STORAGE NAME: h1125a.hcs
DATE: March 27, 2000

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 1125

RELATING TO: Improving Racial and Ethnic Health Outcomes

SPONSOR(S): Representative Bradley

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE SERVICES YEAS 13 NAYS 3
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

I. SUMMARY:

HB 1125 creates the “Reducing Racial and Ethnic Health Disparities: Closing the Gap Act.” The bill provides legislative findings and intent. The bill creates a grant program, to be administered by the Department of Health.

The bill provides duties and responsibilities of the department and authorizes the appointment of an ad hoc advisory committee by the department secretary. The bill provides eligibility, requirements, and procedures for award of grants to local individuals, entities, and organizations to address disparities in racial and ethnic health outcomes.

The bill requires local matching funds or in-kind contributions. The bill provides for dissemination of 1-year grant awards beginning no later than January 1, 2001, subject to specific appropriation. The bill provides for annual applications for grant renewal.

The bill provides an appropriation of $10 million dollars from the General Revenue Fund to the Department of Health to establish and implement the grant program and for one full-time-equivalent position.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

HB 1125 creates the Racial and Ethnic Health Disparities: Closing the Gap Act, which will be housed at and administered by the Department of Health. The program will solicit proposals for grants, award and monitor grants, and conduct multiple statewide “best practice” conferences annually.

B. PRESENT SITUATION:

Background

According to the American Medical Association:

The United States has traditionally been know as the “melting pot,” where hundreds of peoples and cultures from across the world come together, leaving behind their original identities to become “Americans.”

Today, however, instead of assimilating into the dominant culture, immigrants to America are more likely to retain the language, customs, and practices of their country of birth. The current metaphor is not the melting pot but rather the salad bowl, with different nationalities interacting in the workplace and socially, while retaining their cultural heritage. And of course, people of all nationalities have cultural issues related to their age, sex, socioeconomic status, occupation, and so on.

The American health care system also has changed. Despite extensive...legislative and advocacy efforts, startling disparities in health care access continue both in big cities and rural areas, with millions of Americans uninsured and underserved. Ignorance of cultural issues, lack of knowledge, language differences, prejudice, bigotry--whether on the part of the physician or the patient--all serve as barriers to access to effective health care for every American. [*Source: American Medical Association, The Reporter, October 1999.*]

According to the Centers for Disease Control and Prevention:

By the end of year 2000, racial minorities -- African Americans, Asian and Pacific Islander Americans, and Native Americans -- will make up more than 17 percent of the U.S. population. Persons of Hispanic origin, who may be of any race, will make up more than 11 percent.

Compared to the nation as a whole, minority populations, particularly African Americans, suffer higher rates of morbidity and mortality. Native Americans and Hispanics also have worse health outcomes than the total population. Although Asian American and Pacific-Islanders overall have reasonably good health indicators, some subgroups within these populations have very poor health status indicators.

The health status of the nation as a whole has improved significantly during this century. Advances in medical technology, lifestyle improvements, and environmental protections have all led to health gains. Yet these changes have not produced equal benefit in some racial and ethnic populations.

Health disparities among minority populations are generally based on differences in economics, education, and other social conditions, and behavioral factors such as lifestyle and health practices. Minority populations are disproportionately represented among the economically disadvantaged in the United States. The impact of institutionalized racism on health has not been adequately assessed; however, relationships between negative health outcomes, economic deprivation, and lack of adequate access to quality health care have been extensively investigated and documented.

Research and health promotion have increasingly targeted minority ethnic and racial populations in efforts to understand the dimensions of existing problems and work to reduce or eliminate health disparities. But the task is not easy; the problems are of longstanding duration and multi-faceted complexity. Racial and ethnic minority populations differ from one another in social and cultural characteristics, and there is diversity within each racial and ethnic population. Although the increased focus in recent years on health initiatives targeting minority populations has produced some measurable health gains, in many instances the gap in health status continues to widen. [*Source: Centers for Disease Control and Prevention, Office of the Associate Director for Minority Health*.]

According to the Florida Department of Health:

Culturally and ethnically diverse communities are Florida’s fastest growing population segments. Yet, Florida’s ability to affect improvements in many important health outcomes measurements --such as the incidence of infant mortality, cardiovascular disease, cancer, and diabetes--has fallen short of our state’s identified strategic plan goals. The lagging rate of improvements in these communities demands attention.

- Infant mortality rates are nearly doubled for African Americans compared to whites.
- Hispanic whites are 25 percent more likely than non-Hispanic whites to have diabetes.
- Native American youth are 34 percent more likely to be current smokers than non-Hispanic white youth.
- African Americans are nearly six times as likely to die of AIDS than whites.
- The death rate for cancer among African American men is about 50 percent higher than for white men.
- Hispanics are 26 percent more likely than non-Hispanic whites to be obese.
- African Americans are 77 percent more likely to be obese than non-Hispanic whites.
- African Americans are nearly twice as likely to die of stroke than whites.

Federal Initiatives

The Office of Minority Health (OMH) was created by the U.S. Department of Health and Human Services (HHS) in 1985 as a result of the Report of the Secretary's Task Force on Black and Minority Health. The Office of Minority Health Resource Center (OMH-RC) was

created in 1987. OMH-RC serves as a national resource and referral service on minority health issues. The center collects and distributes information on a wide variety of health topics, including substance abuse, cancer, heart disease, violence, diabetes, HIV/AIDS, and infant mortality. The Resource Center also facilitates the exchange of information on minority health issues. Unlike a clearinghouse, OMH-RC offers customized database searches, publications, mailing lists, referrals, and more regarding American Indian and Alaska Native, African American, Asian American and Pacific Islander, and Hispanic populations. The OMH advises the Secretary of HHS and the Office of Public Health and Science (OPHS) on public health issues affecting American Indians and Alaska Natives, Asian Americans, Native Hawaiians and Other Pacific Islanders, Blacks/African Americans, and Hispanics/Latinos. The mission of OMH is to improve the health of racial and ethnic populations through the development of effective health policies and programs that help to eliminate disparities in health.

In February 1998, President Clinton announced Healthy People 2010 program, as part of his Initiative on Race, in an effort to make the elimination of disparities in health outcomes for racial and ethnic minorities in this country a national priority. Later that year, Congress approved the funding for the initiative. The Healthy People 2010 program is a national health promotion and disease prevention initiative that 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: U.S. Department of Health and Human Services, Office of Minority Health, website:* http://www.omhrc.gov/AboutOMH.HTM]

In 1998, the Clinton Administration, via the Health and Human Services Minority HIV/AIDS Initiative, declared HIV/AIDS to be a severe and ongoing health crisis in racial and ethnic minority communities. The initiative began in Fiscal Year 1999 with $156 million, which increased to $250 million in Fiscal Year 2000. The Administration has requested $274 million for Fiscal Year 2001. This initiative provides funds for grants to community-based organizations, research institutions, minority-serving colleges and universities, health care organizations, and state and local health departments through six federal agencies – the Office of Minority Health, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, National Institutes of Health, Indian Health Services, and Health Resources and Services Administration.

The Division of Diabetes Translation (DDT) is a part of the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (DHHS). The division focuses on the following: to understand the problem; to determine the elements of good preventive care; to identify groups at risk for complications or that have low levels of preventive care; and to communicate this information to providers of care, policy makers, intervention program specialists, and others. The division does not support the direct provision of services, but facilitates the efficient, fair, and effective availability of these services to all Americans impacted by diabetes. The division does not do laboratory research and does not routinely fund individual investigators. Significant activities of the division include:

- The National Hispanic/Latino Diabetes Initiative for Action (NH/LDIA), to serve as a blueprint for the DDT to frame interdisciplinary, culturally relevant approaches to control diabetes and its complications in the U.S. Hispanic/Latino community; because it is also a long-range "road map," the initiative is comprehensive in scope; and

- Project DIRECT is a multiyear community diabetes demonstration project, funded primarily by the Centers for Disease Control and Prevention (CDC). DIRECT is an acronym for "Diabetes Intervention Reaching and Educating Communities Together." To reduce the burden of diabetes and its complications in an African-American community through a community diabetes demonstration project.

Florida Governmental Programs

The State of Florida supports minority and ethnic health care through a variety of funding programs throughout the various agencies. The following programs were specifically created to focus on minority and ethnic health issues:

Minority HIV/AIDS Task Force: The Task Force was created by section 200, chapter 99-397, Laws of Florida. Appointed by the Secretary of the Department of Health, the members of the Task Force are commissioned to develop specific recommendations for consideration by the Governor, the Legislature, and the department. These recommendations are primarily designed to address ways to strengthen HIV/AIDS prevention, early intervention and treatment efforts in the state's African-American, Hispanic, and other minority communities. The Task Force is also intended to assist the department in conducting a Black Leadership Conference on HIV/AIDS. The legislation further required the development and implementation of a statewide HIV/AIDS media campaign that is directed towards minorities.

Department of Health, Bureau of HIV/AIDS: This bureau provides a coordinated approach to prevent to spread of HIV/AIDS and provide care and treatment to those already infected. Due to the disporprotionate affect of HIV/AIDS on minority communities, the bureau has implemented several initiatives towards culturally and ethnically diverse communities, including the following: Florida Black Leadership Conference on HIV/AIDS; Florida HIV/AIDS Minority Network; Minority HIV/AIDS Task Force; 7 Regional Minority HIV/AIDS coordinators; and The Church as a Change Agent Workshops. In addition, the HIV/AIDS funding targeted to Minority Communities program has funded the following: 40 prevention contracts, Targeted Outreach to Pregnant Women Act, AIDS Drugs Assistance Programs, Aids Insurance Continuation Programs, Housing Opportunities for Persons with AIDS, and outpatient medical care, pharmaceuticals, dental services, and case-management. Other HIV/AIDS funding allocations have provided training, workshops, and conferences; seroprevalence studies and surveillance activities; collaborative activities between HIV prevention, alcohol, drug abuse, and mental health; peer education projects at three Department of Corrections facilities; statewide condom and literature purchase; and community planning.

Office of Equal Opportunity and Minority Affairs: This office, in addition to its responsibilities for planning, directing, coordinating, and assuring statewide compliance with federal and state civil rights laws and policies relating to the provision of equal opportunities in employment with the Department of Health, is also responsible for development, coordination and supervision of the staff of the minority population outreach program and coordinates the activities of the Minority Health Council of the Tobacco Pilot Program.

In 1999, the office, in conjunction with the U.S. Department of Health and Human Services, sponsored the Inaugural Interagency Minority Health Symposium. The goal of the symposium was to bring together government and community leaders to find more effective ways to address the health care needs of Florida's culturally and ethnically diverse communities. The discussion focused on six major areas of health disparity: maternal/infant

mortality, vaccinations, HIV/AIDS, diabetes, chronic cardiovascular diseases, and cancer. State agencies with programs that target minority populations included: Department of Agriculture and Consumer Services, Department of Community Affairs, Department of Corrections, Department of Children and Family Services, Department of Education, Department of Elderly Affairs, Department of Environmental Protection, Department of Insurance, Department of Juvenile Justice, Department of Management Services, Department of Veterans Affairs, Agency for Health Care Administration, and the Commission for the Transportation Disadvantaged.

The Sickle Cell Education and Counseling Program: This program, located in the Department of Health, provides sickle cell education and counseling of individuals, families, and the general public in Florida. The purpose of this educational effort is to reduce pediatric and adult morbidity and mortality by increasing community awareness of the disease, by identifying available medical and supportive resources to this population and to promptly place those with sickle cell disease in a system of care. This is accomplished through contracts with multiple community providers.

The Bureau of Tuberculosis & Refugee Health: This bureau, located within the Department of Health, provides time-limited health care services to refugees. Within 90 days of arrival, refugees are eligible to receive a domestic health assessment. For the first eight months in the United States, refugees are eligible for Medicaid or refugee medical assistance. After 8 months, refugees access health care services as any other individual would. The current $700,000 funding is from the Office of Refugee Resettlement in Washington via a Preventive Health Services for Refugees Grant for FY 99-00. In addition, the Department of Children and Family Services, Refugee Services funds two positions. In 1998, over $2,000,000 in Refugee Medical Assistance funds was reimbursed to county health departments for the provision of refugee health assessments.

The Community Environmental Health Program: In 1998, s. 381.1015, F.S., was created providing for the Community Environmental Health Program and the Community Environmental Health Advisory Board. The program recognizes that racial minorities and low-income populations experience higher than average exposures to selected pollutants. While exposure does not always result in immediate or acute health effect, high exposures, and the possibility of chronic effects, is a cause for concern. In 1999, the Legislature identified six pilot projects, listed in s. 381.102, F.S., to demonstrate techniques and coordinate with existing resources and programs to ensure health care for residents through disease prevention and health promotion. These pilot projects are located in low-income communities. A report to the Legislature and Governor is due on January 1, 2001, regarding the findings, accomplishments, and recommendations of the pilot projects.

Front Porch Florida: In 1999, s. 14.2015, F.S., was created to form the Front Porch Florida program, an urban revitalization initiative that was designed to build on the strengths of Florida's urban core communities, including the Urban Core Brownfield Cleanup Program.

The Center for Environmental Equity and Justice: In 1998, s. 760.854, F.S., was created to form The Center for Environmental Equity and Justice at the Florida Agricultural and Mechanical University within the Environmental Sciences Institute. The purpose of the center is to conduct and facilitate research, develop policies, and engage in education, training, and community outreach with respect to environmental equity and justice issues.

The following programs, while not created to specifically focus on minority and ethnic health issues, contain elements or programs which focus on minority and ethnic health issues:

- The Florida KidCare Act (ss. 409.810-409.820, F.S.);
- Healthy Families Florida (s. 409.153, F.S.), a partnership between the Ounce of Prevention Fund, a not for profit organization, and the Florida Department of Children and Family Services; and
- The Florida Commission for the Transportationally Disadvantaged (ss. 427.011-427.017, F.S.).

C. EFFECT OF PROPOSED CHANGES:

The bill creates the "Reducing Racial and Ethnic Health Disparities: Closing the Gap Act" to be administered by the Department of Health. A series of "Whereas" clauses provide background information as to the problems that need to be addressed. The bill provides findings and intent. The bill provides the duties and responsibilities of the department. Authorizes the appointment of an ad hoc advisory committee. Provides criteria and procedures for awarding grants to local individuals, entities, and organizations to address the disparities in racial and ethnic health outcomes. Requires local matching funds and allows for in-kind contributions based on county population. Provides for dissemination of 1-year grant awards beginning no later than January 1, 2001, subject to specific appropriation. Provides for annual applications for grant renewal. Provides a $10,000,000 appropriation.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates s. 381.7351, F.S., creating the "Reducing Racial and Ethnic Health Disparities: Closing the Gap Act", ss. 381.7351-381.7356, F.S.

Section 2. Creates s. 381.7352, F.S., providing legislative findings and intent that recognizes that certain racial and ethnic populations in Florida continue to have significantly poor health outcomes. Acknowledges that local governments and communities are best equipped to identify the health education, health promotion, and disease prevention needs of the racial and ethnic populations in those communities, and to mobilize the community to address these disparities and evaluate the effectiveness of the outcomes.

Section 3. Creates s. 381.7353, F.S., relating to the "Reducing Racial and Ethnic Disparities: Closing the Gap grant program" (program), administration of the program, and duties of the Department of Health.

Subsection (1) requires the Department of Health to administer the program.

Subsection (2) requires the department to:

- Publicize the availability of funds and establish the grant application process;
- Provide technical assistance and training, as requested;
- Develop uniform data reporting requirements for evaluation and outcome purposes;
- Develop a monitoring process; and
- Coordinate with existing community-based programs to avoid duplication of effort and promote consistency.

Subsection (3), authorizes the secretary of the department, in accordance with s. 20.43(6), F.S., to appoint an ad hoc advisory committee to:

- Examine areas where public awareness, public education, research, and coordination regarding racial and ethnic health outcome disparities are lacking;
- Consider access and transportation issues contributing to health status disparities; and
- Make recommendations for closing the gaps in health outcomes disparities between racial and ethnic populations.

Section 4. Creates s. 381.7354, F.S., relating to eligibility.

Subsection (1) specifies eligible recipients that may apply for a grant and serve as the lead agency for administration and coordination.

Subsection (2) authorizes multicounty grant proposals, within adjoining counties with populations less than 100,000, with a single lead agency.

Subsection (3) requires that in addition to the grants awarded, up to 20 percent of the funding for the program must be dedicated to projects that address improving racial and ethnic health status within a specific neighborhood, with priority for communities or neighborhoods that have been designated as Front Porch Florida Communities.

Subsection (4) provides that nothing in this act prevents a person, entity, or organization within a county or group of counties from separately contracting for the provision of racial and ethnic health promotion, health awareness, and disease prevention services.

Section 5. Creates s. 381.7355, F.S., relating to project requirements and review criteria.

Subsection (1) requires that grant proposals be submitted to the Department of Health for review.

Subsection (2) requires that each proposal must include decreasing racial and ethnic disparities in one or more of the following: maternal and infant mortality rates, morbidity and mortality rates relating to cancer, HIV/AIDS, cardiovascular disease, or diabetes, or increasing adult and child immunization rates in certain racial and ethnic populations. Each proposal must also include:

- Identification and relevance of the target population;
- Methods for obtaining baseline health status data and assessment of community health needs;
- Mechanism for mobilizing community resources and gaining local commitment;
- Development and implementation of health promotion and disease prevention interventions;
- Development and implementation of health promotion and disease prevention interventions;
- Mechanisms and strategies for evaluating the project’s objectives, procedures, and outcomes;
- A proposed work plan, including a timeline for implementing the project; and
- Likelihood that project activities will occur and continue in the absence of funding.

Subsection (3) requires that priority be given to proposals that:

- Represent the areas with the greatest documented racial and ethnic health status disparities;
- Exceed the minimum local contribution requirements;
- Demonstrate broad-based local support and commitment from entities representing racial and ethnic populations;
- Demonstrate a high degree of participation by the health care community in clinical preventive service activities and community-based health promotion and disease prevention interventions;

- Have been submitted from counties with high proportion of residents living in poverty and with poor health status indicators;
- Demonstrate a coordinated community approach to addressing racial and ethnic health issues within existing publicly financed health care programs;
- Incorporate intervention mechanisms which have a high probability of improving the targeted population's health status; and
- Demonstrate a commitment to quality management in all aspects of project administration and implementation.

Section 6. Creates s. 381.7356, F.S., relating to local matching funds and grant awards.

Subsection (1) authorizes only one grant to be awarded per county, or in a group of adjoining counties from which a multicounty application is submitted. Authorizes neighborhood grants to be awarded in a county or group of adjoining counties which is also receiving a grant award.

Subsection (2) provides that grants must be awarded on a matching basis, with one dollar in local matching funds for each three dollars of grant payments, except:

- In counties with populations greater than 50,000, where up to 50 percent of the local match may be in-kind in the form of free services or human resources. Fifty percent of the local match must be in the form of cash.
- In counties with populations of 50,000 or less, the required matching funds may be provided entirely through in-kind contributions.
- Neighborhood grant awards are not required to have local match.

Subsection (3) provides that the amount of the grant award must be based on the county or neighborhood's population, or on the combined population in a group of adjoining counties from which a multicounty application is submitted, and on other factors, as determined by the department.

Subsection (4) requires the dissemination of the grant awards to begin no later than January 1, 2001.

Subsection (5) requires grants to be funded for 1 year and may be renewed annually upon application to and approval by the department. Renewal is subject to the achievement of quality standards, objectives, and outcomes and to the availability of funds.

Subsection (6) limits the implementation of the program to a specific appropriation being provided in the General Appropriations Act.

Section 7. Provides an appropriation from the General Revenue Fund to the Department of Health of $10 million to be used to establish and implement the Reducing Racial and Ethnic Health Disparities: Closing the Gap grant program, including the funding of one full-time-equivalent position.

Section 8. Provides that the act takes effect upon becoming a law.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

Department of Health:

Non-Recurring or First Year Start-up Effects:

	Amount Year 1	Amount Year 2
EXPENSE:		
Professional Package @ $4,189	$4,180	
Total Expense	$4,180	
OCO:		
Computers 1 @ $3,300	$3,300	
Total OCO	$3,300	
Total Non-Recurring	$7,480	

Recurring or Annualized Continuation Effects:

Salaries/Benefits:		
Senior Management Analysis II 1 @ $40,491/$55,607	$40,491	$55,067
Total Salaries/Benefits	$40,491	$55,067
EXPENSE:		
Professional package Maximum Travel 1 @ $16,505	$16,605	$16, 505
Statewide Conference	$7,000	$7,000
Ad Hoc Advisory Committee Travel Costs @ $5,000/meeting 4 meeting/year	$20,000	
6 meeting/year	$30,000	
Counties, Communities or Neighborhoods grant awards	$ 9,908,524	$ 9,890,888
Total Expense	$ 9,952,029	$ 9,944,393

Total Recurring Costs	$ 9,952,520	$10,000,000
Total Non-recurring and Recurring costs	$10,000,000	$10,000,000

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

Local government applicants for these grant funds must allocate matching funds in instances where their population is greater than 50,000.

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

See comments above.

D. FISCAL COMMENTS:

According to the Department of Health:

Ten million dollars will be appropriated from the General Revenue Fund to the Department of Health to reduce the health status outcomes gap between minorities and non-minorities. The administration of this program will require one professional, highly trained, highly experienced individual. This administration by the Senior Management Analyst II will include:

- Publicizing availability of funds to Florida counties and communities;
- Overseeing review of competitive proposals and award funds;
- Providing technical assistance and training to include an annual statewide “best practices” meeting;
- Developing uniform data reporting requirements for evaluation and accountability purposes;
- Developing a monitoring process to evaluate progress;
- Coordinating with existing community-based programs;
- Providing staff support to the ad hoc advisory committee.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

Several provisions of this bill imply rulemaking authority for the Department of Health. However, the department has not been granted rulemaking authority for this program.

Section 3:
Subsection (2)(a) requires the department to establish an application process for submitting a grant proposal.

Subsection (2)(c) requires the department to develop uniform data reporting requirement for the purpose of evaluating the performance of the grant recipients and demonstrating improved health outcome.

Section 6:
Subsection (3) specifies that the amount of grant awards will, in part, be based on "other facts, as determined by the department."

C. OTHER COMMENTS:

The structure of this new program is generally modeled after the provisions of the Primary Care for Children and Families Challenge Grant Act as specified in ss. 154.501-154.506, F.S., created in 1997.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 23, 2000, the Committee on Health Care Services adopted five amendments, as follows:

Amendment #1 (page 2, line 23) - updated the statistics on African Americans and HIV/AIDS for purposes of a "WHEREAS" clause.

Amendment #2 (page 4, lines 10-23) - adds faith based organizations as participating entities and specifies Front Porch Florida Communities as intended funding recipients.

Amendments #3 (page 6, lines 5-24) and #4 (page 9, lines 6-22) - allows for more than one grant recipient per county and specifies Front Port Florida Communities as intended funding recipients.

Amendment #5 (page 2, between lines 24 and 25) - adds and additional “WHEREAS” clause relating to the fact that African Americans ages 35 and older and Asians over the age of 50 are more likely to develop glaucoma.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Tonya Sue Chavis, Esq.	Phil E. Williams