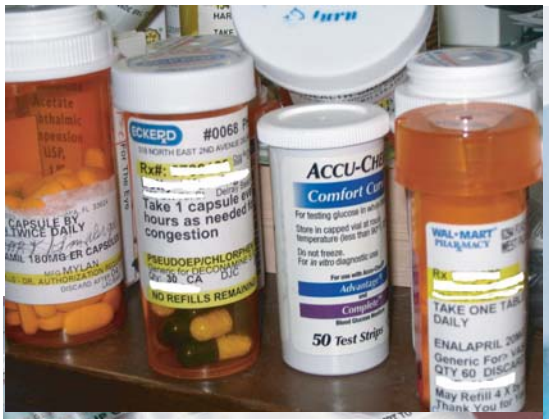


FLORIDA DEPARTMENT OF HEALTH

FY 2004-2005

Annual Report

Office of the Inspector General

Florida Department of Health

professionalism

integrity

independence

leadership

teamwork

FLORIDA DEPARTMENT OF HEALTH

Jeb Bush
Governor

M. Rony François, M.D., M.S.P.H., Ph.D.
Secretary, Department of Health

September 29, 2005

M. Rony François, M.D., M.S.P.H., Ph.D.
Secretary
Florida Department of Health
4052 Bald Cypress Way
Tallahassee, Florida 32399-1700

Dear Secretary Francois:

As required by Section 20.55, Florida Statutes, I am pleased to submit the Office of the Inspector General's 2004-2005 Annual Report which summarizes our accountability activities for the prior fiscal year.

As documented in the attached report, the HIG team contributes significantly to the department's ability to effectively and efficiently accomplish it's mission. This report is a reflection of that value added.

If you have any questions about the contents of this report, please allow me to discuss them with you. We look forward to another productive year and to working with you in your new capacity as our Secretary.

Respectfully,

Charles V. Page
Acting Inspector General

CVP/kp
Attachment

Office of the Inspector General
Annual Report FY 2004-2005

		Executive Summary	1
		Organizational Profile	2
		Mission, Vision, Values	
		Key Products and Services	
		Staff Qualifications	
		Organizational Chart	
	1	Leadership	5
	2	Strategic Planning	7
		Audits	
		Investigations	
		Child Care Food Audit Program	
		Management Reviews	
	3	Customer and Market Focus	12
		Customer and Market Knowledge	
		Customer Relationships and Satisfaction	
	4	Measurement, Analysis, and Knowledge Management	13
		Audits	
		Investigations	
		Other Accountability Products – Hurricane After Action Review	
	5	Human Resource Focus	39
	6	Process Management	40
	7	Organizational Performance Results	41
		Customer-Focused Results	
		Human Resources Results	
		Product and Service Outcomes/Organizational Effectiveness Results	
		Leadership and Social Responsibility Results	
		Appendix	48

Executive Summary

Indispensable Contributions

This report is submitted in compliance with the requirement of Section 20.055, Florida Statutes (F.S.) that each inspector general prepare an annual report summarizing the preceding year's activities. This report summarizes the activities and accomplishments of the Florida Department of Health's Office of Inspector General for the twelve-month period beginning on July 1, 2004 and ending June 30, 2005.

For the fourth consecutive year the Sterling Criteria for Organizational Performance Excellence provide the organizing framework for this report. The seven categories of Sterling Core Values and Concepts provide an appropriate outline to document our efforts to improve the department's accountability and efficiency.

In FY 2004-2005 Florida faced the challenge of a hurricane season unprecedented in recorded history. The state's population and public service infrastructure was gravely impacted by four major hurricanes within a six-week period. In e-mail communications to all employees, Secretary John O. Agwunobi continuously emphasized that responding and supporting the department's response to the public health needs of Florida's hurricane-devastated areas was the most important mission for the department. Public health services are never more visible and needed than in times of such disasters and the Health Office of the Inspector General (HIG), like all department elements, was called upon to fulfill a vital role. The Secretary assigned HIG the responsibility of producing the department's hurricane "after action lessons-learned" report to be used as a guiding document for future disaster response improvements. This intensive effort required the resources of 40% of the investigative staff over a 6 month period. The project culminated in the March 2004 release of a seven-volume "Hurricane After Action Report (AAR)" distributed on CD and posted on the department's intra and internet websites to be used as a guiding document for disaster response planning. Additionally, the AAR has proven to be of great interest to other departments, other states and international organizations, not only as a hurricane lessons-learned reference document but as a model for after action reporting.

While special duties were required by this hurricane season the demands of the normal HIG work load did not cease. Investigative staff received 233 complaints in 2004-2005, triaged 93% of them within 10 days, and closed 235 complaints. Our internal audit staff performed six comprehensive audits and five follow-up reviews of audit findings from prior years. Our Child Care Food Program (CCFP) audit staff completed 386 Child Care Food Program (CCFP) agreed-upon procedures reviews, closed 428 reviews and recovered $456,013.

Organization at-a-glance

Guiding Mission, Vision, Values

Florida Department of Health

Mission *"To promote and protect the health and safety of all people in Florida through the delivery of quality public health services and the promotion of health care standards."*

Governor's Council on Integrity & Efficiency

Vision *"Enhancing Public Trust in Government"*

Mission *"Provide leadership in the promotion of accountability and integrity of State Government."*

The Office of the Inspector General

Vision "Indispensable contributions in achieving excellence."

Mission "Trusted agents providing independent, objective and useful products to facilitate the department's success."

Values Our values reflect a commitment to...

Integrity	honesty, fairness, loyalty, trustworthiness and our customers
Professionalism	specialized study, demonstration of superior skills and being the subject matter expert
Independence	a commitment to self-reliance
Objectivity	the facts uninfluenced by personal prejudices or emotions
Timeliness	promptness
Teamwork	a commitment to collaboration in achieving common goals

Key Products and Services

- audits, investigations, management reviews, and risk reviews (reviews of department-provided medical care where litigation may occur);
- supervision and coordination of other activities promoting economy and efficiency in the administration of programs or in preventing and/or detecting fraud and abuse;
- reviewing and evaluating internal controls;
- informing and keeping agency managers updated regarding any fraud, abuse or other deficiencies in program operations;
- recommending corrective actions to address reported fraud, abuse and deficiencies;
- reporting progress made on audit corrective actions;
- monitoring implementation of changes in response to Auditor General audits;
- developing audit plans based on periodic risk assessments;
- advising on the development of program performance measures;
- assessing reliability and validity of performance measures;
- ensuring coordination among auditing agencies;
- conducting whistle-blower investigations ; and
- consulting with contract managers on an as-needed basis.

Staff Qualifications

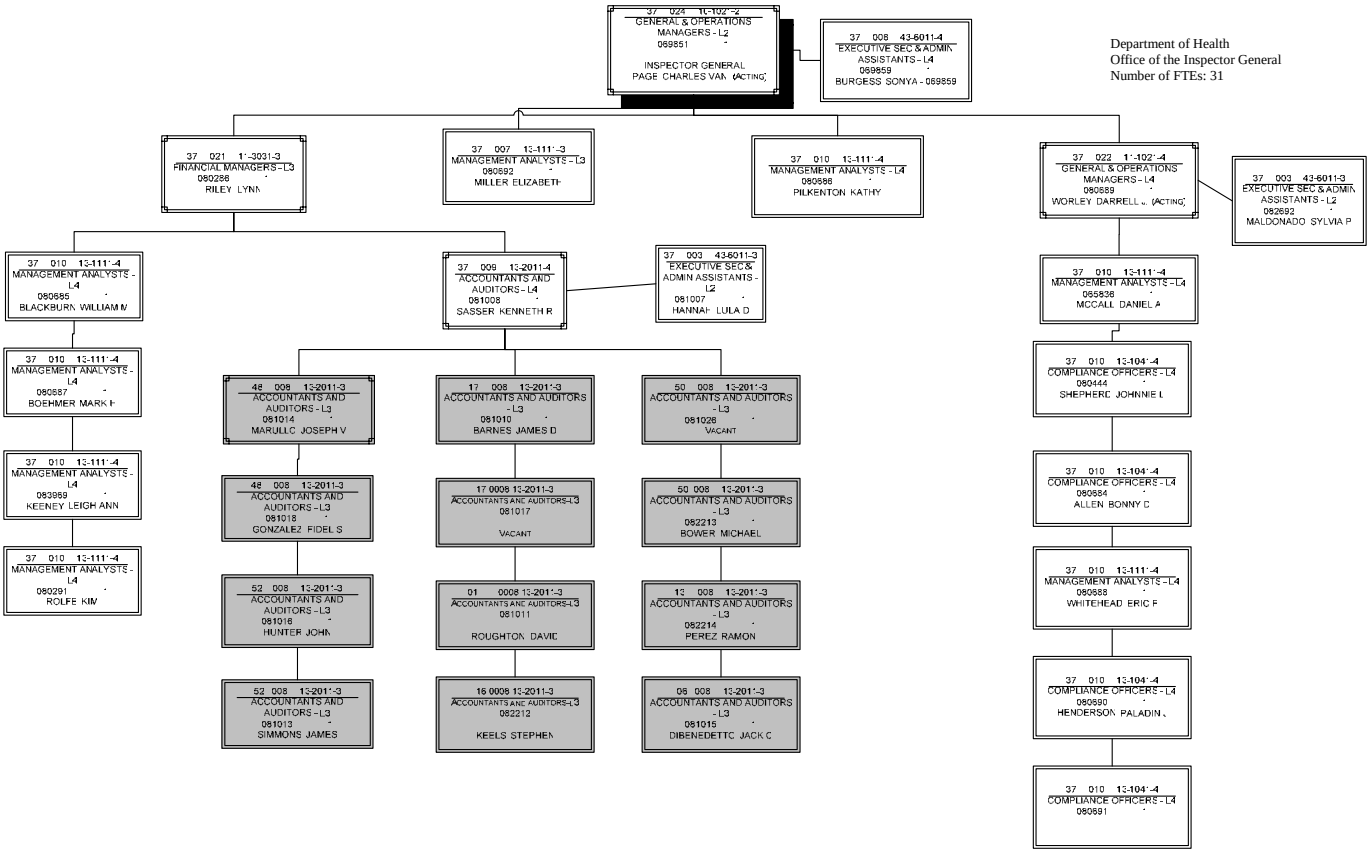
- Of the 27 professional staff, 81% have bachelor's-level college degrees;
- 36% have master's degrees;
- 85% have specialty certifications
- Collectively:

  Audit experience: 364 years

  Investigative experience: 130 years

2	Certified Inspectors General
6	Certified Public Accountants
2	Certified Internal Auditors
1	Certified Government Auditing Professional
4	Certified Inspector General Investigators
1	Certified Government Financial Manager
1	Certified Unemployment Tax Auditor
1	Certified State & Local Tax Accountant
1	Certified Information Systems Auditor
1	Certified Computer Forensics Examiner
1	Certified Electronic Evidence Collection Specialist
1	Seized Computer Evidence Recovery Specialist
1	A+ Certified Professional
4	Certified Contract Managers
4	Former Law Enforcement Officers
1	Certified Mediator

Our 31 staff are distributed across functional areas as shown in the organizational chart below. Additionally, we have 2.5 OPS staff. The Inspector General reports directly to the Secretary. Positions shaded in gray are the Child Care Food Program (CCFP) field auditors who report to the Professional Accountant Supervisor in Tallahassee.



1. Leadership

The HIG leadership team during FY 2004-2005 consisted of:

Charles V. Page, B.S., C.I.G.
Investigative experience of 34 years.
Acting Inspector General since August 2004
(**Linda A. Keen, R.N., M.S.N., J.D., C.I.G.** served as Inspector General for the first month of FY 2004-2005, after which she was appointed Acting Deputy Secretary.)

Darrell J. Worley, C.I.G.I.
Investigative/law enforcement experience of 17 years.
Acting Director of Investigations since August 2004

Lynn H. Riley, C.P.A., C.I.G.
Audit experience of 18 years.
Director of Auditing since March 1997

Kenneth R. Sasser, C.P.A., C.I.A.
Audit experience of 19 years.
Child Care Food Audit Program
Supervisor since October 1997

Leadership and Staff Professional Activities/Affiliations

- Board of Directors and Executive Committee, National Association of Inspectors General
- Team leaders and members of the HIG Management Review Team (MRT)
- Board of Directors and Executive Committee Member, Florida Association of Inspectors General, Tallahassee Chapter
- Audit Round Tables Participant
- Mediator for Executive Direction
- Attendees, 2004 Conference, National Association of Inspectors General

Leadership and Staff Professional Activities/Affiliations (Cont'd)

- Member, Information Technology Tier 2 Governance Committee
- Presentation: "Digital Evidence Preservation and Collection" at the annual DOH System Administrator's Conference
- HIG Representative for the Department Computer Security Incident Response Team
- Members, Institute of Internal Auditors
- IACIS CFCE Coach – coaching two computer forensic examiners through their year long certification process
- Members, Association of Government Accountants, Tallahassee Chapter
- Presentation: Management Review On-line Survey Process at the Annual Southeast Evaluation Association Conference
- Members, Association of Certified Fraud Examiners
- Member, American (and Florida) Institute of Certified Public Accountants
- Served on National Subcommittee to create Certified Inspector General Auditor curriculum
- Members, Southeast Evaluation Association
- Attendee, Governor's Hurricane Conference
- Member, National Association of Executive Secretaries and Administrative Assistants

2. Strategic Planning

Audits

Mission Statement

To provide the agency with an independent assessment of the performance and management of its programs, services and contracting process through audits and audit related products.

Progress on meeting 2004-2005 objectives and goals

Major revisions of our Audit Manual were completed in preparation for our triennial Quality Assurance Review to be performed by the Office of the Auditor General. There was no multi-agency audit coordinated by the Office of the Chief Inspector General during this reporting period. A position was dedicated to the audit liaison responsibilities and corrective action tracking. A risk assessment for information technology systems was completed.

Focus Area for 2005-2006

Completion of the *2005-2006 Audit Plan* as approved by the Secretary.

Objectives

1. Update the risk assessment of department information technology systems.
2. Conduct audits that provide information and recommendations useful to management in accomplishing their objectives.
3. Provide liaison duties between the agency and external auditors, including the Office of the Auditor General, OPPAGA, Department of Financial Services, and Federal auditors.
4. Track management's corrective action plan progress at 6, 12, and 18 months. Report corrective action status to Joint Legislative Auditing Committee, OPPAGA, or Auditor General as required.
5. Conduct follow-up audits to determine whether management's corrective action in response to prior audits has been successfully implemented.
6. Continue to serve in advisory capacity on DOH Tier II and III Governance process for review, approval and prioritization of Information Technology related projects.
7. Participate in another multi-agency audit coordinated through the Executive Office of the Governor, Office of the Chief Inspector General.

Mission Goal

Publish audit reports useful to management.

Enabling Goals

1. Develop an audit plan and program for each audit, specifying a clear scope and objectives.
2. Obtain an understanding of the audited program to help assess the significance of possible audit objectives and feasibility of achieving them.
3. Perform audit testing and evaluation.
4. Confirm issues noted with management.
5. Report findings supported by credible evidence that relates to the audit objectives.
6. Obtain management's review and comments on report findings, including planned corrective actions.

Key Strategies

Hire, retain, and enable qualified audit staff personnel through training, supervision, and coordination to produce quality audits and publish reports useful to management.

Investigations

Mission Statement

To provide management with timely and accurate information upon which to base decisions that promote and protect the health of all people in Florida.

Focus Areas for 2005-2006

Improve the timeliness of our investigative products and tie investigative recommendations to improved program performance.

Objectives

Make investigative recommendations that improve program area performance by tying substantiated allegations to insightful recommendations.

Mission Goal

To promote accountability, integrity and efficiency in the department by insuring that 90% of investigations are reported to management within 90 days. Continue to collect baseline data to assist in evaluation of timeliness and workload completion effectiveness over time.

Enabling Goals

1. Increase investigative capabilities by sustaining the current workforce while providing effective professional and management training for personnel.
2. Support legislative initiatives of the Chief Inspector General (CIG), Executive Office of the Governor to enhance investigative efficiency through administrative subpoena power. Additionally, support the CIG in pursuing clarification of the "whistle-blower" statutory language.
3. Fully train an additional investigator in computer forensic investigative techniques.

Key Strategies

1. Investigations: Investigative preliminary reviews will be accomplished within 10 duty days of receipt by investigators. Investigative plans will be reviewed within 15 duty days of receipt by the Director of Investigations. The final report will be approved for release within 120 days of complaint receipt.
2. Preliminary Inquiries: Preliminary Inquiries will be accomplished within 30 days of receipt by investigators. The closing memorandum with recommendations will be completed within 30 days from receipt for review by the Directory of Investigations. If the Preliminary Inquiry becomes an investigation, an additional 90 days will be allowed for completion of the final report.
3. Management Advisories and Referrals: Complaints that will be referred to management and to other agencies will be reviewed within five duty days of receipt by the investigator or the Intake Coordinator to identify issues. They will be referred no later than 10 duty days from receipt.

Child Care Food Audit Program

Mission Statement

Promote accountability and integrity of the Child Care Food Program (CCFP) by monitoring the performance of sub-grantees of the Bureau of Child Nutrition Programs.

Focus Areas for 2005-2006

Perform audit confirmations, obtain and review audit reports conducted by independent auditors, and conduct agreed-upon procedures reviews of sub-grantees of the Bureau of Child Nutrition Programs.

Objectives

1. Perform 95% of audit confirmations for CCFP subgrantees within five working days of receipt of request for confirmation.
2. Obtain a copy of all independent audits of CCFP sub-grantees required under OMB Circular A-133 and ensure that 90% are received within the timeframes imposed by the circular.
3. Review 95% of all independent audits of CCFP sub-grantees within five working days of receipt of the audit and perform any necessary follow-up procedures.
4. Conduct agreed-upon procedures reviews for one-third of all CCFP sub-grantees as required by federal regulations.
5. Ensure that draft reports for agreed-upon procedures review reports are issued within an average of 60 days from the start of the review.
6. Serve as expert witness at all informal hearings resulting from agreed-upon procedures reviews.

Mission Goal

Perform audit confirmations, obtain and review audit reports conducted by independent auditors, and conduct agreed-upon procedures reviews of CCFP sub-grantees required by federal regulations.

Enabling Goals

Hire and retain sufficient professional and support staff with the knowledge, skills and abilities necessary to achieve our objectives.

Key Strategies

Obtain an additional professional position to conduct fieldwork and review and supervise field staff if funding allows due to the increased numbers of reviews required by program growth and the need to issue reports on a timely basis.

Management Reviews

Mission Statement

Assess management practices, work environment and business outcomes to identify strengths and opportunities for improvement, and recommend operational improvements.

Progress on meeting 2004-2005 objectives and goals

A heavy investigative workload, along with priority given to the Hurricane After Action project, impinged upon our ability to proactively conduct management reviews this fiscal year. While no management reviews were requested or conducted, we did continue to refine our process. For example, we completed development of an on-line survey administration process and staff presented about this process at the 2005 Southeastern Evaluation Association Annual Conference.

Focus Areas for 2005-2006

The management review process is structured to suit the needs of each scheduled event, with a standard set of questions that allows comparison across programs and/or against other assessment instruments, such as the department Employee Satisfaction Survey. Senior department leadership feedback continues to indicate a need for management reviews.

Objectives

1. By March, 2006, identify a county health department or program office that could benefit from a management review.
2. Improve awareness of the management review process and product through direct communications with headquarters and local management.

Mission Goal

Improve or enhance department operations through the management review process.

Enabling Goals

Continue to utilize the Sterling Criteria for Organizational Performance Excellence as a methodological framework for the management review process.

Key Strategies

1. Establish and maintain a core staff to conduct management reviews to include personnel from the Investigations and Internal Audit Sections.
2. Survey HIG investigative and audit staff for suggestions regarding offices/programs that could benefit from a management review and present suggestions to HIG management.
3. Revise management review flow chart and brochure for dissemination to headquarters management (Deputy Secretaries and Division Directors) and to CHD Directors/Administrators.

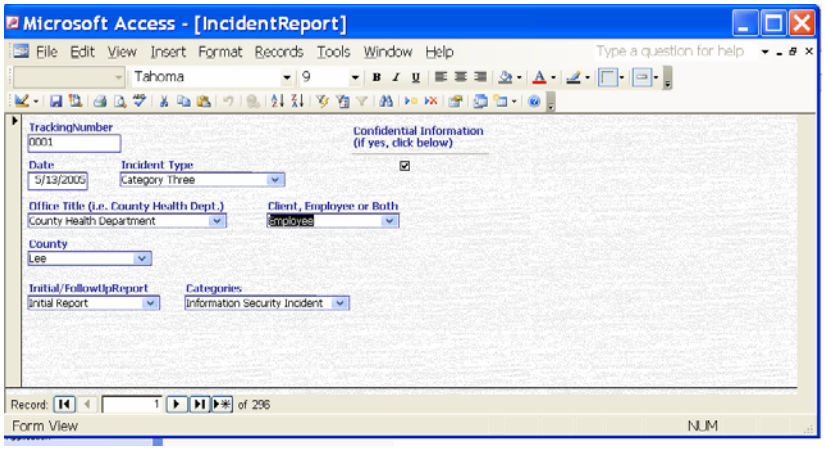
3. Customer and Market Focus

In FY 2004-2005 we continued to address the challenge of balancing the expectations and needs of our various customer and stakeholder groups. We accomplished this through our web-based customer satisfaction survey process, which continues to reflect highly satisfied customers.

Our Customers & Stakeholders

- CHD managers, employees, patients
- Headquarters divisions & program offices
- Department leadership & employees at all levels
- State government leadership
- Florida's taxpayers, residents & visitors

Additionally, our market responsiveness is demonstrated by two unique efforts this past fiscal year. HIG subsumed responsibility for tracking incident reports submitted to the headquarters management level by department and CHD staff in response to serious incidents or events that require reporting and notification of higher-level management. We accomplish tracking of these incidents through a database designed for this purpose.



The second major effort undertaken in response to customer needs was the 2004 Hurricane After Action Review. This process resulted in a seven volume report which contains numerous recommendations for improving the department's emergency health and medical response to disasters (see "4. Measurement, Analysis & Knowledge Management – Other Accountability Products").

4. Measurement, Analysis & Knowledge Management

AUDIT SUMMARIES

The following are summaries of audits and follow-up reviews accomplished during the fiscal year. This year we performed no activities relating to the development, assessment, and validation of performance measures.

Audit Report #AC-04-005
Children's Medical Services Newborn Screening Program Application

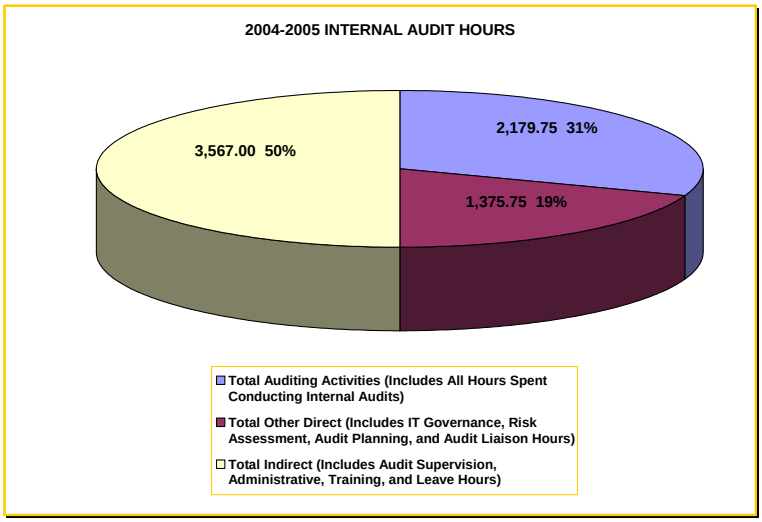
We performed an audit of the Newborn Screening Program Application for the period ending September 24, 2004. Our audit focused on the effectiveness of selected information systems functions, including application controls, access controls, and systems development and maintenance controls.

SUMMARY OF FINDINGS

- Deficiencies were noted in the logical access controls protecting the Newborn Screening Program Application information resources.
- There is insufficient documentation to show that controls related to the authorization and testing of system development and change management processes for the Newborn Screening Program Application are in place.
- Specimen cards are being submitted to the Bureau of Laboratories with incomplete or inaccurate information.

RECOMMENDATIONS

We recommended appropriate logical access controls be implemented or strengthened in order to enhance the security of the Newborn Screening Program Application information resources.



We recommended the Newborn Screening Unit develop a disciplined process for testing and approving modifications to the NSP Application. In addition, formal policies should be developed to ensure that the appropriate documentation is maintained for all change requests.

We recommended the Children's Medical Services Newborn Screening Program institute a formal training program to assist the hospitals, birthing centers, and physician offices in providing complete and accurate specimen cards to the Bureau of Laboratories.

We recommended CMS consult with Bureau of Laboratories to identify which sites are providing the highest level of inaccurate or incomplete specimen cards so training efforts can be focused on those sites.

Audit Report #AC-04-007
Inspections, Investigations and Monitoring by Bureau of Statewide Pharmaceutical Services and Resulting Administrative Fines

We performed an audit of an audit of the Bureau of Statewide Pharmaceutical Services [Bureau] to determine whether controls are in place so inspections,

investigations and monitoring performed by Department of Health personnel are timely, recorded and reported timely, and the outcome of such reporting is acted upon accurately and timely. It was also our objective to determine whether controls are in place so administrative fines imposed under Section 499.066(3), Florida Statutes, are timely and accurately collected and deposited into the Florida Drug, Device, and Cosmetic Trust Fund. We reviewed the period July 1, 2001 through November 30, 2003.

SUMMARY OF FINDINGS

- The Bureau did not have sufficient written policies & procedures.
- Administrative fines were not always pursued or timely collected.
- The Bureau did not have a working process in place to timely review all investigations.
- Internal Controls could be enhanced with additional documentation.

RECOMMENDATIONS

We recommended the Bureau's management develop written procedures that increase productivity, efficiency and effectiveness to ensure appropriate goals and objectives are met. The development of these written procedures could include the constructive input from its field inspectors.

We recommended the Bureau provide investigators real-time access to its Case Management System database.

We recommended the Bureau implement a process for routinely tracking *Notice of Violation* letters with timely follow-up of second notices. This procedure should be written.

We recommended the Bureau pursue legal action or refer to Department of Financial Services for assignment to a collection agency where payment is not received within 90 days for cases upon which agreement has been reached.

We recommended the Bureau accept payment of administrative fines only with guaranteed funds.

Because the *Notice of Violation* letter may create the perception an accounts receivable is due and owing at a point in time when such claim has not been legally established, we recommended the Bureau request the Office of General Counsel review the language of its *Notice of Violation* letter and portions of the Secretary's Delegation of Authority pertaining to the Bureau of Statewide Pharmaceutical Services so that possible ambiguities may be clarified.

We recommended the Bureau review its process and implement improvements to ensure investigation reports completed by its agents are timely reviewed and where administrative enforcement is sought, the Bureau timely enforce these provisions so as to ensure the immediate protection of the public's health, safety and welfare.

We recommended the Bureau document to the Application Form the date the Bureau deems information complete for processing.

We recommended the Bureau implement a written control to update where necessary the "Date Completed Application Received" in its Pharmacy Services 499 Database.

We recommended that as the official record of the Bureau's inspection, the Bureau implement a control to ensure the original E&I Report is timely received and documented to the 499 Establishment File.

As the original report on which the Bureau's investigative cases are built, we recommended the Bureau implement a written control to ensure the original investigation report is signed by the investigator and a supervisor as documentation of review and approval, and documented to the Case File.

Audit Report #AC-04-008
Monitoring Process of the Public Health Dental Program at County Health Departments

We performed an audit of the Office of Dental Health's monitoring process of the Public Health Dental Program at county health departments for the period July 1, 2002 through December 31, 2003, to determine whether the monitoring process of the Public Health Dental Program at county health departments was effective and efficient. We also wanted to determine if adequate controls were in place during the monitoring process in accordance with Sections 154.01 and 381.005, *Florida Statutes*; Chapter 64F-10, FAC, internal operating policies in the *County Health Department Guidebook*, and the *Question/Answer Guidelines*.

SUMMARY OF FINDINGS

- Information that includes policies, procedures and processes, the awarding of primary care funds to CHDs, and selecting CHDs for on-site monitoring was not sufficiently documented.

RECOMMENDATIONS

We recommended the program office develop written policies and procedures to explain and document all its processes, with distribution to CHDs.

We recommended the program office either comply with its current policy of an annual site visit to each CHD dental program, or consider developing a periodic, documented risk-assessment and make site visits to the CHDs the program office considers highest risk.

Audit Report #AC-04-011
Bioterrorism Preparedness and Response Grant - Focus Area C

We performed an audit to determine the effectiveness of internal controls in place to ensure that Recipient Activities are addressed in the Focus Area C Projects, to determine if controls were in place to account for the existence of items purchased with the CDC Bioterrorism Preparedness and Response Grant, and to determine the effectiveness of enhancements made to the core diagnostic capabilities within the Bureau of Laboratories in improving the timeliness of reporting.

SUMMARY OF FINDINGS

The selected controls related to Focus Area C appear to be operating effectively in promoting and encouraging the achievement of management's objectives. Instances were noted where assets purchased with Focus Area C grant monies did not have a DOH property tag and were not recorded in the Asset Management System. These instances were each addressed prior to the end of audit field work and are no longer considered reportable conditions. A comment was made to management making them aware of the situation.

Audit Report #AC-04-012
Bureau of Laboratories' LifeCycle Application

As part of an audit of the Children's Medical Services Newborn Screening Program Application, we performed an audit of the Bureau of Laboratories' LifeCycle Application for the period ending September 24, 2004. Our audit focused on the effectiveness of selected information systems functions, including application controls, access controls, and systems development and maintenance controls.

SUMMARY OF FINDINGS

- Deficiencies were noted in the logical access controls protecting the Bureau of Laboratories' LifeCycle Application information resources.
- During the audit period, the Bureau of Laboratories did not have policies and procedures in place for handling incomplete or inaccurate demographic information on the specimen cards.
- Instances were noted where the demographic information on the source documents

(specimen cards) and the corresponding demographic information in the LifeCycle database contained discrepancies.

RECOMMENDATIONS

We recommended appropriate logical access controls be implemented or strengthened in order to enhance the security of Bureau of Laboratories' LifeCycle Application information resources.

Our recommendation that Bureau of Laboratories develop policies and procedures for handling erroneous demographic information on the specimen cards identified during the data entry process was addressed by the bureau. Subsequent to the end of audit field work, but prior to the issuance of this report, an addendum was made to the *Standard Operating Procedures for Data Entry* that documented the actions to be taken by data entry staff when erroneous information is identified on the specimen card.

We recommended the Bureau of Laboratories implement a quality assurance function to review records entered by the data entry staff to help ensure that the data entered into the LifeCycle Application is complete and accurate.

Audit Report #AC-05-002
Control Over Security Paper at Selected County Health Departments

We performed this audit of controls over security paper at selected CHDs to determine whether security paper is safely stored in a secure area within the vital statistics office, daily logs are in order, voided paper is appropriately handled, inventory is physically counted and current inventory levels can be accounted for. We made unannounced site-visits at 14 CHDs where we performed a physical inventory count of security paper on hand and reviewed available documentation each Chief Deputy Registrar is required to maintain.

SUMMARY OF FINDINGS

- Controls required by Chapter 4 of *Chief Deputy Registrar Operations Manual* were not always in place for the daily accounting of security paper.

RECOMMENDATIONS

We recommended the Office of Vital Statistics implement additional steps to their training, monitoring and review of chief deputy registrars at CHDs to identify and assist CHDs in their security controls over use of security paper.

PRIOR YEAR FOLLOW-UP

Audit #AC-01-003
Bureau of Emergency Medical Services – County Matching Grant Program

The Office of the Inspector General audited the Bureau of Emergency Medical Services County Matching Grant Program for the period July 1, 1999 through February 28, 2001. The objectives included reviewing the EMS County Matching Grant Review Team's review process; awarding of EMS County Matching Grant applications; and determining whether the Bureau of Emergency Medical Services (Bureau) adequately monitored performance of grantees' assurances stated in the grant document.

Recommendations on which corrective action was not completed included the Bureau should consider the feasibility of a long-term review of completed grants on some limited basis, to determine whether grantees achieve projected outcomes. Such results may validate the importance of the program.

Agency senior management was notified and agreed our office would not continue to track this issue until such time as senior management could support that the Bureau made a significant step toward accomplishing its corrective action plan related to this recommendation.

Audit Report #AC-04-002
Grants of the Office of Rural Health Grant Program, Medicare Rural Hospital Flexibility Program, and Small Hospital Improvement Program

We performed an audit of these grant programs to determine whether controls were in place relating to the Office of Rural Health's responsibilities over the application process, review of applications, that office's responsibilities over disbursement of funds, and the review of completion of grantees' projects.

SUMMARY OF FINDINGS

- DOH and the Office of Rural Health did not sufficiently document controls over the grants process.
- Controls over the application and review process needed improvement.
- Grant documents did not include all required language and follow the entire DOH grants process.
- Office of Rural Health did not sufficiently monitor grantees and sub-grantees.
- Statute had not been amended to reflect changes in federal law.
- Regarding advance funding issues, some grants were not appropriately handled.

RECOMMENDATIONS

We recommended the Bureau of Finance & Accounting compile grants-related criteria and develop and publish a procedures manual encapsulating DOH's policies regarding grants from DOH to others and related procedures.

For each of the grant programs, we recommended the Office of Rural Health develop written procedures addressing how incoming applications will be processed, evaluated and reviewed, awarded, and procedures that ensure grant funds are paid to the appropriate entity and also address monitoring grantees for compliance and satisfaction of grant requirements.

For the Office of Rural Health Grant Program and Small Hospital Improvement Program, we recommended written procedures include the process of reviewing applications. We also recommended a policy be added to include analysis or consideration of the success of prior grants made to the same applicant in its evaluation of future grant proposals.

For the Office of Rural Health Grant Program, we recommended management require a duly-authorized representative of the applicant sign the application, and notify applicants they are required to submit by a due date certain. We recommended upon award, a Notice of Grant Award be provided to grantees.

For the Medicare Rural Hospital Flexibility Program, we recommended management ensure applicants are held to grant application requirements, items required to be submitted are included and documented to the grant file, and the Mandatory Criteria Checklist always be documented to the grant file. We also recommended management carry out its own requirements as stipulated in the Application Package, including providing a Notice of Grant Award to grantees.

For the Small Hospital Improvement Program, we recommended that upon award a Notice of Grant Award that includes grant requirements be provided to grantees.

For each of the three grant programs, we recommended management require applicants apply under the legal name of the entity, which in the case of rural hospitals should be the name of the state license holder, and submit for verification the FEI number and other information regarding the legal entity at time of application. Additionally, we recommend management ensure all grant documents be made out only to the name of the legal entity on the application and payment made only to the same legal entity, except where the Office of Rural Health can document a legal name change.

For each of the grant programs, we recommended management include necessary language in all grant

documents (whether via PO or Standard Contract), so that grantees are aware of all federal and state requirements, and are legally bound to such grant terms. We recommended management ensure grant ending-dates (respective of each grant program) are consistent through all grant documentation, including the contract. We also recommend management ensure future grants for each of the three grant programs are presented to the Secretary or a Deputy Secretary for signature. For the Office of Rural Health Grant Program and Small Hospital Improvement Program, we recommended management require grantees identify quantifiable performance measures in their grant applications and then report results of such performance measures in their final report, so that such results may be verified and utilized.

Because documentation of the monitoring process assists management in ensuring that comprehensive monitoring is conducted in a consistent manner, for each of the three grant programs, we recommended management monitor grantees' results, and on at least some limited basis, through in-office procedures and site-visits, select grantees and sub-grantees to verify that assertions made, including performance measures, are accurate and timely completed. We also recommended all documentation in support of such verification is added to the Office of Rural Health's grant file.

For each of the three grant programs, we recommended management hold grantees accountable to submit applications, interim and final reports timely. Receipt of grantees' late-filed final reports should be considered in awarding future grants.

For each of the three grant programs, we recommended management ensure applications, final reports and all other correspondence with grantees are date-stamped at time of receipt. To assist applicants understand they are to be held accountable for grant terms and funds, we also recommended management accept and consider for funding only applications received by the due date stipulated in the Application Package.

For the Medicare Rural Hospital Flexibility Program, where Office of Rural Health requires an accounting of interest earned on advanced funding, we recommend management require grantees to timely and accurately account for such amounts, and include supporting documentation to the grant file.

For the Medicare Rural Hospital Flexibility Program and Small Hospital Improvement Program, where Office of Rural Health provides grants to rural health networks that in turn sub-grant to hospitals, we recommended management either 1) require (through contract language) rural health networks to both monitor sub-grantees and maintain a grant file to document that monitoring, with Office of Rural Health periodically monitoring the rural health network's grant file to ensure compliance with federal and DOH grant requirements; or 2) assume responsibility itself for monitoring sub-grantees.

We recommended management propose amending Section 381.0405(4)(f), Florida Statutes, to either reflect current federal grant programs or delete references.

For each of the three grant programs, we recommended management review how it funds grants to ensure funds that are advance-funded are appropriately handled, and that invoices include justification for a specific extraordinary cash need beyond the initial three months.

Audit Report #AC-04-009
HRSA Hospital Contracts by Office of Public Health Preparedness

We performed an audit of the Bioterrorism Hospital Preparedness Program of the Office of Public Health Preparedness for the period April 1, 2002 through August 31, 2003, to determine whether DOH timely received and approved *Work Plans*, Proof of Purchase (as applicable), *Annual Reports* (as applicable) and other documentation required from providers in accordance with contract language. We reviewed 81 contracts with hospitals, totaling $5,935,607.

SUMMARY OF FINDINGS

- Office of Public Health Preparedness did not receive deliverables timely from hospitals in accordance with contract terms.
- Contract language did not always reflect actual processes followed by the Office of Public Health Preparedness.
- Programmatic Monitoring of more Providers is required.
- Some actions taken by Office of Public Health Preparedness did not protect the agency's contractual interests.

RECOMMENDATIONS

We recommended for future contracts, the Office of Public Health Preparedness a) consider an approach of assigning more contract managers that can work more closely and provide more oversight with their assigned hospitals; b) contractually allow more time for hospitals to develop and present deliverables; and, c) taking an aggressive approach of terminating contracts with hospitals the Office of Public Health Preparedness identifies as unable to deliver required services. Should DOH pursue the use of contract coordinators to report to the contract manager, we recommended the Office also consider at least one additional contract manager over the hospital contracts, so the process and responsibilities are vested in more than one person. We also recommended the Office tie some portion of contract payments to the end of the contract (e.g., where an *Annual Report* or other evaluation report is required, some portion of the contract payment should be tied to this deliverable).

We recommended future contracts developed by the Office contemplate procedures to be followed that require performance by providers and include such language in contracts. Additionally, we recommended the Office hold providers to requirements stipulated in contract language and as changed through contract amendments.

We recommended management review controls over contract management, specifically considering the workload of contract manager(s) to ensure the effective contract management of each contract that includes on-site programmatic monitoring.

We recommended they adhere to DOH policy regarding contracts, including issues related to payment for services/products in accordance with contract language. We also recommended the Office reimburse hospitals only for deliverables developed during the life of the contract, so that the agency does not reimburse others for expenses incurred before contracting with DOH.

Audit #AC-02-004
MERLIN Reporting System

Chapter 381.003 Florida Statutes directs the Department of Health to conduct a communicable disease prevention and control program as part of fulfilling its public health mission. Communicable disease is defined as any disease caused by transmission of a specific infectious agent, or its toxic products, from an infected person, an infected animal, or the environment to a susceptible host, either directly or indirectly. The statute further states that the communicable disease program should include programs for the prevention, control, and reporting of diseases of public health significance. The Division of Disease Control, and the Bureau of Epidemiology specifically, have been charged with the statewide surveillance, investigation, intervention, monitoring, and coordinated reporting of communicable diseases with the exception of tuberculosis, sexually transmitted diseases, and HIV/AIDS. To this end, the Bureau of Epidemiology (Bureau) has developed the Merlin Reporting System.

The Department of Health Office of the Inspector General conducted an internal audit of the Merlin Reporting System for the period ending September 27, 2002, and selected controls through April 11, 2003. Our audit focused on the effectiveness of selected information systems functions, including application controls, access controls, and systems development and maintenance

controls. With the exception of the deficiencies listed below, the selected information technology controls related to the Merlin Reporting System appear to be operating effectively in promoting and encouraging the achievement of management's objectives of compliance with controlling laws, administrative rules, and other guidelines; the reliability, integrity, and availability of data; the effective and efficient operation of information technology functions; and the safeguarding and confidentiality of information resources. No instances of errors, fraud, abuse, illegal acts, or other noncompliance were noted. The audit disclosed the following deficiencies in the management controls related to the Merlin Reporting System.

SUMMARY OF FINDINGS

- Deficiencies were noted in the security controls protecting the Merlin Reporting System information resources.
- Instances were noted where users were not entering communicable disease cases into the Merlin Reporting System in a timely manner.
- Instances were noted where user input controls regarding the input and review of client profile, basic case, and laboratory data entered into the Merlin Reporting System were not operating effectively.
- Deficiencies were noted in the systems development and modification control procedures related to the documentation of management's authorization of change requests and approval of programming modifications prior to the modifications being implemented.
- The Bureau of Epidemiology does not have a documented business continuity/disaster recovery plan in place to ensure that disease surveillance, analysis, tracking, and reporting services can be continued in the event of a disaster or an information technology outage.
- Instances were noted where programmed input controls within the Merlin application were not present, or were not operating effectively.

RECOMMENDATIONS

- We recommended that appropriate security controls be implemented or strengthened in order to enhance the security of the Merlin Reporting System information resources.
- We recommended that management take the appropriate steps to ensure that Merlin case data is entered and reported in a timely manner.
- We recommended that management ensure each case entered at the county health departments is reviewed for completeness and correctness prior to being reported to headquarters. Further, management should also implement a quality assurance function to assist the county health departments in ensuring that the case information in Merlin remains complete, accurate, and reliable.
- The Merlin system owners should review all change requests to ensure that the required items on the checklist have been completed as required. In addition, they should develop formal policies to ensure that the appropriate documentation is maintained for each change request.
- We recommended that management enhance the programmed data input controls within the Merlin application to ensure that the data input into the system remains complete, accurate, and valid.
- We recommended that, in order to ensure continuous business services in the event of a disaster or prolonged IT downtime, the Bureau of Epidemiology develop and document its business continuity/disaster recovery plan.

After the plan has been documented, it should be tested and updated on a regular basis.

Audit #AC-02-012
Administrative Monitoring

The Office of the Inspector General performed an audit of Administrative Monitoring for the period January 1, 2000 through December 31 2001, to determine whether steps of the process are 1) adequate to allow DOH to objectively evaluate the non-programmatic terms and conditions of its contracts; and, 2) are adequately and timely performed.

The primary objective of Administrative Monitoring is to ensure the Provider's administrative records are complete and the Provider is complying with the administrative terms of the contract. The purpose of on-site Monitoring is to (1) determine whether the fiscal and administrative activities of the provider are adequate to manage and administer department funds pertaining to the contract under review; (2) give the department an assurance that the funds contracted for the purchase of services were used appropriately; (3) determine whether documentation exists to support charges against the state; and (4) determine whether the provider required technical assistance regarding its fiscal and administrative activities. During the two years in the audit period, Monitoring at Headquarters produced one Corrective Action Plan.

Providers are not required to be monitored annually and may be exempt from monitoring. Of 2,076 contracts initiated between January 1, 2000 and December 31, 2001, 764 contracts (37%) included exclusion codes denoting they were exempt from monitoring. According to FLAIR, 126 contracts received Administrative Monitoring. Of DOH's more than 600 Providers for FY 2002-2003, Office of Contract Administration reviewed eight Providers on-site in calendar year 2002 through November 27th.

SUMMARY OF FINDINGS

- The Administrative Monitoring process needs to be strengthened.
- The process of planning, coordinating, and reporting of Administrative Monitoring was not always complete.
- The Contract Information File of FLAIR contains inaccurate and/or incomplete data regarding Administrative Monitoring.

RECOMMENDATIONS

- Management should implement one of several alternatives, including:
  1. Improve the current process, including updating the Administrative Monitoring Check-lists to adequately address the objectives of Administrative Monitoring, ensuring staff is adequately trained to perform such procedures, and monitoring the effective use of the Checklist;
  2. Initiate a process of requiring independent accountants to perform agreed-upon procedures on Providers designed to review and assess the objectives of Administrative Monitoring; or,
  3. Develop an alternative procedure that provides the agency assurance regarding the administrative/fiscal component of Providers.
- We also recommended Office of Contract Administration:
  1. Ensure all items on the Administrative Monitoring Checklists are fully completed so that conclusions on items reviewed may be later understood;
  2. Invest more time at each Provider's office to fully address the objectives of Monitoring and conclude regarding audits and records, the provider's accounting system, sampling invoices to determine whether expenditures are

supported by appropriate documentation, insurance, compliance with statutory requirements regarding travel and lobbying, review subcontracts (if any), review documentation of purchasing, and review documentation to determine whether payroll and withholdings are appropriately handled. Add a review of board minutes to the Checklist;

3. Re-design on-site visits to be more in-depth for providers who are new entities;
4. Develop a policy documenting the process of corrective action from original identification through follow-up to ultimate resolution;
5. Further develop and formally document the risk assessment tool to include determining which Providers are at greatest risk and should receive most immediate Monitoring and the justifications for those assessments;
6. Annually determine which Providers receive on-site monitoring based on a score on the risk assessment;
7. Add a component to the annual risk assessment that includes an opportunity for input from contract managers regarding any concerns of which they may be aware;
8. Reevaluate its process of distributing *Administrative Summary Reports* to Contract Managers and Providers to ensure that all effected parties receive a copy; and,
9. Develop a control state-wide (between its office and the CHD Contract Administrators) to ensure that data relating to Administrative Monitoring is accurately input into the *Contract Information File* of FLAIR.

INVESTIGATION SUMMARIES

We conduct all investigations in accordance with the standards of the Office of the Inspector General and the Governor's Council on Integrity and Efficiency. The following is a summary of FY 2004-2005 investigations with significant findings. For a complete listing of all investigative activity refer to the Appendix.

Investigation # 04-022
Alleged Conflict of Interest and Failure to Perform Contracted Services – Duval CHD/Children's Medical Services

During the course of another investigation involving alleged violations of Chapter 112, Florida Statutes and the department's ethics policy, questions were raised regarding a conflict of interest and the use of State trust funds. These questions were relative to persons performing services as department officers, employees or contract providers under Department of Health-State University contracts. During the course of this investigation the Statewide Child Protection Team Medical Director and the Duval County Health Department Director provided answers to investigative questions. The Jacksonville CMS Primary Care Medical Director, the CMS Craniofacial Service Provider #1, the Jacksonville CMS Medical Director, the Jacksonville CMS Assistant Medical Director, and the CMS Craniofacial Service Provider #2 declined to answer investigative questions. Their attorney provided general statements. Allegations, conclusions and recommendations were as follows:

Allegation #1: Conflict of interest for University of Florida (UF) employees, who also represented the department in the following capacities and were also officers and directors of a corporation doing business with the department:

(A) Statewide Child Protection Team Medical Director;

(B) Duval County Health Department (CHD) Director;

(C) Jacksonville Children's Medical Services (CMS) Primary Care Medical Director (M.A.T.C.H. Medical Director); and

(D) CMS Craniofacial Service Provider #1.

This allegation was unsubstantiated. These individuals were not employees of the department. The corporation in question was a not-for-profit corporation. No evidence was found to indicate these individuals were paid for their services to the corporation. The Statewide Child Protection Team Medical Director and the Duval CHD Director provided answers to investigative questions. The Jacksonville CMS Primary Care Medical Director and the CMS Craniofacial Service Provider #1 declined to answer investigative questions.

Allegation #2: Against Duval CHD Director - (A) conflict of interest - misuse of position; (B) doing business with own agency; (C) doing business with an agency that is doing business with employee's own agency. This allegation was substantiated.

Allegation #3: Failure to File Financial Disclosure – substantiated for the following:

(A) Statewide Child Protection Team Medical Director,
(B) Duval CHD Director,
(C) Jacksonville CMS Primary Care Medical Director,
(D) CMS Craniofacial Service Provider #1,
(E) Jacksonville CMS Medical Director,
(F) Jacksonville CMS Assistant Medical Director, and
(G) CMS Craniofacial Service Provider #2.

Allegation #4: Non-Performance of Contract Responsibilities by a University of Florida, Duval CHD Contractor relative to the UF/Duval CHD Primary Physician Care Contract. This allegation was unsubstantiated due to the fact that the Department of Health (department)-UF contract provided for unspecified quantities of medical services, medical administrative services and teaching services.

Allegation #5: Unethical Conduct - Misuse of Position; False or Bogus Contract to Misappropriate State Funds. This allegation was substantiated for the following:

(A) Statewide Child Protection Team Medical Director,
(B) Jacksonville CMS Medical Director,
(C) Jacksonville CMS Assistant Medical Director, and
(D) CMS Craniofacial Service Provider #2.

Allegation #6 – Additional Item: Improper Billing for Physician's Time - The University of Florida billed the department for 100% of a physician's time as a Duval CHD primary care physician. It appears that a not-for-profit corporation also billed the department an unknown amount for his services as CMS Primary Care Medical Director. It appeared that these two entities billed the department for more than 100% of the same physician's time.

This allegation was substantiated. UF had been paid for 100% of the physician's time as a Duval CHD primary care physician. A not-for-profit corporation appears to have been paid an undetermined amount for his services as CMS Primary Care Medical Director. The physician declined to answer investigative questions, but his attorney stated that he is not paid by the not-for-profit corporation.

Allegation #7 – Additional Item: Duval CHD - Contract Payments Improperly Made to Third Party - Duval CHD entered into contracts with a State university and, without a written agreement, allowed UF to assign the contract payments to a not-for-profit corporation, contrary to the provisions of Section 215.965 F.S. A university rule and an Internal Revenue Service determination seemed to indicate that the corporation in question is a part of the university. This allegation was unsubstantiated.

Allegation #8 – Additional Item: Department/CMS - Contract Payments Improperly Made to Third Party – Department of Health HQ-CMS entered into contracts with a State university and, apparently without a written agreement, allowed UF to assign the contract payments to a not-for-profit corporation, contrary to the provisions of Section 215.965 F.S. A university rule and the IRS seemed to indicate that the corporation in question is a part of the university. This allegation was unsubstantiated.

Allegation #9 – Additional Item: Department Hiring Practice - Hiring employees in excess of the number of positions authorized by the Appropriations Act; hiring employees in a manner that interferes with the application of the Code of Conduct for State Officers and Employees. This allegation was substantiated.

Summary of Recommendations:

- The department should amend its contract with UF and its contract with M.A.T.C.H., Inc. pursuant to Section 112.326, F. S., to require the Duval CHD Director, the Jacksonville CMS Primary Care Medical Director and the M.A.T.C.H. corporate officers and directors to comply with the Code of Ethics for State Officers and Employees and department policies as if they were department employees, including filing financial disclosure.

- The department should consider the advisability of continuing to utilize the services of UF employees and corporations whose officers, directors and employees decline to answer questions related to a department internal investigation.
- Any remaining obligation resulting from the purchase order contract between Duval CHD and the Duval CHD Director should be cancelled.
- Department management should review the practice of contracting with and funding UF "to teach residents, medical students, and other health professionals" through the Duval CHD. If a determination is made to continue this practice, the current contract should be amended to quantify the specific number of FTE positions to be devoted to each type of service for which the department contracts. Any such future contracts should also quantify the types of services to be provided.
- Department management should also require UF to provide timesheets or other documents with each billing to show that the specific contracted services were actually provided.
- The department should consider the advisability of continuing to utilize the services of UF personnel who have engaged in devising and executing false or bogus contracts.
- CMS and the Duval CHD should require UF and M.A.T.C.H., Inc. to provide records to show the actual amount of time the physician worked as a Duval CHD primary care physician and the actual amount of time he worked as the Jacksonville CMS Primary Care Medical Director. Any amount paid for services in excess of 100% of his time should be recovered from the appropriate contractor.
- For future billings, CMS and the Duval CHD should require contracted service providers to furnish time and attendance or other documentary evidence to support billing for the physician's services.
- Because the practice of hiring staff through contracts with State universities can result in the department hiring staff in excess of the number of positions authorized by the Legislature, the distortion of financial reporting by the department and the creation of confusion in the application of the Code of Conduct for State Officers and Employees, it is recommended that the department seek a statutory change to authorize this method of employing staff. Also, the current contracts should be amended and all such future contracts should include provisions that require staff hired in this manner to comply with the Code of Ethics for State Officers and Employees and the department Code of Ethics Policy in the same manner as if the Department of Health is their own agency as contemplated in Section 112.313(3), F.S.

Investigation # 04-036
Alleged Violations by EH Director – Polk CHD

This investigation is predicated on a telephone complaint made by a citizen, against a CHD Environmental Administrator. The complainant alleged the Environmental Administrator failed to properly perform his duties and that he provided false testimony in hearings conducted at various levels of the county government pertaining to a county Onsite Sewage Treatment and Disposal Systems (OSTDS) company. The investigation did not substantiate four of five allegations made against the Environmental Administrator; however, the facts substantiated an allegation pertaining to the backdating of files in a citation issued to an OSTDS company. Although this may have been done to facilitate the administrative processing of the citation, backdating should not be condoned.

The core issue underlying this complaint is a county zoning matter. The county OSTDS company has conducted CHD permitted septage operations from their current location since 1984. In February 2003, the complainant, and several neighbors, began to complain about offensive odors. These odors most likely resulted from the transfer of septage from the county OSTDS company's pump-out trucks to the lime stabilization facility. As a result of the citizen's complaint to the county zoning authority,

the county OSTDS company was issued citations related to conducting business in a residential area. In considering the county OSTDS company's subsequent permit application for 'Conditional Use' (CU) of the location, the County Board of Commissioners overturned the County Planning Commission's approval of the county OSTDS company's CU application. Effectively, it appears that the Commissioners decided that the lime stabilization facility was a commercial/industrial operation and not consistent with areas zoned as agricultural/residential-rural such as the location that the county OSTDS company has used for approximately 19 years. It appeared that the county OSTDS company would be permitted to continue office operations and truck parking at their current site, but must move the lime stabilization facility to another location. The Commissioner's decision in this case could effect the estimated 11-15 other county OSTDS companies and may have statewide implications.

Recommendations

- The CHD director should review the information provided in this report and determine if disciplinary action is appropriate.
- The CHD director should revise procedures to assure the timely processing of environmental health citations and to update associated administrative forms and letterheads.
- The CHD director should initiate coordination with the Polk County Planning Commission to determine if County Commissioners' decision of March 3, 2004, has adverse implications for other OSTDS contractors operating lime stabilization facilities in the county.
- The department Bureau Chiefs of OSTDS and Water Programs should review this report for statewide implications, and provide assistance to the CHD as required.

Investigation # 04-077
Alleged Inappropriate Activity and Conflict of Interest – Osceola CHD

The investigation was predicated on allegations of inappropriate billing practices, inappropriate nursing protocols, disallowed staff activity, and conduct unbecoming.

HIG substantiated the allegations that a nurse entered a physician's billing code for a service not provided by said physician; business office management directed staff to change Medicare coding without, in the same communication, instructing staff to obtain physician approval for said action; CHD management charged indigent patients deposits for maternal delivery services prior to Medicaid eligibility determination; a nurse changed a physician's orders for a high risk patient without the physician's consent; a health support technician administered an injection to a patient; and management was aware of suspected signs of intoxication of an employee.

Recommendations

- The Office of the Deputy Secretary for Health/Office of Public Health Nursing should review any violations of nursing protocols cited in this report and take the appropriate actions relating to the CHD nursing director and/or cited nursing personnel.
- CHD management should review the business practices cited in this report and take appropriate actions relating to the

CHD business manager and/or cited business office personnel. A report of CHD management's findings and any corrective actions should be submitted to the Office of the Deputy State Health Officer.

- CHD management should consult with the Agency for Health Care Administration (AHCA), Medicaid Office, to identify and ensure proper billing practices for potential Medicaid recipients, including, but not limited to, undocumented aliens.

- The CHD Administrator should identify the patient who was diagnosed with a dead fetus in 2002, forward the complete patient file to the HIG for review, and initiate a peer review by the Office of Performance Improvement regarding this incident.

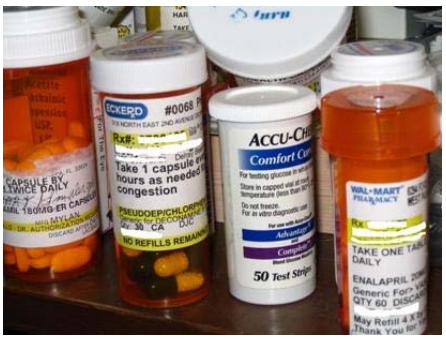
- The Office of Public Health Nursing should review the incident of a Health Support Technician administering patient injections, and consider developing a written policy regarding this matter for the CHD and other CHDs as warranted.

- CHD management should review the findings of this report relating to the employee's appearance of intoxication and comply with the DOH Drug-Free Workplace Policy, in consultation with the department's Bureau of Human Resource Management, Division of Administration.

Investigation # 04-081
Alleged Abuse of Position and Conflict of Interest – Palm Beach CHD

The investigation was predicated on a complaint alleging that subject employee, a CHD Senior Physician, was counseling patients on legal matters and referring patients to his daughter's legal practice. The allegation of mishandling prescription medication was added when HIG staff discovered numerous prescription medications in subject's office that were not secured and many had expired.

HIG substantiated the allegation that the subject conducted legal activities with CHD patients, and referred CHD patients to his daughter, who was an attorney in practice at the subject's law firm. Further, HIG concluded that the subject did not file a Notification of Additional Employment Outside of State Government to declare his business interests, and that he utilized state resources, including time, space and equipment, in pursuit of his private interest in law.



HIG substantiated the allegation that the subject may have violated state law in not securely storing controlled substances in his office and in dispensing outdated controlled substances to persons other than the patients for whom prescribed. He may have also violated state law in dispensing other outdated medicinal drugs (not controlled substances) to persons other than patients for whom prescribed.

Recommendations

- CHD management, in consultation with Legal Counsel, should take appropriate action against the subject for possible violation of department Ethics Codes in the referral of CHD patients to his daughter, who works in his private law practice, and in the use of state property, equipment, and space in pursuit of his private legal interests.

- CHD management should refer the subject to the Board of Medicine, Division of Medical Quality Assurance, for possible violations of medical practice standards and Chapter 893, F.S., for inappropriate dispensing of controlled substances and other prescription medications.

- CHD management should take appropriate action against the subject for refusing to cooperate in an internal investigation.

Investigation # 04–085
Alleged HIPAA Violation – Palm Beach CHD

Information received from a complainant alleged that a CHD employee had inappropriately accessed client medical data and distributed the information to the employee's daughter.

The allegation was substantiated. HIG found that a preponderance of testimony and information suggest the employee inappropriately accessed a client's data. The employee acknowledged, on one occasion, accessing the client's data to obtain pertinent biographical information enabling her to implement legal remedies against the client.

The employee denied subsequent access to the client's data, for personal reasons. However, comparison of the printout supplied by the complainant with two other computer printouts of the client's data appeared conclusive.

Recommendation

- Appropriate disciplinary action should be taken.

Investigation # 04-153
Alleged Improper Business Practices and Conduct Unbecoming a Public Employee – Monroe CHD

The report is predicated on an anonymous complaint alleging improper business practices, violations of the department incident reporting system for thefts, and that the CHD director made threatening statements toward CHD employees.

HIG substantiated allegations that the business manager and business staff violated the prompt payment policy. The business manager did not properly report a theft incident, and the CHD director made threatening comments about employees. The HIG partially substantiated the allegation that the business office was using vendors without current executed contracts. The HIG found one vendor was on state contract and, as a result, did not require a local contract with the CHD.

Recommendations

- The corrective action plan as developed by the technical assistance team from the Bureau of Finance and Accounting should be fully implemented. The Bureau of Finance and Accounting should continue to monitor the CHD to ensure corrective actions are being timely and effectively implemented.

- CHD management should take appropriate action regarding the business manager's handling of the theft incident report. The personnel manager should develop a better system for handling stolen property incident reports and CHD management, in conjunction with the Bureau of Finance and Accounting, should develop effective cash handling procedures.

- The Office of the Deputy State Health Officer and the CHD director should work together to address concerns of CHD staff regarding the director's threatening comments.

Investigation # 04-155 – Preliminary Inquiry/Management Referral
Using State Computer to Access Pornographic Material – HQ/CMS

A department Information Technology Database Administrator was testing new network software and noted suspicious activity coming from a computer assigned to an employee at CMS-Tallahassee and alerted the HIG. An examination of the employee's hard drive conducted by HIG staff revealed the employee had been using his state-assigned computer to access pornographic and sexually explicit web sites.

References to pornography/sexually explicit materials were found in the 19,670 images readily available on the hard drive, including those related to Internet activity. Hundreds of pornographic/sexually explicit .JPG and .JPEG images were observed. Of these images, seventy-one (71) were selected at random and examined in detail. All seventy-one of these images were associated with the employee's user ID. It was noted that these images were accessed on at least five different dates. Computer forensic analysis revealed that the employee's accessing of the web sites was not consistent with accidental access or with virus activity.

It was determined that Children's Medical Services management had the prerogative to further investigate this allegation and take appropriate disciplinary action, so no further investigation by HIG was required. A Management Referral letter was sent to the Medical Director at Tallahassee-CMS, along with the evidence described above and the recommendation that the archived hard drive be held for six months then returned to Tallahassee-CMS.

Investigation # 04-166 (Risk Review)
Serious Incident Report

The case involved a patient who aspirated vomit and subsequently suffered cardiac arrest. We found, based upon the details provided, that staff attempted to act appropriately, but were hampered in their efforts by problems with the crash cart and, potentially, a need for staff to have required training and updated practice using the crash cart. The HIG concluded that resuscitation efforts of staff were inadequate due to an improperly stocked crash cart, resulting in the patient lapsing into a coma and requiring transportation to an acute care hospital.

Recommendations

- Management should implement the recommendations of the internal investigation report as presented by staff. Management should investigate other examples of potential systems that will self-trigger the need to replenish or replace emergency supplies to supplement the changes needed in staff actions. An example is a crash cart alarm system that sounds if not reset at appropriate times.

- Management should make sure all staff receives required training and updates, and practice mock codes on a regular basis.

- Management should consider the addition of an Automated External Defibrillator (AED) to the crash carts. Implementation of this recommendation will require minimal additional training for staff.

- Management will need to reevaluate procedures at frequent intervals to assure that given recommendations are implemented and followed assiduously.

Investigation # 04-158
Alleged Inappropriate Behavior by a Physician – HQ/MQA

A complaint alleging prohibited sexual activity between a licensed doctor and his patient was filed with the Headquarters Division by the patient's spouse. The Division was extremely cautious in proceeding with the case and insisted that the complainant provide a release from the patient or documentary evidence such as a copy of an insurance benefit statement, a bill, an appointment card or a prescription showing the doctor/patient relationship between the persons named in the complaint. After approximately 9½ months, the complainant emailed Governor Bush and the HIG complaining that the Division had not initiated an investigation of his initial complaint.

When Division personnel were contacted by the HIG investigator and advised that the complainant had written the Governor and the HIG complaining that the Division had not initiated an investigation of his complaint, the Division immediately proceeded to initiate the investigation. The Division apparently applied a different standard of legal sufficiency than it had applied when the initial complaint was received.

Recommendation

- The Headquarters Division should review its definition of the term "legally sufficient" as it related to complaints against medical practitioners and take the steps necessary to consistently apply that standard when determining the legal sufficiency of a complaint.

Investigation # 04-167
Alleged Misuse of Grant Money – Pinellas CHD

This investigation was initiated based upon an anonymous complaint alleging a CHD was improperly using its employees to staff and operate a not-for-profit corporation receiving grant funds from the CHD. The complaint alleged that the grant funds were not being used for the intended purpose and that two of the CHD employees involved have possibly committed criminal acts outside of their employment with the CHD.

The not-for-profit corporation in question had contracted with the CHD since 2001, to provide health services to citizens of the county. Six regular CHD employees and one contract employee had served as non-compensated members of the Board of Directors of the not-for-profit corporation. The Florida Commission on Ethics has ruled that no prohibited conflict is created by an employee serving as a non-compensated board member for a not-for-profit corporation that is doing business with an employee's agency. Therefore, no prohibited conflict of interest appears to have been created by their service on the corporate board of directors.

None of the allegations in the complaint were substantiated; however, the investigation revealed that fifteen CHD employees had accepted employment by the not-for-profit corporation which created a prohibited conflict of interest. The fifteen CHD employees, including six of those who also served on the Board of Directors, were employed by and paid by the not-for-profit corporation for providing services related to the contract with the CHD. Such employment by an entity that is doing business with the CHD appears to have created a prohibited conflict of interest for these fifteen employees.

The CHD personnel office did not have a record of any of these employees filing a Report of Employment Outside of State Government form as required by department Policy.

If the CHD wishes to allow its employees to continue outside employment with the not-for-profit corporation we recommend that the CHD consult with the Department Ethics Officer and make certain that such employment does not constitute a prohibited conflict of interest. It should also make certain that all employment of its employees, outside of State government, is reported to and approved by management, as required by department policy, prior to such employment.

Recommendation

- The CHD should, after consultation with the Department Ethics Officer, take appropriate disciplinary action against any of its employees who have violated the conflict of interest statute by their employment with the not-for-profit corporation and those who failed to file a Notice of Employment Outside State Government as required by DOH policy.

Investigation # 04-180
Alleged Non-Reporting of Criminal Violations – HQ/MQA

This investigation was initiated based upon an email complaint in which the complainant alleged that the department had not reported to the appropriate prosecuting authority, criminal acts by licensed health care practitioners as required by statute and department policy.

After requesting and receiving copies of several closed case files, the complainant provided the Headquarters Division with several lists of cases in which he stated that criminal acts were found, but not reported to prosecutors. The Division reviewed

some of the cases related to sexual misconduct and subsequently reported the complaints to prosecutors. The Division procedures, adopted in August 2002, require investigators to report criminal allegations to prosecutors; however, some were not reported and supervisors did not ensure that the procedures were followed.

The Division was asked to provide the investigator with a list of criminal acts reported to prosecutors. After first stating that no such list could be produced by the current database, the Division eventually provided a list of 172 cases reported to prosecutors since July 1, 2002.

The allegation was substantiated. Not all criminal acts found during Division investigations had been reported to prosecutors as required by Section 456.066, F.S. and department policy.

Recommendations

- The division should develop a specific written plan for reviewing its old case files and reporting to the appropriate prosecuting authority, cases in which legal sufficiency was found, if the offense for which legal sufficiency was found was defined by statute as a criminal offense. The plan should include a review of all cases for all Boards for which a criminal penalty is provided by statute, whether misdemeanor or felony. The plan should provide for the immediate review of cases that are within the statute of limitations for criminal prosecution. Cases beyond the statute of limitations should be handled as available resources dictate.

- Current procedures should be modified to require that criminal acts, not criminal allegations, be reported to appropriate prosecutors. The procedures should require supervisors to verify that the statutory reporting requirements are met in all cases. The procedure should also identify a time frame for reporting such criminal acts.

- Every investigative file for complaints received and investigated by the division should contain documentary evidence indicating that a determination was made as to whether criminal acts were found, and if so, that the criminal acts were reported to the appropriate prosecuting authority.

- The division's case tracking system should include data fields indicating whether criminal acts were found in each case and whether those criminal acts were reported to a prosecutor.

Investigation # 05-028
Alleged Security Breach – Palm Beach CHD

An Information Security Coordinator advised she was notified that approximately fifteen pages of an HIV NIR (No Identified Risk) line list were unaccounted for. Regarding this alleged breach of security, the HIG inquiry did not determine the disposition of the pages indicated missing from the NIR line list or identify the person(s) responsible for their disappearance. However, during the investigation other misconduct was noted and substantiated including employee misconduct, providing false or misleading information during an official administrative inquiry. Also substantiated were issues of failure to follow instructions, insubordination and misuse of state resources.

The HIG determined that a senior employee presented false information to HIG staff during the course of an official administrative inquiry and attempted to coerce, or persuade other employees to conspire with him to manufacture a false version of the events to remove him from accountability for his violation of policy. The investigation revealed that despite

repeated warnings and counseling this senior employee disregarded his supervisor's direction to stop misusing state resources for his personal benefit.

The supervisor for this section missed several opportunities to address, and curtail undesired activities by his subordinates. His inaction or ineffective action fostered an atmosphere wherein a subordinate felt the supervisory chain was incapable of providing repeatedly sought relief, and felt compelled to submit to a senior employee's repeated request for assistance with personal matters.

Recommendations

- Appropriate disciplinary action should be taken.
- Each member of the AIDS/Surveillance team should receive documented counseling stressing attention to details, and personal ethics.
- Management should closely scrutinize the supervision, operation, and morale in this unit and make adjustments as appropriate.

Investigation # 05-069
Alleged Theft of Laptops – Duval CHD

This investigation pertained to the theft of two laptop computers reported by an employee. The computers were assigned to a Director of Communicable Disease, and Health Center Administrator, who determined them to be missing. A police report and an Incident Report were filed.

The computers were stolen on April 14th, most likely during the window of opportunity that existed from 5:00 – 11:00 P.M., by unidentified individual(s). The opportune time for the crime was during the cleaning staff's meal break, 6:30 – 7:30 P.M., when there were only two persons known to be in the building – the security guard and one employee. A suspect was subsequently apprehended. The CHD has initiated action to review physical security policy. The department's Physical Security Guide also was noted to need updating. However, the failure to lock an office door established the conditions allowing for the theft. The allegation that the computers were not properly secured was therefore found to be substantiated.

Recommendations

- The CHD director should expedite administrative action to establish a physical security policy and protocols to become compliant with the department's Physical Security Guide.
- The CHD director, in collaboration with the Shands Director of Security, should conduct a risk analysis of the Boulevard Comprehensive Care Center to identify vulnerabilities and establish appropriate safeguards.
- The CHD director should coordinate with the Shands Director of Security and the county sheriff's office to determine if law enforcement is successful in recovering the computers.
- The Deputy Secretary should initiate a review and update of the department's Physical Security Guide, dated 9/30/98.

Investigation #05-071
Alleged Falsification of Official Documents - State Laboratory Services

This investigation was predicated on a telephone call received from an employee in the Bureau of Laboratory Services (BOL). The administrator indicated that a probationary employee had been terminated for falsifying a document. During the subsequent review of documentation surrounding the termination, an email was located that indicated a second BOL employee was aware of the falsification of the document and, in fact, had suggested the falsification to the probationary employee. The administrator requested the matter be investigated to determine whether or not the current BOL employee participated in falsifying the document.

Based on the investigative findings, HIG substantiated that an employee knowingly participated in the falsification of an official document related to malaria testing. At best, the employee was indifferent to what the actual laboratory results were for the test in question. His own statements indicate that another employee more experienced in the area of molecular microbiology was uncertain about what to do when the CDC (Centers for Disease Control) pointed out that they had reached the wrong laboratory result. The subject stated he dismissed that scientist's suggestion that they run the test again, which would have been appropriate under the SOP (standard operating procedures) for their project. Also, instead of urging his colleague to confer with their supervisory chain, the subject sent his colleague an email urging him to blame the mistake on clerical error. The probationary employee did as advised, taking a course of action which led to his subsequent termination.

HIG also determined that the employee failed to follow operating procedures. The employee stated that he and his colleague were trying to follow the SOP as closely as possible, but then later stated he never read the SOP and did not consider it valid because the administrator had not signed a final version. During his HIG interview, the employee make statements that indicated he was unaware that refining the SOP was part of his project, but he also made numerous statements indicating he was aware that the SOP was a work in progress, and that his supervisory chain was expecting him to follow the guidelines and note any areas that needed to be further revised as the project progressed.

Recommendation

- Appropriate disciplinary action should be taken.

Investigation # 05-073
Alleged Unlawful Credit Card Fees – Office of Vital Statistics

This investigation was initiated based upon a complaint from a citizen who alleged that the Office of Vital Statistics charged him a $5 fee for using a credit card to pay a $15 fee for a birth certificate.

The Office of Vital Statistics had allowed a private company to install a phone line and a credit card machine in its office. Staff were accepting credit card orders and processing them through the private company credit card machine installed in the office. For about three weeks, this machine was also used at the front counter of the Office of Vital Statistics for walk in customers. At the time of the investigation the supervisor of the Office of Vital Statistics stated that the machine had been removed from the front counter.

The Office of Vital Statistics processed the complainant's order through the private company which charged a $5 fee for its service. The allegation was determined to be unsubstantiated as the charge did not appear to be a charge for using a credit card

since the company charge is the same without regard to method of payment. However, the Office of Vital Statistics appeared to be providing assistance to the private company by allowing the company to install a telephone line and credit card machine and by allowing DOH employees to accept and process orders for the company.

Recommendation

- The Office of Vital Statistics should discontinue the practice of allowing the private company to install phone lines and credit card machines and discontinue allowing staff to accept credit card orders on behalf of the private company. The Office of Vital Statistics should also remove all statements from its website that indicate it accepts credit card orders. It should be made clear that credit card orders are offered only by a private company that is not affiliated with the DOH Office of Vital Statistics.

Investigation # 05-075
Alleged Improper Mileage Claims – Orange CHD

This investigation was based on an Interoffice Memorandum from a CHD employee forwarding evidence of possible travel fraud by two employees of the CHD Tuberculosis (TB) Program. Both employees provided direct observed therapy (DOT) to an assigned case load of clients. To conduct DOT requires that employees travel daily to various locations within the county where they provide medication and observe clients swallowing the medications. The employees were alleged to have falsified their work-related privately owned vehicle (POV) mileage on state travel expense reimbursement forms. The allegation was unsubstantiated for one employee and substantiated for the other.

For the unsubstantiated finding, Finance and Accounting staff failed to take into account the fact that management had authorized the employee to deploy from home each morning and go directly to the first TB DOT client and to work a DOT client route to the clinic and return home via DOT client routing in the afternoons.

Findings indicated that the other employee routinely submitted travel logs indicating mileages in rounded figures such as 5, 10, 15, 20, etc. Additionally, the travel logs indicate odometer readings starting at less than the ending odometer readings recorded at the end of the previous day. When questioned by the CHD's Finance and Accounting staff, the employee stated that different vehicles were used.

A random check of the employee's travel logs using MAPQUEST indicated a marked difference in the mileage claimed and that necessary to conduct the required travel. The rounding of mileage further indicates inaccurate entries made by the employee in the travel log. It is improbable that any two vehicles would have odometer readings so close to one another across a variety of examples observed in the travel logs. Additionally, it appears the employee made a false statement to the CHD Finance and Accounting staff when asked about the odometer differences in the travel claim.

Recommendations

- The CHD director should consult with legal counsel to determine criminal ramifications as stated in Chapter 112.061, F.S., paragraph (10). (NOTE: The subject's statements contained herein cannot be used in a criminal case.) [*Edward J. Garrity vs. State of New Jersey, 1/16/67*]

- The CHD director should consider disciplinary action as appropriate.

- The CHD Office of Finance and Accounting should recalculate the employee's FY 2004-2005 travel using the employee's home as the point of origin and, if appropriate, termination to determine the amount of reimbursement required. (NOTE: "*Whoever shall receive an allowance or reimbursement by means of a false claim shall be civilly liable in the amount of the overpayment for the reimbursement of the public fund from which the claim was paid.*") [Chapter 112.061, para (10) Fraudulent Claims.]

- The CHD director should require all supervisors to review with their employees the certification paragraph located above the signature block on the State of Florida Voucher For Reimbursement of Travel Expenses form which states: "*I hereby certify or affirm and declare that this claim for reimbursement is true and correct in every material matter… and that this voucher conforms in every respect with the requirements of Section 112.061, Florida Statutes.*"

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OTHER ACCOUNTABILITY PRODUCTS

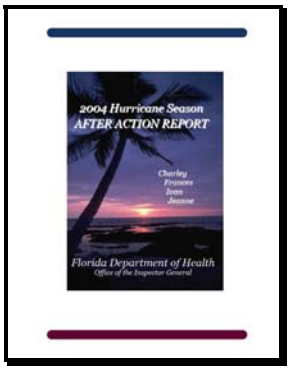
Hurricane After Action Review

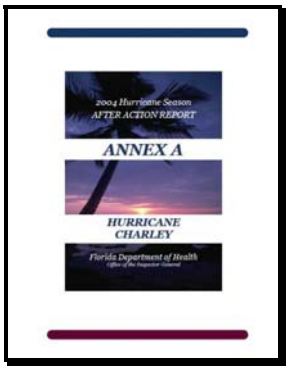
Due to the impact on Florida of the unprecedented 2004 hurricane season, HIG was called upon to perform a duty unparalleled in state history. We formed a five-member Hurricane After Action Review (AAR) Team which was charged by the Secretary with creating a quality improvement process that examined the Department of Health's preparation and response to four landfalling hurricanes. Like the 2004 hurricane season, the need for this process was unprecedented in state history. While after action reviews had been accomplished before, never to the scope, depth and breadth of what was required by the 2004 season – this necessitated development of a new methodology. There was no prior planning or existing guidance available covering events of this magnitude. The only records found regarding public health operations in Hurricane Andrew consist of two summary pages. This lack of historical reference was unfortunate given the crucial need for understanding of lessons learned from prior catastrophic events.

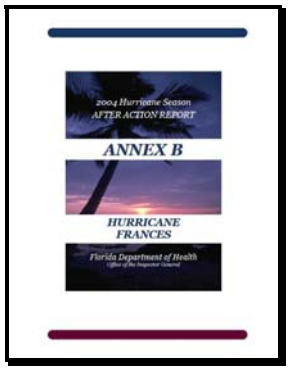
The review process developed by the AAR Team, which can be adapted and implemented by other organizations and government entities, resulted in a seven volume after action report that will serve as a historical record and reference document for future emergency planners. The master report contains 84 summary recommendations drawn from the several hundred detailed recommendations located thoughout the seven volumes. The report is serving as a guiding blueprint from which the department is implementing improvements anticipated to result not only in significant cost savings to the state, but in community health improvements and, potentially, in lives saved. Additionally, the report and recommendations apply not only to hurricane emergencies. The lessons learned that were captured readily apply to an all-hazards disaster planning approach, thus having homeland security implications.

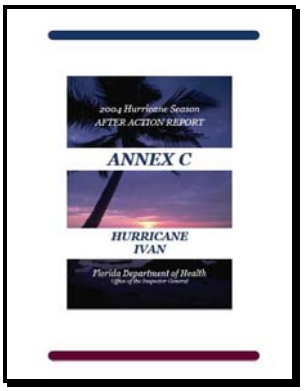
DOH medical and nursing staff deploy to Pensacola as part of the department's Hurricane Ivan response.

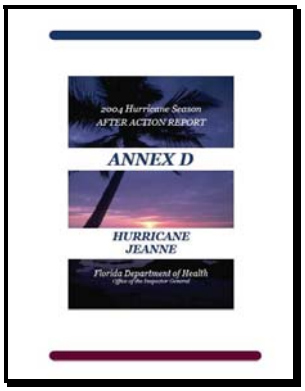
The full Hurricane After Action Report is available on CD from the Department of Health Office of the Inspector General or at our website: http://www.doh.state.fl.us/IG/AAR/2004/AfterActionReport.htm

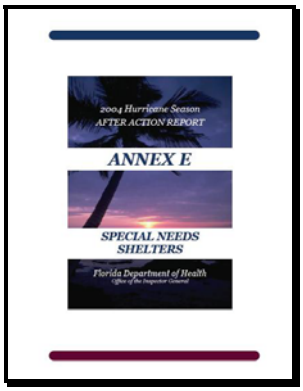


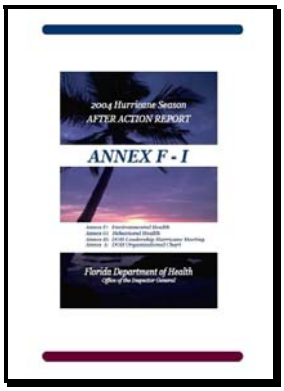












5. Human Resource Focus

Professional growth is a valued goal and one that is highly supported by HIG management. The key to HIG staff development has been the pursuit of diverse and relevant training. HIG staff have attended numerous training events including:

- Audit staff

Florida Institute of Certified Public Accountants Fall Conference; Kenesic Interviewing Training; Overview of the Florida Commission on Human Relations; Microsoft Access Level 2 & 3; Medicaid and Elder Law Issues in Florida; Reining in Audit Cycle Time; Effective Contract Auditing; Information Security Training; Yellow Book Update; FSU Spring Accounting Conference; Implementing the Single Audit Act; Auditing Automated Applications; The New Chief Audit Executive; Advancing Accountability.

Training fees accounted for almost **one-third** of expense category expenditures.

- Investigative staff

Continuing Professional Education for Association of Inspectors General Certification; Southeast Evaluation Association Essential Skills in Evaluation Training; Advanced Reid Technique of Interviewing and Interrogation; Southeast Cybercrime Summit – HTCIA Computer Forensics Training; Certified IG Investigator Training.

No employee performance bonuses were available for award during FY 2004-2005, however, other motivational strategies such as generous training availability, discussed above, and the allowance of flexible working hours continued. Flexible working hours is a great benefit to employee morale and productivity, particularly for employees with family obligations, care giving responsibilities, commuting issues, educational endeavors, or other commitments that cannot be met during the typical 8 a.m. to 5 p.m. Monday through Friday workweek. Our leadership continues to recognize that fact and has been fully supportive of alternative work schedules. While not unique to our office, this benefit is another key factor in providing a positive and supportive work environment.

6. Process Management

Process management systems and tools are the key to stratifying the volume of information and issues that come to the attention of HIG staff.

Our investigations triage approach yields a reasonable and efficient method of allocating resource inputs from our investigative teams. This method categorizes complaints into several key action strata with differing resource requirements and timelines for completion. These key strata include: information only, referral, management advisory, investigative assists, preliminary inquiry, and full investigation. Though fewer in frequency, additional classifications include whistle-blower complaints and risk reviews. The latter is per an agreement with the General Counsel's Office that HIG staff, in concert with qualified medical reviewers, will investigate department-provided medical care in cases where litigation may occur.

Key HIG Processes:

- **Audits**
- **Investigations**
- **Management Reviews**
- **Risk Reviews**
- **Other Accountability Products (e.g., Hurricane After Action Review)**
- **Administration**

Complaint Triage Process

- Information Only (NF)
- Referral (RF)
- Management Advisory (MA)
- Investigative Assists (INA)
- Preliminary Inquiry (PI)
- Investigation (IN)
- Whistle Blower (WB)
- Risk Review (RR)

Refer to Appendix for a complete listing of 2004-2005 closed complaints.

Events this fiscal year required the development of new processes including the Incident Report Tracking Database and the Hurricane After Action Review and Reporting process. The latter was necessitated by the Secretary's tasking of the HIG to conduct a review of the department's response to the 2004 hurricane season. The focus was on compiling lessons learned that, when implemented, could improve the department's future health and medical emergency response.

Enhancements were also made this year to the Audit Corrective Action Tracking System, whereby audit staff can timely inform management of auditee implementation of needed corrections.

7. Organizational Performance Results

To assess our performance as an organization we rely on performance measures, customer and employee satisfaction indicators and external review results. Our performance over 2004-2005 reflects both successes and opportunities to improve our contributions to the department's mission.

- *"Honest and fair investigation"*
- *"I expected the same professional service I have always gotten and I was not disappointed."*

  – *Respondents to investigative quality survey*

Customer-Focused Results

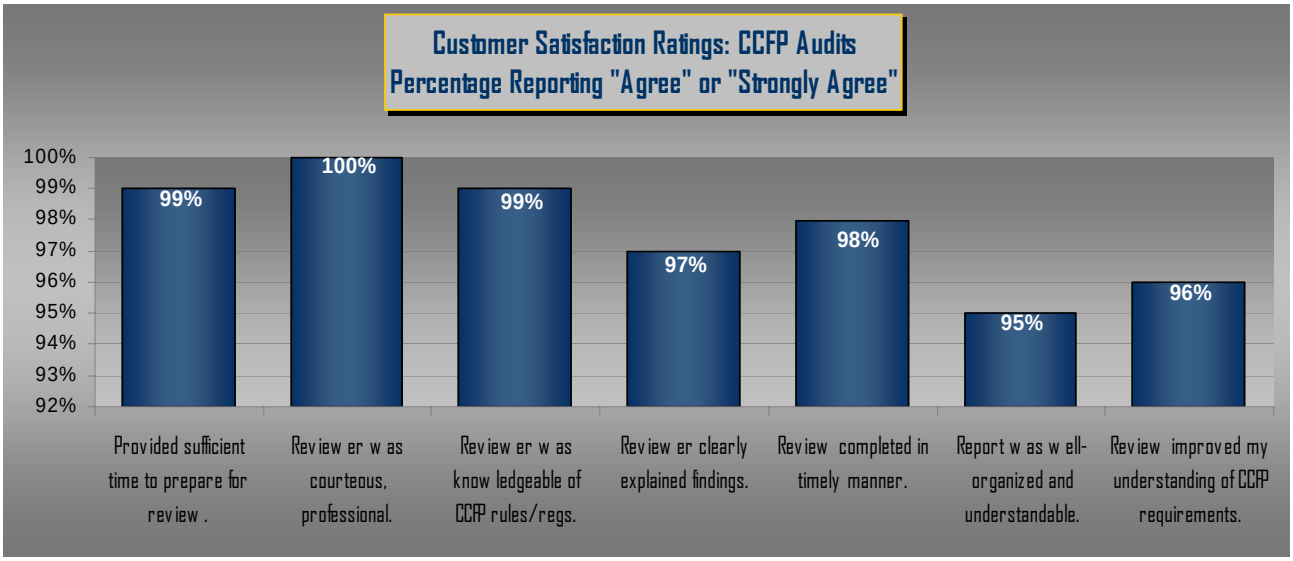
We continue use of a web-based process of assessing customer needs and satisfaction. Our customers, whether they be Headquarters or CHD managers or staff, or Child Care Food Program (CCFP) participants, consistently rank our services highly.

In the Investigations area, our overall average customer satisfaction rating was **3.75** on a scale of 1 through 4 with 4 reflecting the most positive ranking of "strongly agree." Additionally, 100% of customers responding to the survey reported they either "strongly agreed" or "agreed" with all four quality measures listed on the chart below.

Child Care Food Program (CCFP) audits were also rated highly by customers. As in the prior fiscal year, 100% of respondents reported they either strongly agreed or agreed that the reviewer was courteous and professional, and all other quality indicators received customer ratings in the 90th percentile.

"The reviewer was excellent. We learned a lot from him and he cleared some questions for us."

➢ *Respondent to CCFP Audit quality survey*



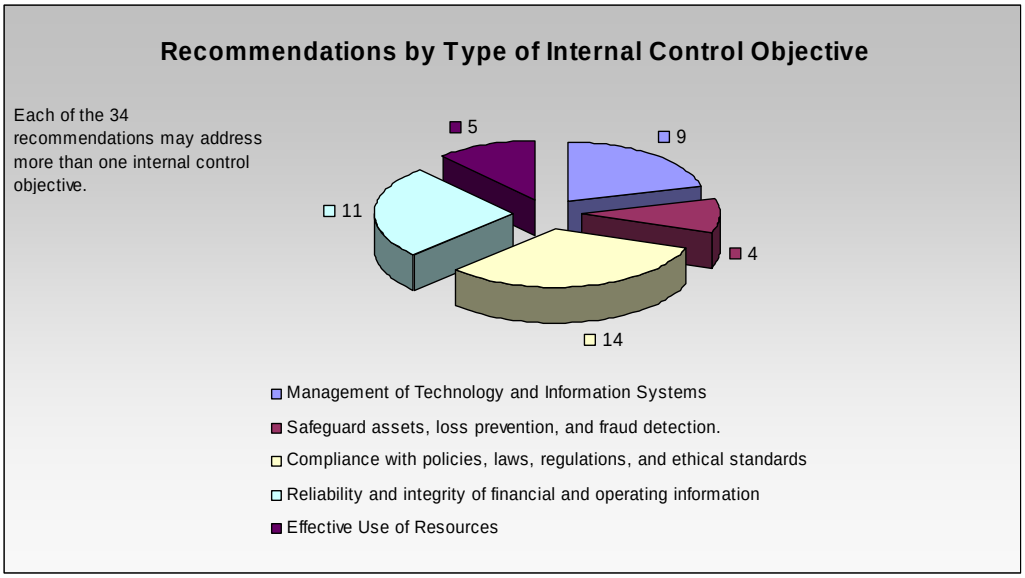
Human Resource Results

In FY 2004-2005, our total full-time equivalent staff of 31 had a 19% turnover rate with the loss of six staff and the hiring of four replacements (one position turned over twice). The department did not conduct an employee satisfaction survey during the fiscal year.

Product and Service Outcomes/Organizational Effectiveness Results

Internal Audit

The HIG Internal Audit unit performed six comprehensive audits and five follow-up reviews of audit findings and recommendations from prior years. Of 34 recommendations made, the majority related to internal control objectives associated with policies, laws, regulations and ethical standard compliance issues, followed closely by issues regarding reliability and integrity of financial and operating information.



CCFP Audits

Baseline Child Care Food Program (CCFP) audit performance data continues to reflect progress toward meeting and refining production and timeline objectives:

CCFP Production/Timeline Objectives	Result Achieved
Obtain all independent audits of CCFP sub-grantees required under OMB Circular a-133 within required timeframes.	69%
Review all independent audits of CCFP sub-grantees within 5 working days and perform any necessary follow-up.	98%
Conduct the number of agreed-upon procedures reviews of CCFP sub-grantees required by federal regulations.	386
Average # of days from:	
➢ start of review to issuance of draft report	80
➢ start of review to submission to supervisor	27
➢ review submission to supervisor and review by supervisor	34
➢ review by supervisor to issuance of draft report	19

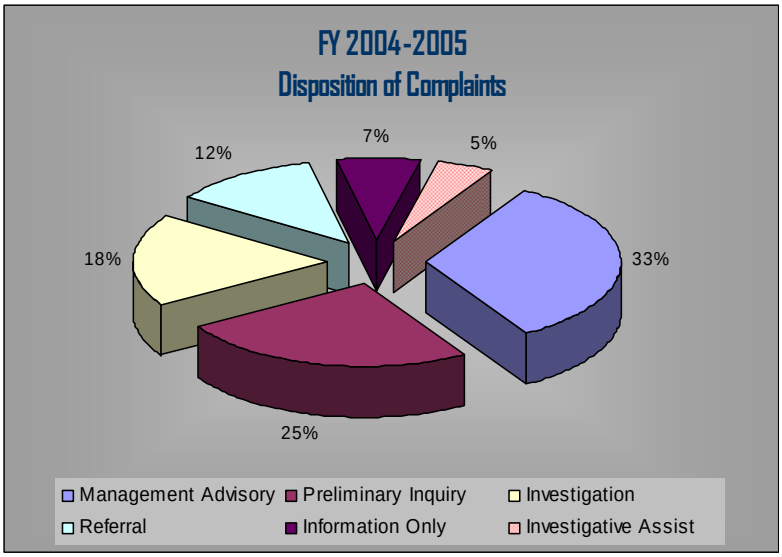
Additionally, we served as expert witness in four CCFP administrative hearings; we completed 386 Child Care Food Program (CCFP) agreed-upon procedures reviews, and identified $280,729 in questioned costs. CCFP reviews covered $12,912,518 in program expenditures. We closed 428 reviews resulting in $554,368 in questioned costs. Of that amount, $456,013 was recovered through collections. We also performed audit

confirmations and reviewed audits conducted by Certified Public Accountants for 111 CCFP contractors covering an estimated $52,751,968 expended by the program.

CCFP Review Outcomes				
Agreed-Upon Procedures Reviews		Amount Reviewed	Costs Questioned	Amount Recovered
Performed:	386	$12,912,518	$280,729	N/A
Closed:	428	$18,312.738	$554,368	$456,013
Audit Confirmations:	111	$52,751,968	N/A	N/A

Investigations

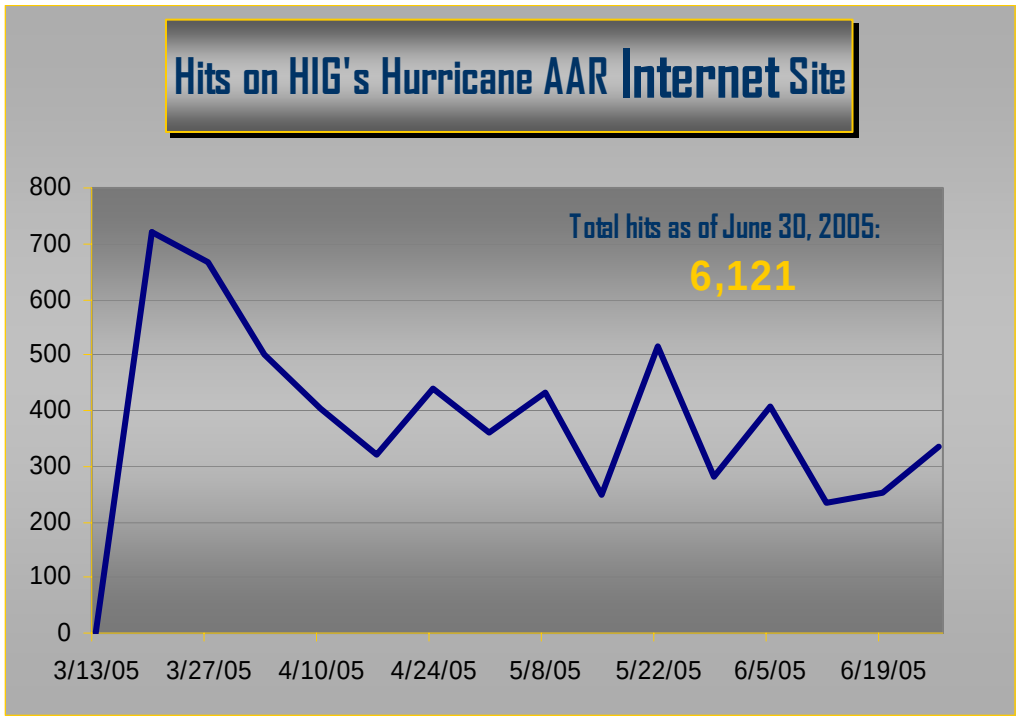
Investigative staff received a total of 233 complaints in 2004-2005 and closed a total of 235 complaints. Complaints arise from a variety of settings within the County Health Department and Division environments. They are triaged as to urgency and assigned to staff or referred as appropriate. We triaged 93% of all complaints within 10 duty days, completed 67% of our preliminary investigations within 30 days and 76% of full investigations within 120 days. Refer to the appendix for a complete listing of FY 2004-2005 closed complaints.



Other Accountability Products

Hurricane After Action Report

The widespread interest in the 2004 Hurricane After Action Report upon its release in March 2005 is evidenced by thousands of hits to the department's AAR intranet and internet websites from the dates of posting through June 30. Tracking software reveals that website visitors range from government entities at federal, state and local levels in the U.S., private industry, public and private research and academic institutions, along with hundreds of international visitors.



Feedback received from the recipients of the Hurricane After Action Report indicated positive acceptance of the product. Comments on the AAR included the following:

- *"...we really appreciate receiving your report. We will use it as part of our preparation for emergency operations."*

  Luci Hadi, Secretary
  Department of Children & Families

- *"Our comment would be..."wow." Nice job. We will use this as our template for future products."*

  Bill Spann, Chief-of-Staff
  Department of Children & Families

- *"Excellent, as expected."*

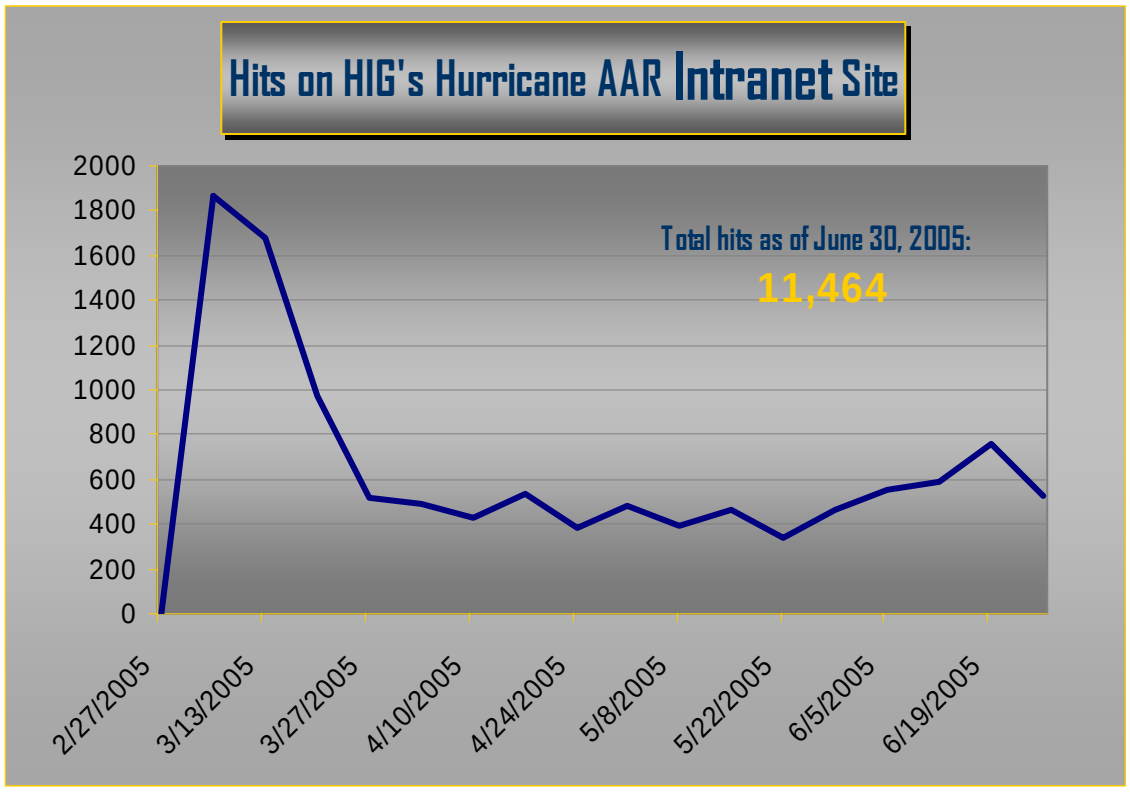
  Nancy Humbert, Deputy Secretary
  Department of Health

- *"...extremely comprehensive and it felt like I was reliving the whole hurricane again. The conditions of the special needs shelters outlined in your report can only lead to some constructive improvements....this is a fine piece of work."*

  Tom Liberti, Bureau Chief
  Department of Health

And from an Escambia County Health Department nurse who endured the landfall of Hurricane Ivan in a special needs shelter:

- *"You guys did a wonderful job on that report! Everyone should read it...it talks about issues, not people...I've been giving out the website and I tell everyone to read it...It's really good!...God bless you for that...God bless you."*



Leadership and Social Responsibility Results

While there were no external reviews of HIG during the fiscal year, peer and stakeholder trust of our services continued to be evidenced by requests through investigative assists offered to such agencies as the FBI and other law enforcement organizations.

Concluding Comments

This fiscal year brought many challenges, not the least of which included workload disruptions due to the unprecedented hurricane season. HIG leadership and staff met the challenge by producing the Hurricane After Action Report while maintaining effective triage and investigative case processing. Audit staff contributed significant recommendations for improving department operations and CCFP audit staff recouped significant funds through their audit process. Throughout this challenging year, HIG staff and leadership continued pursuit of our vision - making indispensable contributions to the department.

APPENDIX

Department of Health
Office of the Inspector General
Closed Complaints 2004-2005

Number	Type	Alleged Subject	Disposition
02-130	IN	Alleged inappropriate behavior of state employee	Unsubstantiated
03-188	MA	Alleged abuse of activity sheets	Referred to Management
03-190	IN	Alleged program fraud/abuse	Substantiated
03-198	PI	Alleged forged signature	Referred to Law Enforcement
03-206	PI	Alleged contract discrepancies	Information recorded for possible future use
04-008	PI	Alleged embezzlement	Referred to Law Enforcement
04-019	PI	Alleged HIPAA violation/access to AIDS-HIV client information	Unsubstantiated
04-022	IN	Alleged conflict of interest and failure to perform contracted services	Substantiated
04-036	IN	Alleged violations by EH director	Substantiated
04-047	PI	Alleged HIPAA violation	Information recorded for possible future use
04-056	PI	Alleged harassment, retaliation and battery	Information recorded for possible future use
04-057	PI	Alleged HIPAA violation	Unsubstantiated
04-073	IN	Alleged sale of stolen property	Substantiated
04-077	IN	Alleged inappropriate medical exam	Substantiated
04-079	INA	Alleged fraud	Assisted MDOIG
04-080	INA	Alleged stolen/lost blank birth certificates	Assisted FDLE
04-081	IN	Alleged conflict of interest	Substantiated
04-082	PI	Alleged HIPAA violation	Unsubstantiated
04-084	IN	Alleged theft of fuel	Unsubstantiated
04-085	IN	Alleged HIPAA violation	Substantiated
04-091	MA	Alleged discrimination actions	Referred to Management
04-093	IN	Alleged HIPAA violation	Unsubstantiated
04-094	PI	Alleged HIPAA violation	Information recorded for possible future use
04-099	PI	Alleged HIPAA violation	Unsubstantiated
04-103	IN	Alleged HIPAA violation	Substantiated
04-106	IN	Alleged alteration of records	Unsubstantiated
04-107	PI	Alleged illegal harassment	Unsubstantiated
04-110	IN	Alleged abuse of military leave	Unsubstantiated
04-111	PI	Alleged chiropractic exam fraud	Unsubstantiated
04-115	IN	Alleged bogus citation and favoritism	Substantiated
04-117	MA	Alleged misuse of state funds	Referred to Management
04-125	INA	Alleged client abuse	Assisted Law Enforcement
04-126	IN	Alleged breach of confidentiality	Unsubstantiated
04-127	MA	Alleged incompetence by state employee	Referred to Management
04-130	PI	Alleged breach of confidentiality	Substantiated
04-131	IN	Alleged excessive prescriptions	Substantiated
04-132	PI	Alleged misuse/abuse of state equipment	Unsubstantiated

Legend				
	IN - Investigation	NF – Information Only	RF – Referral	PI – Preliminary Inquiry
	MA – Management Advisory	INA – Investigative Assist	RR – Risk Review	WB – Whistle-blower

Number	Type	Alleged Subject	Disposition
04-133	IN	Alleged abuse of laptop	Substantiated
04-135	INA	Alleged Medicaid fraud	Assisted FBI
04-136	MA	Alleged order to cease and desist operation of private EMT school	Referred to Management
04-137	IN	Alleged alternation of forms	Substantiated
04-138	MA	Alleged refused to bill for treatment	Referred to Management
04-139	MA	Alleged unreasonable charge for medical records	Referred to Management
04-141	MA	Alleged misconduct by EH Administrator	Referred to Management
04-142	PI	Alleged favoritism and preferences	Information recorded for possible future use
04-143	PI	Alleged denial of Public Records Request	Information only
04-144	MA	Alleged rude treatment by a DOH employee	Referred to Management
04-145	MA	Alleged breach of personnel policy	Referred to Management
04-146	MA	Alleged harassment	Referred to Management
04-147	PI	Alleged possible fraud	Unsubstantiated
04-148	IN	Alleged inappropriate purchasing practices	Unsubstantiated
04-149	MA	Alleged unjust treatment of employees	Referred to Management
04-150	RF	Alleged HIPAA violations	Referred to AHCA
04-151	MA	Alleged malpractice by physician	Referred to Management
04-152	RF	Alleged loss of rights	Referred to AHCA
04-153	IN	Alleged improper business practices and conduct unbecoming a public employee	Substantiated
04-154	MA	Alleged non-use of gloves	Referred to Management
04-155	PI	Alleged misuse/abuse of state computer	Substantiated
04-156	IN	Alleged misconduct by an employee	Substantiated
04-157	PI	Alleged misuse/abuse of state computer	Substantiated
04-158	IN	Alleged inappropriate behavior by a physician	Substantiated
04-159	PI	Alleged harassment & hostile environment	Unsubstantiated
04-160	MA	Alleged misdiagnosis of STD	Referred to Management
04-161	RF	Alleged overdose of prescribed drugs	Referred to AHCA
04-162	RF	Alleged inept medical care	Referred to AHCA
04-163	PI	Alleged violation of ethics & abuse of state time	Unsubstantiated
04-164	MA	Alleged mismanagement	Referred to Management
04-165	IN	Alleged HIPAA Violation	Substantiated
04-166	RR	Alleged risk	Substantiated
04-167	IN	Alleged misuse of grant money	Substantiated
04-168	PI	Alleged misuse of position	Unsubstantiated
04-169	PI	Alleged various discrepancies with employment	Unsubstantiated
04-170	NF	Alleged abuse/neglect by a CHD client	Information only
04-171	PI	Alleged physical abuse	Unsubstantiated
04-172	MA	Alleged mishandling of secure ADAP equipment	Referred to Management
04-173	NF	Alleged misuse of state laptop	Information only
04-174	PI	Alleged mismanagement	Unsubstantiated
04-175	PI	Alleged breach of confidentiality	Information recorded for possible future use
04-176	MA	Alleged mismanagement	Referred to Management
04-177	MA	Alleged negative health risk	Referred to Management
04-178	MA	Alleged misconduct/abuse of authority by state employee	Referred to Management
04-179	MA	Alleged failure to meet course standards	Referred to Management

Legend				
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Number	Type	Alleged Subject	Disposition
04-180	IN	Alleged non-reporting of criminal violations	Substantiated
04-181	MA	Alleged medical malpractice	Referred to Management
04-182	PI	Alleged falsification of timesheet	Information only
04-183	PI	Alleged abuse of power; conduct unbecoming & nepotism	Unsubstantiated
04-184	MA	Alleged unethical medical practices	Referred to Management
04-185	MA	Alleged unfair practices during hurricane duty	Referred to Management
04-186	RF	Alleged Whistleblower complaint	Referred to Complainant
04-187	IN	Alleged falsification of lab report	Unsubstantiated
04-188	INA	Alleged theft of medications	Assisted Law Enforcement
04-189	RF	Alleged sick building	Referred to Children's & Families IG
04-190	PI	Alleged lying/perjury during hearing	Unsubstantiated
04-191	MA	Alleged rudeness by clinic staff	Referred to Management
04-192	MA	Alleged problem with returned mail	Referred to Management
04-193	MA	Alleged poor performance	Referred to Management
04-194	MA	Alleged misconduct by employee	Referred to Management
04-195	MA	Alleged rude behavior of state employee	Referred to Management
04-196	RF	Alleged problems at Assisted Living Facility	Referred to AHCA
04-197	INA	Alleged theft of security papers	Assisted Vital Statistics
04-198	PI	Alleged misuse of DOH logo	Referred to Law Enforcement
04-199	INA	Alleged unauthorized access of computer network resources by an employee	Assisted IT
04-200	PI	Alleged negative decisions against WIC vendor	Referred to Complainant
04-202	NF	Alleged various discrepancies with People's First System	Information only
04-203	MA	Alleged various discrepancies with dentists	Referred to Management
04-204	RF	Alleged restaurant staff unsanitary	Referred to DBPR
04-205	NF	Alleged discrimination against gays & lesbians	Information only
04-206	MA	Alleged bad attitude and unconcern by state employee	Referred to Management
04-207	PI	Alleged theft	Referred to Law Enforcement
04-208	MA	Alleged inappropriate behavior by CHD Director	Referred to Management
04-209	MA	Alleged illness from Dibrom	Referred to Management
04-210	PI	Alleged wrongful termination of employees	Unsubstantiated
04-211	MA	Alleged unfair work schedules	Referred to Management
04-212	MA	Alleged withholding of overpayment	Referred to Management
04-213	PI	Alleged various discrepancies with employment	Unsubstantiated
04-214	NF	Alleged retaliation	Information only
04-215	RF	Alleged poor working environment	Referred to AHCA
04-216	PI	Alleged sexual harassment	Unsubstantiated
04-217	MA	Alleged STD, child abuse & drug dealing	Referred to Management
04-218	MA	Alleged abuse by EMT	Referred to Management
04-219	PI	Alleged harassment & unreasonable recurring inspections	Unsubstantiated
04-220	MA	Alleged revocation of certificate	Referred to Management
04-221	MA	Alleged use of prescription pad by patient	Referred to Management
04-222	MA	Alleged non-returned phone calls	Referred to Management
04-223	MA	Alleged mismanagement	Referred to Management
04-224	RF	Alleged mistreatment by hospital staff	Referred to AHCA
04-225	NF	Alleged refusal for help	Information only

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04-226	MA	Alleged unfair treatment	Referred to Management
04-227	IN	Alleged discrepancies with the Board of Psychological Examiners	Unsubstantiated
04-228	IN	Alleged threat by CMS	Unsubstantiated
04-229	RF	Alleged Medicaid fraud	Referred to AG
04-232	MA	Alleged uncertified technicians	Referred to Management
04-233	PI	Alleged HIPAA violation	Substantiated
04-234	MA	Alleged noisy test area	Referred to Management
04-235	NF	Alleged mistreatment by staff	Information only
04-236	RF	Alleged cruel and unnecessary punishment	Referred to CMA
04-238	MA	Alleged abuse of power and state monies	Referred to Management
04-240	MA	Alleged improper medical service	Referred to Management
04-241	MA	Alleged incorrect report	Referred to Management
04-243	MA	Alleged dissatisfaction with DDD decision	Referred to Management
05-001	MA	Alleged Internet misuse	Referred to Management
05-002	MA	Alleged discrimination by DDD	Referred to Management
05-003	RF	Alleged problem recouping money	Referred to AHCA
05-004	RF	Alleged unsanitary conditions at motel	Referred to DBPR
05-005	INA	Alleged sexual assault and battery	Assisted CHD
05-006	MA	Alleged medical test without permission	Referred to Management
05-007	MA	Alleged misconduct	Referred to Management
05-008	PI	Alleged unfair bid award	Information only
05-009	PI	Alleged HIPAA violation	Information recorded for possible future use
05-010	RF	Alleged HIPAA violation	Referred to USDHHS
05-011	RF	Alleged HIPAA violation	Referred to USDHHS
05-012	RF	Alleged cancellation of coverage without notice	Referred to CMS
05-013	MA	Alleged misdiagnosis and poor customer service	Referred to Management
05-014	RF	Alleged discrimination	Referred to EEO
05-015	PI	Alleged missing lab specimens	Substantiated
05-016	NF	Alleged illegal behavior	Information only
05-017	PI	Alleged failure to report abuse by a mandatory reporter	Substantiated
05-018	RF	Alleged false worker's comp claim	Referred to FLDFS
05-019	PI	Alleged false claims of academic degree or title	Unsubstantiated
05-020	PI	Alleged unauthorized access to network files	Referred to IT
05-021	INA	Alleged stolen computer equipment	Assisted Law Enforcement
05-022	PI	Alleged security breaches	Referred to Management
05-023	RF	Alleged unlicensed activity	Referred to Environmental Health
05-024	NF	Alleged exposure to sulfur	Information only
05-025	MA	Alleged animals in office	Referred to Management
05-026	RF	Alleged non-payment for translating services	Referred to Law Enforcement
05-027	RF	Alleged poisoning	Referred to Department of Corrections
05-028	IN	Alleged security breach	Substantiated
05-030	MA	Alleged unsatisfactory medical treatment	Referred to Management
05-031	NF	Alleged HIPAA violation (not CHD)	Information only
05-032	IN	Alleged problem with testing application	Substantiated
05-033	IN	Alleged inappropriate use of position	Unsubstantiated
05-034	IN	Alleged breach of confidential information	Substantiated

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05-035	NF	Alleged unmet public records request	Information only
05-036	MA	Alleged poor treatment by doctor	Referred to Management
05-038	MA	Alleged MQA not mediating offenses	Referred to Management
05-040	MA	Alleged misuse of State property	Referred to Management
05-041	MA	Alleged denial of services at CHD	Referred to Management
05-043	PI	Alleged theft in CHD	Referred to CHD
05-044	MA	Alleged difficulty and delay in receiving birth certificates	Referred to Management
05-046	RF	Alleged violation of confidentiality/privacy	Referred to USDHHS
05-047	MA	Alleged unearned on-call pay	Referred to Management
05-048	MA	Alleged unfair hiring practices	Referred to Management
05-049	MA	Alleged discrimination	Referred to Management
05-050	PI	Alleged unauthorized access of computer network resources (Malware)	Unsubstantiated
05-051	INA	Alleged illegal practice	Assisted FBI
05-052	PI	Alleged inadequate notification of hearing and public records request	Referred to MQA
05-053	PI	Alleged misrepresentation using DOH letterhead	Referred back to MQA
05-054	MA	Alleged fraudulent activity in CNA training	Referred to Management
05-055	PI	Alleged HIPAA violation	Information only
05-056	NF	Alleged confusion regarding paper to sign	Information only
05-057	RF	Alleged violation of policy, rule or statute	Refered to DMS
05-058	PI	Alleged illegal dispensing of drugs	Unsubstantiated
05-059	PI	Alleged unprofessional behavior by physician	Referred to MQA
05-060	RF	Alleged non-response from Healthy Kids	Referred to Children's & Families IG
05-061	MA	Alleged inappropriate behavior by employee	Referred to Management
05-062	MA	Alleged promotion of employee	Referred to Management
05-063	PI	Alleged falsification of patient's chart	Information only
05-064	PI	Alleged conviction not posted	Referred to MQA
05-065	MA	Alleged mismanagement and discrimination	Referred to Management
05-066	PI	Alleged altering of documents	Unsubstantiated
05-067	MA	Alleged CNA examination imposter	Referred to Management
05-069	IN	Alleged theft of laptops	Substantiated
05-070	MA	Alleged no response from DOH	Referred to Management
05-071	IN	Alleged falsification of official documents and failure to follow operating procedures	Substantiated
05-072	MA	Alleged rudeness & broken appointments	Referred to Management
05-073	IN	Alleged unlawful credit card fees	Substantiated
05-074	PI	Alleged misuse of email	Substantiated
05-075	IN	Alleged improper mileage claims	Substantiated
05-077	PI	Alleged retaliation	Unsubstantiated
05-078	PI	Alleged improper suspension of medical license	Unsubstantiated
05-079	PI	Alleged acceptance of faulty bid	Unsubstantiated
05-080	IN	Alleged misuse of email	Substantiated
05-081	IN	Alleged hostile work environment, discrimination & reprisal	Unsubstantiated
05-082	IN	Alleged inappropriate use of email	Substantiated
05-083	NF	Alleged issues with USF	Information only
05-084	MA	Alleged inappropriate use of building security system	Referred to Management
05-085	MA	Alleged delay in receiving vaccines	Referred to Management

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05-086	IN	Alleged inappropriate use of email	Substantiated
05-087	RF	Alleged bad drinking water	Referred to Department of Corrections
05-088	MA	Alleged illegal payment of contract funds	Referred to Management
05-090	MA	Alleged physical attack by pharmacist	Referred to Management
05-092	IN	Alleged unfair termination	Unsubstantiated
05-097	MA	Alleged refusal for treatment	Referred to Management
05-100	INA	Alleged pharmacy investigation	Information only
05-101	PI	Alleged inappropriate email	Information recorded for possible future use
05-103	RF	Alleged HIPAA violation	Referred to USDHHS
05-104	NF	Alleged refusal to provide medical treatment	Information only
05-105	NF	Alleged fraudulent activities by dentist	Information only
05-106	MA	Alleged overbilling	Referred to Management
05-108	MA	Alleged favoritism for physicians	Referred to Management
05-110	PI	Alleged inadequate inspection of septic site and soil conditions	Unsubstantiated
05-113	MA	Alleged discrimination	Referred to Management
05-116	RF	Alleged cruel and unusual punishment	Referred to Department of Corrections
05-117	NF	Alleged monetary gain for expediting claims	Information only

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