) can provide the service (e.g., National Environmental Health Association and Florida Environmental Health Association).	July 1, 2011 – June 30, 2012	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Environmental Laboratory Certification	Laboratory Services	Privatize this service; other entity(ies) can provide the service.	July 1, 2011 – June 30, 2012	**FTE** 14 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $1,123,706 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR ELIMINATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funding Reduction
Abandoned Baby Program	Family Health Services	Eliminate this program; other entity(ies) could educate and promote awareness of the service (e.g., Silverio Foundation).	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
AGAPE Mobile Dental Clinic Funding	Family Health Services	Eliminate this funding; not based on prioritization from a statewide perspective.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $500,000 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Alpha One Program Funding *(Alachua County)*	Family Health Services	Eliminate this funding; not based on prioritization from a statewide perspective.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $345,169 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Area Health Education Center (AHEC) Network Funding	Health Access and Tobacco	Eliminate this funding; the network may pursue funding through other sources.	July 1, 2011 – July 31, 2011	**FTE** 1 **OPS** 0 **Contract** 0	**General Revenue** $4,801,743 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR ELIMINATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funding Reduction
Arthritis Control and Education Program	Family Health Services	Eliminate this grant-funded* program; a national or community organization(s) (e.g., Health Foundation of South Florida or Arthritis Foundation) could provide this service. **Grant ends June 29, 2012.*	July 1, 2011 – June 30, 2012	**FTE** 6 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $494,372
Asthma Prevention and Control	Family Health Services / Environmental Health	Eliminate this grant-funded* program; a state university or the American Lung Association could provide this service. **Grant ends August 31, 2014.*	July 1, 2011 – June 30, 2012	**FTE** 0 **OPS** 0 **Contract** 3	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $320,000
Central Florida Health Care, Inc. Funding *(Lake Wales Federally Qualified Health Center)*	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $1,000,000 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Community Smiles Funding *(Miami-Dade County Dental Research Clinic)*	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $283,643 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR ELIMINATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funding Reduction
Compressed Air Program	Environmental Health	Eliminate this program, regulation is unnecessary; in the past 10 years, the department has not received any sample results that exceeded established standards.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Deerfield Beach High School Community Clinic Funding *(Deerfield Beach School Health Clinic)*	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 2 **OPS** 0 **Contract** 0	**General Revenue** $367,149 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Early Child Comprehensive System's Grant *(Community Based Integrated Service Systems)*	Family Health Services	Eliminate this grant-funded* program. The department will not submit a reapplication; other public and private entity(ies) may apply. **Grant ends May 31, 2012.*	July 1, 2011 – May 31, 2012	**FTE** 1 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $132,000
Economic Opportunities – Jessie Trice Cancer Center Funding *(Miami-Dade County)*	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $52,422 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR ELIMINATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction		Funding Reduction	
Epilepsy Case Management and Education	Family Health Services	Eliminate this program; other entity(ies) can provide this service.	July 1, 2011 – July 31, 2011	**FTE**	1	**General Revenue**	$2,107,152
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$1,524,061
						Federal Trust Fund	$0
Escambia County Dental Project Funding	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE**	0	**General Revenue**	$136,149
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0
Facility Inspections for Body Art *(Including body piercing and tattooing facilities)*	Environmental Health	Eliminate this program; the department can increase public awareness of health risks without regulation of facilities.	July 1, 2011 – July 31, 2011	**FTE**	0	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0
Family Health Centers of Southwest Florida, Inc. Funding *(Dental Projects for Charlotte, Collier and Lee Counties)*	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE**	0	**General Revenue**	$453,834
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR ELIMINATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funding Reduction
Fetal Alcohol Spectrum Disorder Funding *(Sarasota County)*	Children's Medical Services	Eliminating this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $380,000 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Florida Center for Universal Research to Eradicate Disease *(Florida CURED)*	Public Health Research	Eliminate this program; overly broad mission, limited authority, and indeterminate results.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $250,000 **Federal Trust Fund** $0
Foster Care Food Inspections	Environmental Health	Eliminate this service; duplicative of Department of Children and Families (DCF) regulation. See *Report of the Childcare Standards and Improvement Workgroup*, *DCF, January 19, 2011.*	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Haitian American Council Against Cancer Funding *(Miami-Dade County)*	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $163,839 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR ELIMINATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction		Funding Reduction	
HIV/AIDS Outreach Program Funding *(Southwest Florida)*	Disease Control	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE**	0	**General Revenue**	$239,996
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0
Immunization Field Program *(Regional Administrative Positions)*	Disease Control	Eliminate this program; administrative support functions can be redistributed among existing staff.	July 1, 2011 – June 30, 2012	**FTE**	12	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$553,143
Injury Prevention Program *(Non-U.S. Centers for Disease Control [CDC] grant activities)*	Emergency Medical Services	Eliminate the non-CDC grant activities in this program; other entity(ies) provide this service.	July 1, 2011 – July 31, 2011	**FTE**	6	**General Revenue**	$0
				OPS	1	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$539,848
						Federal Trust Fund	$0
Islet Cell Transplantation to Cure Diabetes Funding	Children's Medical Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE**	0	**General Revenue**	$213,332
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR ELIMINATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction		Funding Reduction	
Jessie Trice Cancer Center/Health Choice Funding *(Miami -Dade County)*	Health Access and Tobacco	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE**	0	**General Revenue**	$156,485
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0
La Liga-League Against Cancer Funding	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE**	0	**General Revenue**	$900,000
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0
Lantana Laboratory Facility	Laboratory Services	Eliminate funding for this facility; services for the surrounding counties will be transferred to the other four public health laboratories in the department's network.	July 1, 2011 – December 31, 2011	**FTE**	3	**General Revenue**	$0
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$558,838
						Federal Trust Fund	$0
Manatee County Rural Health Services Funding	Health Access and Tobacco	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE**	0	**General Revenue**	$90,000
				OPS	0	**Tobacco**	$0
				Contract	0	**State Trust Fund**	$0
						Federal Trust Fund	$0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR ELIMINATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funding Reduction
Minority Outreach Funding: Penalver Clinic *(Miami-Dade County)*	Minority Health	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $349,481 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Nursing Student Tuition Assistance Program Funding *(Nova University Nursing Assistance Program)*	Public Health Nursing	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $194,159 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Primary Care / Adult Funding	Family Health Services	Eliminate this funding for the provision of primary care adult health care services. The department's continuing provision of individual medical (primary) care should be a local (community) decision, based on local needs, using local resources to sustain the services.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $14,603,957 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR ELIMINATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funding Reduction
Primary Care / Child Funding	Family Health Services	Eliminate this funding for the provision of primary care child health care services. The department's continuing provision of individual medical (primary) care should be a local (community) decision, based on local needs, using local resources to sustain the services.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $7,692,164 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Public Health Ethics / Bioethics Program	Public Health Research	Eliminate this program; other entity(ies) can provide this service.	July 1, 2011 – July 31, 2011	**FTE** 2 **OPS** .5 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $124,099 **Federal Trust Fund** $0
Reducing Oral Health Disparities Funding	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $346,678 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
South Florida AIDS Network Funding: Jackson Memorial *(Miami-Dade County)*	Disease Control	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $719,989 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR ELIMINATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funding Reduction
Southwest Alachua County Primary and Community Health Care Clinic Funding	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $98,529 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
State Rape Crisis Trust Fund	Family Health Services	Eliminate this trust fund; other federal, state, and private funding may be available to administer rape prevention, education, and rape crisis services. If fee collection is continued, funds should be distributed at the county level.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $2,064,417 **Federal Trust Fund** $0
Statewide Dentistry Network Funding *(Escambia County)*	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – July 31, 2011	**FTE** 0 **OPS** 0 **Contract** 1	**General Revenue** $112,892 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
Tanning Facility Inspections	Environmental Health	Eliminate this program; the department can increase public awareness of health risks without regulation of facilities.	July 1, 2011 – July 31, 2011	**FTE** 1 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $32,307 **Federal Trust Fund** $0

CENTRAL OFFICE SERVICES, PROGRAMS AND ACTIVITIES RECOMMENDED FOR ELIMINATION:

Program or Activity	Current Division	Description of Alternative to Implement	Implementation Schedule	Staff Reduction	Funding Reduction
Targeted Oral Health Services System *(Maintenance)*	Family Health Services	Eliminate this grant-funded* project; other entities can apply for grant. **Grant ends August 31, 2011.*	July 1, 2011 – August 31, 2011	**FTE** 1 **OPS** 0 **Contract** 0	**General Revenue** $0 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0
University of Florida (UF) College of Dentistry Funding *(UF Dental Clinics)*	Family Health Services	Eliminate this funding; not based on statewide prioritization of community needs.	July 1, 2011 – May 31, 2012	**FTE** 0 **OPS** 0 **Contract** 0	**General Revenue** $714,519 **Tobacco** $0 **State Trust Fund** $0 **Federal Trust Fund** $0

RECOMMENDATIONS FOR RESTRUCTURE

The department, its divisions, and programs within divisions, should be organized in a more efficient and effective manner, and each division's missions, goals and objectives can be redefined.

Recommended Actions to Restructure the Department's Current Divisions

The following table provides a summary of recommended actions related to the department's divisions established in section 20.43, F.S.

TABLE: Summary of Recommended Actions by Current Division

CURRENT DIVISION	RECOMMENDED ACTION
Emergency Medical Operations	Eliminate division; retain and improve remaining functions within the proposed Division of Preparedness & Response
Environmental Health	Eliminate division; retain and improve remaining functions within the proposed Division of Disease Control & Prevention
Disease Control	Eliminate division; retain and improve remaining functions within the proposed Division of Disease Control & Prevention
Family Health Services	Eliminate division; retain and improve remaining functions within the proposed Division of Community Health Services
Children's Medical Services Prevention and Intervention	Transfer Child Protection Teams to Department of Children and Families; merge remaining Prevention & Intervention programs with Children's Medical Services Network
Children's Medical Services Network	Outsource Network functions; transfer remaining functions to Agency for Health Care Administration
Information Technology	Eliminate division; retain and improve remaining functions within the proposed Division of Public Health Statistics and Performance Management
Disability Determinations	Transfer or retain at the direction of the Legislature
Medical Quality Assurance	Retain and improve restructured division
Administration	Retain and improve restructured division
Health Access and Tobacco	Eliminate division; transfer certain functions; retain and improve remaining functions within the restructured Division of Medical Quality Assurance and the proposed Division of Disease Control & Prevention

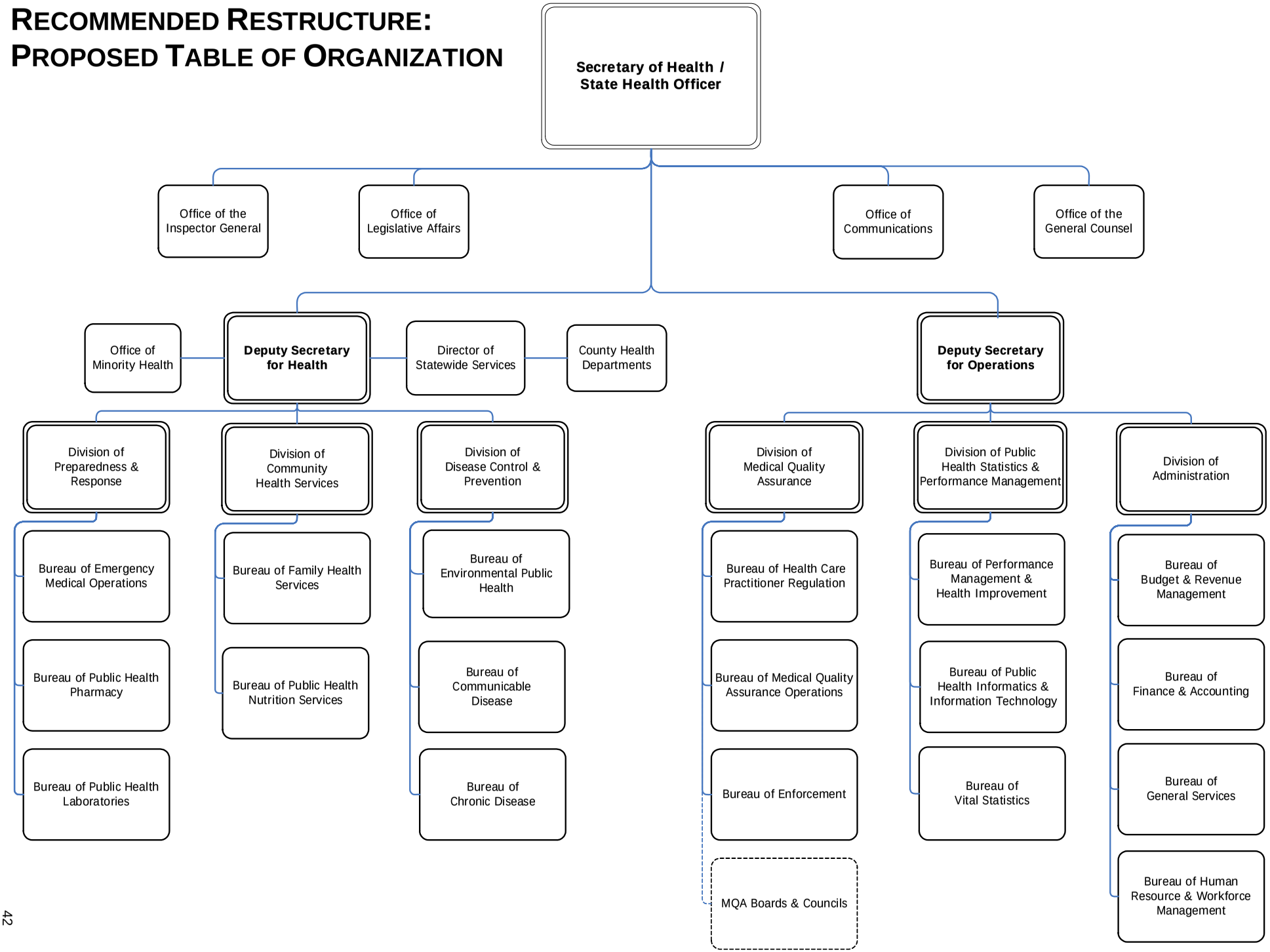
Recommended Actions for Current Bureaus and Offices Not Located Within a Division

The following table provides a summary of recommendations for action related to current stand-alone bureaus and offices reviewed by the department, beyond those established in section 20.43, F.S.

TABLE: Summary of Recommended Actions, by Current Bureau or Office Not Within a Division

CURRENT BUREAU OR OFFICE	PROPOSED ACTION
Bureau of Laboratory Services	Retain and improve bureau within proposed Division of Preparedness and Response
Bureau of Statewide Pharmaceutical Services	Retain and improve bureau within proposed Division of Preparedness and Response
Office of Health Statistics and Assessment	Eliminate office; retain and improve functions within the proposed Division of Public Health Statistics and Performance Management; this division will also include the remaining retained and improved information technology functions
Office of Public Health Research	Eliminate office; retain and improve remaining functions within the proposed Divisions of Administration
Office of Public Health Nursing	Eliminate office; retain and improve remaining functions within the proposed Division of Preparedness and Response, Division of Public Health Statistics and Performance Management and the restructured Division of Medical Quality Assurance
Office of Minority Health	Retain and improve the office

RECOMMENDED RESTRUCTURE: PROPOSED TABLE OF ORGANIZATION



PROPOSED DIVISION OF PREPAREDNESS AND RESPONSE

The following is a summary of the rationale, relatedness to public health function(s), return on investment, and funding support for the proposed Division of Preparedness and Response. Details on proposed bureaus and programs within this proposed division follow.

Rationale
The proposed Division of Preparedness and Response will work to minimize loss of life, injury and illness from natural or man-made disasters through sustaining a framework for preparedness and response.

Relatedness to a Public Health Function(s)
Programs within the proposed Division of Preparedness and Response will support six of the proposed department responsibilities (public health functions):

(a) Identify, diagnose, and conduct surveillance of diseases and health conditions in the state, accumulating health statistics necessary to establish trends.

(b) Implement interventions that prevent or limit the impact or spread of diseases and health conditions.

(c) Collect, manage, and analyze vital statistics and other health data to inform and formulate public health policy and planning.

(d) Maintain and coordinate preparedness for and responses to public health emergencies in the state.

(e) Provide or assure the provision of quality health and related services to identified populations in the state.

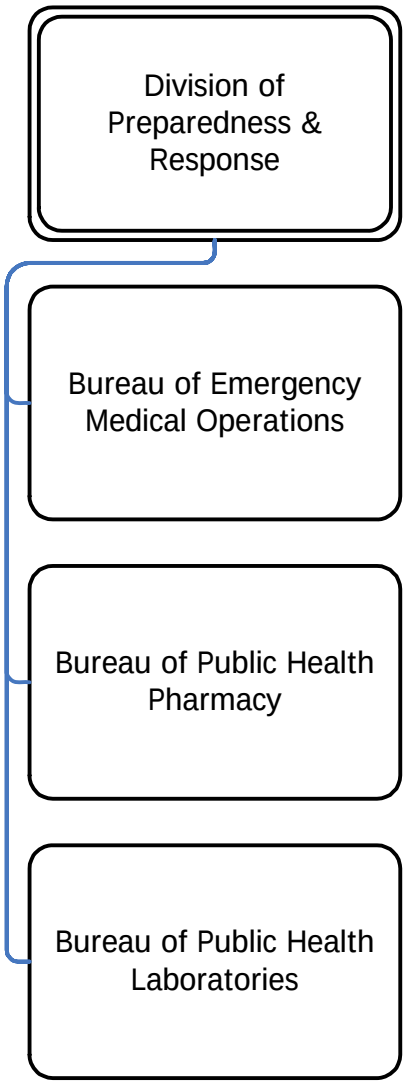
(g) Regulate health practitioners, to the extent authorized by the legislature, as necessary for the preservation of the health, safety, and welfare of the public.

Return on Investment
See return on investment provided in the table, “Proposed Division of Preparedness and Response: Associated Proposed Bureaus and Programs.”

Federal Funding Support
Six of the twelve programs within this division receive federal funding support. Specific funding support is indicated in the table, “Proposed Division of Preparedness and Response: Associated Proposed Bureaus and Programs.”

PROPOSED DIVISION OF PREPAREDNESS AND RESPONSE (CONTINUED)

Proposed Division Structure



PROPOSED DIVISION OF PREPAREDNESS AND RESPONSE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
BUREAU OF EMERGENCY MEDICAL OPERATIONS				
Emergency Medical Services	This program will sustain and improve the framework for statewide preparedness and response by ensuring a coordinated emergency medical services system of pre-hospital care.	(a), (b), (c), (d), (e), (g)	Emergency Medical Services (EMS) responds to 3.1 million requests for services per year in Florida. Florida pre-hospital emergency medical technicians (EMTs), paramedics, and 911 telecommunicators are trained and equipped to provide correct, high quality, expedient emergency medical care on over 3.1 million calls from the public each year. 270 EMS agencies use 4000 vehicles and aircraft to save lives, reduce disability, and prevent suffering. *[Source: DOH Division of Emergency Medical Operations, Bureau of Emergency Medical Services data]* Examples: For every investment of $39 spent on emergency vehicle equipment for cardiac arrest, one life-year is saved. The Bureau of Emergency Medical Services grant program has distributed an average of $643,823 each year for the past five years, which was used to purchase Automated External Defibrillators (AED) and cardiac monitors. This investment resulted in over 16,500 years of life saved each year. *[Source: Five-Hundred Life-Saving Interventions and Their Cost Effectiveness. Teng et al. 1995;369-390]* The cost per life-year improvements mentioned were listed as one of the top 500 cost-effective life-saving interventions available in the U.S. *[Source: Soc for Risk Analysis. Teng et al. 1995;369-390]*	Federal Trust Fund State Trust Fund

PROPOSED DIVISION OF PREPAREDNESS AND RESPONSE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Preparedness and Response	This program will sustain and improve the framework for statewide preparedness and response by ensuring a ready public health and health care system.	(a), (b), (c), (d), (e)	Achieving National Target Capabilities for Readiness: The National Preparedness Guidelines provide the framework for a capability-based preparedness system that ensures readiness to respond to large-scale events. In 2010, each state was assessed by the Department of Homeland Security on the achievement of the 37 priority capabilities using a 10 point scale designed to measure progress (0=no progress, 10=achieved). Florida received an average score of 5.7 (moderate progress) on the 19 public health and medical capabilities. Of the 19, Florida demonstrated substantial progress, a score of 7 or greater, for the following capabilities: • Planning • Epidemiological Surveillance and Investigation • Laboratory Testing • Mass Care – Special Needs Sheltering • Emergency Operations Center Management *[Source: http://www.fema.gov/pdf/government/npg.pdf]* Achieving National Standards for Mass Prophylaxis: The national target for the mass prophylaxis capability is for states to dispense vaccinations or medications to entire affected communities within 48 hours of the incident. The percent of population saved increases as the length of time it takes to serve the entire community is reduced (75% saved if the time is 12 days and 99% saved if the time is 48 hours). States are assessed annually on their Strategic National Stockpile program to ensure readiness to meet the 48-hour timeframe. Since 2006, the	Federal Trust Fund General Revenue

PROPOSED DIVISION OF PREPAREDNESS AND RESPONSE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
			Centers for Disease Control and Prevention have conducted assessments using a percentage score. Florida received a Strategic National Stockpile Technical Assistance Review (TAR) score of 98 in 2009; this high score exempted Florida from a review in 2010 (the national target for 2010 was a score of 79).	
BUREAU OF PUBLIC HEALTH PHARMACY				
AIDS Drug Assistance Program (ADAP) Pharmacy Dispensing	This program will continue to dispense ADAP drugs for the patients of the 54 county health departments that do not maintain a pharmacy.	(b), (d), (e)	Dispensing ADAP drugs through the central pharmacy benefits the ADAP program by virtue of dispensing charges that are one-half that of other state agency pharmacies and one-quarter that of retail pharmacy dispensing charges. *[Source: Department of Health, Bureau of Statewide Pharmaceutical Services analysis, 2010]*	Federal Trust Fund General Revenue
Department of Corrections Drug Repackaging Program *(Memorandum of Agreement between Department of Health and Department of Corrections)*	This program will continue to repackage drugs for the Department of Corrections' inmates.	(b), (e)	In July 2009, the department's Bureau of Statewide Pharmaceutical Services executed an interagency agreement with DOC to provide bulk repackaging services (producing individual punchcards of medication) for two regional DOC pharmacies. This program was subsequently expanded to include four regional pharmacies in January 2010. By the end of FY 2009-2010, the bureau had repackaged 983,937 cards; as of November 2010, cost avoidance for DOC totaled $1,373,610. *[Source: Department of Health, Bureau of Statewide Pharmaceutical Services analysis, 2010]*	General Revenue

PROPOSED DIVISION OF PREPAREDNESS AND RESPONSE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Department of Corrections Sexually Transmitted Disease (STD) Specialty Care Program *(Memorandum of Agreement between Department of Health and Department of Corrections)*	This program will continue to dispense drugs to the Department of Correction (DOC)'s inmates with sexually transmitted diseases, based on U.S. Department of Health and Human Services medical service provision, and in compliance with Public Law 102-585, Section 340B Public Health System.	(b), (e)	Serving all eligible DOC inmates will continue to result in filling/re-filling over 180,000 scripts per year. At the dispensing charge of $1.57, about 20% more revenue will be generated than the program cost. This results in an ROI of 20%. DOC also avoids about 34% of the cost of drugs, because the department is able to procure the drugs at 340B Public Health System prices. *[Sources: (1) OPPAGA feasibility of Consolidating Statewide Pharmaceutical Services) http://www.oppaga.state.fl.us/Monitordocs/Reports/pdf/Feasibility_of_Consolidating_Statewide_Pharmaceutical_Services.pdf, (2) Collaboration in Corrections: Florida's 340B Pilot Project http://www.doh.state.fl.us/disease_ctrl/aids/Prevention/Corrections/Disease_Lockdown_fall_09.pdf and (3) Heinz Family Philanthropies: 340B Prescription Drug Pricing – Opportunities are available http://www.heinzfamilyfoundation.org/programs/hope_ri/340b.aspx]*	General Revenue State Trust Fund
Pharmacy Dispensing/ Repackaging Support to CHDs	This program will continue to dispense and repackage drugs for CHDs that do not maintain pharmacies.	(b), (d), (e)	Central Pharmacy costs for dispensing and overhead are 78% lower than CHD pharmacy costs, and are 22% lower than the least costly retail mail order pharmacies. *[Source: Consolidate and/or outsource pharmaceutical repacking: http://www.floridataxwatch.org/resources/pdf/HealthcareRecommendations.pdf]*	General Revenue
Public Health Preparedness (PHP)	This program will continue to provide pharmaceutical services to comply with the state's emergency preparedness requirements. This includes oversight of the acquisition, storage, deployment, utilization and management of the state emergency medication stockpile.	(b), (d), (e)	Every $1.00 spent on preparedness saves $6.00 to $9.00 when disaster strikes. *[Source: http://www.examiner.com/homeland-security-in-chicago/chicago-ranked-the-top-three-cities-when-it-comes-to-preparedness?render=print]*	Federal Trust Fund

PROPOSED DIVISION OF PREPAREDNESS AND RESPONSE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
BUREAU OF PUBLIC HEALTH LABORATORIES				
Drinking Water Microbiology	This program will continue to work to ensure safe drinking water by detecting harmful microorganisms and ensure that recreational waters do not exceed established limits for harmful bacteria.	(a), (b), (c), (d), (e), (g)	Polluted recreational water can lead to gastrointestinal illness, acute respiratory disease and ear and eye infections. Estimated economic burden in the United States per event: • Gastrointestinal illness: $36.58 • Acute respiratory disease: $76.76 • Ear ailment: $37.86 • Eye ailment: $27.31 These costs can become a substantial public health burden when millions of exposures per year result in hundreds of thousands of illnesses. *[Source: Dwight RH, et al. Estimating the economic burden from illnesses associated with recreational coastal water pollution, a case study in Orange County, California. J Environ Manage. 2005; 76(2): 95-103.]*	General Revenue State Trust Fund
Environmental Chemistry	This program will continue to work to ensure safe drinking water, food, air, and soil by detecting harmful chemicals.	(a), (b), (c), (d), (e), (g)	The value of this program lies in the detection of carcinogens, mutagens and toxins in the environment in order to avoid exposure of humans and animals to hazardous levels of these substances, as well as the ability to respond to an emergency event. For example, by ensuring arsenic contaminants are lower than or equal to 10 parts per billion in drinking water it is estimated that 37-56 bladder and lung cancer cases, and all associated costs, were avoided. *[Sources: EPA, National Primary Drinking Water Regulations; Arsenic and Clarifications to Compliance and New Source Contaminants Monitoring; Final Rules, 66 Fed. Reg. 6976, 7009, 7017 (Jan. 22, 2001) (rounded to two significant figures). Costs and benefits are in 1999 dollars.) Heinzerling L, Ackerman F. 2002. Pricing the Priceless: Cost-benefit analysis of environmental*	General Revenue State Trust Fund

PROPOSED DIVISION OF PREPAREDNESS AND RESPONSE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
			protection. Georgetown Environmental Law and Policy Institute *Georgetown University Law Center.* *http://ase.tufts.edu/gdae/publications/c-b%20pamphlet%20final.pdf]*	
Infectious Diseases	This program will continue to provide rapid detection, identification, and characterization of disease-causing microorganisms.	(a), (b), (c), (d), (e), (g)	Rabies: In 2009, the cost avoidance/savings realized by testing for rabies before treating was >$2,785,000; costs are >$1,000 for rabies post-exposure treatment per patient when administered (2,785 tests were performed for rabies exposure that tested negative in 2009, avoiding patient treatment). *[Source: 2011 Rabies Guide, Florida Dept. of Health, http://www.doh.state.fl.us/Environment/medicine/rabies/Documents/RabiesGuide2011Binder.pdf]* Tuberculosis (TB): The savings/cost avoidance from each case of multidrug resistant TB prevented is approximately $250,000. *[Source: Plan to Combat Extensively Drug-Resistant Tuberculosis: Recommendations of the Federal Tuberculosis Task Force (ACIP). Morbidity Mortality Weekly Report, February 13, 2009 / Vol. 58 / No. RR--3 / Pg. 1–43* *http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5803a1.htm]* Foodborne and Waterborne Diseases: If rapid laboratory diagnosis prevents 1,500 new cases of salmonellosis annually, then the cost avoidance is more than $12.9 million annually. *[Source: Report from the Produce Safety Project at Georgetown University: "Health Related Costs From Food Related Illness in the United States," March 2010.* *http://www.producesafetyproject.org/admin/assets/files/Health-Related-Foodborne-Illness-Costs-Report.pdf-1.pdf]*	Federal Trust Fund General Revenue State Trust Fund

PROPOSED DIVISION OF PREPAREDNESS AND RESPONSE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Newborn Screening Laboratory Testing	This program will continue to test all newborn babies in Florida for metabolic, endocrine, hemoglobin and genetic disorders, including Cystic fibrosis, in order to prevent death or significant developmental disability.	(a), (b), (c), (d), (e), (g)	Florida screens all newborns for hearing impairment and for 34 metabolic disorders that lead to death or significant developmental disability. Newborn screening has been demonstrated to prevent developmental disabilities and reduce the need for special education services. The U.S. Centers for Disease Control and Prevention reports that the present value of lifetime costs of developmental disabilities that are prevented by newborn screening ranges from $500,000 to $1 million. The lifetime savings for these conditions in Florida far exceed the costs of implementing and maintaining a statewide newborn screening program. *[Sources: (1) Grosse S. Does newborn screening save money? The difference between cost-effective and cost-saving interventions. The Journal of Pediatrics, 146 (2): 168-170. (2) Prevention Pays. Office of Health Statistics and Assessment Florida Department of Health, June 2010. http://www.doh.state.fl.us/Planning_eval/phstats/PrevPays/PreventionPays.pdf]*	State Trust Fund

PROPOSED DIVISION OF PREPAREDNESS AND RESPONSE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Public Health Preparedness Laboratory Testing	As the only public health laboratory in Florida, designated by the U.S. Centers for Disease Control and Prevention to respond to incidents of bioterrorism, this testing program will continue to minimize the exposure time of Floridians to biological and chemical agents.	(a), (b), (c), (d), (e), (g)	Early detection and treatment leads to reduced morbidity and mortality from exposure/infection. Quick action limits the spread of disease and saves lives. During the many "white powder" (suspected anthrax) incidents around the state (submitted for testing 24/7), the public health laboratory system provided a meaningful response to first responders and the public within six hours of laboratory receipt. This is well within the recommended post-exposure treatment window associated with the biological agents for which we can test. *[Source: Actual turn around time data compiled by the Bureau of Laboratories, over a two-year period.]*	Federal Trust Fund General Revenue State Trust Fund

PROPOSED DIVISION OF COMMUNITY HEALTH SERVICES

The following is a summary of the rationale, relatedness to public health function(s), return on investment, and funding support for the proposed Division of Community Health Services. Details on proposed bureaus and programs within this proposed division follow.

Rationale

This proposed division will assure the provision of provide health services within the community to specified populations in cooperation with state and local partners.

Relatedness to Public Health Function(s):

The programs within the proposed Division of Community Health Services will support four of the proposed department responsibilities (public health functions):

(a) Identify, diagnose, and conduct surveillance of diseases and health conditions in the state, accumulating health statistics necessary to establish disease trends

(b) Implement interventions that prevent or limit the impact or spread of disease

(c) Collect, manage, and analyze vital statistics and other health data to inform and formulate public health policy and planning

(e) Provide or assure the provision of quality health and related services to identified populations in the state

Return on Investment (ROI)

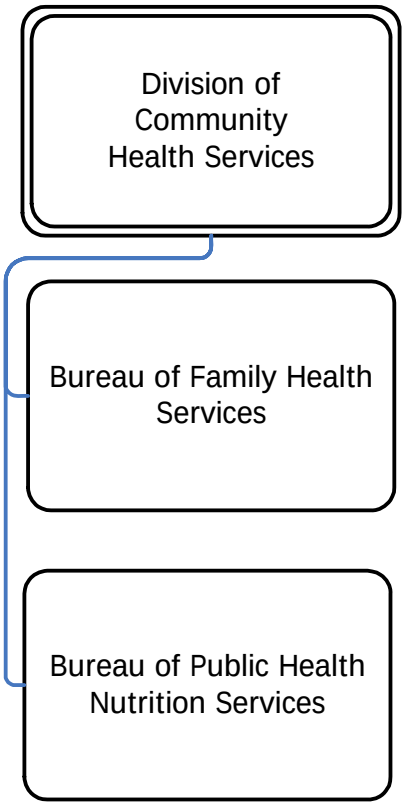
See return on investment provided in the table, “Proposed Division of Community Health Services: Associated Proposed Bureaus and Programs.”

Federal Funding Support:

All eleven programs within this division receive federal funding support. Specific funding support is indicated in the table, “Proposed Division of Community Health Services: Associated Proposed Bureaus and Programs.”

PROPOSED DIVISION OF COMMUNITY HEALTH SERVICES (CONTINUED)

Proposed Division Structure



PROPOSED DIVISION OF COMMUNITY HEALTH SERVICES: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
BUREAU OF FAMILY HEALTH SERVICES				
Dental Health	This program, in collaboration with the county health departments, will continue to facilitate an integrated, coordinated oral health system between the public and private sectors.	(a), (b), (c), (e)	Medicaid-enrolled children who have their first preventive dental visit by age 1 are more likely to have future preventive visits and to experience lower dental-related costs. When these children are seen for their first preventive visit before the age of 1, subsequent dental costs average $262 for a visit. When these children are seen for their first preventive visit between ages 4-5, the subsequent average dental-related cost is $546. *[Source:PedDentistryJ 28 (2006):102-105]* Dental sealants prevent 60% of decay in molars after only one application and cost one-third as much as filling a cavity. *[Sources: (1) American Dental Association 2007 Survey of Dental Fees; (2) Task Force on Community Preventive Services, AmJ PrevMed, 23 (2002):21-54.]* Every $1 invested in water fluoridation saves $38 dollars in dental treatment costs. *[Source: Centers for Disease Control and Prevention. Cost savings of community water fluoridation.] Available at:* http://www.cdc.gov/fluoridation/fact_sheets/cost.htm	General Revenue Federal Trust Fund
Family Planning	This program, in collaboration with the county health departments, will continue to provide comprehensive services related to family planning.	(a), (b), (c), (e)	National studies find that for every $1.00 spent on family planning, $4.36 in health care costs is saved. This estimate of savings does not include longer-term savings associated with fewer special need school age children due to fewer low birth weight babies or lower rates of child abuse. Low birth-weight babies or babies from unplanned and unwanted pregnancies are at increased risk for child abuse. *[Source: Estimated Medicaid Savings From Florida's Family Planning Program, 2009]*	General Revenue State Trust Fund Federal Trust Fund

PROPOSED DIVISION OF COMMUNITY HEALTH SERVICES: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Maternal and Child Health Practice and Analysis	This program will continue to monitor and investigate current maternal and child health issues, provide data analysis and technical support, and evaluate programs within the division.	(c)	Health information specific to maternal and child health is essential to assure data driven and evidence-based decision-making and the best return on investment. *[Source: Future of Public Health, Institute of Medicine, 1998 & 2008; Public Health Function Project, 1999]*	General Revenue Federal Trust Fund
Maternal and Infant Health *(Inclusive of Healthy Start)*	This program will continue to work toward improving the health and development outcomes of pregnant women, infants and children up to age three; implementing Evidence-based maternal and child health programs; and providing health care services to those not eligible for services elsewhere, in partnership with local, state and national organizations.	(a), (b), (c), (e)	Good preconception health decreases the chance of a poor maternal and/or birth outcome, thus saving the costs related to maternal and/or infant morbidity or mortality. Each year, 12% of babies are born premature, 8% are born with low birth weight, and 3% have major birth defects. Of women giving birth, 31% suffer pregnancy complications. *[Source: Florida Preconception Health Indicator Report, http://www.cdc.gov/ncbddd/preconception/whypreconception.htm]* In 2005, preterm birth had an estimated annual cost in the United States of $51,600 for each infant born preterm, totaling approximately $26.2 billion. *[Source: William J. Hueston, MD, Robert G. Quattlebaum, MD, MPH and Joseph J. Benich, MD, How Much Money Can Early Prenatal Care for Teen Pregnancies Save?: A Cost-Benefit Analysis The Journal of the American Board of Family Medicine 21 (3): 184-190 (2008)]* The average medical cost for a low birth weight infant during the first year of life is $24,697. In contrast, the corresponding cost for an infant with a birth weight of over 2500 grams is $1,554. *[Source: Lewit et al., 1995 adjusted for inflation using CPI (1996:1988=1.6465), as referenced in the U.S. Environmental Protection Agency, Cost of Illness Handbook]*	General Revenue State Trust Fund Federal Trust Fund

PROPOSED DIVISION OF COMMUNITY HEALTH SERVICES: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Child & Adolescent Health	This program will continue to emphasize the importance of focusing on the strengths of young people – instead of their risk factors – to ensure that all youth grow up to be healthy members of society.	(b), (c)	For every $1.00 spent, there is a potential return on investment of $10.51. *[Source: The Cost and Financing of Youth Development in America. Washington, DC: Academy for Educational Development (AED) – Center for Youth Development and Policy Research. 2001.]*	Federal Trust Fund
School Health Services	This program will continue to provide direction and oversight to ensure county-level provision of statutorily mandated health services to Florida public school students in pre-kindergarten through grade 12.	(b), (c), (e)	<u>Full service funding</u> Each $1.00 of state funding ($8,500,000) resulted in $1.36 of in-kind services provided by community partners ($11,880,289). <u>Comprehensive funding</u> Each $1.00 of state funding results in $2.48 per hour in saved classroom time. *[Source: 2008-2009 Annual School Health Services Report, 2008 -2009 Schedule C Allocations, and Florida Department of Education Finance Program 2008 -2009 Final Calculation]*	General Revenue Tobacco Federal Trust Fund
Sexual Violence Prevention *(Rape Prevention Education and Sexual Assault Victim Services)*	This program will continue to work toward changing social norms in order to prevent sexual violence in Florida. This will occur through provision of a statewide, integrated system of primary rape prevention education that is locally relevant and culturally sensitive. It will continue to prevent first-time victimization or perpetration and provide crisis intervention services for primary and secondary victims of sexual assault.	(a), (b), (c), (e)	The average cost of being a rape victim is estimated to be $110,000. *[Source: Report on the Prevalence, Incidence and Consequences of Violence Against Women, Tjaden & Thoenes, 1998]* In 2009, Florida Department of Law Enforcement reported 10,227 total forcible sex offenses – an estimated cost of $1,124,970,000. *[Source: Florida Statistical Analysis Center: FDLE (1971-2009). Crime in Florida, Florida uniform crime report [computer program]. Tallahassee, FL. Computation of average treatment costs of $110,000 per rape victim multiplied by 10,227 victims equals projected costs of $1,124,970,000.]* The U.S. Centers for Disease Control and Prevention estimates that the cost of intimate partner rape, physical assault and	State Trust Fund Federal Trust Fund

PROPOSED DIVISION OF COMMUNITY HEALTH SERVICES: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
			stalking totaled $5.8 billion each year, for direct medical and mental health care services and lost productivity. When updated to 2003 dollars, the cost is more than $8.3 billion. *[Source: U.S. Centers for Disease Control and Prevention, Injury Prevention & Control: Violence Prevention, http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/consequences.html]*	
BUREAU OF PUBLIC HEALTH NUTRITION SERVICES				
Child Care Food Programs *(Including Afterschool Nutrition Program and Homeless Children Nutrition Program)*	This program will continue to provide reimbursement for meals through public/private partnerships with children's service organizations (1,600 contractors), to children in child care centers, family child care homes, recreational centers, afterschool enrichment programs, domestic violence shelters and homeless shelters.	(e)	A study of 3- and 5-year-old, low-income children demonstrated that participation in this program was associated with a significantly lower body mass index (an indication for obesity), and indicated the significance of the role the program serves in preventing childhood obesity. *[Source: Kimbro, R. T. & Rigby, E. (2010). Federal food policy and childhood obesity: a solution or part of the problem? Health Affairs, 29(3), 411-418]* Studies have found that obese children also contribute to the rising cost of Medicaid - obese children stay nearly a full day (0.85 day) longer in the hospital when ill, resulting in $1,634 per patient in increased hospital charges. *[Source: Confronting America's Childhood Obesity Epidemic - How the Health Care Reform Law Will Help Prevent and Reduce Obesity, http://www.americanprogress.org/issues/2010/05/pdf/childhood_obesity.pdf]*	Federal Trust Fund

PROPOSED DIVISION OF COMMUNITY HEALTH SERVICES: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	This program will continue to provide the following services to low- and moderate-income pregnant, postpartum and breastfeeding women, infants and children under five years of age: food education and counseling; breastfeeding promotion and support; and health care and referrals, including referrals for immunizations and supplemental foods. This program will also continue to authorize, train, and monitor approximately 2,000 participating WIC grocery stores.	(e)	Research has shown that for every $1.00 spent on the prenatal component of the WIC program, there is a cost savings of $3.50. *[Source: U.S. General Accounting Office. Early Intervention: Federal Investments Like WIC Can Produce Savings. April 1992]* Birth outcome data of pregnant women receiving Medicaid indicated that participation in the prenatal Women, Infants, and Children Program (WIC) in Florida had a significantly positive effect on birth outcomes. Infants of women receiving prenatal Medicaid benefits, who were also enrolled in WIC during their pregnancies, had a reduced risk of infant and neonatal mortality, as well as a lower prevalence of being born low birth weight/very low birth weight. *[Source: The Impact of WIC on Birth Outcomes in Women Receiving Medicaid-Funded Pregnancy Services Issue Brief June 2003 http://mch.peds.ufl.edu/research/policybriefs/2002_2003/impact_wic_birth_outcomes.pdf]* Prenatal participation in a WIC program reduced the rate of low birth weight. It was estimated that for each $1.00 spent on WIC services, Medicaid savings in costs for newborn medical care were $2.91. *[Source: Buescher, PA., Larson, LC., Nelson, MD, Lenihan, AJ, Prenatal WIC Participation Can Reduce Low Birth Weight and Newborn Medical Costs: A Cost Benefit Analysis of WIC Participation in North Carolina, Journal of American Dietetic Association, Volume 93, Issue 2, February 1993, Pages 163-166].*	Federal Trust Fund

PROPOSED DIVISION OF COMMUNITY HEALTH SERVICES: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
WIC Breastfeeding Peer Counseling	This program will continue to provide basic breastfeeding education and support to prenatal and postpartum women, to increase breastfeeding initiation, duration, and exclusivity rates.	(e)	Breastfeeding protects babies from infections and illnesses that include diarrhea, ear infections and pneumonia. Breastfed babies are less likely to develop asthma. Children who are breastfed for at least six months are less likely to become obese. Breastfeeding also reduces the risk of sudden infant death syndrome (SIDS). Mothers who breastfeed have a decreased risk of breast and ovarian cancers. *[Source: The Surgeon General's Call to Action to Support Breastfeeding Fact Sheet, January 20, 2011 http://www.surgeongeneral.gov/topics/breastfeeding/factsheet.html]* In addition to having more illnesses, formula-fed infants financially impact the health care system. In the first year of life, there were 2033 excess office visits, 212 excess days of hospitalization, and 609 excess prescriptions for three illnesses (lower respiratory tract illnesses, ear infections, and gastrointestinal illness) per 1000 never-breastfed infants compared with 1000 infants exclusively breastfed for at least 3 months. These additional health care services cost the health care system between $331 and $475 per never-breastfed infant during the first year of life. *[Source: Ball, TM., Wright, AL., Health Care Costs of Formula-feeding in the First Year of Life, Pediatrics 1999; 103:870-876]*	Federal Trust Fund

PROPOSED DIVISION OF COMMUNITY HEALTH SERVICES: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
WIC Farmer's Market Nutrition Program *Partnership with the Florida Department of Agriculture and Consumer Services (DACS)*	This program will continue to supplement the WIC food package with locally grown fresh fruits and vegetables purchased from local farmers' markets. This program will also continue to expand awareness and use of farmers' markets and promote farmers' market sales.	(e)	A survey of women participating in WIC found that those who had participated in the program reported a higher daily intake of vegetables than did other WIC participants. *[Source: Kropf ML, Holben DH, Holcomb Jr JP, Anderson H. Food Security Status and Produce Intake and Behaviors of Special Supplemental Nutrition Program for Women, Infants, and Children and Farmers' Market Nutrition Program Participants. J Am Diet Assoc. 2007;107(11):1903-1908.]*	Federal Trust Fund State Trust Fund *(state match provided by DACS)*

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION

The following is a summary of the rationale, relatedness to public health function(s), return on investment, and funding support for the proposed Division of Disease Control and Prevention. Details on proposed bureaus and programs within this proposed division follow.

Rationale

This proposed division will work to prevent the occurrence and progression of disease, health problems, and environmental health hazards.

Relatedness to Public Health Function(s):

The programs within the proposed Division of Disease Control and Prevention will support six of the proposed department responsibilities (public health functions):

(a) Identify, diagnose, and conduct surveillance of diseases and health conditions in the state, accumulating health statistics necessary to establish trends.

(b) Implement interventions that prevent or limit the impact or spread of diseases and health conditions.

(c) Collect, manage, and analyze vital statistics and other health data to inform and formulate public health policy and planning.

(d) Maintain and coordinate preparedness for and responses to public health emergencies in the state.

(e) Provide or assure the provision of quality health and related services to identified populations in the state.

(f) Regulate environmental activities that have a direct impact on public health in the state.

Return on Investment (ROI)

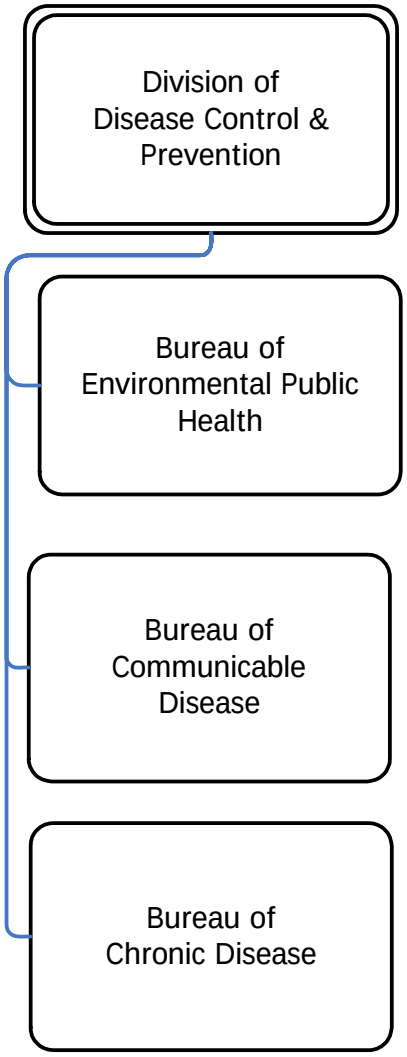
See return on investment provided in the table, “Proposed Division of Disease Control and Prevention: Associated Proposed Bureaus and Programs.”

Federal Funding Support:

All twelve programs within this division receive federal funding support. Specific funding support is indicated in the table, “Proposed Division of Disease Control and Prevention: Associated Proposed Bureaus and Programs.”

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION (CONTINUED)

Proposed Division Structure



PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
BUREAU OF ENVIRONMENTAL PUBLIC HEALTH				
Community Environmental Health	This program will continue to inspect group care facilities and migrant camps to ensure minimum health and safety standards are implemented; provide information and referrals regarding radon exposure and indoor air quality; and provide technical expertise to support healthy communities.	(b), (c), (f)	Radon mitigations prompted by activities of the radon program annually result in 12.5 lives saved, $3.3 million in costs avoided. For every $1.00 invested in the program's activities, $9.20 are saved or avoided in disease or health-related costs. *[Sources: (1) WHO: http://www.who.int/ionizing_radiation/env/radon/en/index2.html; (2) Department of Health: internal analysis of reports from radon mitigations and radon pre- and post- mitigation testing NCI: http://progressreport.cancer.gov/doc_detail.asp?pid=1&did=2007&chid=75&coid=726&mid]* Department indoor air investigation activities from 2009 and 2010 found no public health risks from homes with corrosive drywall. The effort saved $150 million to the state housing industry or an ROI of over $275 per each $1.00 spent. Over 3,000 homeowners chose to keep their homes rather than abandon them because of perceived risks to their health (as reflected in the number of homeowners who filed for corrosive drywall property tax abatement). Abandonment would have resulted in a minimum cost of $50,000 per home from foreclosure proceedings. *[Sources: Congressional oversight panel report: http://cop.senate.gov/documents/cop-100909-report.pdf; Department of Health survey of county property appraisers.]*	General Revenue State Trust Fund Federal Trust Fund

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Environmental Public Health Medicine	This program, in collaboration with county health departments, will continue to assess health risks to humans from exposure to environmental disease hazards and investigate disease clusters (foodborne and other), in order to implement measures to prevent and control human diseases. This program will also continue to provide technical consultation on the prevention and control of human diseases from environmental exposures. This program will continue to include a statewide Environmental Public Health Tracking (EPHT) system to conduct enhanced surveillance of environmental exposures and health outcomes, and to provide data communities can use to understand disease risks and improve their health.	(a), (b), (c)	The cost of foodborne illness to the state of Florida has been estimated at $9.8 billion dollars, $1,984 per case. Rapidly detecting outbreaks, investigating, and recommending control and prevention measures prevents additional cases in a current outbreak and potentially prevents future outbreaks. *[Source: Health-Related Costs from Foodborne Illness in the United States. Robert Scharff. 2010 http://www.producesafetyproject.org/admin/assets/files/Health-Related-Foodborne-Illness-Costs-Report.pdf-1.pdf]* Increased public awareness of statewide mosquito disease activity and disease prevention measures results in less human exposure, illness, and death. Treatment costs approximately $225,000 per fatal West Nile Virus case. Costs per patient for illness not resulting in death are approximately $136,839. *[Source: Zohrabian A, Meltzer MI, Ratard R, Billah K, Molinari NA, Roy K, et al. West Nile virus economic impact, Louisiana, 2002. Emer Infect Dis. 2004;1736-44. http://www.cdc.gov/ncidod/EID/vol10no10/03-0925.htm]* Through the rabies control program, when animals are quarantined, people are not treated unnecessarily with rabies vaccine. As a result, of these actions the estimated rabies cost avoidance per year is 500 x $3,000=$1,500,000 (Individual avoided rabies postexposure prophylaxis series = $3,000). *[Source: Shwiff SA, Sterner RT, Jay MT, Parikh S, Bellomy A, Meltzer MI, Rupprecht CE, Slate D. 2007. Direst and indirect costs of rabies exposure: a retrospective study in southern California (1998-2002). J Wildl Dis. 43(2):251-257]*	Federal Trust Fund General Revenue State Trust Fund

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
			It is estimated that for every $1.00 invested in Environmental Public Health Tracking activities, a return of $1.44 in reductions in health care costs are anticipated. In Florida, that would amount to a return on investment of $360,800 annually. *[Sources: (1) Return on Investment of Nationwide Health Tracking, A Report of the Public Health Foundation, 2001. http://healthyamericans.org/reports/files/phfreport.pdf (2) Charleston, AE, Banerjee, A, Carande-Kulis, VG. 2008. Measuring Success: The Case for Calculating the Return on Investment of Environmental Public Health Tracking. J Public Health Management Practice. 14(6):600–604. http://journals.lww.com/jphmp/Fulltext/2008/11000/Measuring_Success__The_Case_for_Calculating_the.14.aspx]*	
Public Health Water	This program will continue to provide public health expertise for the implementation of federal water standards at the state level; monitor and analyze drinking water from public water systems and private wells; and monitor water from beaches, swimming pools, spas, and fresh-water bathing places to prevent waterborne disease. This program will also continue to regulate onsite sewage to prevent ground and surface water contamination from improper disposal of septic waste.	(a), (c), (f)	The department invests approximately $0.23 per person per year for safe water regulation. The cost of disease from drinking contaminated water is estimated to be from $116 for a mild case to $34,000 for a severe case per person. In 2009, there were 11,144 reported cases of enteric disease in Florida. If the balance of the population of Florida was protected from even a mild case of disease this would result in a cost avoidance of a minimum of $928 million. *[Sources: U.S. Environmental Protection Agency cost analysis for Safe Drinking Water Act; U.S. Centers for Disease Control National Bureau of Economic Research and Beach, et al, Emerging Infectious Diseases, April 2003.]* Through the onsite sewage permitting process, the failure rate for newly constructed septic tanks (within three to four years) has been decreased from 33% during the 1960s to about 5% in Florida today. *[Source: Environmental Health Database:*	General Revenue State Trust Fund Federal Trust Fund

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
			(McGauhey and Winneberger: Studies of the failure of septic tank percolation systems. Journal WPCF May 1964: 593-606]	
Radiation Prevention and Control Program	This program will continue to protect people and their environment from unnecessary radiation exposure, through inspection, monitoring, and investigation of radioactive machines and materials, applying federal standards. This program will also continue to operate the statewide health physics laboratory for the radiological analysis of all types of media (water, soil, vegetation, air and foodstuffs) and maintain a comprehensive emergency training and response program.	(b), (c), (f)	In the certification and inspection process, approximately 90 cancer deaths in Florida are prevented per year by ensuring a reduction of 10milliREM to ionizing radiation exposure. Annual expenditures for certification and inspection process are $2.8 million, for an annual estimated cost savings of $9 million (90 cancer deaths x $100,000 average cost for treatment). *[Source: National Council on Radiation Protection and Measurements, Report No. 91]* The average cost for cancer treatments is $100,000 per year per patient. Therefore, for each $1.00 spent on the certification and inspection program, the state saves $3.11. *[Sources: National Council on Radiation Protection and Measurements (NCRP)Report No. 91, U.S EPA, Radiation Risks and Realities, May 2007, American Society of Clinical Oncology, Journal of Oncology Practice, Understanding Patient Perspectives on Communication About the Cost of Cancer Care: A Review of the Literature, July 15, 2010]*	General Revenue State Trust Fund Federal Trust Fund
BUREAU OF COMMUNICABLE DISEASE				
Acute Disease Epidemiology	This program will continue to monitor for the new onset of diseases and conditions that affect public health; provide expertise and consultation on the prevention and control of communicable diseases; investigate disease outbreaks; and make specific recommendations pertaining to response.	(a)	Florida has a robust syndromic surveillance system and collects real-time information about incoming patients to emergency departments in 156 hospitals in Florida. This allows early detection and minimization of outbreaks with cost benefit examples outlined below. From the time of infection with *Escherichia coli O157:H7* until the time of death, the societal costs for a patient are $991,221. It is estimated that if five cases were averted annually, the	General Revenue Federal Trust Fund

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
			system would recover all its costs; Florida reported 94 cases in 2009. *[Source: Elbasha EH, Fitzsimmons TD, Meltzer MI, 2000. Costs and Benefits of a Subtype-Specific Surveillance System for Identifying Escherichia coli O157:H7 Outbreaks. Emerging Infectious Diseases. 6(3):293-297.]* Preventing one case of methicillin-resistant *Staphylococcus aureus* (MRSA), will reduce health costs of approximately $7,000 per case, and reduce the length of hospitalization from 10 to 4.6 days for all other stays. *[Source: Statistical Brief #35. Healthcare Cost and Utilization Project (HCUP). July 2007. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb35.jsp]* In 2001, prompt investigation by Florida epidemiologists of the first U.S. bioterrorism-related inhalation anthrax attack in Palm Beach likely prevented many additional deaths, by identifying 1,114 persons at risk. These people received prophylaxis. *[Source: First Case of Bioterrorism-Related Inhalational Anthrax in the United States, Palm Beach County, Florida, 2001 http://www.cdc.gov/mmwr/preview/mmwrhtml/su5301a4.htm]* In 2009, there were 5,291 laboratory-confirmed cases of 2009 H1N1 influenza reported in Florida (only those people tested and confirmed as having H1N1 influenza). The estimated number actually infected was 3.5 million; there were also 436 tracked outbreaks and 187 deaths in Florida from H1N1 influenza. Epidemiologists used seven different surveillance systems to track influenza during this pandemic. This information was used to	

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
			control disease spread in local communities and by the U.S. Centers for Disease Control and Prevention (CDC), the department and the Florida State Emergency Response Team (SERT) to make recommendations to physicians, businesses and the public about influenza prevention. *[Sources: (1) Florida Morbidity Statistics Report 2009, Florida Department of Health, and (2) Influenza H1N1 seroprevalence survey, November-December 2009, U.S. Centers for Disease Control and Prevention and Florida Department of Health, unpublished data.]*	
HIV/AIDS *(Inclusive of the AIDS Drug Assistance Program (ADAP)*	This program, in collaboration with county health departments, will continue to reduce new HIV infections, increase the number of people aware of their HIV status, and increase the proportion of HIV-infected people linked to care and treatment. The statewide pharmacy will continue to be integral to the treatment of HIV-infected persons, a critical component of this program (see ADAP Pharmacy Dispensing in the proposed Bureau of Public Health Pharmacy, within the proposed Division of Preparedness and Response).	(a), (b), (c), (e)	In 2007, HIV/AIDS declined from being the first to the third leading cause of death for black males ages 25-44; this was the first such decline in more than 15 years. *[Source: Department of Health Long-Range Program Plan, FY 2011-2012 – FY 2014-2015]* From 2000 to 2009, diagnosed HIV cases have decreased by 26% among blacks. The racial/ethnic gap has been closing; in 2000 the HIV case rate among blacks was 11 times greater than among whites, but in 2009, it was only 7 times greater. *[Source: Department of Health Long-Range Program Plan, FY 2011-2012 – FY 2014-2015]* For every HIV infection that is prevented, an estimated $355,000 is saved in the cost of providing lifetime HIV care and treatment, resulting in significant cost-savings for the health care system. *[Source: U.S. Centers for Disease Control and Prevention http://www.cdc.gov/hiv/resources/reports/hiv_prev_us.htm]*	General Revenue Federal Trust Fund

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Immunization	This program, in collaboration with the county health departments, will continue to promote, monitor, and provide technical assistance to facilitate the completion of childhood and adult immunizations, in accordance with the recommendations of the U.S. Centers for Disease Control Advisory Committee on Immunization Practices (ACIP).	(b), (c)	The U.S. Centers for Disease Control and Prevention (CDC) has calculated that every $1 spent on immunization saves $18.40, producing societal aggregate savings of $42 billion. These savings include indirect costs to society, a measurement of losses due to missed work, death, and disability as well as direct medical costs. *[Source: U.S. Centers for Disease Control and Prevention, National Immunization Program presentation at the "Pediatric Academic Societies Conference" in Seattle Washington, May 2003.]*	General Revenue Tobacco Federal Trust Fund

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Sexually Transmitted Disease	This program, in collaboration with the county health departments, will continue to reduce new sexually transmitted disease (STD) infections, increase the number of people aware of their STD diagnosis, conduct partner notification, and reduce the spread of STDs. The statewide pharmacy will continue to be integral to the treatment of STD-infected persons, a critical component of this program (see proposed Bureau of Public Health Pharmacy, within the proposed Division of Preparedness and Response).	(a), (b), (c)	In 1996, $395 million in direct medical costs for Florida were attributed to STDs which can be averted through prevention and treatment intervention efforts. *[Source: The Henry J Kaiser Family Foundation, Estimates of Direct Medical Costs of STDs in the United States. http://www.kff.org/womenshealth/1447-std_rep3.cfm)]* Disease intervention efforts by Florida's STD program successfully averted* over $39 million dollars in direct medical costs to Florida's overall healthcare system in 2009, related to complications from untreated and undiagnosed STDs. **Florida's reported 2009 STD cases and case management information contained in the Patient Reporting Investigation Surveillance Manager (PRISM) application were used to calculate costs averted based on the cited sources.* *[Sources: (1) U.S. Centers for Disease Control and Prevention. Cost-benefit ratios of prevention. STD-HIV Interchange (January 1992) 4-5. (2) Chesson, Harrell W; Collins, Dayne; Koski, Kathryn. Formulas for estimating the costs averted by sexually transmitted infection (STI) prevention programs in the United States. Cost Effectiveness and Resource Allocation, 2008, 6:10. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2426671/?log%24=activity]* Estimated reductions in new cases of gonorrhea and syphilis from 1990 to 2003 saved $5 billion in direct medical costs in the U.S. *[Source: Chesson HW, Gift TL, Pulver ALS. The economic value of reductions in gonorrhea and syphilis incidence in the United States, 1990-2003. Preventive Medicine 2006; 43: 411–415.]*	General Revenue Federal Trust Fund

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Tuberculosis	This program, in collaboration with county health departments, will continue to support prevention, treatment, and elimination of Tuberculosis (TB) and Latent TB Infection in Florida. The statewide pharmacy will continue to be integral to the treatment of Tuberculosis-infected persons, a critical component of this program (see proposed Bureau of Public Health Pharmacy, within the proposed Division of Preparedness and Response).	(a), (b)	An untreated infectious TB person may infect between 10-15 people per year. On average, every dollar spent on TB control, saves $3 to $4 in treatment costs. It is estimated that preventing a single drug resistant TB case, saves the public health system over $250,000. It is estimated that screening and treating dormant TB infections for a single year would prevent 9,000-10,000 active TB cases in the U.S. and save $60-$90 million, (the translated amount for Florida would be approximately 10% or $6-$9 million). *[Sources: (1) Plan to Combat Extensively Drug-Resistant Tuberculosis: Recommendations of the Federal Tuberculosis Task Force (ACIP). Morbidity Mortality Weekly Report, February 13, 2009 / Vol. 58 / No. RR--3 / Pg. 1 – 43 http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5803a1.htm; and (2) National Foundation for Infectious Diseases, http://www.nfid.org/factsheets/tb.shtml]*	General Revenue Federal Trust Fund

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
BUREAU OF CHRONIC DISEASE				
Chronic Disease Epidemiology	This program will continue to inform and formulate public health policy, and plan programs to prevent the occurrence and progression of noncommunicable diseases, health conditions, and disabilities, through surveillance, reporting, investigation, data management and analysis, and training of private and public health professionals.	(a), (c)	Chronic disease epidemiology provides the state and county health departments with a set of skills and expertise that is critical to public health decision-making. With the assistance of chronic disease epidemiologists, senior health officials, chronic disease program managers and other decision-makers can interpret and understand data better, and can translate that information into effective public health action. *[Source: "Essential Functions of Chronic Disease Epidemiology In State Health Departments," Council of State and Territorial Epidemiologists, Chronic Disease Epidemiology Capacity Building Workgroup, September 2004.]* The department's surveillance systems on morbidity, mortality, and health behaviors provide the state and local communities with the foundational data needed to develop and validate cost-effective disease prevention and intervention strategies. *[Source: Florida Department of Health: 2007 Behavioral Risk Factor Surveillance Summary (BRFSS) CDC Summary Tables. http://www.doh.state.fl.us/Disease_ctrl/epi/brfss/CDC_Summary_Pages/2007_summaryreports.html Lim S, Surendera Babu A, Johnson T, et al. Florida Annual Cancer Report: 2007 Incidence and Mortality. Tallahassee: Florida Department of Health, 2011]* As an example of data from the surveillance system being used to validate the cost-effectiveness of a specific prevention strategy, the Pregnancy Risk Assessment Monitoring System (PRAMS) data reveal a 7.5% increase in breastfeeding at 8 weeks postpartum between 2000 and 2008. Breastfeeding is associated with a reduced risk of childhood	General Revenue Federal Trust Fund

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
			obesity; the longer the duration, the lesser the chance the child will become overweight. *[Source: Harder T, Bergmann R, Kallischnigg G, Plagemann A. Duration of breastfeeding and risk of overweight: a meta-analysis. Am J Epidemiol 2005; 162:397-403. https://apps.nccd.cdc.gov/Ponder/UserMgmt/Default.aspx]*	
Chronic Disease Prevention & Control	This program will continue to assist county health departments in developing and operating community programs to prevent and control chronic disease. Chronic diseases have been defined by the Legislature including, but not limited to: heart disease, hypertension, diabetes, renal disease, chronic obstructive lung disease and cancer. Based on the surveillance systems data, the following have been selected for primary focus in Florida: • Decrease rates of obesity • Increase percentage of adults who are at a healthy weight • Reduce the burden of cancer, including breast and cervical cancer, colorectal cancer, and skin cancer • Reduce prevalence and incidence of heart disease • Reduce prevalence and incidence of diabetes	(a), (c)	By making reasonable improvements in preventing and managing chronic disease, 3.2 million cases of chronic conditions can be avoided in 2023. These reasonable improvements could reduce future economic costs of disease in Florida by 26.9% ($91billion) in 2023. $73 billion of this would come from gains in productivity; $18 billion would come from reduced treatment spending. *[Source: DeVol, Ross, and Armen Bedroussian, An Unhealthy America: The Economic Burden of Chronic Disease, Milken Institute, October 2007. Report available at www.milkeninstitute.org]* An investment of $10 per person per year in proven community-based disease prevention programs could yield a net national savings of more than $2.8 billion annually in health care costs in one to two years, more than $16 billion annually within five years, and nearly $18 billion annually in 10 to 20 years. *[Source: Shortchanging America's Health, A State-by-State Look at How Federal Public Health Dollars are Spent and Key State Health Facts, Issue Report, March 2009 Trust for America's Health]* A cost analysis of disease management programs combined with diabetes education found a return on investment of $4.34:$1. County-level Behavioral Risk Factor	Federal Trust Fund

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
			Surveillance System (BRFSS) data not only identify the prevalence of diabetes, but also individual health behaviors that impact the progression and severity of the disease. Based on these data, intervention efforts are directed to the counties most in need with the goal of improving quality of care and reducing medical costs. *[Source: Berg GD, Wadhwa S. (2002). Diabetes disease management in a community-based setting. Managed Care 11(6), 45-50.]* A sustained 10% weight loss will reduce an overweight person's lifetime medical costs by $2,200 to $5,300 by lowering costs associated with hypertension, type 2 diabetes, heart disease, stroke, and high cholesterol. *[Source: CDC Preventing Chronic Diseases: Investing Wisely in Health. www.cdc.gov/nccdphp/publications]* It is estimated that nationally, 14,000 lives could be saved annually if 90 percent of adults age 50 and older were up to date on their colorectal cancer screenings. If all people were screened periodically with recommended methods, 33,000 colorectal cancer deaths could be prevented each year. *[Source: National Commission on Prevention Priorities. Preventive Care: A National Profile on Use, Disparities, and Health Benefits. Partnership for Prevention, August 2007]* A mammogram every one to two years can reduce the risk of death from breast cancer by approximately 20 to 25 percent over 10 years for women ages 40 and older. *[Source: U.S. Preventive Services Task force. "What's New? Screening for Breast Cancer." Rockville, Maryland: Agency for Healthcare Research and Quality, 2002]*	

PROPOSED DIVISION OF DISEASE CONTROL AND PREVENTION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Tobacco Prevention	This program, in collaboration with stakeholders, will continue activities focused on reducing tobacco use and exposure to secondhand smoke.	(a), (b), (c), (e)	As much as $4.2 billion in total personal health care expenditures have been saved as a result of the reduction in adult smoking prevalence. *[Source: National Center for Rural Health Works, Oklahoma State University, 2007-2009]*	Tobacco Federal Trust Fund

RESTRUCTURED DIVISION OF MEDICAL QUALITY ASSURANCE

The following is a summary of the rationale, relatedness to public health function(s), return on investment, and funding support for the restructured Division of Medical Quality Assurance. Details on proposed bureaus and programs within this restructured division follow.

Rationale

This restructured division will work to protect the public through licensure of qualified health care practitioners, enforcement of laws governing their practice, and provision of health care practitioner information.

Relatedness to Public Health Function(s):

The programs within the restructured Division of Medical Quality Assurance will support three of the proposed department responsibilities (public health functions):

(c) Collect, manage, and analyze vital statistics and other health data to inform and formulate public health policy and planning.

(e) Provide or assure the provision of quality health care related services to identified populations in the state

(g) Regulate health practitioners, to the extent authorized by the legislature, as necessary for the preservation of the health, safety, and welfare of the public

Return on Investment (ROI):

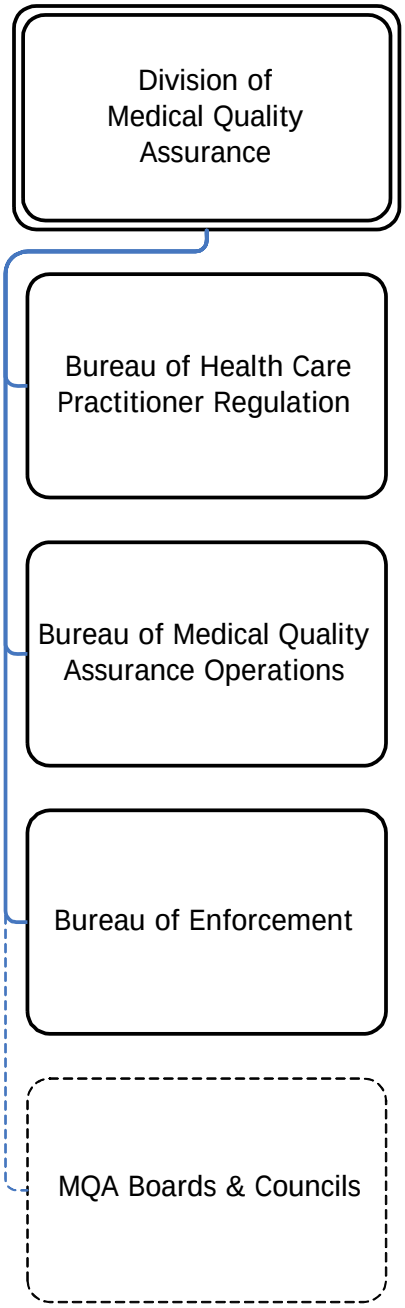
See return on investment provided in the table, “Restructured Division of Medical Quality Assurance: Associated Proposed Bureaus and Programs.”

Federal Funding Support

Three of nine programs within this restructured division receive federal funding support. Specific funding support is indicated in the table, “Restructured Division of Medical Quality Assurance: Associated Proposed Bureaus and Programs.”

RESTRUCTURED DIVISION OF MEDICAL QUALITY ASSURANCE (CONTINUED)

Proposed Division Structure



RESTRUCTURED DIVISION OF MEDICAL QUALITY ASSURANCE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
DIRECTOR'S OFFICE				
Impaired Practitioner Program	This program will continue to ensure public health and safety by monitoring health care practitioners who are impaired as a result of misuse or abuse of alcohol and/or drugs; or due to a mental or physical condition that could affect the licensee's ability to practice with skill and safety.	(g)	From July 2009 to June 2010 (FY 2009-2010), the program had 2,853 participants. Practitioners are detoxified, counseled and monitored during the 5-year recovery process, through contracted services. Based on a study by the University of Florida, 88.6% will successfully complete the 5-year program without any relapses. As a result, 2,528 (2,853 x .886) participants have been able to continue to provide safe healthcare services in their given professions. The earning potential in Florida for health care practitioners and technical occupations, according to the Agency for Workforce Innovation, Labor Market Statistics 2010 Edition, is $55,700. The potential wages for these licensees to earn are $140,809,600. *[Sources: www.floridawages.com and www.bls.gov]*	State Trust Fund
Health Care Professional Shortage Area Designations	This program will continue to serve as the federally designated State Primary Care Office for the Department of Health and Human Services. This program will continue to coordinate 34 federal programs requiring the Health Professional Shortage (HPSA) or Medially Underserved Areas (MUA) designation.	(e), (g)	The National Health Service Corps (NHSC) programs in Florida include 279 NHSC providers in underserved areas in Florida. Of these, 103 are primary care physicians. In addition, 90 J1 visa waiver physicians are also working in underserved areas throughout the state. The economic impact (revenues and payroll) of these programs is approximately $463 million ($2.4 million x 193 physicians). *[Source: National Center for Rural Healthworks]* The return on investment for the state is $1,432 per each dollar of funding received by the State Primary Care Office ($463 million divided by $327,375).	General Revenue Federal Trust Fund

RESTRUCTURED DIVISION OF MEDICAL QUALITY ASSURANCE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Prescription Drug Monitoring Program (PDMP)	This program, when implemented, will establish a database of controlled substances dispensed in Florida.	(e), (g)	Program not implemented as of date of this report; therefore, no data for calculating an ROI.	Federal Trust Fund
Volunteer Health Services *(Volunteer Health Care Provider Program)*	This program will work with community partners to provide medical care for the uninsured and underinsured, through the use of volunteer health care providers.	(e), (g)	For every $1 invested in this program, $415 in free health care services is provided through community partnerships. *[Source: Volunteer Health Care Provider Program Annual Report 2011.]*	General Revenue
BUREAU OF HEALTH CARE PRACTITIONER REGULATION				
Health Care Practitioner Regulation	This program will continue programmatic activities related to licensure of health care practitioners and regulated facilities. This program regulates seven types of facilities and 200-plus license types in over 40 health care professions through coordination with 22 boards and 6 councils.	(g)	The Division of Medical Quality Assurance (MQA) total expenditures for FY 09-10 of $63,417,645 divided by the total number of licenses 993,296* equals an average operating cost of $63.85 per license. This continues the three-year decrease in average cost per license ($65.24 for FY 08-09, $72.17 for FY 07-08). *(*NOTE: This number does not include Drugs, Devices & Cosmetics, which transfers to Department of Business and Professional Regulation in October 2011.)* For an average annual operating cost of $63.85 per license, the earning potential in Florida for health care practitioners and technical occupations, according to the Agency for Workforce Innovation, Labor Market Statistics 2010 Edition, is $55,700. Of the 993,296 licenses, 783,932 licensed health care practitioners have in-state addresses. The potential wages for these licensees to earn are $43,665,012,400. Based upon the U.S. Department of Labor, Bureau of Labor Statistics, December 2010 Consumer Price Index of 1.5%, the total potential economic impact is $654,975,186. Thus, for every $1.00	State Trust Fund Federal Trust Fund

RESTRUCTURED DIVISION OF MEDICAL QUALITY ASSURANCE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
			spent by the division, $10.33 is returned to the economy, which represents a 932.80% ROI. *[Sources: www.floridawages.com and www.bls.gov]*	
Medical Quality Assurance Operations	This program will continue to respond to public records requests; provide health care practitioner information to more than 35,000 callers per month; renew the licenses of more than 1 million facilities and practitioners; plan, coordinate and direct examination development, scheduling, scoring, score reporting, post-examination reviews, and defense of examinations; conduct criminal background checks; update practitioner profiles with disciplinary information; query and report to the National Practitioner Databank.	(c), (e), (g)	The Division of Medical Quality Assurance (MQA) total expenditures for FY09-10 of $63,417,645 divided by the total number of licenses 993,296* equals an average operating cost of $63.85 per license. This continues the three-year decrease in average cost per license ($65.24 for FY08-09, $72.17 for FY07-08). *(*NOTE: This number does not include Drugs, Devices & Cosmetics, which transfers to Department of Business and Professional Regulation in October 2011.)* For an average annual operating cost of $63.85 per license, the earning potential in Florida for health care practitioners and technical occupations, according to the Agency for Workforce Innovation, Labor Market Statistics 2010 Edition, is $55,700. Of the 993,296 licenses, 783,932 licensed health care practitioners have in-state addresses. The potential wages for these licensees to earn are $43,665,012,400. Based upon the U.S. Department of Labor, Bureau of Labor Statistics, December 2010 Consumer Price Index of 1.5%, the total potential economic impact is $654,975,186. Thus, for every $1.00 spent by the division, $10.33 is returned to the economy, which represents a 932.80% ROI. *[Sources: www.floridawages.com and www.bls.gov]* From July 2009 to June 2010 (FY 2009-2010), 6,148 exams were administered. Of these, 5,309 passed the exam, creating the potential to be licensed and earn wages. The earning potential in Florida for health care practitioners	State Trust Fund

RESTRUCTURED DIVISION OF MEDICAL QUALITY ASSURANCE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
			and technical occupations, according to the Agency for Workforce Innovation, Labor Market Statistics 2010 Edition, is $55,700. The potential wages to be earned are $295,711,300. Based upon the U.S. Department of Labor, Bureau of Labor Statistics, December 2010 Consumer Price Index of 1.5%, the total potential economic impact is $4,435,670. Thus, for every $1.00 spent by the testing section, $3.89 is returned to the economy, which represents a 288.72% ROI. *[Sources: www.floridawages.com and www.bls.gov]*	
Physician Workforce Assessment and Development, Community Hospital Education Program (CHEP)	This program will continue to serve as a coordinating body to assess physician workforce, and will provide information to the Physician Workforce Advisory Council to create and maintain strategies to ensure an adequate physician workforce. The CHEP program is an awards-based program, targeting primary care residency programs.	(c), (e)	The program's total expenditures for FY 09-10 were $73,498. This program provides assessment data to determine healthcare workforce needs for medical schools, graduate medical education, rural and socio-economically deprived areas. Every physician employed generates $2.4 million in revenues and payroll. *[Sources: Robert Graham Center at graham-center.org and National Center for Rural Health Works: http://www.okruralhealthworks.org/]*	General Revenue
BUREAU OF ENFORCEMENT				
Consumer Services, Investigative Services, and Compliance Management	This program will continue to analyze complaints and statutorily mandated reports for possible violations of applicable laws and rules; conduct alternative dispute resolutions; investigate allegations of misconduct by licensees; conduct pre-licensure and periodic inspections; monitor compliance with final orders issued in disciplinary proceedings; and coordinate and cooperate with various state and federal law	(e), (g)	An exact monetary ROI cannot be calculated, but enforcement costs result in: • Protection of the public by providing recourse to the consumer when harmed • Remediation of health care practitioners and facilities so they can continue to practice and operate • Removal of health care practitioners and closure of facilities when they cannot practice or operate safely to prevent reoccurrence of harm	State Trust Fund

RESTRUCTURED DIVISION OF MEDICAL QUALITY ASSURANCE: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
	enforcement and prosecutorial agencies to assist in obtaining criminal convictions.			
Prosecution Services	This program will continue to prosecute cases resulting from complaints filed against licensed health care practitioners and facilities; issue emergency suspension and restriction orders to immediately prevent the most dangerous licensees from continuing their practices; enforce subpoenas in circuit court; issue administrative complaints charging violations of applicable state statutes; conduct formal trials and other disciplinary proceedings; defend disciplinary orders that are appealed; and coordinate and cooperate with various state and federal law enforcement and prosecutorial agencies to assist in obtaining criminal convictions.	(e), (g)	An exact monetary ROI cannot be calculated, but prosecution costs result in: • Protection of the public by providing recourse to the consumer when harmed • Remediation of health care practitioners and facilities so they can continue to practice and operate • Removal of health care practitioners and closure of facilities when they cannot practice or operate safely to prevent reoccurrence of harm	State Trust Fund

PROPOSED DIVISION OF PUBLIC HEALTH STATISTICS AND PERFORMANCE MANAGEMENT

The following is a summary of the rationale, relatedness to public health function(s), return on investment, and funding support for the proposed Division of Public Health Statistics and Performance Management. Details on proposed bureaus and programs within this proposed division follow.

Rationale
This proposed division will work to protect and improve the health of the public through the coordination of departmental performance management systems, and the collection and utilization of health information and statistics for monitoring the health of the state's population. Programs will focus on assuring the security and reliability of health information, and will provide this health information to the people of Florida.

The department uses this health information (data) to inform its strategic priorities, and subsequent business and operational planning. Programs will work with all entities throughout the department to coordinate and align local business and operational plans to statewide priorities and organizational planning efforts. In addition, the division will work with department staff to promote management and continuous improvement of all processes to positively impact business and health outcomes at both the programmatic and organizational level. The division will also provide organizational information technology support functions.

Relatedness to Public Health Function(s):
The programs within the proposed Division of Public Health Statistics and Performance Management will support two of the proposed department responsibilities (public health functions):

(c) Collect, manage, and analyze vital statistics and other health data to inform and formulate public health policy and planning.

(e) Provide or assure the provision of quality health and related services to identified populations in the state.

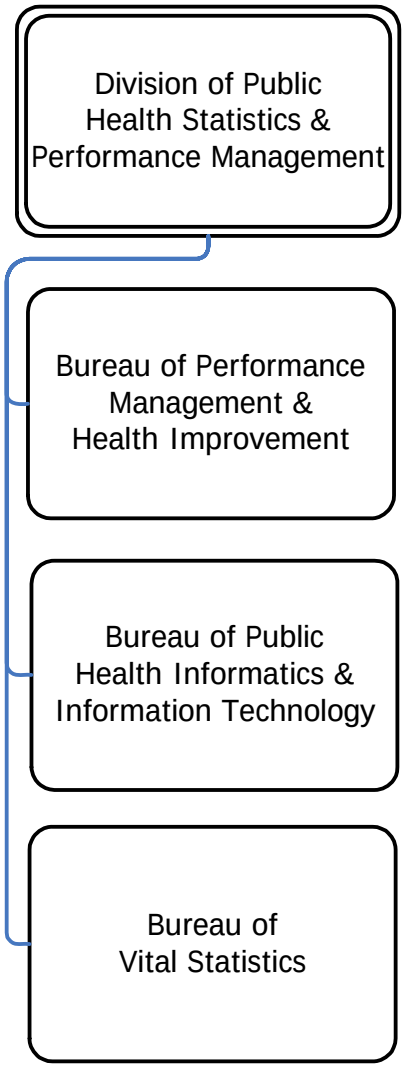
In addition, certain programs within this proposed division will provide support operations and processes for staff to carrying out all of the department's responsibilities (public health functions).

Return on Investment (ROI):
See return on investment provided in the table, "Proposed Division of Public Health Statistics and Performance Management."

Federal Funding Support
Two of the four programs within this proposed division receive federal funding support. Specific funding support is indicated in the table, "Proposed Division of Public Health Statistics and Performance Management."

PROPOSED DIVISION OF PUBLIC HEALTH STATISTICS AND PERFORMANCE MANAGEMENT (CONTINUED)

Proposed Division Structure



PROPOSED DIVISION OF PUBLIC HEALTH STATISTICS & PERFORMANCE MANAGEMENT: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
BUREAU OF PERFORMANCE MANAGEMENT AND HEALTH IMPROVEMENT				
Performance Management and Health Improvement	This program will continue to support departmental performance management systems, including state and community health improvement planning activities, community health assessment, and performance improvement processes; and will ensure that performance indicators are efficiently collected, reported and utilized on a continuous basis to drive performance improvement.	(c), (e)	Community Health Improvement activities supported by this program leveraged $53,000,000 in community resources and grants with the investment of 50 FTE statewide, resulting in approximately $10 gained for every $1.00 spent. *[Source: Florida 2010 Community Health Improvement Survey of County Health Departments; see also NACCHO citation: http://www.naccho.org/topics/modelpractices/database/practice.cfm?practiceID=453]* Automation of health statistics reporting activities has saved over $133,000 annually since 2005. *[Reference: Davis Productivity, Florida Vital Statistics Automation Team Award]* Targeted performance improvement interventions in third-party billing generate an additional $10 million annually resulting in over $100 gained for every $1.00 spent *[Reference: Department of Health, Davis Productivity Award 2008]* The return on investment (ROI) for the department's performance management framework is evidenced at the community (county health department [CHD]) level, both through increased process efficiency and improvement in selected (priority) health outcomes. Ninety percent of Florida's health departments have implemented a formal process to improve performance, as compared to 67% of health departments from 15 other states. Seventy-five percent of health departments completing the survey in 2009 and 2010, indicated implementing one or more quality improvement projects in	General Revenue State Trust Fund Federal Trust Fund

PROPOSED DIVISION OF PUBLIC HEALTH STATISTICS & PERFORMANCE MANAGEMENT: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
BUREAU OF PUBLIC HEALTH INFORMATICS AND INFORMATION TECHNOLOGY				
			the last 12 months. *[Source: Item questions 60 and 61, Items - Multi-State Learning Collaborative Annual Survey 2009 and 2010, State Specific Report #2, Summary Findings for Florida, November 2010, University of Southern Maine.]*	
Public Health Informatics	This program will continue to coordinate and support the county health department health information management activities. This includes the facilitation of clinical content standards and policy; development coordination and end user support of the electronic health record and clinic management information systems; and coordination of health information exchange processes between health departments and other health providers on a statewide basis.	(c)	Improved automation of county health department billing processes has increased revenue collections by an average of 5% annually. *[Source: Department of Health, County Health Department Revenue trend analysis, 2005-2007]* The automated Medicaid billing payment posting process has resulted in annualized savings of $800,000. *[Source: 2007 Analysis of County Health Department FTE Savings]* The adoption of an electronic health record will result in the following efficiencies: An estimated savings of $86,400 per provider over the first 5 years. *[Source: Wang, et al, "A Cost Benefit Analysis of Electronic Medical records in Primary Care", The American Journal of Medicine, April 1, 2003, Volume 114]* Provider electronic entry of clinical documentation increases the accuracy of documentation and reduces workload. Cost and time reductions of up to 70% have been documented. *[Source: Nicholas E. Davies Symposium Proceedings 2001. Award for behavioral health, Heritage Health Center Inc. Healthcare Information and Management Systems Society (HIMSS), Chicago, IL]*	General Revenue State Trust Fund

PROPOSED DIVISION OF PUBLIC HEALTH STATISTICS & PERFORMANCE MANAGEMENT: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Information Technology Business Development, Infrastructure, and Operations	This program will continue to assist divisions and program offices to implement efficient technology-based business solutions, and ensure confidentiality, integrity and availability. This program will also continue to provide enterprise website support services and facilitation of web development, and provide secure, efficient means to move data within the agency, between systems, and between the agency and external entities. Additionally, this program will continue to support the department's public health preparedness effort by providing technical and administrative expertise during emergencies and for continuity of operations.	The programs within this proposed division will provide support operations and processes for staff to carry out all of the department's responsibilities (public health functions).	The department's standard for business development, infrastructure and operations is set at 1% of total agency costs; actual costs are less, at 0.78%. *[Source: Department of Health Long Range Program Plan, 2010-2011]* The impact of information technology on efficiency and effectiveness is evidenced throughout the department's programs. As exhibited in disease surveillance through electronic lab results, electronic receipt and transmission of this data improves both reporting and timeliness, with 4.4 times as many cases, and 7.9 days faster per case. This improvement allows for more rapid response to disease outbreaks. *[Source: Medscape Today, Comparing Completeness and Timeliness of Automated Electronic Lab Reporting, http://www.medscape.com/viewarticle/569969_3.]*	General Revenue State Trust Fund Federal Trust Fund
BUREAU OF VITAL STATISTICS				
Vital Statistics	This program will continue to provide for the timely and accurate registration, certification, amendment, archiving, and statistical analysis of Florida's vital records. These include birth, death, fetal death, marriage, and dissolution of marriage records of the State of Florida.	(c)	Implementation of electronic real-time verification of Social Security numbers of deceased persons in Florida has saved the Social Security Administration (SSA) $3 million dollars a year in overpayments and fraud by providing more timely and accurate death reports allowing SSA to terminate benefits. *[Source: SSA August 2010 Trustees report: 2009-2014 interim estimates of US benefits and administrative costs and SSA December 2009 Florida Statistics: Benefits and Beneficiaries of the month Assumptions.]*	State Trust Fund

RESTRUCTURED DIVISION OF ADMINISTRATION

The following is a summary of the rationale, relatedness to public health function(s), return on investment, and funding support for the restructured Division of Administration. Details on proposed bureaus and programs within this restructured division follow.

Rationale

This restructured division will provide infrastructure support and coordination for the department's administrative functions including budget, procurement, human resources, contracts, finance and accounting, and general services to ensure efficient and effective business processes throughout the organization.

Relatedness to Public Health Function(s)

The majority of programs within this proposed division will provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions). Additionally, the division will specifically support one of the proposed department responsibilities (public health functions):

(c) Collect, manage, and analyze vital statistics and other health data to inform and formulate public health policy and planning

Return on Investment (ROI):

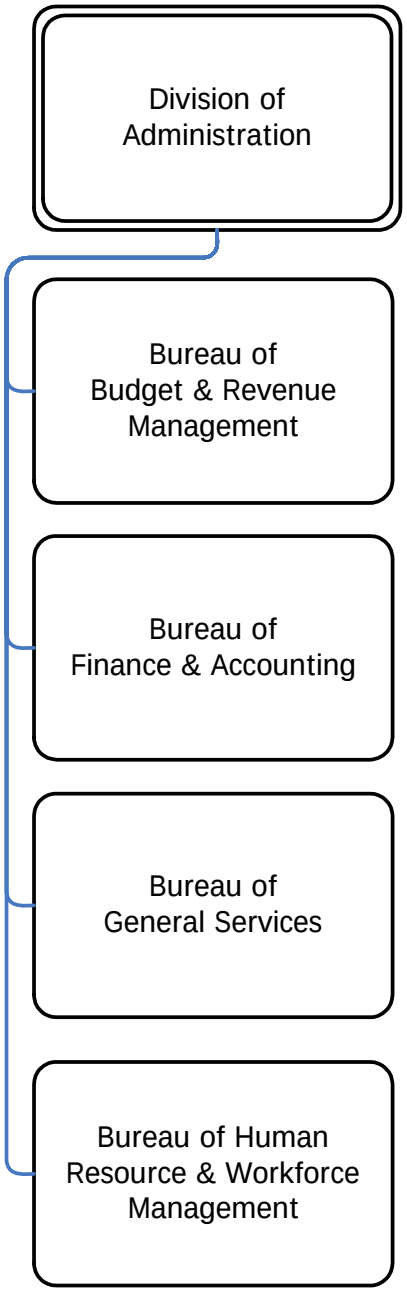
See return on investment provided in the table, "Restructured Division of Administration."

Federal Funding Support

None of the fourteen programs within this proposed division receive federal funding support. Specific funding support is indicated in the table, "Restructured Division of Administration."

RESTRUCTURED DIVISION OF ADMINISTRATION (CONTINUED)

Proposed Division Structure:



PROPOSED DIVISION OF ADMINISTRATION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
DIRECTOR'S OFFICE				
Florida Biomedical Research	This program will continue to support two legislatively created research programs: **James & Esther King Biomedical Research Program** This program will continue to provide grant funding, through a peer-reviewed, competitive process, in order to support research initiatives that address the health care problems of Floridians in the areas of tobacco-related cancers, cardiovascular disease, stroke, and pulmonary disease. **Bankhead-Coley Cancer Research Program:** This program will continue to provide grant funding, through a peer-reviewed, competitive process, to advance progress toward cures for cancer.	(c)	Grants awarded through the James & Esther King Biomedical Research Program between 2001-2008 ($58.7 million in funding) have leveraged an additional $127 million in national grant support. *[Source: James and Esther King Biomedical Research Program Annual Report, 2008 and 2009 www.floridabiomed.com]* Grants awarded through the Bankhead-Coley Cancer Research Program between 2006-2008 ($24.7 million in funding) have leveraged an additional $72.3 million in national grant support. *[Source: Bankhead-Coley Cancer Research Program Annual Report, 2008 and 2009 www.floridabiomed.com]*	General Revenue State Trust Fund
BUREAU OF BUDGET AND REVENUE MANAGEMENT				
Budget	This program will continue to support the legislative budgeting process for the department.	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	This program operates at a cost 50% lower than federal and state term contract rates for similar services. *[Source: MyFloridaMarketPlace]*	State Trust Fund

PROPOSED DIVISION OF ADMINISTRATION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Revenue Management	This program will continue to manage, track, and maximize all federal and non-federal funds appropriated in the department's trust funds.	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	This program operates at a cost 50% lower than federal and state term contract rates for similar services. *[Source: MyFloridaMarketPlace]*	State Trust Fund
BUREAU OF FINANCE AND ACCOUNTING				
Accounting Policies and Systems	This program will continue to provide accounting policies, business management training, financial statements and develop and maintain accounting control systems.	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	This program operates at a cost 70% lower than federal and state term contract rates for similar services. *[Source: MyFloridaMarketPlace]*	State Trust Fund
Contract Administrative Monitoring	This program will continue to manage the Florida Single Audit process; conduct administrative and fiscal monitoring of contracts funded with federal and/or state financial assistance for compliance; and provide financial assistance contracting policy, technical support, and training.	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	This program operates at a cost 54% lower than federal and state term contract rates for similar services. *[Source: MyFloridaMarketPlace]*	State Trust Fund
Disbursements	This program will continue to process and manage accounts payable and distribute warrants.	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	This program operates at a cost 16% lower than federal and state term contract rates for similar services. *[Source: MyFloridaMarketPlace]*	State Trust Fund

PROPOSED DIVISION OF ADMINISTRATION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Purchasing Card Administration & Emergency Support Function 8 Finances	This program will continue to administer the purchasing card (p-card) system; provide p-card policy, technical support and training; monitor p-card compliance and performance; and audit and process p-card payments for central office and 13 county health departments. This program will also continue to manage disaster/ emergency response and recovery expenditures; report to Florida Division of Emergency Management and Federal Emergency Management Agency; and secure reimbursement.	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	This program operates at a cost 25% lower than federal and state term contract rates for similar services. *[Source: MyFloridaMarketPlace]*	State Trust Fund
BUREAU OF GENERAL SERVICES				
Contract Administration	This program will continue to review and execute DOH contracts, amendments and renewals; train and certify all contract managers; and maintain the contract information databases.	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	This program operates at a cost 71% lower than federal and state term contract rates for similar services. *[Source: MyFloridaMarketPlace]*	State Trust Fund
Design and Construction	This program will continue to negotiate contracts for design services and construction management services; provide architectural oversight, and ensure fiscal accountability of fixed capital construction and renovation projects.	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	This program operates at a cost 47% lower than federal and state term contract rates for similar services. *[Source: MyFloridaMarketPlace]*	State Trust Fund

PROPOSED DIVISION OF ADMINISTRATION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Purchasing	This program will continue to direct and control the department's procurement of goods and services through competitive solicitations, direct purchase orders; and ensure diversity in contracting through the minority business program.	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	This program operates at a cost 81% lower than federal and state term contract rates for similar services. *[Source: MyFloridaMarketPlace]*	State Trust Fund
Support Services	This program will continue to direct central office and county health departments leasing activities, agency fleet management, departmental records retention, insurance oversight, forms distribution, facilities management and safety program; serve as the liaison to the Departments of Management Services and Financial Services; develop and implement policies to ensure compliance with state and federal law.	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	This program operates at a cost 59% lower than federal and state term contract rates for similar services. *[Source: MyFloridaMarketPlace]*	State Trust Fund
BUREAU OF HUMAN RESOURCE AND WORKFORCE MANAGEMENT				
Human Resource Management	This program will continue to direct and control human resource activities to ensure employees are placed in appropriate occupations, based on duties and responsibilities; employees injured on the job seek medical treatment and return to work as quickly as medically feasible; and personnel actions are processed according to state and federal laws. This program will also continue to provide assistance to managers	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	The ROI for this bureau is evidenced by the staffing ratios achieved. Research indicates that 1:100 is the most common ratio. Employers with 7,500 or more employees and a broad scope of responsibility, such as that of the bureau, have a staffing ratio of approximately 1:63. The bureau provides direct services to approximately 7,659 department employees in 26 county health departments, 22 Children's Medical Services (CMS) offices, and all central office divisions, as well as technical support to the remaining CHDs. The bureau's staffing ratio is approximately 1:280 employees. This	State Trust Fund

PROPOSED DIVISION OF ADMINISTRATION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
	and employees for recruitment, labor/employee relations, benefit and retirement related issues; and provide technical assistance to CHDs.		efficiency saves thousands of dollars in salaries and benefits. *[Sources: (1) "Staffing the Human Resources Function" by Robin Russell and David Harrop, http://mcgladreypullen.com/Issues/hrstaffing.html). . (2) Society for Human Resource Management (SHRM) Human Capital Benchmarking Study 2008 Executive Summary, http://www.shrm.org/Research/Documents/2008%20Executive%20Summary_FINAL.pdf; (3) Department of Health Internal Impromptu Report]*	
Equal Employment Opportunity (EEO)	This program will continue to take all actions required for the effective direction and administration of equal opportunity policy in accordance with Titles VI and VII of the Civil Rights Act of 1964, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, the Florida Civil Rights Act and other laws, rules and regulations relating to nondiscrimination in employment and service delivery. The program will also continue to provide training, and ensure employment and contracting policies support federal and state mandates; and annually prepare the federally required Affirmative Action Plan.	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	The department is required to file annually an Affirmative Action Plan to receive federal funds. EEO policies and trainings have resulted in positive outcomes. For example, minority hiring from 1998 to 2007 showed a positive trend; in the Senior Management Service category, an increase of minorities from 6.70 % to 24.35%. In addition, in 2007, 48.1% of the department's workforce were minorities, compared to the available minority labor workforce of 33.1%. *[Source: Department of Health's Affirmative Action Plan, 2008]*	State Trust Fund

PROPOSED DIVISION OF ADMINISTRATION: ASSOCIATED PROPOSED BUREAUS AND PROGRAMS

Proposed Program	Rationale	Relatedness to Public Health Function(s)	Return on Investment (ROI)	Funding Support
Workforce Development	This program will ensure the department has a knowledgeable and sustainable workforce to ensure continuity of operations. This program will continue to administer, manage, and provide technical assistance for the department's in-house learning management system (LMS).	Provide administrative functions and support business practices and processes for staff to utilize in carrying out all of the department's responsibilities (public health functions).	Workforce Development's staffing ratio is approximately 1:2,125 employees. Workforce Development provides these services at an average of 29% less than the private sector. *[Source: Florida Department of Management Services 2009/2010 Annual Workforce Report]* ROI for leadership development and succession planning includes an average increase of 5.2% in productivity per employee, and notable decrease in turnover (cost of losing a typical employee is approximately $50,000). *[Source: Consulting Psychology Journal, 2002, "The Return on Investment of Leadership Development: Differentiating our Discipline"]* For every supervisor that takes the mandatory leadership training in-house, cost savings range from a minimum of $195 up to $3,500 per supervisor trained in-house. Among employees who say their [agency] offers poor development opportunities, 41% plan to leave within 12 months (versus only 12% who rate their opportunities as excellent). *[Source: Business Week, 1999]* With over 428 LMS users and 6,738 courses, at an average of one call per week from each user (a conservative estimate), contracting for these services would cost approximately $42,800 monthly vs. $30,388 monthly for this aspect of customer support.	State Trust Fund

RETAINED AND IMPROVED OFFICE OF MINORITY HEALTH

The following is a summary of the rationale, relatedness to public health function(s), return on investment, and funding support for the retained and improved Office of Minority Health.

Rationale:
This retained and improved office will lead the department's efforts to address health disparities and health outcomes by partnering with local communities to reduce the costly impact of health disparities on Florida's health care system; administering the Closing the Gap grants with a focus on sustainable and accountable statewide programs addressing health disparities; and coordinating and providing the cultural and linguistic competency training for the department's workforce, in accordance with the National Standards on Culturally and Linguistically Appropriate Services.

Relatedness to Public Health Function(s):
The activities performed by this office will support three of the proposed DOH responsibilities (public health functions):

(b) Implement interventions that prevent or limit the impact or spread of disease

(c) Inform public health policy, planning and program development in order to promote the health status of people in the state.

(e) Provide or assure the provision of quality health and related services to identified populations in the state

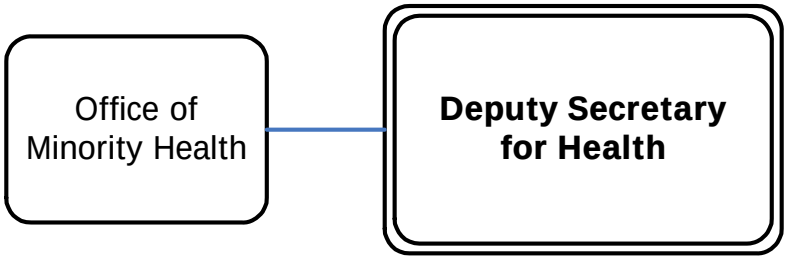
Return on Investment (ROI):
"Cultural Competency should be included as part of the strategic plan and business aspect of health care organizations with hopes of a sustained competitive advantage over organizations that do not recognize the need for such efforts." *[Source: Rose, Patti R., Cultural Competency for Health Administration and Public Health, 2011]*

It is important for the state's public health agency to focus on those populations that have an unequal burden of disease because these efforts can reduce costs associated with unnecessary emergency room visits and increase patient enrollment in Health Maintenance Organizations (HMO), which improves care for underserved populations. *[Source: "Opening Doors Project", Reducing Sociocultural Barriers to Health Care - Robert Wood Johnson Foundation & Henry J. Kaiser Family Foundation, 1997]*

"Quality of care is reliant on an organization's ability to communicate effectively and understand the cultural factors that affect health behavior." *[Source: D. Reynolds, "Improving Care and Interactions with Racially and Ethnically Diverse Populations in Health Care Organizations", Journal of Health Care Management 49 (4), 2004 pp. 237-246]*

Funding Support:
This office receives general revenue and federal funding support.

Proposed Office Structure:



EFFICIENCIES

Through the evaluation and justification review process, the department identified process and infrastructure efficiencies.

This section of the report summarizes the recommended efficiencies by providing:

- Proposed Division (where process or infrastructure efficiencies would be made)
- Recommended Efficiency
- Implementation Schedule
- Staff Reduction
- Annual Reduced Expenditures

The following table will provide this information for each efficiency recommendation.

EFFICIENCY RECOMMENDATIONS

Proposed Division	Recommended Efficiency	Implementation Schedule	Staff Reduction	Annual Reduced Expenditures
Administration	Merge the Bureaus of Revenue Management and Budget Management.	Upon approval of recommendation	**FTE** 2 **OPS** 0 **Contract** 0	$166,059 *(staff salary & benefits)*
Administration	Implement an automated travel voucher system.	Upon approval of recommendation	**FTE** 10 **OPS** 0 **Contract** 0	$450,000 *(staff salary & benefits)*
Administration	Centralize the processing of accounts payable for small county health departments.	Upon approval of recommendation	**FTE** 10 **OPS** 0 **Contract** 0	$450,000 *(staff salary & benefits)*
Administration	Consolidate and centralize human resource services for central office and 67 county health departments.	Upon approval of recommendation	**FTE** 81 **OPS** 0 **Contract** 0	$3,827,250 *(staff salary & benefits)*

EFFICIENCY RECOMMENDATIONS

Proposed Division	Recommended Efficiency	Implementation Schedule	Staff Reduction	Annual Reduced Expenditures
Children's Medical Services (CMS)	Merge the Divisions of CMS Network and CMS Prevention and Intervention into a single Division of Children's Medical Services. The reduced expenditures reflect the elimination of a deputy secretary, a division director, and three staff.	Upon approval of recommendation	**FTE** 5 **OPS** 0 **Contract** 0	$501,555 *(staff salary & benefits)*
Children's Medical Services	Reduce staffing due to efficiency gained in automating claims processing functions. *(Year 1 Implementation)*	July 1, 2011 – June 30, 2012	**FTE** 7.5 **OPS** 7.5 **Contract** 0	$900,000 *(staff salary & benefits)*
Children's Medical Services	Reduce staffing due to efficiency gained in automating claims processing functions. *(Year 2 Implementation)*	July 1, 2012 – June 30, 2013	**FTE** 7.5 **OPS** 7.5 **Contract** 0	$900,000 *(staff salary & benefits)*
Community Health Services	Reduce administrative support for the restructured division.	Upon approval of recommendation	**FTE** 6.5 **OPS** 0 **Contract** 0	$267,091 *(staff salary & benefits)*

EFFICIENCY RECOMMENDATIONS

Proposed Division Name	Recommended Efficiency	Implementation Schedule	Staff Reduction	Annual Reduced Expenditures
Community Health Services	Consolidate the administrative structure that supports the Child Care Food Programs and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).	Upon approval of recommendation	**FTE** 2 **OPS** 0 **Contract** 0	$0* **Federal funds for these positions must be utilized in the program, and will be redirected for other program activities.*
Disease Control and Prevention	Merge bureaus within the existing Division of Disease Control, thereby eliminating a bureau chief position from epidemiology.	Upon approval of recommendation	**FTE** 1 **OPS** 0 **Contract** 0	$108,000 *(staff salary & benefits)*
Disease Control and Prevention	Reduce staffing in the HIV/AIDS Program based on proposed restructure.	Upon approval of recommendation	**FTE** 8 **OPS** 0 **Contract** 0	$388,800 *(staff salary & benefits)*
Disease Control and Prevention	Modify the administrative infrastructure that supports the Sexually Transmitted Disease Program, and reduce outreach activities.	Upon approval of recommendation	**FTE** 8 **OPS** 1 **Contract** 0	$298,903 *(staff salary & benefits)*

EFFICIENCY RECOMMENDATIONS

Proposed Division	Recommended Efficiency	Implementation Schedule	Staff Reduction	Annual Reduced Expenditures
Disease Control and Prevention	Downsize and relocate specialized in-patient tuberculosis (TB) services at A.G. Holley State Hospital.	Upon approval of recommendation	**FTE** 155 **OPS** 0 **Contract** 3	$6,312,656* *(staff salary & benefits)* **Depending upon the plan approved by the Legislature, adequate funds will be required to provide TB services.*
Medical Quality Assurance	Consolidate the Emergency Medical Technician (EMT) / Paramedic / Radiology Technologist Office into the Board of Pharmacy Office, thereby eliminating an executive director position.	December 1, 2011 – June 30, 2012	**FTE** 1 **OPS** 0 **Contract** 0	$55,972 *(staff salary & benefits)*
Medical Quality Assurance	Merge the Bureau of Management Services and the Bureau of Operations, thereby eliminating a bureau chief position.	Upon approval of recommendation	**FTE** 1 **OPS** 0 **Contract** 0	$71,439 *(staff salary & benefits)*
Minority Health	Reduce requested funding for Closing the Gap grants.	Upon approval of recommendation	**FTE** 0 **OPS** 0 **Contract** 0	$132,617 *(contracted services)*

EFFICIENCY RECOMMENDATIONS

Proposed Division	Recommended Efficiency	Implementation Schedule	Staff Reduction	Annual Reduced Expenditures
Officer of Women's Health Strategy	Eliminate the Officer of Women's Health Strategy designation, thereby eliminating one support staff position.	Upon approval of recommendation	**FTE** 1 **OPS** 0 **Contract** 0	$62,221 *(staff salary & benefits)*
Preparedness & Response	Reduce administrative support for the division as a result of proposed restructure. *(Year 1 Implementation)*	July 1, 2011 – June 30, 2012	**FTE** 2 **OPS** 2.25 **Contract** 4	$486,417 *(staff salary & benefits)*
Preparedness & Response	Reduce administrative support for the division as a result of proposed restructuring. *(Year 2 Implementation)*	July 1, 2012 – June 30, 2013	**FTE** 5 **OPS** 1.1 **Contract** 2	$697,925 *(staff salary & benefits)*

IV. CONCLUSION

The evaluation and justification review revealed many opportunities for improvement; however, two are fundamental: first, the department must establish a clear mission; and secondly, the department must establish – then cultivate – a culture of accountability and performance excellence.

Mission clarity is essential to the department's ability to determine its priorities and efficiently and effectively distribute the state's limited resources. Even more importantly, the effective distribution of resources and their impact on the health of people in Florida is directly linked to the state's prosperity.

Organizational accountability requires more than a legislative directive. Department leadership at all levels must be held accountable for improved business results in order to positively impact the health status of people in Florida. Increasing organizational efficiency through elimination of duplicative programs and activities is only a first step; reducing and restructuring the department is of little benefit without equal effort in better management coordination and standardization of the department's internal processes.

Process improvement is where organizational efficiency is gained. To improve internal process efficiency, the state's control systems – e.g., PeopleFirst, FLAIR (Florida Accounting Information System), (FIRS) Financial Information Resource System – must keep pace, providing the department with accurate data, to set realistic improvement targets. The review revealed numerous department process inefficiencies; these are identified for immediate improvement.

The organizational structure of the department impacts its efficiency, effectiveness, and capability to meet its goals and objectives. The department's legislatively-required Long Range Program Plan (LRPP) that outlines the major (health related) goals and objectives will be revised if the department's proposed recommendations for reduction and restructure are implemented. In addition, the results of a concurrent review of all central office program staff geographically located outside Tallahassee will be analyzed to determine the efficacy of their placement. This assessment will require additional information from local (CHD) health officers and staff.

Given the complexity of the health needs of Florida, the department must strategically identify the state's health priorities and resource those with the highest potential for improving the health status of the state. These priorities should be informed through analysis of the (collective) results from local health improvement plans. Improvement in health priorities depends, in part, on the department's capability to formulate, align and communicate effective strategies.

Leaders at all levels are responsible for organizational effectiveness and culture change. Changing employees' attitudes, behaviors and beliefs is the first step to achieving culture change. Leaders must set the example. Implementation of budget-based performance measures and establishment of a management planning cycle with regular progress reviews will create accountability necessary to incentivize the workforce. The success of the department's transformation will be reflected in the pride of the employees and the quality of their work product. Tracking and communicating the department's resulting gains in efficiency and organizational effectiveness will provide the department momentum to continuously improve.

SUMMARY OF RECOMMENDED DEPARTMENT REDUCTIONS AND RESTRUCTURE

Ch. 2010-161, § 34, Laws of Florida, requires the department to reduce and restructure through identification of efficiencies and discontinuation of programs, activities, and associated resources.

As this law does not define “discontinuation,” the department defined it as, “an evaluation conclusion that characterizes the suitability of each program or activity for transfer, outsource, privatization or elimination.”

The reductions in this report:

- Reduce or eliminate the department’s focus on a service, program or activity by transferring it to another state agency.
- Increase opportunities for other public and private entities to provide a service, program or activity based on the state and/or local communities’ needs by outsourcing or privatizing the delivery of the service, program or activity.
- Eliminate state government’s involvement in a service, program or activity.

These recommended reductions result in several changes: (1) a reduction in the department’s overall budget; (2) a reduction in the number of central office staff; and (3) a restructured Department of Health as a result of reducing the number of services, programs and activities provided directly by the Department of Health’s central office.

The department’s total proposed reductions of funding and staff reflect results of implementing all recommended discontinuations and proposed process efficiencies. Staff and positions proposed for discontinuation include those reporting to a central office division, program or activity; not all are geographically located in Tallahassee. Three tables summarize the department’s reductions.

Table 1: Department Reduction by Funding Type
This table summarizes the funding related to the recommended actions in this report by five sub-categories to be transferred, outsourced, privatized, eliminated or improved efficiency.

Table 2: Department Reduction of Staff
This table summarizes the number of staff (FTE, OPS and Contract) related to the recommended actions in this report that will be transferred or eliminated due to outsourcing, privatizing, and eliminating services, programs or activities as well as recommended efficiencies.

Table 3: Department Restructure
This table summarizes the structural changes made in the recommended restructure of the department.

TABLE 1: Department Reduction by Funding Type ($)

Funding Type	Reduction through Transfer *(Funds to Another State Government Entity)*	Reduction through Outsource *(Funds to Contracted Services)*	Reduction through Privatization	Reduction Through Elimination	Reduction through Efficiencies	TOTAL Funding Impact
State General Revenue	$15,091,459	$20,367,721	$0	$37,023,281	N/A	**$72,482,461**
Tobacco Settlement Trust Fund	$0	$0	$0	$0	N/A	**$0**
State Trust Fund	$41,775,324	$15,087,760	$1,123,706	$5,093,570	N/A	**$63,080,360**
Federal Trust Fund*	$26,066,911	$6,628,985	$0	$1,499,515	N/A	**$34,195,411**
Multiple Funding Types	N/A	N/A	N/A	N/A	$16,076,905	**$16,076,905**
TOTAL	**$82,933,694**	**$42,084,466**	**$1,123,706**	**$43,616,366**	**$16,076,905**	**$185,835,137**

Federal Trust – assumes termination of grants and associated funding no later than June 30, 2012.

TABLE 2: Department Reduction of Staff (#)

Staff Category	Reduction through Transfer *(Staff to Another State Government Entity)*	Reduction through Outsource	Reduction through Privatization	Reduction through Elimination	Reduction through Efficiencies	TOTAL Staff Reduction
FTE	124.5	723	14	36	313.5	**1211**
OPS	37	277	0	1.5	19.35	**334.85**
Contract	18.5	31	0	4	9	**62.5**
TOTAL	**180**	**1031**	**14**	**41.5**	**341.85**	**1608.35**

TABLE 3: Department Restructure

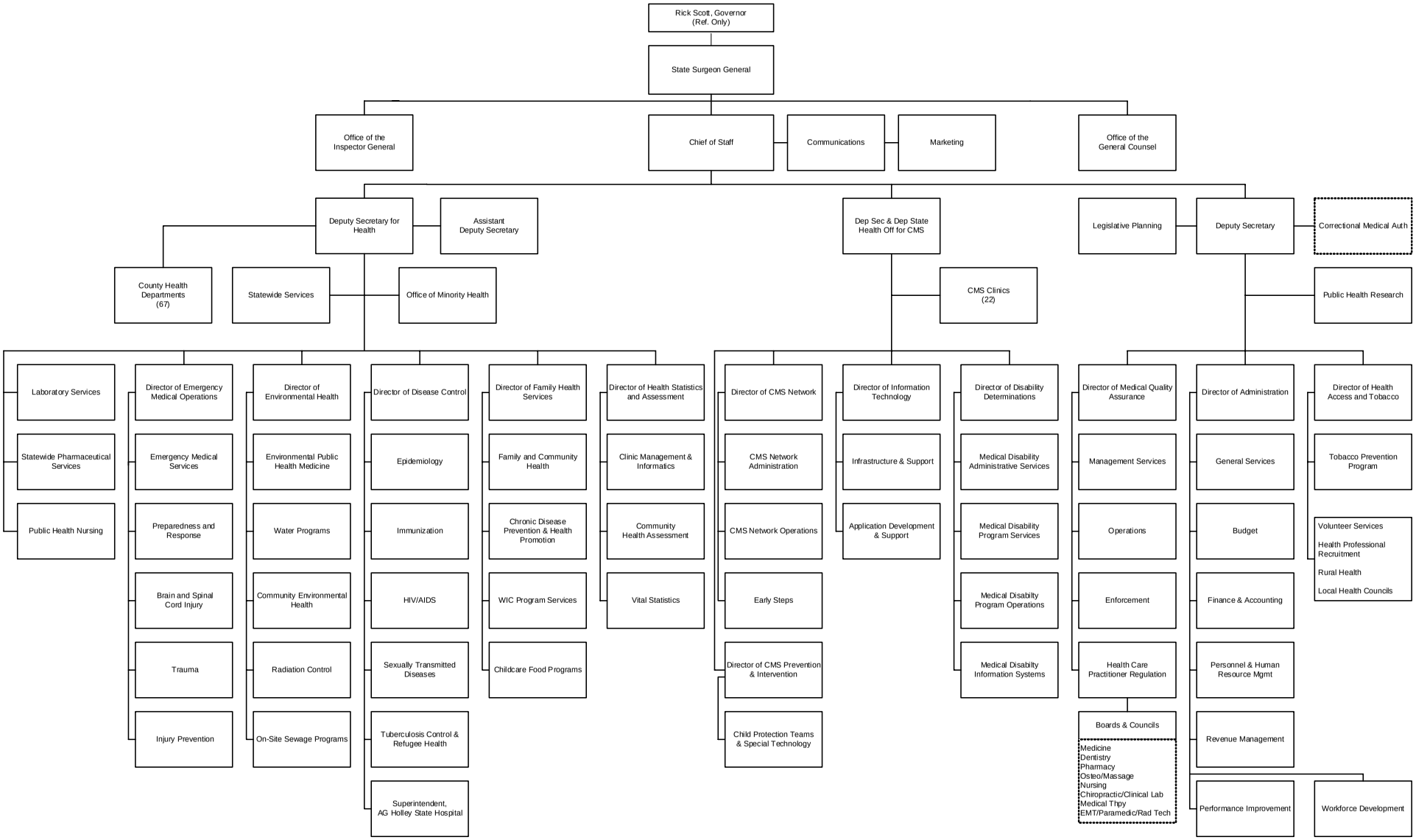
Category	Current	Recommended	Net Reduction
Deputy Secretaries	3	2	**1**
Divisions	11	6	**5**
Bureaus	50	18	**32**
Stand-Alone Bureaus	2	0	**2**
Stand-Alone Offices	11	5	**6**

V. APPENDICES

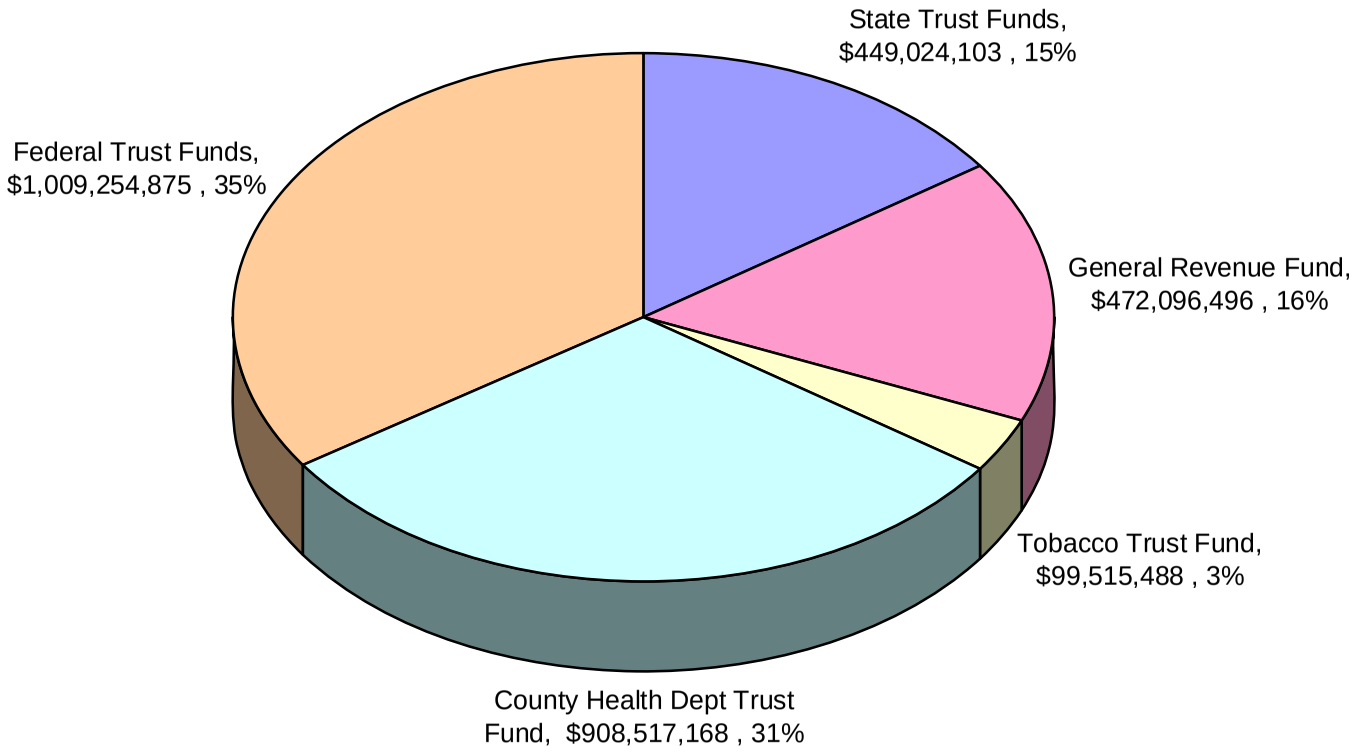
1. *Current Department of Health Table of Organization*
2. *Current Department of Health Appropriation by Fund Source FY 2010-2011*
3. *Chapter 2010-161 § 34, Laws of Florida, Review and Report Requirements*
4. *Evaluation & Justification Review Planning Milestones*
5. *Evaluation & Justification Review Implementation Plan*
6. *Assessment Tool*
7. *External Stakeholders Meeting Agenda*
8. *External Stakeholders Meeting Invitee List*
9. *External Stakeholders Meeting Notes*
10. *Procedures for Assisting Affected Employees*

State of Florida
Department of Health

MARCH 1, 2011



Department of Health Appropriation by Fund Source FY 2010-2011 $2,938,408,130



CHAPTER 2010-161 § 34, LAWS OF FLORIDA REQUIREMENTS

EVALUATION AND JUSTIFICATION REVIEW	REPORT
Identifiable cost of each division and programs within the division	**Evaluation and justification review findings and recommendations** *Review should recommend the reduction and restructuring of department bureaus and divisions.*
Specific purpose of each division and programs within the division, **AND** **Specific public health benefit** derived therefrom	
Progress toward achieving the outputs and outcomes associated with each division and programs within the division	**For DIVISIONS and BUREAUS recommended for the department to RETAIN AND IMPROVE:**
Explanation of circumstances contributing to the department's ability to achieve, not achieve, or exceed its projected outputs and outcomes, as defined in s. 216.011, F.S., associated with each division and programs within the division	▪ **Rationale** for each department division and programs within the division
	▪ **Return on investment** of each division and programs within the division
Alternate courses of action that would result in administration of the same program in a more efficient or effective manner. **Courses of action** to be considered **must include,** but are **not limited to:** ▪ Whether each division's **mission, goals, or objectives should be redefined** ▪ Whether the division or programs within the division **could be administered more efficiently or effectively** to: → avoid duplication of activities, and → ensure that activities are adequately coordinated ▪ Whether the division and programs within the division could be performed **more efficiently or more effectively by another unit of government or a private entity** ▪ When compared to costs, **whether effectiveness warrants elimination** of the division or programs within the division or, if the division or a program within the division serves a limited interest, whether the division or program should be redesigned to **require users to finance program costs** ▪ Whether the **cost to administer** the division or program within the division **exceeds license and other fee revenues** paid by those being regulated ▪ Whether **other changes could improve the efficiency and effectiveness** of the division or programs within the division.	▪ **Relatedness** of the division and programs within the division **to a public health function**
	▪ **Any federal funding support** for each division and programs within the division
	For DIVISIONS AND PROGRAMS recommended for the department to DISCONTINUE (TRANSFER, OUTSOURCE, PRIVATIZE and ELIMINATE):
	▪ Description of **alternatives to implement** such recommendation
	▪ **Implementation schedule** for discontinuation
	▪ Recommended **procedures for assisting state agency employees** affected by the discontinuation
Consequences of discontinuing such division or programs within the division	
Whether **current performance measures and standards should be reviewed or amended** to assist department efforts in achieving outputs and outcome measures	
Whether the **information reported as part of the state's performance-based budgeting system has relevance and utility for the evaluation** of each division and programs within the division	
Whether department management has **established control systems sufficient to ensure that performance data** are maintained and supported by department records and accurately presented in department performance reports	

Evaluation & Justification Review
Planning Milestones
July 2010 – March 2011

Month	Milestone	Product(s)
July	Examine evaluation and justification review requirements per HB 5311, Section 34	• Planning workgroup & charter • Communication plan • Strategies for implementation
	Develop strategies to complete evaluation and justification review requirements	• Legislative implementation plan • Executive guidance • Inventory assessment tool
August - October	Inventory department programs	• Required data • Legislative input for additional data
	Analyze results	• Additional required data • Preliminary assumptions
	Obtain internal stakeholder input	• Guiding principles • Clarified mission • Revised responsibilities • Input from internal stakeholders
November	Obtain external review panel input	• Input from external subject matter experts
December	Obtain Transition Team feedback	• Feedback from Transition Team
January - February	Final draft report on evaluation and justification review findings and recommendations	• Input from the Governor's office • Input from new executive management team • Finalized findings & recommendations • Written report
March 1	Submit final report to designated legislative staff and Governor	• Legislative directive met

EVALUATION AND JUSTIFICATION REVIEW IMPLEMENTATION PLAN

BILL NUMBER:	**HB 5311, Section 34**	**LEAD:**	**State Surgeon General**
BILL SUBJECT:	**Department of Health Evaluation and Justification Review**	**KEY COORDINATORS:**	**Senior Staff Planning Workgroup**

LEGISLATIVE DIRECTIVE:

The Department of Health shall conduct an evaluation and justification review of each division established under section 20.43, F.S.

No later than March 1, 2011, the department shall submit a report on its evaluation and justification review findings and recommendations to the President of the Senate, the Speaker of the House of Representatives, the chairs of the appropriate substantive committees, the chairs of the appropriations committees, the Legislative Auditing Committee, the Governor, and the State Surgeon General.

DOH MAJOR ACTION STEPS TO IMPLEMENT DIRECTIVE	ACTION STEP DUE DATE	RESPONSIBILITY	COORDINATION WITH	STATUS/RESULTS
Identify internal (staff) planning workgroup members & establish purpose (charter)	**August 1, 2010**	**State Surgeon General**	**Executive Management**	**COMPLETE** Other staff with specific expertise and skill in systems design, planning, facilitation, data analysis and quality/performance improvement will be assigned to support the workgroup Planning considerations include: ▪ Assumption that transition will impact DOH leadership and potentially impact ability to meet the directive

EVALUATION AND JUSTIFICATION REVIEW IMPLEMENTATION PLAN

DOH MAJOR ACTION STEPS TO IMPLEMENT DIRECTIVE	ACTION STEP DUE DATE	RESPONSIBILITY	COORDINATION WITH	STATUS/RESULTS
Identify overall strategy, planning considerations, action plan objectives, development of novel work processes, major work products & key milestones, including the necessary timeline to successfully meet deliverable report to the Legislature	**August 1, 2010**	**Internal Planning Workgroup**	**Executive Management**	**COMPLETE** Planning considerations include: • Key internal and external stakeholder input needed for valid and comprehensive review • Identify needed internal expertise for development of tools and processes for evaluation
Identify internal communication strategies & methods for conducting the review process: staff workgroups, discussion forums, etc.	**August 31, 2010**	**Internal Planning Workgroup**	**Executive Management**	**COMPLETE** Planning considerations include: • Importance of key staff involvement in the process of review • Internal process transparency and communication important for valid results and accountability in planning for organizational improvements

EVALUATION AND JUSTIFICATION REVIEW IMPLEMENTATION PLAN

DOH MAJOR ACTION STEPS TO IMPLEMENT DIRECTIVE	ACTION STEP DUE DATE	RESPONSIBILITY	COORDINATION WITH	STATUS/RESULTS
Develop & deploy assessment tools, including tool to document a comprehensive inventory of DOH divisions and programs	**August 31, 2010**	**Internal Planning Workgroup**	**DOH divisions, and programs**	**COMPLETE** Planning considerations include: • Develop a standardized tool to collect data as directed in the bill • Review and analyze the data; determine need for additional information
Divisions & programs complete comprehensive assessment	**September 14, 2010**	**Internal Planning Workgroup**	**DOH divisions, and programs**	**COMPLETE** Planning considerations include: • Timeliness of response and accuracy of data • Key internal staff to analyze and clarify information provided in the assessment tool
Plan, coordinate & complete a series of internally facilitated DOH staff workshops to review and discuss results of assessment	**September & October, 2010**	**Internal Planning Workgroup**	**DOH divisions, programs and county health departments**	**COMPLETE** Planning considerations include: • Time necessary to analyze results of workshops and follow up with key staff to clarify information as necessary

EVALUATION AND JUSTIFICATION REVIEW IMPLEMENTATION PLAN

DOH MAJOR ACTION STEPS TO IMPLEMENT DIRECTIVE	ACTION STEP DUE DATE	RESPONSIBILITY	COORDINATION WITH	STATUS/RESULTS
Identify input needed from external subject matter experts including key House & Senate legislative staff	**October 30, 2010**	**Internal Planning Workgroup**	**Executive Management** **Legislative staff**	**COMPLETE** Planning considerations include: • External input necessary to further inform review process and results
Identify potential external review panel members	**November 15, 2010**	**Internal Planning Workgroup**	**Executive Management**	**COMPLETE** Planning considerations include: • All potential external review panel members subject to review and approval of DOH executive management and legislative staff prior to invitation

EVALUATION AND JUSTIFICATION REVIEW IMPLEMENTATION PLAN

DOH MAJOR ACTION STEPS TO IMPLEMENT DIRECTIVE	ACTION STEP DUE DATE	RESPONSIBILITY	COORDINATION WITH	STATUS/RESULTS
Plan, coordinate & complete an internally facilitated meeting of external subject matter (public health and organizational management) experts to provide input into evaluation and justification review process and results	**November 15, 2010**	**Internal Planning Workgroup**	**Executive Management**	**COMPLETE** Planning considerations include: • Important for DOH to provide an opportunity for public and subject matter experts to give input • Important for DOH staff to observe proceeding-not to bias external expert input – meeting is a time for experts to hear from each; ask technical questions and provide input
Executive management review of the format & agenda of the external expert panel member meeting and revise as necessary	**November 15, 2010**	**Executive Management**	**Internal Planning Workgroup**	**COMPLETE** Planning considerations include: • DOH executive management should attend meeting

EVALUATION AND JUSTIFICATION REVIEW IMPLEMENTATION PLAN

DOH MAJOR ACTION STEPS TO IMPLEMENT DIRECTIVE	ACTION STEP DUE DATE	RESPONSIBILITY	COORDINATION WITH	STATUS/RESULTS
Convene external review panel	**November 19, 2010**	**State Surgeon General** **Internal Planning Workgroup**	**External Review Panel**	**COMPLETE** Planning considerations include: • Detailed meeting logistics in consideration of panel member's contribution of their time and expertise • House and Senate legislative staff invited to attend
Review results of external input	**November 30, 2010**	**Internal Planning Workgroup**	**Executive Management**	**COMPLETE** Planning considerations include: • Meeting notes taken and provided to attendees • Use results to inform review

EVALUATION AND JUSTIFICATION REVIEW IMPLEMENTATION PLAN

DOH MAJOR ACTION STEPS TO IMPLEMENT DIRECTIVE	ACTION STEP DUE DATE	RESPONSIBILITY	COORDINATION WITH	STATUS/RESULTS
Address issues that may impact process resulting from (possible) transition of DOH executive management **Continue feedback process**	**December 20, 2010**	**Internal Planning Workgroup** **Executive Management**	**DOH Senior Leaders**	**COMPLETE** Planning considerations include: • Planning for the evaluation and justification review process, results and products should consider (and overcome) any barriers to completion • Continuous verification and validation of proposed actions • Transition Team feedback
Identify preliminary proposed Actions **Notify EOG of preliminary review results; seek additional input and guidance**	**January 14, 2011**	**(New) Executive Management**	**EOG**	**COMPLETE** Planning considerations include: • EOG input

EVALUATION AND JUSTIFICATION REVIEW IMPLEMENTATION PLAN

DOH MAJOR ACTION STEPS TO IMPLEMENT DIRECTIVE	ACTION STEP DUE DATE	RESPONSIBILITY	COORDINATION WITH	STATUS/RESULTS
Continue input process & validate decisions on proposed actions	**February 9, 2011**	**Internal Planning Workgroup**	**Executive Management**	**COMPLETE** Planning considerations include: • Highly detailed work plan developed to ensure timeliness of final report • County Health Department Input • DOH General Counsel input
Revise/approve proposed actions	**February 15, 2011**	**Executive Management**	**General Counsel**	**COMPLETE** Planning considerations include: • EOG input • DOH Legal Review
Draft proposed actions into a report	**February 18, 2011**	**Executive Management**	**EOG**	**COMPLETE**
Submit Department of Health final report on findings and recommendations as appropriate	**March 1, 2011**	**Executive Management**		**COMPLETE**

Assessment Tool

Section I			
Division			
Program			
Description (Purpose)			
Updated: Description (1 - 2 Sentences)			
Statutory Authority			
Total Expenditures *(FY 09-10)*		**General Revenue**	
Program Component		**Tobacco**	
Match/MOE		**State Trust Fund**	
CHD Schedule C		**Federal Trust Fund**	
Number of Staff	**FTE**		
	OPS		
	Contract		
Match Amount ($)			
Match Requirement		**Match Penalty**	
MOE Amount ($)			
MOE Requirement		**MOE Penalty**	

Section II					
Long Range Program Plan (LRPP) Exhibits II and III *(Fiscal Year - July 2008 - June 2009)*				**Performance Trend**	
Outcome Measure(s)	**Approved Standard (Target)**	**Current Performance**	**Explanation** *(Internal or External Factors)*	**Performance Trend** *(Better, Worse, or No Trend)*	**Performance Trend Data Source**

Output Measure(s)	**Approved Standard (Target)**	**Current Performance**	**Explanation** *(Internal or External Factors)*	**Performance Trend** *(Better, Worse, or No Trend)*	**Performance Trend Data Source**

Section III			
DOH Responsibility			
Public Health Function (*Indicate **all** that apply)*	**Ten Essential Public Health Services**	**Select all that Apply (X)**	
	Monitor health status		
	Diagnose and investigate		
	Inform, educate, and empower		
	Mobilize community partnerships		
	Develop policies and plans		
	Enforce laws and regulations		
	Link people to needed services / assure care		
	Assure a competent workforce		
	Evaluate health services		
	Research		
	Not Applicable		

Assessment Tool

Program Activities that Benefit the Public	Activity	Quantity (# provided)	Activity Benefit(s)	Return on Investment (Cost Avoidance) or Cost-Effectiveness Measure	Evidence / Research Supporting Return on Investment or Cost Effectiveness Measure

Regularly Reported Measures	Standard (Target)	Current Performance	Explanation *(Internal or External Factors; Select from Drop-down List)*	Performance Trend *(Better, Worse, or No Trend)*	Performance Trend Data Source

AGENDA
External Stakeholders Meeting
November 19, 2010

Capital Circle Office Complex
Building 4052, Room 301
4052 Bald Cypress Way
Tallahassee, Florida

Purpose

Further inform the department's Evaluation and Justification Review planning process through external subject matter input

Time	Topic	Lead
10:00 a.m.	Welcome	Dr. Dennis Cookro, Medical Advisor
10:05 a.m.	Opening Remarks and Introductions	Dr. Ana Viamonte Ros, State Surgeon General
10:30 a.m.	Presentation: Moving to the Future	Bill Little, Administrator Sarasota County Health Department
11:00 a.m.	Panel Member Discussion	Dr. Dennis Cookro
12:00 p.m.	Lunch	
12:30 p.m.	Panel Member Discussion, Continued	Dr. Dennis Cookro
2:45 p.m.	Next Steps	Dr. Dennis Cookro
3:00 p.m.	Adjourn	

EXTERNAL STAKEHOLDERS MEETING
NOVEMBER 19, 2010
INVITEE LIST

Name	Affiliation	Subject Matter Expertise	Attendance
Barbara MacArthur	Chief Nursing Officer, Tallahassee Memorial Hospital	Health	***Attended***
Dr. Alicestine Ashford	Florida A & M University, Institute of Public Health	Public Health Leadership	***Attended***
Dr. Bruce McIntosh	First Coast Child Protection Team	Child Abuse	***Attended***
Dr. David Fairbanks	Deputy Secretary, Department of Children and Families (DCF)	State Government	***Attended***
Dr. Donna J. Petersen	Dean, College of Public Health, University of South Florida	Public Health Leadership	***Attended***
Dr. James T. Howell	Board Member, Florida Public Health Institute Chair, Department of Rural Medicine and Professor of Public Health Nova Southeastern University College of Osteopathic Medicine	Public Health Leadership	***Attended***
Dr. John Curran	Associate Vice President for Academic and Faculty Affairs, University of South Florida (USF) Health Senior Executive Associate Dean, USF College of Medicine	Academic Medicine	***Attended***

EXTERNAL STAKEHOLDERS MEETING
NOVEMBER 19, 2010
INVITEE LIST

Name	Affiliation	Subject Matter Expertise	Attendance
Dr. Les Beitsch	Florida State University College of Medicine	Public Health Accreditation	***Attended***
Dr. Lisa Cosgrove	President, Florida Pediatric Society	Community-based Pediatrics	***Attended***
Dr. Patricia J. Blanco University Pediatrics	Pediatrics	Community-based Pediatrics	***Attended***
Dr. Perry Brown	FAMU Institute of Public Health	Public Health Leadership	***Attended***
Dr. Robert G. Brooks	University of South Florida College of Medicine	Public Health Leadership	***Attended***
Edward A. Feaver	Health Care Advisory Council Member, Florida Public Interest Research Group (PIRG)	Child Welfare	***Attended***
Elizabeth Dudek	Interim Secretary, Agency for Health Care Administration (AHCA)	State Government	***Attended***

EXTERNAL STAKEHOLDERS MEETING
NOVEMBER 19, 2010
INVITEE LIST

Name	Affiliation	Subject Matter Expertise	Attendance
Rick G. Hunter, Ph.D.	Former Deputy State Health Officer, Florida Department of Health Board Member, Florida Public Health Institute President/CEO, Present Food Technology Service, Inc.	Environmental Health	***Attended***
Samuel P. Bell III	President, Florida Public Health Foundation Vice Board Chair, Florida Public Health Institute	Public Health Advocate	***Attended***
Sandy Magyar	Executive Director, Florida Public Health Association	Public Health Leadership	***Attended***
Amanda Prater	Legislative Staff Florida House of Representatives, House Health and Human Services Committee	State Government	***Attended***
Leah Holt	Legislative Staff Florida House of Representatives House Health and Human Services Committee	State Government	***Attended***
Mandy O'Callaghan	Legislative Staff Florida Senate Senior Attorney Senate Health Regulation Committee	State Government	***Attended***

EXTERNAL STAKEHOLDERS MEETING
NOVEMBER 19, 2010
INVITEE LIST

Name	Title	Subject Matter Expertise	Contact Information
Allan G. Bense	Vice-Chair Enterprise Florida, Inc. Partner Former State Representative	Business	***Did not attend***
Colleen Castille	Former Secretary, Florida Department of Environmental Protection Managing Partner, Go Green Strategies (Castille, DeFoor & Armstrong)	Environmental Health	***Did not attend***
David Lawrence, Jr.	President and Co-chair, The Children's Movement of Florida	Early Childhood	***Did not attend***
Diana Ragbeer	Director of Public Policy and Communications	Community Activities Child Insurance	***Did not attend***
Dr. Alfreda Blackshear	Pediatrician	Community-based Pediatrics	***Did not attend***
Dr. Cynthia Harris	Director of the Institute of Public Health and Associate Professor, Florida A & M University	Public Health Leadership	***Did not attend***
George H. Sheldon	Secretary, Department of Children and Families (DCF)	State Government	***Did not attend***

EXTERNAL STAKEHOLDERS MEETING
NOVEMBER 19, 2010
INVITEE LIST

Name	Title	Subject Matter Expertise	Contact Information
Paul Belcher	Senior Vice President, Florida Hospital Association	Chair, DOH 1996 Transition Team	***Did not attend***
J. Eric Pridgeon	Legislative Staff	State Government	***Did not attend***
D. Brian Clark	Legislative Staff	State Government	***Did not attend***

EXTERNAL STAKEHOLDERS MEETING
NOVEMBER 19, 2010
DISCUSSION NOTES

DEPARTMENT OF HEALTH / DEPARTMENT OF PUBLIC HEALTH DISCUSSION

- Historically, the logic of being a Department of Health was that there would be an elevation of the importance of the role of health as opposed to being part of an umbrella agency; and to provide a "home" for health professionals
- Cost of changing name – changing perception; expense not worthwhile and changing the names is not what is needed
- The more expansive term "health" is more fitting for a state agency

GUIDING PRINCIPLES

What principles should guide our vision for a future department of health?

- Use a public health version of Hippocratic oath when determining how to organize – limit risks to population; do no harm
- Align to 10 Essential Public Health Services (EPHS)
- Preserve state-county relationship at local level
- Identify at what level the decisions are being made or can be made
- Conduct gap analysis regarding needs and core functions and agency roles
- Driven by data and input from community
- Ensure scale and scope match – funding and scale should be reflected to include 40 M people—Florida is a highly visited state that means potential for public health impacts beyond the resident population
- Evaluate effectiveness of services
- Create policy driven by data; the data comes from research but must also have customer feedback
- Keep the local workforce. Having a workforce at every level throughout the 67 counties is a benefit. Most businesses would rather work with local person rather than someone from "Tallahassee" or anther part of the state.
- Create better networking / partnerships
- Work with other state agencies to perform functions
- Need to clearly delineate agency roles to prevent duplication
    - Agency for Health Care Administration (AHCA)
    - Department of Children and Families (DCF)
    - Department of Health (DOH)
    - Department of Elder Affairs (DOEA)
    - Department of Agriculture and Consumer Services (DOACS)
    - Department of Environmental Protection (DEP)
- Consider the role of a volunteer board to steer the department
- Integration of funds and programs across diseases and conditions
- Look at the budget by functions

EXTERNAL STAKEHOLDERS MEETING
NOVEMBER 19, 2010
DISCUSSION NOTES

ROLES OF DOH

- "Protection" should come before "promotion" in the mission statement
- Replace promote with improve in the mission statement
- The source for health information - "Health Advisor" role
- Advocacy role - analyze health issues of all populations and create policies
- Champion children's health (use medical home model)
- Preserve care for vulnerable populations
- Champion and advocate
- Preserve capacity - don't use the Patient Protection and Affordable Care Act as an excuse not doing something
- Protection role – the department's role covers all residents and visitors
- Assure quality medical care for all populations—must evaluate effectiveness of services
- Recognize a role for research to develop new insights into care and systems
- Share research with the legislature
- Need a higher overall assurance role regarding health care delivery systems and relationship to the Medicaid system
- Need to prioritize the populations of risk and vulnerability
- Develop policies across the population re health care systems
- Assure competent work force

STRATEGIC ISSUES

What are the strategic issues that a future department of health will face that could influence its structure and function?

- Children's health issues
- Use a medical home model to champion children's health
- Assuring a competent workforce – entire public health system (EPHS #8)
- Develop relationships with Federally Qualified Health Centers (FQHCs) and how we work together with the community
- Patient Protection and Affordable Care Act
- Budget demands – do we have the right allocation of funds? Previously, 70% of budget was for services or linking people to services (EPHS #7)
- Importance of prevention and promotion
- Equalize spend Medicaid dollars on adults & children health care issues (not one population against another)
- Be prepared if the legislature decided not to accept Medicaid dollars
    - How many CHDs could function as independent entity without these dollars?
- Strategy for CHDs: consider expanding safety net; becoming a FQHC

EXTERNAL STAKEHOLDERS MEETING
NOVEMBER 19, 2010
DISCUSSION NOTES

FUNCTIONS AND RESPONSIBILITIES

What are the key functions and responsibilities of a future department of health?

- Responsible for and authority for health of citizens (services are provided patchwork quilt fashion and someone needs to coordinate across agencies)
- 10 Essential Public Health Services—Dr. Brooks 2005 study indicated that 70% of budget for DOH was utilized for linking people to services
- Basic core functions of public health
- Board of licensing
- Children's Medical Services
- County Health Departments
- Regulation of food establishments and linking outbreak investigations to regulatory / investigations needs to be in one agency
- Healthy growth / smart growth – what is health's role?
- Policy development
- Community engagement
- Investigations of outbreaks or causes of morbidity and mortality
- Integrated programs (historical perspectives use funds creatively not by just source but by need to collaborate to achieve a goal)
- Legislatively requested functions often take DOH in different directions
- Lead for reviewing the whole health system and developing a state of Florida plan for addressing the health of Floridians
    - There may be duplication if don't review whole health system
- Individual services costs often support the population services because the funds for population services are inadequate

OPPORTUNITIES

What will be gained or lost by transferring functions to other agencies or entities?

What do you see as opportunities for integrating and collaborating with other agencies and entities to achieve improved public health outcomes?

If intent is to be smaller, outsourcing or moving programs that are cost neutral and maybe outside core responsibilities should be considered; without losing sight of strengthening the whole department of health, including core functions that may be under-resourced currently.

MAY NEED TO CONSIDER DIFFERENT STRUCTURE, FOR EXAMPLE:

- Health care board with volunteers rather than attorneys
    - Promotes volunteerism

What functions have other states outsourced effectively?

EXTERNAL STAKEHOLDERS MEETING
NOVEMBER 19, 2010
DISCUSSION NOTES

DISCUSSION ON TRANSFERRING MEDICAL QUALITY ASSURANCE (MQA)

Where can we create efficiencies? More streamlined services?

- Make best case possible to remain at health
- Health care practitioners feel the need to be in a health agency

DISCUSSION ON TRANSFERRING DIVISION OF DISABILITY DETERMINATIONS (DDD)

- Federal government pays DOH to handle the administrative and legal services of Division of Disability Determinations (DDD) ($4.7M)
- Under current Federal law, DDD employees must be state employees
- Should be in an agency that relates to health
- Does not take anything away from DOH
- Currently partners effectively with DCF

DISCUSSION ON TRANSFERRING SCHOOL HEALTH TO DEPARTMENT OF EDUCATION (DOE)

- Some states do have school health in Department of Education
- Florida – joint administration between DOH and DOE; includes local school board funding in many counties
- School health clinic – health issue; sometimes only medical home for adolescents
- Requires legislative change, may not be a core mission for DOE

DISCUSSION ON TRANSFERRING BUREAU OF COMMUNITY ENVIRONMENTAL HEALTH

- This function may belong in other agencies related to the environment
- Purpose is to address human disease of environmental origin
- DOH has a local workforce to address
- Environmental Health is a core competency in public health

DISCUSSION ON TRANSFERRING CORRECTIONAL MEDICAL AUTHORITY (CMA)

- Can or should CMA be transferred to Agency for Health Care Administration (AHCA)

DISCUSSION ON TRANSFERRING BRAIN AND SPINAL CORD PROGRAM

- This is a waiver program, seems that it would fit with AHCA and managed care approach

OPPORTUNITIES

- Strengthen collaborations with other agencies to increase health outcomes (Possible agencies include: Elder Affairs, Education, Department of Juvenile Justice (DJJ)
- Combine chronic illnesses into one category
- Streamline programs (chronic disease, infectious disease)
- Increase community partnerships
- Collectively begin a new public health educational campaign with legislature; show benefit of public health on local services
- Consider looking at what it would take to make a local health department effective in impacting community health; build plan from local to state level
- Increase billing to private insurance and “enforcement or encouragement” language from legislature that would require private insurance to pay for the newborn screening test (part of federal language). Private insurance will pay for newborn screening.
- Mental health care linkages are necessary
- Clarify role between DOH and AHCA

EXTERNAL STAKEHOLDERS MEETING
NOVEMBER 19, 2010
DISCUSSION NOTES

OUTSOURCE

What criteria would you use to determine whether or not a program, function or service should be outsourced?

What departmental programs, functions or services would you consider for outsourcing?

DISCUSSION ON OUTSOURCING BRAIN AND SPINAL CORD INJURY PROGRAM

- Consider whether or not it could be contracted out to the private sector

DISCUSSION OF MIGRATING PRIMARY CARE OUT OF COUNTY HEALTH DEPARTMENTS (CHDS)

- There may be impacts from health care reform and the resulting increased number of providers
- There may be opportunities to better collaborate with Federally Qualified Health Centers (FQHCs) and at least 8 county health departments (CHD) are also FQHCs
- CHDs should analyze their primary care services. Should primary care be
    - continued
    - expanded
    - discontinued
- Develop a rational plan to move/transfer primary care services in the next two years

DISCUSSION ON OUTSOURCING LABORATORIES

- If outsourced, it will weaken DOH's ability to respond in an emergency
- State labs provide services not offered by private labs (ex: rabies testing)
- The chemistries and routine labs are already outsourced

DISCUSSION ON OUTSOURCING COUNTY HEALTH DEPARTMENTS

- Can CHDs operate independently or under county government? Currently use a contractual partnership model
- Strengths of current structure (centralized under the state's health office):
    - CHDs operate as businesses
    - Services are tailored to community needs
    - Flat structure of DOH
    - Statewide quality improvement initiatives; ex: response to National Public Health Performance Standards (NPHPS)
    - CHDs are also county agencies – define services delivered by CHD and what are core vs. locally determined needed services funded locally
    - Consistent policy direction; Human Resources, Information Technology, etc.
    - Consistency in structure for disasters
    - Implement policy, interventions in consistent way statewide
    - Local innovation can be evaluated and shared with others
- Cons of outsourcing:
    - Data / evidence of quality will be harder to obtain
    - Duplicate administrative structure 67 times
    - Working with local governments
    - Some counties will not provide all core services

EXTERNAL STAKEHOLDERS MEETING
NOVEMBER 19, 2010
DISCUSSION NOTES

DISCUSSION ABOUT BUDGET
- Identify budget by functions – how much do we spend on primary care, etc., May be more informative to legislature
- How do we use our detailed budget to show ratio to functions?

SUGGESTIONS:
- Approach - planning requirement with timeframes; flexibility; localize planning process; shape process; Will know more about affordable health care act and FQHC, etc.; better product / transformation; buy time
- Consider requesting additional time to develop a comprehensive plan (with an aggressive timeframe and strategy) after review of data to ensure "no harm done" to safety net; and increasing partnerships and collaborations with other health care providers
- Clearly define core functions; prioritize; provide rationale for programs remaining, moving, outsourcing, etc;
- Consider laying out reductions "matter of fact" if we cut $, it will impact these services
- Ecological approach
- Go after legislation that supports networking and research and the legislative authority for nominal recognition of research
- Focus a strategy on looking at 16% GR funding remaining in DOH and determine what, if anything could be cut;
- Ensure there is a clear understanding of legislative intent of both DOH and AHCA
- Advocate to legislature on basis of research
- Research what functions have other states outsourced effectively

ADDITIONAL COMMENT: CHDs should not compete with local physicians in their service to community

STRATEGY TO GO BACK TO LEGISLATURE: (Kim Berfield)
- focused proposal
- quantify (show how it makes a difference)
- start with 7 responsibilities outlined in HB 7183
- clear vision: distinction public health and health delivery
- should CHDs be providing primary care
- use business case
- streamline efforts

PROCEDURES FOR ASSISTING AFFECTED EMPLOYEES

As an employee who is being affected by a reduction in workforce, you are afforded certain options with regard to your benefits. This is to inform you of those options and to provide a mechanism for the appropriate processing of your accumulated leave and insurance benefits. Please indicate your options on the enclosed form and return it to the Human Resources office. In addition, you may be eligible to receive unemployment compensation benefits.

INSURANCE & BENEFITS

Health Insurance: The state will pay the usual premium payment for any month during which the employee was on the payroll for at least one day in the previous month. Coverage under a health insurance plan will be effective through the end of the next month.

An employee who is laid off shall be eligible to continue health insurance coverage while in layoff status for up to two years. The employee must pay the entire premium and premium payments should be submitted to the People First Service Center by the 10th of each month for payment of the next month's coverage. Below are the monthly premium rates for health insurance, effective December 2010 (January 2011 coverage).

	Standard Plans	Health Investor Health Plans
Individual	$549.80	$514.80
Family	$1,243.34	$1,127.64

Employees who do not wish to continue coverage under the layoff provision may apply for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). This provides that terminating insured employees and their covered dependents may elect to continue their group health, dental and vision coverage (and pay the full premium plus a 2% administrative fee) for up to 18 months from the date employment terminates or until the employee becomes covered under another group plan, whichever is first. The employee will receive an application for COBRA benefits from the People First Service Center within 30 days of termination. The employee has 60 days from receipt of the application to elect continuation of coverage. Employees who take the full 60 days from receipt of the application before electing continuation of coverage will be required to make up the premium under payments. You may contact the People First Service Center at 1-866-663-4735.

COBRA Premium Rates for Health Insurance, effective May 1, 2010 (June coverage)

	Standard Plans	Health Investor Health Plans
Individual	$534.09	$455.90
Family	$1,207.82	$1,004.81

The termination of an employee is a qualifying event that would allow the employee's spouse, if he/she is a state employee, to enroll in the State Group Health Program or any other pre-taxed supplemental plan being carried by the terminating spouse, within 31 days. The spouse must contact the People First Service Center immediately for further direction to complete any enrollments or changes, if necessary. Delaying this process will result in a premium underpayment.

State Life Insurance (Basic): An employee who is laid off shall be eligible to continue basic life insurance coverage while in layoff status for up to 24 months. The employee must pay the entire premium. Premium payments should be submitted to the People First Service Center by the 10th of each month for payment of the next months' coverage. The premium payment for life insurance will vary depending on the employee's salary.

The basic State Group Life Insurance policy, underwritten by Minnesota Life can be converted to an individual plan. If the employee wishes to have the insurance converted, contact Minnesota Life at 1-888-826-2756 within 31 days from the date coverage ends.

State Life Insurance (Optional): The optional State Group Life insurance, underwritten by Minnesota Life, is portable provided you meet certain requirements. An employee must apply for coverage under this portability option within 31 days after the optional life coverage ends. Please contact Minnesota Life at 1-888-826-2756 for information.

Flexible Benefit Plans:

Dependent Day Care Reimbursement Account - Participation in this account will terminate with the last payroll deduction.

Medical Reimbursement Account - Participation in this account will terminate with the last payroll deduction. The employee may elect one of the following options to continue participation:

- Full payment of the balance due can be deducted from the annual and sick leave payment. This would be on a pretax basis.

- Partial payment of the balance due can be deducted from the annual and sick leave payment. This would be on a pretax basis. The remaining balance will be paid by personal check or money order within 45 days of election although it would not provide any pretax advantage.

- Full payment of the balance due, paid by personal check or money order, within 45 days of election. This option has no pretax advantages.

- Monthly payments of balance due paid by personal check or money order by the first of each month and will include a 2% administrative fee. This option has no pretax advantages.

For more information on the above subjects, please visit https://peoplefirst.myflorida.com/logon.htm.

Deferred Compensation: Employees must contact their provider within 30 days of termination in order to give and/or receive instructions on their account. If the provider cannot be reached, contact the Division of Deferred Compensation at (850) 413-3162 or toll-free (877) 299-8002. For more information, please visit www.myfloridadeferredcomp.com.

Other Miscellaneous Deductions: The employee must contact each individual company and make arrangements to continue coverage, if possible, and make premium payments. The employee should contact the companies within 31 days of termination to avoid a lapse in coverage.

LEAVE & ATTENDANCE

Annual Leave:

- **For Career Service (CS) employees**: A CS employee with twelve months of service, who is being laid off, shall be paid for all unused annual leave up to 240 hours unless the employee requests in writing that the annual leave be retained up to a maximum of one year, pending reemployment. If the employee is not reemployed within one year, unused annual leave held in abeyance shall be paid. If the employee is reemployed within one year, annual leave credits shall be restored if the employee so requests in writing and repays the full amount of any lump-sum payment received for accumulated leave credits.

- **For Selected Exempt Service (SES) employees**: An SES employee who is being laid off shall be paid for all unused annual leave up to 480 hours, with the current year's accrual prorated, unless the employee requests in writing that the annual leave be retained up to a maximum of one year, pending reemployment. If the employee is not reemployed within one year, unused annual leave held in abeyance shall be paid. If the employee is reemployed within one year, annual leave credits shall be restored if the employee so requests in writing and repays the full amount of any lump-sum payment received for accumulated leave credits.

Sick Leave (CS and SES): If an employee is laid off, the following provisions govern accrued sick leave credits.

1. If the employee has ten years or more of creditable state service and is otherwise eligible for receipt of sick leave payment pursuant to the rule, the agency shall pay for the credits at the time of layoff, unless the employee requests in writing that the agency hold the credits in abeyance pending reemployment within one year.

2. If the employee is reemployed within one year following layoff, an agency shall restore the credits to the employee, provided the employee requests restoration in writing and returns the full amount of any payment received at the time of layoff for the credits.

3. If the employee is not eligible for receipt of sick leave payment at the time of layoff, the agency shall hold the credits in abeyance and, if the employee is reemployed within one year following layoff, shall credit them to the employee upon reemployment.

Employees with at least ten years of creditable service requesting payment will be paid for 1/4 of all unused sick leave earned after October 1, 1973, up to a maximum payment of 480 hours and 1/8 of all unused sick leave earned prior to October 1, 1973.

Sick Leave Pool Donation: A sick leave pool member may elect to donate up to 16 hours of sick leave to their sick leave pool upon termination.

Sick Leave Donation: Prior to separation an employee may donate all sick leave credits in excess of 80 hours to an eligible employee. These hours are taken before any payment option above is calculated and both employees must still be active on the payroll at the time of the donation.

Special Compensatory Leave: All employees with a special compensatory leave balance will be paid upon termination.

Regular Compensatory Leave (applies to Career Service only): If an employee is laid off, the agency shall hold the credits in abeyance and, if the employee is reemployed within one year following layoff, shall credit them to the employee upon reemployment.

Leave Payment to a Deferred Compensation Program: An employee terminating from state government may elect to have the leave payment or portion thereof deducted into a deferred compensation program instead of receiving payment upon termination. This option provides a pretax advantage; however, your request must be made prior to payout.

FLORIDA RETIREMENT SYSTEM (FRS)

Vesting: FRS Pension Plan participants are vested with six years of creditable service and qualify for normal retirement at age 62 or at 30 years of creditable service, regardless of age. FRS Investments Plan participants vest after one year of creditable service.

Receiving a Retirement Check: You must terminate employment to be eligible to receive retirement benefits. You are considered terminated only after you stop all employment relationships with all Florida Retirement System (FRS) employers. There are reemployment restrictions for retirees of both the Pension Plan and the Investment Plan.

FRS Pension Plan:

- A retiree who returns to work with an FRS employer during the first 6 calendar months after retirement voids his/her retirement. All retirement benefits, including DROP distribution, must be repaid and the retiree must reapply for retirement, establishing a later effective date of retirement.

- A retiree cannot earn both a salary and retirement benefits for twelve months after the effective date of retirement. The Division will suspend the benefits during the months worked during the 12-month limitation period. You should contact the Division of Retirement for additional information at 1-888-738-2252 if you are retire and are considering reemployment during this period.

- Retirees initially reemployed on or after July 1, 2010, are not eligible for renewed membership in the FRS.

FRS Investment Plan:

For information regarding distribution options and reemployment restrictions after retirement from the FRS Investment Plan, please visit www.MyFRS.com or contact the FRS Financial Guidance Line at toll-free 1-866-446-9377.

UNEMPLOYMENT COMPENSATION

To determine eligibility, you may contact the Agency for Workforce Innovation.

For more information, please visit http://www.floridajobs.org.

IMPORTANT REMINDER: Please review and make necessary updates to your home and/or mailing address information in the People First system prior to your separation to ensure that you receive insurance and other critical information after your separation.

ACCUMULATED LEAVE OPTIONS FOLLOWING LAYOFF

1. I request payment of annual leave. ☐

2. I request that annual leave be held in abeyance. ☐

3. I request payment of sick leave (if I am eligible for payment pursuant to the Personnel Rules). ☐

4. I request that sick leave be held in abeyance. ☐

_____ _____
Signature of Employee Date

Social Security Number: - -

RETURN TO THE SERVICING HUMAN RESOURCE OFFICE

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"Privatization: Questions State and Local Decisionmakers Used When Considering Privatization Options," U.S. General Accounting Office, General Government Division, April 1998.

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"Summary Guide: Business Case Development Process," Florida Council on Efficient Government, Rev. December 26, 2007.

VII. GLOSSARY OF TERMS

ACRONYM / TERM	DEFINITION
10 Essential Public Health Services	Describes the public health activities that should be undertaken in all communities, and provides a guiding framework for the responsibilities of local public health systems. *(Source: U.S. Centers for Disease Control and Prevention)*
A. G. Holley State Hospital	Florida's state Tuberculosis hospital; provides in-patient care for patients with complex, multi-drug resistant TB, as well as patients requiring court-ordered in-patient treatment.
AHCA	Florida Agency for Healthcare Administration
All-Hazards Emergency Response	The all-hazards emergency response model prepares a generalized emergency response system. First responders are trained to respond to terrorism events in the same way that they would respond to other disasters, such as floods, hurricanes, toxic spills, plane crashes, and fires. *(Source: Hough L. Terrorism in America: Gearing Up for Future Attacks has become a New Priority. The Bulletin from John F. Kennedy School of Government; Autumn 2001: 18-23.)*
All-Hazards Preparedness (Emergency Response) Plan	An action plan for the jurisdiction developed to mitigate, respond to, and recover from a natural disaster, terrorist event, or other emergency that threatens people, property, business, or the community. The plan identifies persons, equipment, and resources for activation in an emergency and includes steps to coordinate and guide the response and recovery efforts of the jurisdiction. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control)*
APHA	American Public Health Association
Assessment	One of the three core functions of public health, as identified in the 1988 Institute of Medicine report, "The Future of Public Health." Assessment involves the monitoring of disease incidence and other threats and risks to the community's health in order to identify health issues, as well as investigating and diagnosing health problems and hazards affecting a community. *(Source: Institute of Medicine Committee for the Study of the Future of Public Health)*
Assurance	One of the three core functions of public health, as identified in the 1988 Institute of Medicine report, "The Future of Public Health." Assurance refers to the process of determining that "services necessary to achieve agreed upon goals are provided, either by encouraging actions by other entities (public or private sector), by requiring such action through regulation, or by providing services directly." *(Source: Institute of Medicine Committee for the Study of the Future of Public Health)*
ASTHO	Association of State and Territorial Health Officers
Baseline	Base level of previous or current performance that can be used to set improvement goals and provide a basis for assessing future progress.
Behavioral Risk Factor Surveillance Survey (BRFSS)	A national survey of behavioral risk factors conducted by states with support from the U.S. Centers for Disease Control and Prevention. Behavioral risk factors include behaviors that are believed to cause, or to be contributing factors to most accidents, injuries, disease, and death during youth and adolescence as well as significant morbidity and mortality in later life. *(Reference: http://www.cdc.gov/brfss/)*

ACRONYM / TERM	DEFINITION
Benchmark	Point of reference or a standard against which measurements can be compared. In the context of indicators and public health, a benchmark is an accurate data point, which is used as a reference for future comparisons (similar to a baseline). Sometimes it also refers to "best practices" in a particular field. *(Source: Norris T, Atkisson A, et al. The Community Indicators Handbook: Measuring Progress toward Healthy and Sustainable Communities. San Francisco, CA: Redefining Progress; 1997.)*
Best Practice(s)	The best clinical or administrative practice or approach at the moment, given the situation, the consumer's or community's needs and desires, the evidence about what works for the situation/need/desire, and the resources available. Organizations also often use *promising practices* – clinical or administrative practices for which there is considerable evidence or expert consensus and which show promise in improving outcomes, but which are not yet proven by the highest or strongest scientific evidence. *(Source: The American College of Mental Health Administration and The Technical Assistance Collaborative, Inc. Turning Knowledge into Practice. Boston, MA: The Technical Assistance Collaborative; 2003.)*
Capacity	Capacity consists of the resources and relationships necessary to carry out the core functions and essential services of public health; these include human resources, information resources, fiscal and physical resources, and appropriate relationships among the system components. *(Source: Turnock, BJ. Public Health: What It Is and How It Works. Gaithersburg, MD: Aspen Publishers, Inc., 1997.)*
CDC	U.S. Centers for Disease Control and Prevention
CHARTS	Community Health Assessment Resource Tool Set. The department's single, Internet site, through which the general public, local health planners, researchers, department staff, and others can easily access health indicator data at the community and statewide level.
Client	Any individual or entity served by the department, or that receives or uses department resources or services.
CMA	Correctional Medical Authority. Assigned to the department for administrative purposes only, in section 945.602.(1), F.S.
CMS	Children's Medical Services. The department currently includes a Division of Children's Medical Services Network, and a Division of Children's Medical Services Prevention and Intervention.
Communicable Disease	This category includes diseases that are usually transmitted through person-to-person contact, or shared use of contaminated instruments/materials. Many of these diseases can be prevented through the use of protective measures, such as a high level of vaccine coverage of vulnerable populations. *(Source: U.S. Centers for Disease Control and Prevention)*
Community Health Assessment	Community health assessment involves regularly and systematically collecting, analyzing, and making available information on the health of a community, including statistics on health status, community health needs, epidemiologic and other studies of health problems. *(Source: U.S. Centers for Disease Control and Prevention)*

ACRONYM / TERM	DEFINITION
Community Health Improvement Plan (CHIP)	A long-term, systematic effort to address health problems, based on results of assessment activities. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities, and coordinate and strategically allocate resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health at the local level. *(Source: United States Department of Health and Human Services. Healthy People 2010. Washington, DC: U.S. Department of Health and Human Services; 2000.)*
Community Health Profile	A comprehensive compilation of measures that contributes to a description of health status at a community level, and the resources available to address health needs. Measures are tracked over time to determine trends, to evaluate health interventions or policy decisions, compare community data with peer, state, national or benchmark measures, and establish priorities through an informed community process. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control)*
Continuing Education and Training	Work extension opportunities including workshops, seminars, conferences, distance learning, and other formal and informal educational opportunities. These activities are intended to strengthen, update, and add to the professional knowledge and skills of employees in the state and local public health system. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control)*
Core Competencies	A set of skills that is essential for an individual to be accepted as competent in a particular discipline or topic. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control)*
Core Functions of Public Health	Three core functions of public health, as identified in the 1988 Institute of Medicine report, “The Future of Public Health.” These include assessment, assurance, and policy development (all defined in this glossary). These are the basic functions for public health to assure conditions in which people can be healthy. *(Source: Institute of Medicine Committee for the Study of the Future of Public Health)*
Cost-Benefit Analysis	A management tool that involves calculating or estimating the monetary costs and potential benefits of a proposed course of action.
County Health Department (CHD)	The governmental presence at the local level responsible for public health functions. Florida’s (67) CHDs are organized in a centralized model, reporting to both the state health office and the county commission.
Cultural Competence	A set of skills that result in an individual understanding and appreciating cultural differences and similarities within, among, and between groups and individuals. This competence requires that the individual draw on the community-based values, traditions, and customs to work with knowledgeable persons within or from a community in developing targeted interventions and communications.
Data	Information necessary to inform processes, decisions, and resource allocation; includes business and public health information.
Demographics	The characteristics of human populations and population segments, especially when used to identify consumer markets.

ACRONYM / TERM	DEFINITION
DCF	Florida Department of Children and Families
DEP	Florida Department of Environmental Protection
DMS	Florida Department of Management Services
DOC	Florida Department of Corrections
DOE	Florida Department of Education
DOH	Florida Department of Health
DMS	Florida Department of Management Services
Eliminate (Recommendation)	Discontinuation of a program or activity by the department, not recommended for reassignment to any other state agency or private entity.
Emergency Support Function 8 (ESF-8)	Responsible for coordinating Florida's statewide public health and medical resources, capabilities, capacities, and response in an all-hazards environment during natural or man-made disasters.
Environmental Hazards	Situations or materials that pose a threat to human health and safety in the built or natural environment, as well as to the health and safety of other animals and plants, and to the proper functioning of an ecosystem, habitat, or other natural resource.
Environmental Risk	The likelihood of eating, drinking, breathing, or contacting some unhealthy factor in the environment and the severity of the illness that may result; the probability of loss or injury; a hazard or peril.
Epidemiology	The study of the distribution and determinants of health-related status or events in specified populations, and the application of this study to control of health problems. The department uses a distributed operational model for its epidemiology functions. Epidemiology is the general study of the distribution and determinants of health-related status or events in specified populations, and the application of this study to control health problems. Specific epidemiology functions are located (distributed) in various department programs. This approach places epidemiologists within the program area corresponding with their area of expertise. *(Source: A Dictionary of Epidemiology. Second Edition. New York: Oxford University Press; 1988.)*
Evidenced-based Interventions	The systematic selection, implementation, and evaluation of strategies, programs and policies with evidence from the scientific literature that they have demonstrated effectiveness in accomplishing intended outcomes. *(Source: American Journal of Health Education, 2001)*
Federal Mandates	Any provision in a bill or joint resolution before Congress or in a proposed or final Federal regulation that would impose a duty that is enforceable by administrative, civil, or criminal penalty or by injunction.
FIRS	Financial and Information Reporting System
FLAIR	Florida Accounting Information System

ACRONYM / TERM	DEFINITION
Geographic Information System (GIS)	Digital technology with data management system capability that provides tools for the capture, storage, manipulation, analysis, and visualization of spatial data. These spatial attributes enable previously disparate data sets to be integrated into a digital mapping environment.
Goal	Broad, long-term aims that define a desired result associated with identified strategic issues.
Health	A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. *(Source: World Health Organization)*
Health Care Provider	Person, agency, department, unit, subcontractor, or other entity that delivers a health-related service; examples include hospitals, clinics, free clinics, community health centers, private practitioners, the local health department, etc. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control)*
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA Includes: • Title I - Protects health insurance coverage for workers and their families when they change or lose their jobs. • Title II - Requires the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and addresses the security and privacy of health information.
Health Promotion	Health promotion is an intervention strategy that seeks to eliminate or reduce exposures to harmful factors by modifying human behaviors. Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health. This process enables individuals and communities to control and improve their own health. Health promotion approaches provide opportunities for people to identify problems, develop solutions, and work in partnerships that build on existing skills and strengths. *(Source: Turnock, B. Public Health: What It Is and How It Works, Aspen Publishers, 2001)*
Health Status Indicator	A single measure that purports to reflect the health status of an individual or defined group.
Health Status Report	A product from the review of key indicators of the health status of Floridians. In narrative and graphic displays, this report shows demographic and socioeconomic characteristics, health risk factors, health status including morbidity and mortality, health resource availability, and other indicators of quality of life.
Healthy People 2020	A national health promotion and disease prevention initiative of the U.S. Department of Health and Human Services; brings together national, state, and local government agencies; nonprofit, voluntary, and professional organizations; businesses; communities; and individuals to improve the health of all Americans, eliminate disparities in health, and improve years and quality of healthy life. *(Source: www.healthypeople.gov)*

ACRONYM / TERM	DEFINITION
Implementation Schedule	For purposes of this report, a date range during which a plan to complete a recommended action would be carried out. All recommended implementation schedules found in this report are subject to change, contingent upon legislative approval and possible further direction.
Incidence	Rate of occurrence of new cases of a specified condition in a specified population within some time interval, usually a year. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control)*
Infant Mortality Rate	A death rate calculated by dividing the number of infant deaths during a calendar year by the number of live births reported in the same year. This rate is expressed as the number of infant deaths per 1,000 live births.
Infectious Disease	A disease caused by a living organism. An infectious disease may or may not be transmissible from person-to-person, animal-to-person, or insect-to-person. *(Source: Gostin L and Hodges J. The Model State Emergency Health Powers Act; Draft dated 10/23/01.)*
Infrastructure	The systems, competencies, relationships, and resources that enable performance of public health's core functions and essential services in every community. Categories include human, organizational, informational, and fiscal resources. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control)*
LTBI	Latent tuberculosis infection
Learning Management System	An information technology (IT) solution that enables the management and delivery of training and tracking of the use, successful completion, and evaluation of training by learners.
Local Health Officer	An individual who is hired or appointed to lead a local governmental public health agency; has direct responsibility for the day-to-day operations, management, and direction of the local governmental public health agency. In Florida, these individuals are generally called a county health department "director" (physician licensed under chapter 458, F.S., or chapter 459, F.S.) or "administrator" (non-physician).
LRPP	Long Range Program Plan. The department completes a new LRPP every five years, revises annually, and submits to legislature, Governor, and posts on the Internet for public consumption, as required in section 216.013, F.S.
Mobilizing for Action through Planning and Partnerships (MAPP)	Community-wide strategic planning tool for health improvement, developed by the National Association of County and City Health Officials (NACCHO) and Centers for Disease Control and Prevention (CDC).
Morbidity	Illness or lack of health caused by disease, disability, or injury. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control)*
Mortality	A measure of the incidence of deaths in a population. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control)*

ACRONYM / TERM	DEFINITION
National Voluntary Public Health Accreditation	Accreditation is a system of common standards used to measure performance. The national voluntary accreditation program for state, local, territorial and tribal public health departments is intended to improve and protect the health of every community by advancing the quality and performance of public health departments. The accrediting body for national public health accreditation is the Public Health Accreditation Board (PHAB). *(Reference: www.phaboard.org)*
NACCHO	National Association of County and City Health Officials
Needs Assessment	A structured process to determine the needs of a designated population (e.g. individuals; agency; system).
National Public Health Performance Standards Program (NPHPSP)	The U.S. Centers for Disease Control and Prevention (CDC) national partnership initiative to improve the practice of public health and the performance of public health systems. Includes three instruments: the State Public Health System Performance Assessment; the Local Public Health System Performance Assessment; and the Local Public Health Governance Performance Assessment. *(Reference: www.cdc.gov/nphpsp/)*
National Incident Management System (NIMS)	A comprehensive framework developed by the U.S. Department of Homeland Security, establishing incident management processes, protocols, and procedures that responders use to more effectively coordinate and conduct response to domestic incidents no matter what the cause, size, or complexity. *(Reference: http://www.fema.gov/emergency/nims/AboutNIMS.shtm)*
Objectives	Results of specific activities or outcomes to be achieved over a stated time. Objectives are specific, measurable, and realistic statements of intention. Objectives state *who* will experience what change or benefit and how much change is to be experienced in *what time*. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control)*
Operating Costs	The day-to-day expenses incurred in running an organization or project.
Operational Definition of a Functional Local Health Department	A statement to create a shared understanding of what people in any community, regardless of size, can expect from their local health department; published by the National Association of County and City Health Officials (NACCHO) in November 2005. Sets forth a series of standards based on the 10 Essential Public Health Services, and serves as the framework for the standards of the national voluntary accreditation program operated by the Public Health Accreditation Board (PHAB). *(Reference: http://www.naccho.org/topics/infrastructure/accreditation/OpDef.cfm)*
Outcomes	Long-term end goals that are influenced by the project, but that usually have other influences affecting them as well. Outcomes reflect the actual results achieved, as well as the impact or benefit of a program.
Outsource	Discontinuation of a program or activity by the department, with direct contractual oversight retained by the department.

ACRONYM / TERM	DEFINITION
Performance Management	The practice of actively using performance data to improve the public's health; involves strategic use of performance measures and standards to establish performance targets and goals. Performance management practices can also be used to prioritize and distribute resources; to inform managers about needed adjustments or changes in policy or program directions to meet goals; to frame reports on the success in meeting performance goals; and to improve the quality of public health practice. *(Source: Turning Point Performance Management National Excellence Collaborative. From Silos to Systems: Using Performance Management to Improve the Public's Health. Washington, DC: Public Health Foundation; 2003.)*
Performance Measures	Tools or information used to measure results and ensure accountability; specific quantitative representation of capacity, process, or outcome deemed relevant to the assessment of performance. *(Source: Lichiello, P. Turning Point Guidebook for Performance Measurement, Turning Point National Program Office, December 1999.)*
Performance Standard	A generally accepted, objective form of measurement that serves as a rule or guideline against which an organization's level of performance can be compared. *(Source: Lichiello, P. Turning Point Guidebook for Performance Measurement, Turning Point National Program Office, December 1999.)*
Population Health	Interventions aimed at disease prevention and health promotion that affect an entire population and extend beyond medical treatment by targeting underlying risks, such as tobacco, drug, and alcohol use; diet and sedentary lifestyles; and environmental factors. *(Source: Turnock BJ. Public Health: What It Is and How It Works. Gaithersburg, MD: Aspen Publishers, Inc.; 1997)*
Primary Care	For purposes of this report, medical treatment – not related to specific preventive services and limiting the spread of disease – for those people in Florida where availability of basic health care services is a need.
Priorities	Strategically selected areas on which the department focuses resources (human, financial, other). In some instances, priorities are further identified as those responsibilities expressly assigned statutorily to the department.
Privatize	Discontinuation of a program or activity by government; program or activity may be carried out by a private sector (for profit or not-for-profit) entity or entities; no government oversight – contractual or otherwise – by the department or any other state agency
Process Evaluation	Measures that investigate issues regarding the program's current operations or the implementation of new initiatives. Indicators most often focus on what a program does, who does it, and how it is done.
Protocol for Assessing Community Excellence in Environmental Health (PACE-EH)	A community environmental health assessment and planning tool developed by the National Association of County and City Health Officials (NACCHO) to assist local health departments and their communities in prioritizing environmental health issues. *(Reference: http://www.cdc.gov/nceh/ehs/ceha/background.htm)*

ACRONYM / TERM	DEFINITION
Public Health	The science of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; control of community infections; education of individuals; organization of medical and nursing service for the early diagnosis and treatment of disease; and development of the social systems to ensure every individual has a standard of living adequate for the maintenance of health. The mission of public health is to fulfill society's desire to create conditions so that people can be healthy. *(Sources: Winslow CEA. Man and Epidemics. Princeton, N.J.: Princeton University Press, 1952; and (2) Institute of Medicine. The Future of Public Health. Washington, DC: The National Academy Pres, 1988.)*
Public Health Accreditation Board (PHAB)	The accrediting body for voluntary national public health accreditation. Created to manage and promote the national accreditation program scheduled to launch in 2011. *(Reference: www.phaboard.org)*
Public Health Emergency	An occurrence or imminent threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or novel and highly infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long term disability. Such health condition includes, but is not limited to, an illness or health condition resulting from a natural disaster. *(Source: Gostin L and Hodges J. The Model State Emergency Health Powers Act; Draft dated 10/23/01)*
Public Health System	Human, informational, financial, and organizational resources, including public, private, and voluntary organizations and individuals that contribute to the public's health. Florida's public health system is addressed in section 381.001, F.S. *(Source: National Association of County and City Health Officials)*
Quality Improvement (QI)	An ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities, outcomes.
Qualitative Data	Variables or data that cannot be measured and are not necessarily represented in numerical form, such as results from focus groups or interviews with individuals. *(Source: Mendenhall, William; Statistics for Management and Economics; 1978)*
Quantitative Data	Measurement variables or data that can be measured and represented on a numerical scale, such as number of services, annual revenue, and number of employees. *(Source: Mendenhall, William; Statistics for Management and Economics; 1978)*
Reportable Disease	Health condition required through statute, ordinance or administrative rule to be reported to a public health agency when it is diagnosed in an individual. *(Reference: http://www.cdc.gov/osels/ph_surveillance/nndss/nndsshis.htm)*
Request for Proposal (RFP)	A formal invitation containing a scope of work which seeks a formal response (proposal) describing both methodology and compensation to form the basis of a contract.
Retain As Is	Continue a division, program, or activity as currently existing – in form or function – within the Department of Health. No division, program, or activity reviewed is recommended for retention as is.

ACRONYM / TERM	DEFINITION
Retain and Improve	Continue a division, program, or activity – in form or function – within the Department of Health, with corresponding recommended opportunities to increase programmatic, cost, or structural efficiency and/or effectiveness.
Return on Investment (ROI)	Performance measure used to evaluate the efficiency of an investment or compare the efficiency of a number of different investments. Value can be characterized quantitatively (# or $, including cost savings) or qualitatively (public health benefit).
STD	Sexually transmitted disease
Stakeholder	Any person or group with a vested interest in the outcome of a project or plan.
State Agency	Any Florida governmental entity, including the state university system.
State Emergency Operations Center (EOC)	Facility located in Tallahassee at which the statewide coordination of information and resources to support domestic incident management activities normally takes place.
State Health Improvement Plan	A written document that addresses health problems in a state; assesses applicable data; develops measurable health objectives and indicators; inventories statewide resources; develops and implements coordinated strategies; and cultivates "ownership" of the entire process.
State Health Officer	The chief health official in each state and territorial public health agency of the United States, the U.S. Territories, and the District of Columbia. The chief health officials of these jurisdictions are dedicated to formulating and influencing sound public health policy, and to assuring excellence in state-based public health practice. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control and Prevention)*
State Health Profile	A comprehensive compilation of measures organized into a public report that describes the health status of the state's population and the resources available to address health needs. Measures may be tracked over time to identify trends, to evaluate health interventions or policy decisions, to compare state data with peer, national or benchmark measures, and to establish priorities through an informed statewide process. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control and Prevention)*
Strategic Plan	A document that reports on the decisions and actions that will guide an organization to achieve its vision.
Surveillance	The ongoing systematic collection, analysis, and interpretation of specific data (e.g., agent/hazard, risk factor, exposure, health event) essential to the planning, implementation, and evaluation of public health practice, integrated with the timely dissemination of these data to those responsible for prevention and control. *(Source: National Public Health Performance Standards Program, U.S. Centers for Disease Control and Prevention)*
TB	Tuberculosis

ACRONYM / TERM	DEFINITION
Underserved Populations	Populations with barriers to the health care system include the uninsured, the underinsured and socially disadvantaged people. Socially disadvantaged people include all people who, for reasons of age, lack of education, poverty, culture, race, language, religion, national origin, physical disability, or mental disability, may encounter barriers to entry into a coordinated system of public health services and clinical care. *(Source: U.S. Centers for Disease Control and Prevention)*
Vital Statistics	Data derived from certificates and reports of birth, death, fetal death, induced termination of pregnancy, marriage, (divorce, dissolution of marriage, or annulment) and related reports.
WIC	Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
Years of Potential Life Lost (YPLL)	A measure of premature death, or death that occurs before age 75, the average life span. This measure is useful for assessing the impact of a particular public health problem on the economy in terms of lost work years and earnings, and on family life in terms of impact on surviving spouses and children. It should be noted that a large percentage of the causes of YPLL are preventable through behavior modification, lifestyle changes, and substance abuse reduction. *(Source: U.S. Centers for Disease Control and Prevention)*

An Opportunity to Redesign Florida's Forensic Mental Health System

WHY IT IS IMPORTANT:

In Fiscal Year 06/07 the Department of Children and Families (DCF) was faced with a forensic waiting list that reached as high as 340. The Florida Legislature authorized the Department to use existing dollars in FY 06-07 and appropriated an annualized amount of over $53 million in FY 07-08 to open additional facility bed capacity and to increase community forensic services. Since that time, commitments to forensic facilities have not increased, and in fact, have decreased slightly since FY 07/08. The Department asserts this decrease in commitments is primarily due to the increase in available community services (residential, community/in-jail competency restoration, case management, mental health court).

In August 2009, DCF, the Eleventh Judicial Circuit of Florida, and Bayview Center for Mental Health implemented a pilot program, the Miami Dade Forensic Alternative Center (MD-FAC). The intent of this program was to demonstrate the feasibility of diverting individuals with mental illnesses adjudicated Incompetent to Proceed from state hospital placement to placement in community-based treatment and competency restoration services. This program, which now also accepts individuals adjudicated Not Guilty by Reason of Insanity, is:

- less expensive to operate than a maximum security forensic facility;
- keeps individuals in the program versus rebooking them into the jail following restoration of competency;
- provides assistance to individuals in accessing entitlement benefits and other means to build economic self-sufficiency;
- develops a comprehensive transition plan for eventual return to a less restrictive community placement; and
- provides ongoing assistance, support and monitoring following discharge from inpatient treatment, and community re-entry.

The average length of stay for this program is less than a maximum security facility (an average number of days from admission to date the court is notified an individual is considered competency of 99 days, compared with 138 days for forensic facilities). The average cost per bed is currently $274 a day, but would reduce to $229 a day if capacity is increased to 20 beds. The average cost per bed for a forensic facility is $333 a day.

HOW FURTHER FORENSIC REDESIGN WOULD BE ACCOMPLISHED:

The Department recommends reducing the size of North Florida Evaluation and Treatment Facility (NFETC), a 216 bed forensic facility in Gainesville, to 100 beds. The current annual budget is $26.2 million annually. After reducing the budget by an anticipated $6 million (in administrative and 7% cuts) and $718,000 for risk management, there will be approximately $19.4 million remaining. Operating a 100 bed facility would cost approximately $12.8 million annually, leaving approximately $6.7 million to transfer to the community/assist with further budget reductions. Based on areas of the state with the

largest numbers of forensic commitments, the Department recommends transferring $5.7 million to the community to open 60 additional commitment beds to serve Pinellas/Hillsborough, Clay/Duval/Nassau and Dade/Broward/Monroe Counties. One million dollars would remain to assist with further budget reductions.

In addition, the Department would recommend re-opening 25 beds that are currently closed at Treasure Coast Forensic Treatment Center (funding for this program currently pays for the MD-FAC Program). Reducing NFETC to 100 beds and re-opening 25 Treasure Coast beds would result in a net loss of 91 maximum security forensic facility beds.

FUTURE OPPORTUNITIES TO CLOSE ADDITIONAL FORENSIC MAXIMUM SECURITY BEDS:

The MD-FAC Program, which opened in the early part of FY 09-10 served 24 individuals in its first year of operation. Between FY 08-09 and 09-10, commitments from Dade County decreased by 20. Using that ratio, an additional 60 beds would potentially decrease commitments by as many as 50 a year. If that occurred, the Department would propose the closure of additional forensic facility beds in FY 12-13. Closure of 60 additional beds would result in a savings of approximately $4 million (savings would be smaller since indirect costs would not significantly reduce with a small bed closure).

SPAN OF CONTROL
AGENCY FOR PERSONS WITH DISABILITIES

	Current Ratio	Proposed Ratio	Potential Savings
Agency for Persons With Disabilities	**1:5.1**	1:6.1	
Total Supervisors	589.0	490.0	
Total Positions	2,995.0	2995.0	
Home and Community Services	1:5.3	1:7.7	
Program Management and Compliance	1:4.5	1:7.2	
Developmental Services Public Facilities	1:5.2	1:5.8	

For the purposes of this exercise, the Agency for Persons with Disabilities has made the following assumptions:

Developmental Services Public Facilities

The line level staffing patterns for the facilities of MRDP, Sunland and Tacachale are established in accordance with Federal Law or in accordance with requirements for custody and control for individuals charged with felonies or committed to the custody of the state as a consequence of being determined incompetent to proceed following a felony arrest. Only management staffing ratios were addressed.
Actions contemplated to reach the seven to one supervision ratio include the following:

- Unify the Human Resources function at Sunland and MRDP eliminating duplicative staff
- Combine the nursing teams from Sunland and MRDP into one unit
- Combine the behavioral support teams at Sunland and MRDP into one unit
- Combine the social services units at MRDP and Sunland under one supervisor
- Restructure the two management teams for Sunland and MRDP into one team

Tacachale presents a unique difficulty as many of the positions are required by federal law and the distance from the other facilities limits the Agency's capacity to combine functions. The management structure at this facility will be restructured to meet this objective as is practicable.

Home and Community Services

Barriers to reaching the one to seven goal in this budget entity are chiefly geographic and area office size in terms of the number of employees. Each office, as feasible, will be restructured to a one to seven supervisor to staff ratio. Some offices have as few as three employees and the outcome will be more form over function.

Program Management and Compliance

There are a number of supervisors within this office which have less than seven direct reports. For this analysis, the agency director has been exempted from this requirement. In addition, the manner which best practice dictates handling of financial transactions also determines some of the structure. Most supervisors within this office are working supervisors whose duties mirror their employees to a degree. The approach to be followed involves collapsing the number of units into a smaller number and demoting existing supervisors into the new units. The primary source of savings will be the ten percent differential between supervisors and their employees.

FLORIDA'S LOW-INCOME POOL & THE LIP COUNCIL RECOMMENDED MODEL

Steve Ecenia

Rutledge, Ecenia & Purnell, P.A.

March 11, 2011

While it is clear that certain hospital systems carry a significant responsibility for providing access to the poor throughout the state, both in terms of admissions and ER visits, a proper comparison would add the burden for ALL public, tax-subsidized hospitals together and compare those volumes with the other hospitals.

The following table attempts to quantify the amount of total burden carried for the major systems combined.

System	Indigent Admissions *	Indigent Admissions as % of State Total	LIP Council Proposed NET LIP Payments **	Proposed LIP Council NET LIP Payments as Percent of Total
Investor Owned (HCA, Tenet and HMA)	150,865	23.2%	$62,623,098	5.8%
Major Public Hospital Systems (Jackson, North Broward, South Broward, Lee Memorial, Halifax, Sarasota)	138,634	21.3%	$425,954,025	39.20%

* "Indigent Admissions" are the total Medicaid, Medicaid HMO, Charity and ½ Bad Debt admissions as reported in or calculated from the 2009 FHURS data, which amounts to 649,502.
** "LIP Council Proposed NET LIP Payments" is the total amount in the pool, which amounts to $1,086,587,482.

The same analysis as the prior table, but based on ER Visits.

System	Indigent ER Visits *	Indigent ER Visits as % of State Total	LIP Council Proposed NET LIP Payments **	Proposed LIP Council NET LIP Payments as Percent of Total
Investor Owned (HCA, Tenet and HMA)	628489	27.6%	$62,623,098	5.8%
Major Public, tax supported Hospital Systems (Jackson, North Broward, South Broward, Lee Memorial, Halifax, Sarasota)	432062	19.0%	$425,954,025	39.20%

* "Indigent ER Visits" are the total Medicaid, Medicaid HMO, and Charity ER Visits as reported for 2009 AHCA ED and Inpatient Quarterly Databases, which amounts to 2,274,128.

** "LIP Council Proposed NET LIP Payments" is the total amount in the pool, which amounts to $1,086,587,482.

Same analysis as the prior table, but including Mt. Sinai, Bayfront, Shands, Orlando Regional and Tampa General to the public hospital category as members of the safety net hospital alliance; and adding the Adventist System and BayCare as non-safety net hospitals, but which provide significant volumes of care for the uninsured.

System	Indigent ER Visits *	Indigent ER Visits as % of State Total	LIP Council Proposed NET LIP Payments **	Proposed LIP Council NET LIP Payments as Percent of Total
Investor Owned plus major two major not for profit systems (HCA, Tenet, BayCare, Adventists and HMA)	974,752	42.9%	$133,934,728	12.3%
Major Public Hospital Systems Plus Some Members of Safety Net Alliance (Jackson, North Broward, South Broward, Lee Memorial, Halifax, Sarasota, Mt. Sinai, Bayfront, Shands, Orlando Health, Tampa General)	586,991	25.8%	$712,065,110	65.5%

* "Indigent ER Visits" are the total Medicaid, Medicaid HMO, and Charity ER Visits as reported for 2009 AHCA ED and Inpatient Quarterly Databases, which amounts to 2,274,128.

** "LIP Council Proposed NET LIP Payments" is the total amount in the pool, which amounts to $1,086,587,482.

Same analysis as the prior table, but based on Admissions.

System	Indigent Admissions *	Indigent Admissions as % of State Total	LIP Council Proposed NET LIP Payments **	Proposed LIP Council NET LIP Payments as Percent of Total
Investor Owned plus major two major not for profit systems (HCA, Tenet, BayCare, Adventists and HMA)	231,738	35.7%	$133,934,728	12.3%
Major Public Hospital Systems Plus Some Members of Safety Net Alliance (Jackson, North Broward, South Broward, Lee Memorial, Halifax, Sarasota, Mt. Sinai, Bayfront, Shands, Orlando Health, Tampa General)	229,426	35.3%	$712,065,110	65.5%

* "Indigent Admissions" are the total Medicaid, Medicaid HMO, Charity and ½ Bad Debt admissions as reported in or calculated from the 2009 FHURS data, which amounts to 649,502.

** "LIP Council Proposed NET LIP Payments" is the total amount in the pool, which amounts to $1,086,587,482.

The flaw in using cost, without any efficiency factor applied, to the LIP formula – Jackson Comparison

	Case Mix	Cost per Adj. Admit	CMA Cost/AA	Service Index	Adjusted Admissions	Savings if JMH operated at comparable efficiency	Uncomp Admits
Jackson	1.4509	16,067	11,074	72.9	101,185		58,347
Shands Jax	1.5762	9,975	6,329	70.7		480,122,825	16,338
Shands Gainesville	1.7843	13,743	7,702	77.9		341,195,820	15,709

* savings is calculated by multiplying the difference between two hospitals' CMA Cost/AA by the number of adjusted admissions at the reference hospital

The flaw in using cost, without any efficiency factor applied, to the LIP formula – Memorial Hospital comparison

	Case Mix	Cost per Adj. Admit	CMA Cost/AA	Service Index	Adjusted Admissions	Savings if MH operated at comparable efficiency	Uncomp Admits
Memorial Hospital - Tax district	**1.44**	**10,775**	**7,465**	**61.3**	**64,713**		**15,772**
St. Joseph	**1.3791**	**8,053**	**5,839**	**61.6**		**105,223,338**	**17,030**
Tallahassee Memorial	**1.4338**	**8,166**	**5,696**	**68**		**114,477,297**	**7,427**
Florida Hospital	**1.3977**	**10,312**	**7,378**	**70.7**		**5,630,031**	**32,148**

* savings is calculated by multiplying the difference between two hospitals' CMA Cost/AA by the number of adjusted admissions at the reference hospital

The flaw in using cost, without any efficiency factor applied, to the LIP formula – Broward General comparison

	Case Mix	Cost per Adj. Admit	CMA Cost/AA	Service Index	Adjusted Admissions	Savings if BG operated at comparable efficiency	Uncomp Admits
Broward General - Tax District	**1.4336**	**8,988**	**6,269**	**64.7**	**44,481**		**16,743**
Lakeland Regional	**1.4497**	**8,100**	**5,587**	**58.6**		**30,336,042**	**11,292**
Tallahassee Memorial	**1.4338**	**8,166**	**5,696**	**68**		**25,487,613**	**7,427**
Morton Plant	**1.5076**	**8,097**	**5,371**	**65.7**		**39,943,938**	**5,390**

* savings is calculated by multiplying the difference between two hospitals' CMA Cost/AA by the number of adjusted admissions at the reference hospital

The flaw in using cost, without any efficiency factor applied, to the LIP formula – Halifax Health comparison

	Case Mix	Cost per Adj. Admit	CMA Cost/AA	Service Index	Adjusted Admissions	Savings if HH operated at comparable efficiency	Uncomp Admits
Halifax Health - Tax District	1.4036	9,849	7,017	68.4	41,360		6,745
Baptist Medical Center	1.4281	8,905	6,236	65.7		32,302,160	9,709
Tallahassee Memorial	1.4338	8,166	5,696	68		54,636,560	7,427
Morton Plant	1.5076	8,097	5,371	65.7		68,078,560	5,390

* savings is calculated by multiplying the difference between two hospitals' CMA Cost/AA by the number of adjusted admissions at the reference hospital

From: Peacock, Lee [mailto:Lee.Peacock@ahca.myflorida.com]
Sent: Tuesday, October 26, 2010 8:54 AM
To: Lmccartney@FloridaJusticeAssociation.org
Cc: Barrett, Jennifer
Subject: Medicaid TPL Casualty recoveries

Good morning Lynn. In response to your October 20, 2010 email and our October 25, 2010 telephone conversation, I am forwarding you the dollar amounts recovered through the casualty portion of our recovery program for the past seven years. As we discussed, these amounts include all tort recoveries for a fiscal year and I am not able to provide you with individual amounts for particular tort types such as med-malpractice and nursing home cases.

Fiscal year	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010
(millions)	$22,431,466	$27,252,053	$26,648,342	$18,062,167	$17,681,026	$16,537,665	$18,747,553

Lee Peacock
Agency for Health Care Administration
Division of Operations
Medicaid Third Party Liability
Phone: 850-412-4139
Fax: 850-414-2604

Projected Economic Impact on the State of Florida

Line	Description	Figure	Notes/Source
1	Number of Medicaid Medical Malpractice Resolved Claims	551	CFO Report - Exhibit I - Line 7
2	Percentage of Cases above the Caps	50.00%	CFO Report - Exhibit I - Line 8
3	Number of Impacted Cases	276	Calculated (1*2)
4	Percentage of Cases that are wrongful Death	35.00%	Estimate
5	Percentage of Cases that require future medical treatment	65.00%	Estimate
6	Number of Cases that require future medical treatment	179	Calculated (5*3)
7	Average Present Value of Medicaid Billing	750,000	Estimate
8	Florida's Exposure to additional Medicaid Billing (Present Value)	134,306,250	Calculated (6*7)
9	Medicaid Lien Reimbursement	10,000,000	Agency for Health Care Administration; Phil Williams
10	**Total Impact**	**144,306,250**	**Calculated (9+10)**

Substance Abuse Treatment is Cost Efficient

Adult Substance Abuse GR = **$29.2 million**
Individuals Served w/GR = 55,200 (40% of 138,000 total adults served)

Increased Prison Costs
(if 10% go to prison)

5,520 x $53.34 x 365 = **$107 million**
individuals — daily prison rate — days

Increased Child Welfare Costs
(if 10% have a child in child welfare system)

5,520 x $10,000 = **$55 million**
individuals — per child/per year

Increased Health Care Costs
(if adult GR eliminated)

$29 million x $2.00 increased costs = **$58 million**
OR
$29 million x $3.52 increased costs = **$102 million**

65% of inmates have substance abuse problems

52% in treatment today have criminal justice involvement

46% of those in treatment have dependant children

50-80% youth in child welfare due to parental substance abuse problems

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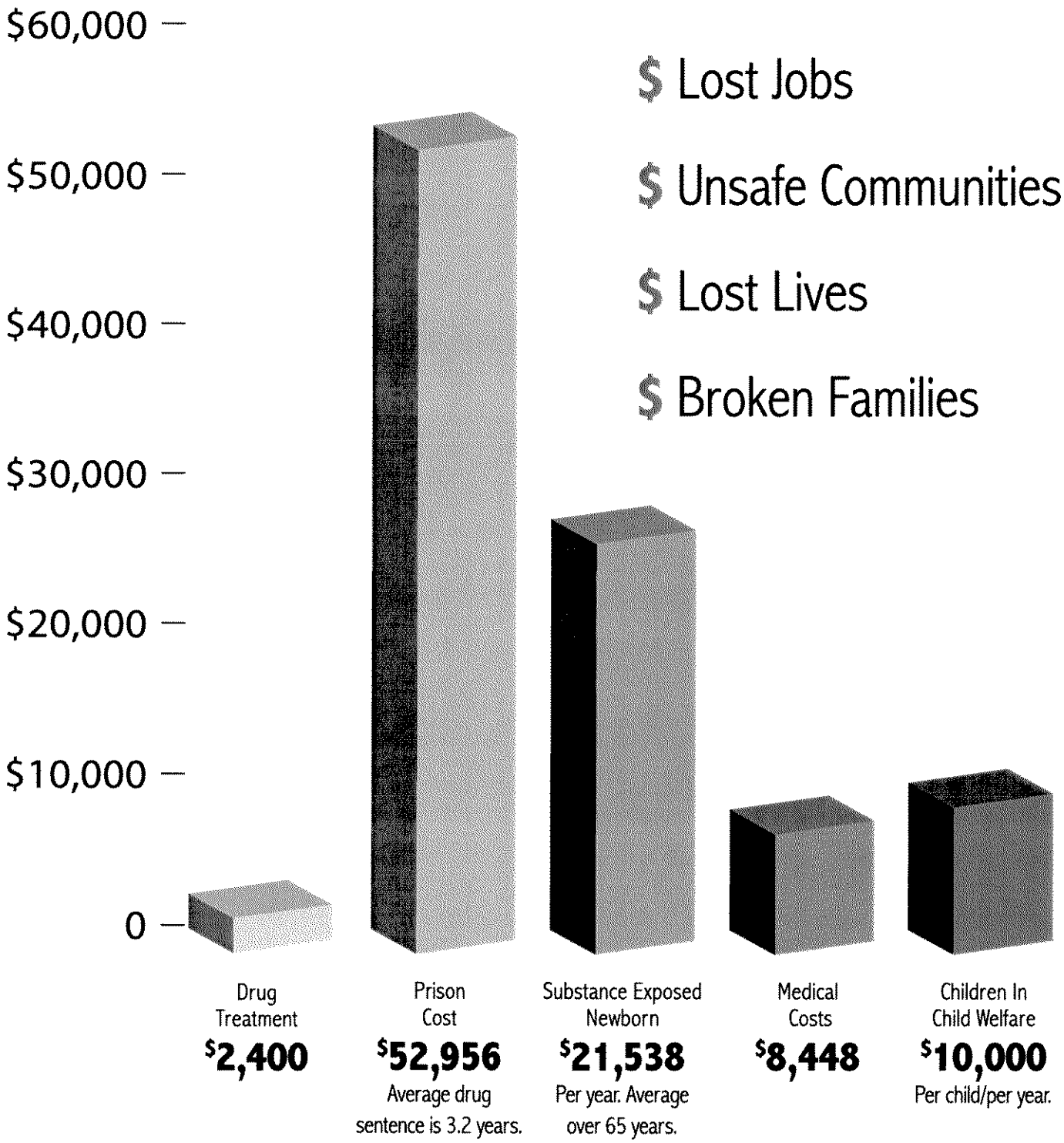
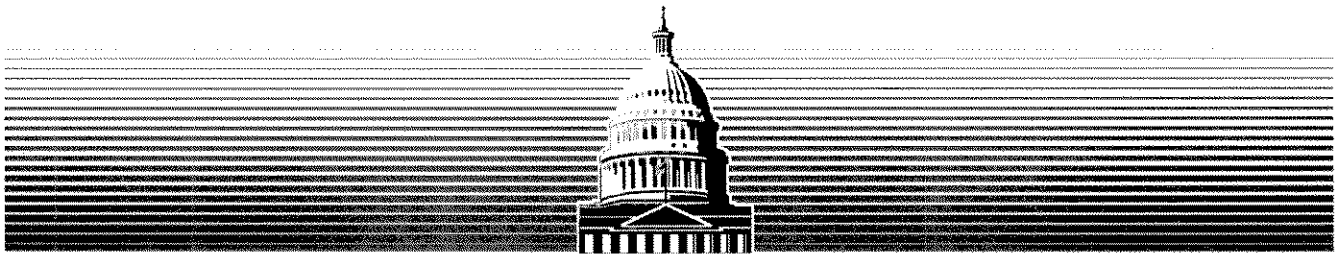
$2 increased medical costs- Washington state study OR $3.52 increased medical costs- Maryland state study

Substance Abuse Treatment is a Sound Investment

Continue Investment or Pay Tomorrow





LEGISLATIVE POSITION

FLORIDA ALCOHOL AND DRUG ABUSE ASSOCIATION

10 REASONS TO FUND SUBSTANCE ABUSE DISORDER TREATMENT

- IT MAKES GOOD BUSINESS SENSE -

- **Treatment is Cheaper than the Consequences**
  ---$2,400 for treatment vs. $52,956 for prison
  ---$2,400 for treatment vs. $10,000 per child annually in child welfare system
  ---$2,400 for treatment vs. $1.4 million lifetime cost for substance exposed newborn

- **Treatment Works** - 58% Individuals Receiving Treatment are Successful - A better record than other chronic health diseases

- **Treatment is <u>not</u> a Revolving Door** - 77% in treatment have only one contact in 12 months

- **Treatment is Cost Efficient** – each $1 in State GR generates $2 additional in federal block grant funds and local match

- **Treatment Reduces Medical Expenses** – Every $1 spent on treatment saves $2.00 to $3.52 in additional medical-related costs

- **Treatment Reduces Crime** – Studies report 40-60% reduction

- **Treatment Supports Local Jobs** – 69% of adults are employed post treatment

- **Treatment Employs Local Citizens** in over 16,650 jobs statewide – doctors, nurses, counselors and administrative staff who work at local businesses

- **Treatment Supports Local Economy** – over 1,490 vendors supply community treatment companies

- **85% of Those Currently in Treatment do not Qualify for Medicaid;** of those who do qualify, 56% need a substance abuse treatment service Medicaid does not cover

3/7/11

Florida Alcohol and Drug Abuse Association • 2868 Mahan Drive, Suite 1 • Tallahassee, FL 32308
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