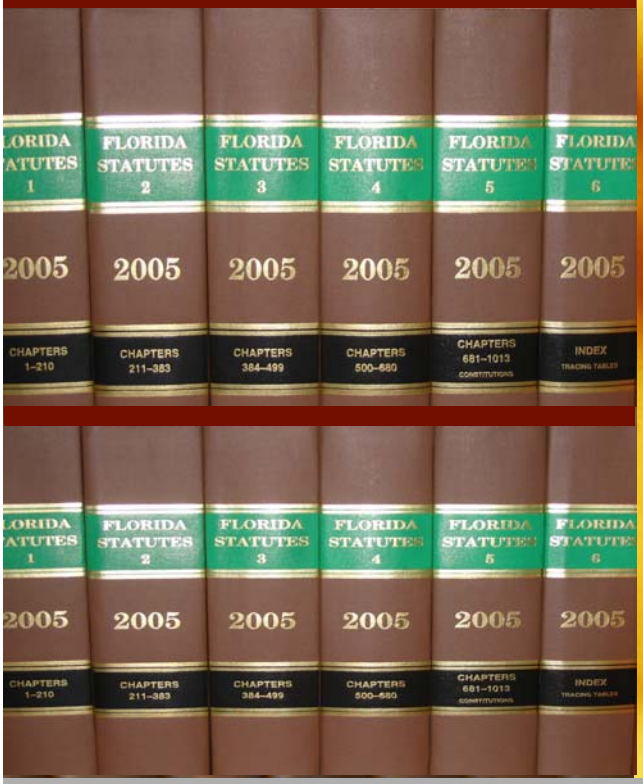


FLORIDA DEPARTMENT OF HEALTH

FY 2005-2006

Annual Report

Office of the Inspector General

Florida Department of Health

professionalism

integrity

accountability

independence

teamwork

FLORIDA DEPARTMENT OF HEALTH

Jeb Bush
Governor

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

September 26, 2006

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 2005-2006 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 its 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 sharing another productive year.

Respectfully,

Linda A. Keen

Linda A. Keen, R.N., M.S., J.D.
Inspector General

LAK/kp
Attachment

Office of the Inspector General
Annual Report FY 2005-2006

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 (HIG) for the twelve-month period beginning on July 1, 2005 and ending June 30, 2006.

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.

This was a year of change and transition for the HIG. Our Inspector General was tapped to serve as an Acting Deputy Secretary for the first half of the fiscal year. Serving in her stead as Acting Inspector General was our Director of Investigations. During the second half of the fiscal year a great deal of staff time and effort was put forth on integrating the functions and staff of the department's Equal Opportunity Program, subsequent to the transfer of that program into the HIG by the former Secretary of Health. A program review was conducted by HIG staff that resulted in the formulation of a workplan for integrating functions and making program improvements focused on increasing customer satisfaction with EO investigations, training, and other products.

A leadership change in the Child Care Food Program Compliance Review Section of the HIG occurred at approximately mid-year. This change presented the opportunity for revisiting the role and function of that program within the HIG. A program review was conducted which resulted in recommendations for reorganization, planned to occur in the 2006-2007 fiscal year.

While special projects and flexibility were required by circumstances this year, the demands of the normal HIG work load continued. Investigative staff received 232 complaints in 2005-2006, triaged 93% of them within 10 days, and closed 222 complaints. Internal audit staff performed four comprehensive audits and one follow-up review of audit findings from prior years. Child Care Food Program (CCFP) compliance review staff completed 250 Child Care Food Program (CCFP) administrative compliance reviews and identified $1,961,791 in questioned costs.

Organizational Profile

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

Key Products and Services

- audits, investigations, management reviews, program reviews, 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

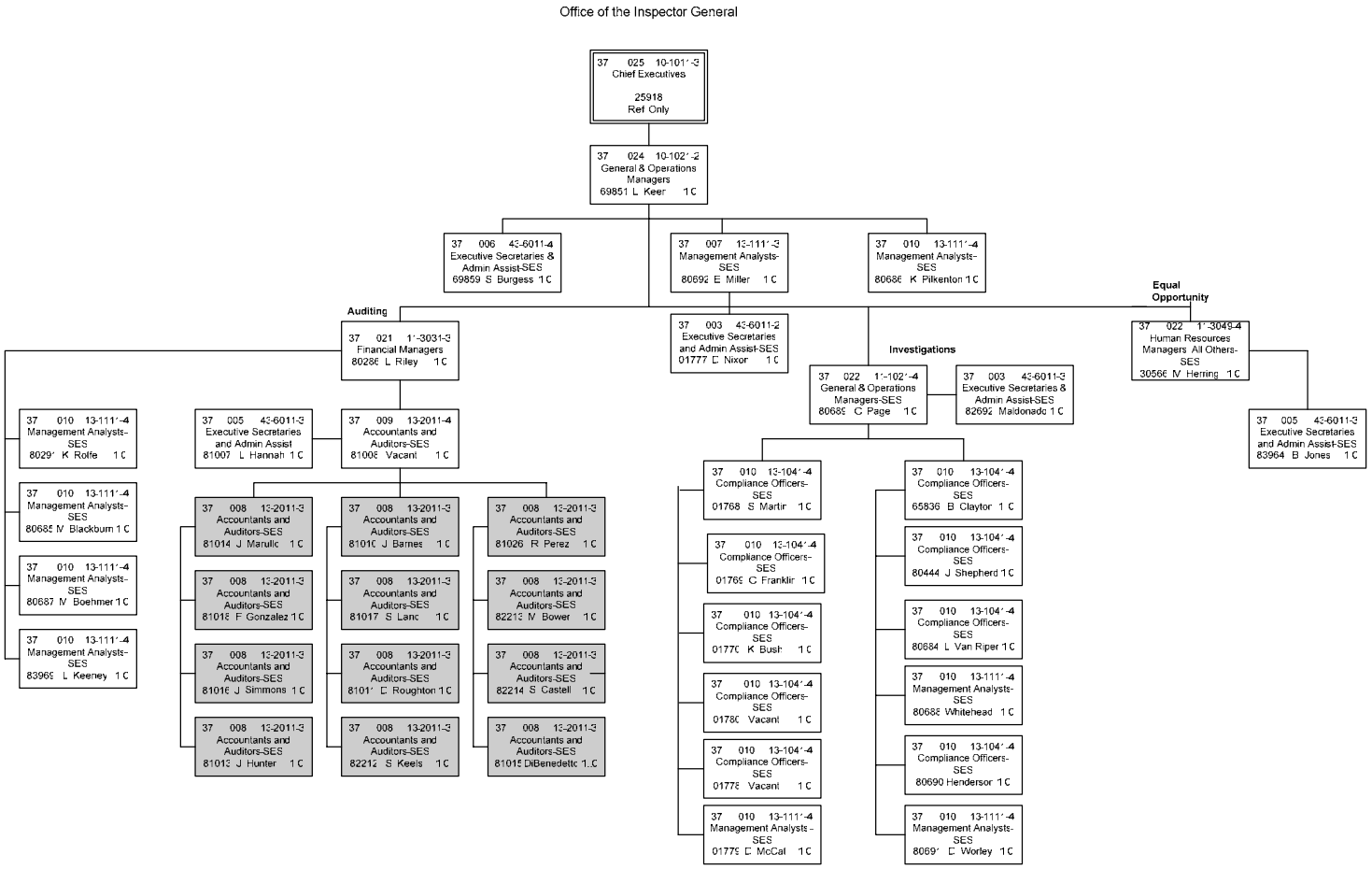
- Of the 33 professional staff, 89% have bachelor's-level college degrees;
- 36% have master's degrees or higher;
- 52% have specialty certifications
- Collectively:

  Audit experience: 301 years

  Investigative experience: 209 years

This year our staff increased by six due to transfer of the Equal Opportunity Program into the HIG. Our 40 staff are distributed across functional areas as shown in the organizational chart below. Additionally, we have 4 OPS staff. Positions shaded in gray are CCFP field audit staff. The Inspector General reports directly to the Secretary.

3	Certified Inspectors General
5	Certified Public Accountants
2	Certified Internal Auditors
2	Certified Government Auditing Professionals
7	Certified Inspector General Investigators
1	Certified Government Financial Manager
1	Certified Unemployment Tax Auditor
1	Certified Information Systems Auditor
3	Certified Contract Managers
5	Former Law Enforcement Officers
1	Certified Law Enforcement Instructor
1	Certified Crime Scene Technician
1	FCIC/NCIC Certified Investigator
3	Certified Mediator
1	Registered Nurse
1	Attorney
1	National Public Health Leadership Institute Graduate



1. Leadership

The HIG leadership team during FY 2005-2006 consisted of:

Linda A. Keen, R.N., M.S.N., J.D., C.I.G.
Served as Inspector General for the second half of the fiscal year (served as Acting Deputy Secretary for the first half)

Charles V. Page, B.S., C.I.G.
Investigative experience of 38 years
Served as Acting Inspector General for the first half of the fiscal year

Darrell J. Worley, C.I.G.I.
Investigative/law enforcement experience of 18 years
Served as Acting Director of Investigations for the first half of the fiscal year

Lynn H. Riley, C.P.A., C.I.G.
Audit experience of 25 years
Director of Auditing since March 1997

Kenneth R. Sasser, C.P.A., C.I.A.
Audit experience of 20 years
Child Care Food Audit Program
Supervisor from October 1997 to February 2006

Leadership and Staff Professional Activities/Affiliations

- Immediate Past President, Florida Public Health Association (FPHA)
- Past FPHA Parliamentarian & Silent Auction Chair, 1997 to 2005
- Board of Directors and Executive Committee Member, National Association of Inspectors General
- Board of Directors and Executive Committee Member, Florida Association of Inspectors General, Tallahassee Chapter
- Mediator for Executive Direction
- Attendees, 2006 Conference, National Association of Inspectors General
- Board Member, Florida Academy of Health Care Attorneys

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

- Member, Information Technology Tier 2 Governance Committee
- HIG Representative for the Department Computer Security Incident Response Team
- Members, Institute of Internal Auditors
- Members, Association of Inspectors General
- Members, Association of Government Accountants, Tallahassee Chapter
- Members, Association of Certified Fraud Examiners
- Members, American (and Florida) Institute of Certified Public Accountants
- Members, Southeast Evaluation Association
- Member, Information Security Audit and Control Association
- Chairperson, Organizing Committee for the Capital City ISACA Chapter
- Member, National Public Health Leadership Society

2. Strategic Planning

Audits

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

Progress on meeting 2005-2006 objectives and goals
We received our triennial Quality Assurance Review (QAR) performed by the Office of the Auditor General. The QAR resulted in a clean opinion (no findings or deficiencies noted) regarding the audit function within the Office of the Inspector General. There was no multi-agency audit coordinated by the Office of the Chief Inspector General during this reporting period. An agency-wide risk assessment was completed and an annual and long-term audit plan was developed.

Focus Area for 2006-2007
Execution of the *2006-2007 Audit Plan* as approved by the Secretary. Continue enhancing auditor expertise through training and certification.

Objectives
1. Conduct internal audits that provide information and recommendations useful to the agency's management in accomplishing their objectives, whose role it is to ensure public resources are used efficiently, economically and legally.
2. Provide liaison duties between the agency and external auditors, including the Office of the Auditor General, OPPAGA, Department of Financial Services, and federal auditors.
3. Track the progress of management's corrective action plan 6, 12, and 18 months. Report the status of such plans to Joint Legislative Auditing Committee, OPPAGA, and Auditor General as required.
4. Conduct follow-up audits to determine whether management's corrective action in response to prior audits has been successfully implemented.
5. Continue to serve in advisory capacity on the agency's Tier II and III Governance process for review, approval and prioritization of Information Technology related projects.
6. Participate in any multi-agency audit coordinated through the Executive Office of the Governor, Office of the Chief Inspector General, as determined appropriate at that time.

Mission Goal
Promote accountability, integrity and efficiency throughout the agency by identifying and reporting unmitigated risks to management through Performance, Compliance, and Information Technology audits of various programs and systems.

Enabling Goals

1. Use Risk Assessment to identify high risk areas and systems that should be audited.
2. Develop an audit plan and program for each audit, defining a clear scope and objectives.
3. Obtain an understanding of the program or system being audited to help identify management's processes and controls in order to further access possible weaknesses.
4. Perform audit testing and evaluation.
5. Confirm with management issues noted during the audit.
6. Report findings supported by credible evidence that relates to the audit objectives.
7. Obtain management's response on report findings, including their planned corrective actions.
8. Track and report management's progress as corrective action plans are accomplished.

Key Strategies

Hire, retain, and enable qualified audit staff 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.

Progress on meeting 2005-2006 objectives and goals

Major revisions were made to the Investigations Manual to address various process changes. Additionally, the Investigations Unit was re-organized as a result of the transfer of the Equal Opportunity investigations function to the HIG during this reporting period. All investigators received training in Equal Opportunity investigations during a one week course for new investigators conducted by the federal Equal Employment Opportunity Commission during the past year. Only one employee departed during the year and was quickly replaced with a qualified applicant.

Focus Areas for 2006-2007

Continue to improve the timeliness of our investigative products and tie investigative recommendations to improved program performance. Three employees will obtain Certified Inspector General Investigator designation during the year. An additional investigator is receiving training in computer forensic investigative techniques.

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

This will be the last year the CCFP is included in the HIG Annual Report as the program is to be transferred to another division. Focus areas will be set by management in that division.

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

The HIG exceeded Objective #1 by 100%. Two management reviews were conducted, completed, and issued prior to June 30, 2006. HIG reviewed the Bureau of Laboratories (BOL) and the Bureau of Statewide Pharmaceutical Services (BSPS). Objective #2 was successfully accomplished by communicating the management review process to the Deputy Secretary for Health, who subsequently requested three reviews.

The HIG accomplished the Mission Goal of improving or enhancing department operations through providing useful and strategic recommendations to assist with the selection of a new BOL Chief; to identify critical needs and concerns in both the BOL and the BSPS; and to provide a strategic "road map" for transitional activities in both Bureaus. The HIG accomplished the Enabling Goal by continuing to use the Sterling Criteria as a methodological framework.

Focus Areas for 2006-2007

Refine the management review process to be flexible in meeting the dynamic needs of senior management at the state and local levels through the provision of complete or partial products. The complete management review consists of an online employee survey, personal employee interviews, documentary reviews, and a stakeholder survey. These products could be offered individually.

Objectives

1. By August 30, 2006, revise and distribute an informational circular on management reviews to senior DOH and local CHD/CMS management.

2. By February 31, 2007, conduct two complete and/or partial management reviews of programs or offices within DOH.

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. Maintain a core staff of investigators and auditors ready to conduct management reviews.

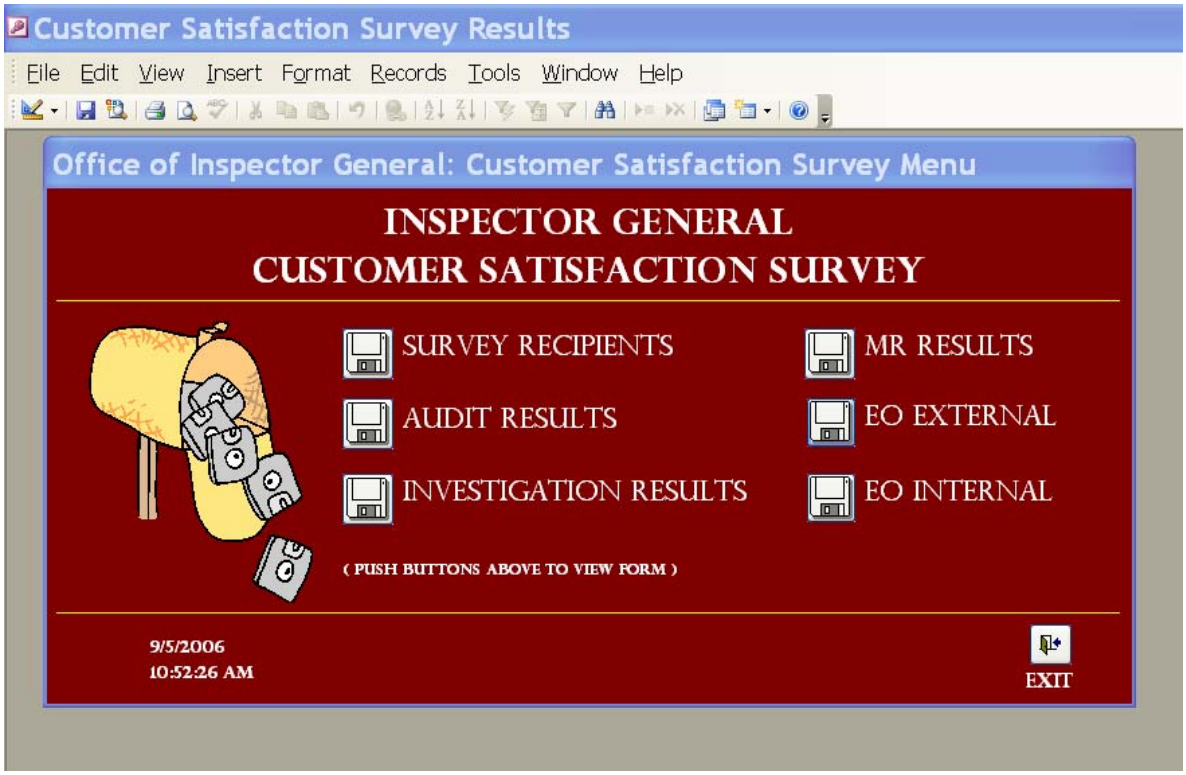
2. Train one additional HIG employee to assume leadership of a management review team.

3. Customer and Market Focus

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

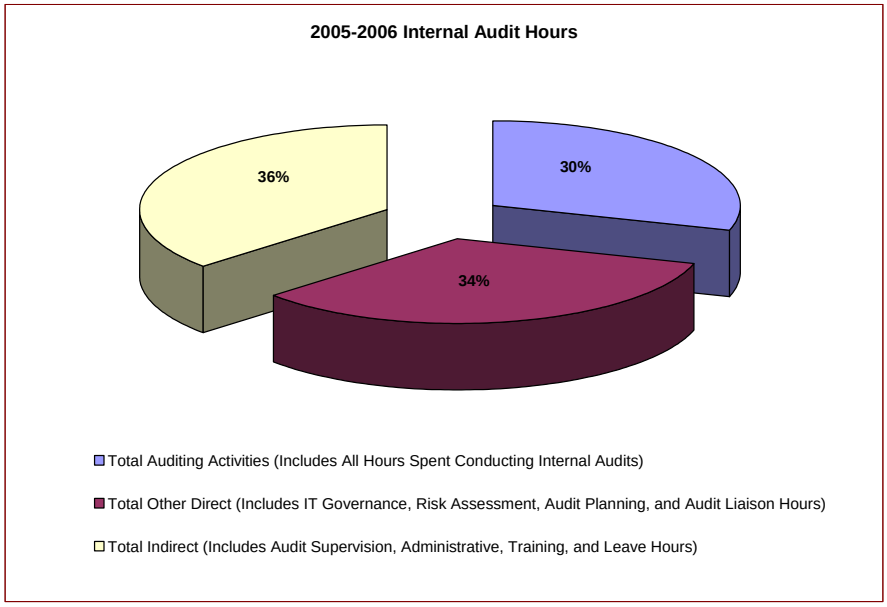
Challenges brought by the mid-year transfer of the Equal Opportunity (EO) Program into the HIG and subsequent re-organization provided impetus for revisiting our customer satisfaction instruments and methods. EO investigation customer satisfaction surveys were developed in order to ensure we learn from our processes and continually strive to meet the needs of our customers. Recipients of our surveys (customers) are typically persons in the first and/or second tier of management responsible for the program area or location where the investigation occurred, provided those individuals were not the subject of the investigation. We continue to address the challenge of balancing the expectations and needs of our various customer and stakeholder groups through adoption of these new EO-specific instruments. Additionally, we adjusted our web-based process and customer satisfaction database to accommodate inclusion of EO results.



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. Total Internal Audit hours were fairly evenly distributed among auditing, direct, and indirect activities as reflected in the chart below.



Audit Report #AC-05-003
Florida Abstinence Education Program

We performed an audit of contractual services contracts entered into between DOH and its providers (including county health departments) during the period October 1, 2003 through September 30, 2004, containing federal funds under the CFDA number 93.235, *Abstinence Education*, authorized under Section 510 of Title V of the Social Security Act. The objective was to determine whether DOH Abstinence Education Program staff sufficiently monitored the completion of providers' deliverables in accordance with terms of DOH's contract(s).

The Abstinence Education Program Office contracted with 17 providers (including 4 CHDs) for grants totaling $1,631,153.

SUMMARY OF FINDINGS

- Additional steps would enhance monitoring of subrecipients to ensure federal funds are appropriately spent and results are correctly reported.

- The Program Office did not sufficiently document the selection process and determination of cost, and include documentation in the Contract File.

- Title V contracts that also included TANF funds did not include either on the face of the Standard Contract or the Financial and Audit Compliance Attachment that the contracts also included TANF funds, or that the TANF funds required a 10% match.

RECOMMENDATIONS

We recommended the Program Office monitor providers to ensure where providers subcontract for services, the contract manager annually reviews the subcontract and where the subcontract is approved, so document the approval to the contract file.

We recommended that in its review of subcontracts, the Program Office ensure contract language addresses monitoring of the subcontractor by DOH's provider, specify a dollar amount limit, and include DOH's *Standard Contract*.

We recommended the Program Office amend the language of their *Attachment I* to the *Standard Contract* to tie payment (and therefore include sanctions for non-performance) to the satisfactory completion of all deliverables.

To ensure information is correct and accurate, we recommended the Program Office routinely reconcile back to providers' original reports all performance indicators used to report performance outside the Program Office.

We recommended DOH use only Certified Contract Managers (DOH employees) to manage DOH's contracts.

Because there appeared to be a systemic issue of contract managers not understanding the limits of review performed by their offices, we recommended both the Office of Contract Administration and the Office of the General Counsel communicate to agency contract managers the purpose and limitations of such review.

We recommended where available exemptions from competitive bidding are used, the Program Office adequately document all aspects of the procurement process, including negotiations and price.

So that reviewers who subsequently inspect contract files (including supervisors, management, and auditors) are able to more accurately and fairly conclude on events of the grant's life, we recommended the Program Office ensure contract managers include all pertinent supporting documentation to the Bid and Contract Files.

Because there appeared to be a systemic issue of contract managers not understanding the documentation requirements when contracting intra-agency, we recommended both the Office of Contract Administration and the Office of the General Counsel communicate to agency contract managers such requirements.

So that subrecipients and their independent auditor may more easily identify the type of funds included in a grant, we recommended the Program Office in accordance with OMB *Circular* A-133 identify throughout the grant

document, including the *Financial and Compliance Audit Attachment*, each type of funds, to include: CFDA title and number, award name and number, award year, if the award year is research and development, and name of the federal agency, and any match requirements.

Audit Report #AC-05-004
Office of Health Professional Recruitment

We performed an audit of Office of Health Professional Recruitment's administration of the Florida Health Services Corps for the period April 1, 2004 through March 31, 2005, as authorized and described by Section 381.0302, *Florida Statutes*, to determine whether DOH was in compliance with Section 381.0302, *Florida Statutes*, in developing the Florida Health Services Corps.

SUMMARY OF FINDINGS

- Because the Florida Health Services Corps has gone un-funded since 1996, it no longer functions and its enabling statute may be obsolete.

RECOMMENDATIONS
We recommended the Office of Health Professional Recruitment consider recommending to the legislature that Section 381.0302, *Florida Statutes* be either deleted or amended.

Audit Report #AC-05-005
Emergency Medical Services Trust Fund

We performed an audit of the Trust Fund for the period July 1, 2004 through March 31, 2005, to determine whether controls were in place sufficient to 1) maintain accurate reporting of beginning and ending balances; and, 2) identify and record revenues received from sources as specified by law were accurately calculated and disbursed or expended as also specified by law.

SUMMARY OF FINDINGS

- Amounts relied upon in distributing County Grants, County Matching Grants and Rural Matching Grants were not correctly calculated.
- Funds deposited into the Trust Fund from the collection of civil and traffic fines and used for administering Chapter 401, Florida Statutes, exceeded 15%, in part because expenditures unrelated to improving and expanding pre-hospital emergency medical services were paid.
- Expenditures were not always appropriately coded. Consequently, revenues from sources as specified by law were not always expended as specified by law.
- Sufficient controls were not in place over the Trust Fund Cash Analysis. Consequently, adjustments were reflected as changes between one year's ending balance and next year's beginning balance, and adjustments were not sufficiently documented with some adjustments resulting in inappropriate charges against OCAs.
- The Bureau did not have a monitoring process in place associated with administering the approval of EMT and Paramedic training programs to ensure fees did not exceed costs.

- Controls were not in place so the Bureau may verify the appropriateness of amounts transferred into the EMS Trust Fund from Department of Revenue and Department of Highway Safety and Motor Vehicles.

- Not all fees were included on the Bureau's Schedule of Fees. Additionally, the Bureau did not maintain a subsidiary report to detail the composition of the fees it received.

- The Bureau has not developed rule or written policies to ensure administrative fines for violations by EMTs/Paramedics and violations of cease and desist orders by unlicensed persons are collected and deposited into the EMS Trust Fund. Additionally, prior to and during the audit period no fines were assessed or collected.

- The Bureau did not have sufficient control over receipts, so that all refund checks are uniformly processed, that includes recording against the municipality/county's grant records, and coding into FLAIR.

- Refunds of unexpended grants were not recycled in subsequent years as grant money to further assist local governments and EMS organizations.

- A refund of County Grant Program funds of $801,183 originally overpaid in service charges was not distributed to counties, but $517,380 of the funds was used to reimburse other trust funds for expenditures, including salaries unrelated to improving and expanding pre-hospital emergency medical services.

- The Bureau did not analyze trust fund cash during annual budget planning and making budget requests.

- The Office of Trauma has not developed a process to use administrative remedies (including fines) against trauma agencies and trauma centers, and has not developed written policies to ensure that fines for violations would be deposited into the EMS Trust Fund.

- No funds in the EMS Trust Fund were directly returned to trauma centers, counties or municipalities to improve trauma services.

- Amounts owed to and due from other trust funds were not reconciled.

- Program deficits for Licensure and Certification may continue to be an issue.

RECOMMENDATIONS

We recommended the Bureau of Emergency Medical Services reconcile to the amounts calculated and paid by the Office of Revenue Management for the 7.3% service charge, in considering the amount available for the *County Grant Program*, administrative expense and *EMS County Matching Grant Program* and *Rural Matching Grant Program*.

We recommended the Bureau re-design its spreadsheet so that it may correctly calculate and distribute the amounts available for the *County Grant Program*, administrative expenditures, and the *EMS County Matching Grant Program* and *Rural Matching Grant Program*.

We recommended the Bureau regularly review expenditures charged to the OCA N2000-*EMS Traffic Violation Fines* to identify expenditures which may not be for capital equipment outlay, personnel, community education, evaluation, and other costs directly associated with administering Chapter 401.

We recommended DOH management review salaries and other expenditures not related to the improvement and expansion of pre-hospital emergency medical services that have been routinely charged to the Trust Fund, and find other sources of funds to support such expenditures.

We recommended the Bureau enhance efforts to review invoices to consider and identify expenditures to their appropriate funding source, so payments may be appropriately coded.

We recommended the Office of Revenue Management update its written procedures to document the appropriate completion and use of the Trust Fund Cash Analysis.

We recommended the Office of Revenue Management improve its controls to complete Trust Fund Cash Analysis sheets with July 1 beginning balances by OCA the same as the previous day's ending balance, and subsequently use it as a tool to analyze and explain changes in an OCA balance during the year.

We recommended the Office of Revenue Management maintain supporting documentation when adjustments are made between OCAs. This supporting documentation should include the responsible program office's review and approval, so to document that any statutory limitations associated with funds by OCA have been appropriately considered.

We recommended the Bureau of EMS add a control to monitor annual revenues and costs specific to the approval of re-certification training programs.

We recommended the Bureau perform a routine analytical review of Trust Fund revenues to include estimates based on revenue reported by the counties, which would also include an analysis that such amounts are correct as they are transferred through DHSMV and DOR to the Trust Fund.

We recommended that for fines, fees, and other receipts the Bureau collects, the Bureau produce and maintain accurate information regarding those fees, so management may have such information available for analysis and comparison to the cost of providing the service in order to budget for and adequately fund the activity.

We recommended the Bureau develop rules or written policies to ensure administrative fines for violations by EMTs/Paramedics and violations of a notice to cease and desist by unlicensed persons are collected and deposited into the EMS Trust Fund.

We recommended the Bureau implement a control to ensure all refund checks go to the same staff person for uniform processing that includes recording against the local government's grant records and a routine reconciliation to FLAIR.

We recommended the Bureau complete the *Receipt/Correction Receipt* Form in its entirety when preparing deposits from any source.

We recommended the Bureau maintain the identity of refunds received back from grantees each year, and re-award these funds to local governments and EMS organizations in the form of *County Matching Grants* and *Rural Matching*

Grants, including more than $45,000 in refunds received during the 2004-2005 fiscal year.

We recommended the Bureau add the amount of the refund of $801,183 to the next awarding cycle of the *County Grant Program* so these funds may be used by the respective counties to improve and expand pre-hospital emergency medical services.

We recommended Bureau of EMS and Office of Trauma staffs consider and document such consideration in annual planning and making budget requests to ensure expenditures approximate revenues and available cash.

We recommended that as an integral part of its responsibilities to ensure trauma service systems are held to the highest level of readiness and response services and in compliance with Section 395.401(3), *Florida Statutes*, the Office of Trauma develop and document a process that includes administrative remedies (including fines) against trauma agencies and trauma centers, and to ensure that fines for violations would be deposited into the EMS Trust Fund.

We recommended management take action to further the intended purpose of improving trauma services throughout the state of Florida for its citizens and visitors.

We recommended the Bureau routinely review expenditures incurred under N2000 (or any other EMS Trust Fund OCA) in other trust funds and reconcile all such differences.

We recommended the Bureau ensure revenues are sufficient to cover program expenditures related to OCA IL000-*EMS Licensure and Certification*, which may include seeking an increase in fees and should include monitoring expenditures to ensure they are in line with anticipated revenues over each 2 year cycle.

Audit Report #AC-05-006
Medical Quality Assurance COMPAS Application

We performed an audit of Division of Medical Quality Assurance's COMPAS application. The review included an evaluation of the integrity of the data within the COMPAS application during the period September 27, 2004 through January 31, 2006. The objectives were to determine the effectiveness of selected information technology controls in promoting and encouraging the reliability, integrity, and availability of data within the COMPAS application, to determine the appropriateness of user access levels for COMPAS users, to identify unmitigated risks related to the use of COMPAS within the MQA licensure and enforcement process, and to provide guidance as needed for the on-going data clean-up efforts.

SUMMARY OF FINDINGS

- Instances were noted where deactivated disposition codes were accepted by the COMPAS Enforcement Module.
- Instances were noted where programmed input controls within the COMPAS application were not operating effectively.
- Instances were noted where COMPAS contained invalid social security numbers for active licensees.
- Instances were noted where COMPAS contained duplicate social security numbers for active licensees in the 1501 profession.

- Instances were noted where COMPAS contained birth dates for active licensees that were either missing, in the future, or were improbable due to the age of the practitioner as a result of the recorded birth date.

- Deficiencies were noted in the security controls protecting COMPAS information resources.

RECOMMENDATIONS

We recommended management more fully utilize available data input controls to reduce the risk that invalid, incomplete, and unreliable data is input into the COMPAS application. A review process should be initiated to ensure the codes available for selection within COMPAS remain valid.

We recommended management review the identified deficiencies in the programmed data input controls within the COMPAS application and make the necessary enhancements to ensure that the data input into the system remains complete, accurate, and valid.

We recommended management more fully utilize available data input controls to reduce the risk that invalid, incomplete, and unreliable social security numbers are entered into the COMPAS application. Also, a review process should be initiated to ensure that, at a minimum, valid social security numbers are obtained for currently active licensed practitioners.

We recommended management ensure through the use of data input controls and further training that duplicate social security numbers and multiple licenses within the same profession code are prohibited. Also, a review process should be initiated to ensure that, at a minimum, duplicate social security numbers and instances of multiple licenses within a profession code are identified and corrected for currently active licensed practitioners.

We recommended management ensure through the use of data input controls and reasonableness checks for historical data loaded into COMPAS, that invalid or unreasonable birth dates are prohibited. Also, a review process should be initiated to ensure that, at a minimum, incorrect or nonexistent birth date information is identified and corrected for currently active licensed practitioners.

We recommended appropriate security controls be implemented or strengthened in order to enhance the security of COMPAS information resources.

PRIOR YEAR FOLLOW-UP

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 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 the 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.

INVESTIGATION SUMMARIES

We conduct all investigations in accordance with the standards of the Office of the Inspector General and the Association of Inspectors General. The following is a summary of FY 2005-2006 investigations with significant findings. For a complete listing of all investigative activity refer to the Appendix.

Investigation # 04-201
Alleged Contractual Services by Former Employees – Division of DOH

This investigation pertained to former department employees who allegedly accepted employment with a business entity within two years following their separation from the department that resulted in the performance of contractual work on a project that they had responsibility for while department employees. A field audit conducted by the State's Auditor General identified a possible ethics conflict and recommended Inspector General inquiry. It was alleged that the former employees participated in the preparation of an application for a federal grant to be used to enhance Strategic National Stockpile (SNS) training and planning. The funds were subsequently acquired by the department and used to fund the SNS project through a contract with a community college. The community college subcontracted the SNS project to a private contractor. Both former department employees allegedly subcontracted with contractor to perform work on the SNS program within the two year prohibited period established by Section 112.3185, Florida Statute.

Allegation 1: The former director of a division of DOH participated in the preparation of an application for a federal grant to be used to enhance Strategic National Stockpile (SNS) training and planning. Following his retirement from the Department, he subcontracted with the contractor, and worked as the SNS program manager in violation of Section 112.3185(4), Florida Statutes.

Allegation 2: The former training and plans officer of a division of DOH participated in the preparation of an application for a federal grant to be used to enhance Strategic National Stockpile (SNS) training and planning. Following his separation from the department, he subcontracted with the contractor, and worked as a program team member for the SNS project in violation of Section 112.3185(4), Florida Statutes.

Both allegations were substantiated.

Recommendations

- The department should forward this report as a complaint to the Ethics Commission for review and final determination as appropriate.
- The Office of the Deputy Secretary for Health should direct a review of the department's standard contract provisions and determine if a procedural step is needed in planning meetings with prospective contractors that elevates awareness regarding the requirement to obtain department approval prior to subcontracting work.
- The Office of the Deputy Secretary for Health should confirm the interpretation of the federal audit review pertaining to recovery of overpaid funds and determine appropriate actions to resolve and close that issue with Tallahassee Community College.

Investigation #05-068
Alleged Fraudulent Activity, Unethical Behavior, and Conduct Unbecoming – Miami CHD

This investigation was predicated upon a complaint alleging subject employees in the Septic Tank Program Office were involved in unethical behavior and potentially fraudulent activity with Septic Tank Program Office contractors.

HIG reviewed relevant records and documents, and conducted interviews of CHD Septic Tank Program Office management and employees. HIG also interviewed external witnesses and conducted surveillance activities.

The HIG substantiated the allegations that subject employees had taken money from regulated contractors and had provided septic system plan specifications under false pretenses. The HIG further found the appearance of a conflict of interest by one subject employee because of his family and social connections to a septic system design firm.

Recommendations

- CHD management should take the appropriate personnel disciplinary action against the three subject employees based upon the findings and conclusions of this report.

- CHD management should institute some form of quality assurance review of all professional employees within the Septic Tank Program Office to deter and/or identify any future abuses and to institute processes for appropriate handling of abuses.

Investigation #05-102
Alleged Breach of Confidential Information – Gulf CHD

This investigation was based on a memorandum submitted by the department's Privacy Officer, indicating that a breach of patient information may have occurred at a County Health Department (CHD). The alleged breach resulted from the CHD Administrator's directive for staff to release patient demographic data including social security numbers to a laboratory service. An electronic listing of demographic information for 5,394 clients was electronically provided to the laboratory for the purpose of preloading a client database in anticipation of laboratory services supporting the CHD. According to the Privacy Officer's interpretation, the lump-sum release of client information violates privacy rights because many of the named individuals may not actually receive laboratory services from that laboratory.

Allegation 1: A County Health Department Administrator improperly directed the release of client demographic data including social security numbers to a laboratory resulting in a breach of confidentiality under provision of the Health Insurance Portability Accountability Act (HIPAA) and Florida Statute (FS). Unsubstantiated

The Administrator has the authority to effect business decisions for the CHD. He acknowledges making the decision to provide client demographic information to preload the laboratory's database. The decision was reached following consultation with staff and consideration of CHD management team view points. He did not consult legal counsel. The data that was released is considered protected health information. As a covered entity, the laboratory is required to secure the client data

which appears to be the case. No apparent compromise of client information or privacy has resulted from this situation. A laboratory service contract or a written business agreement should have been established. The absence of a business agreement or contract suggests the need for legal review of this relationship in consideration of the Administrator's exemption request, and prior to any further use of the laboratory's services.

Recommendations

- The Office of the Deputy Secretary for Health should request a legal review of the Gulf CHD-Nationwide Laboratory Services (NLS) relationship and respond to the subject's exceptions request.

- The department's HIPAA policy (DOHP 30-1-03) should establish procedures for exchanging individually identifiable information such as demographic data, i.e. PHI, with covered entities and business associates.

- The department's HIPAA policy (DOHP 30-1-03) paragraph V. B., definition of PHI should be expanded to include client demographic information such as name, social security number, address, telephone number, etc., as indicated by 45 CFR 160.103, as individually identifiable information and therefore constitutes PHI.

- CHD Administrators or Directors should consult their respective legal counsel for HIPAA advice before releasing lump-sum PHI to another covered entity, business associate, or law enforcement agency.

- The GCHD Administrator must conduct a records check to determine if any of the named clients had withdrawn their consent in part V of their respective DH 3204 and consult with the CHD's legal counsel should such a situation be identified.

Investigation #05-111
Alleged Mismanagement – St. Johns CHD

This investigation was predicated upon the resignation letter of a former Systems Administrator, County Health Department (CHD) alleging that CHD managers were being pre-selected; the CHD attorney was serving as the Assistant CHD Director; and the Human Services Program Manager for a grant program violated patient confidentiality, violated software license requirements, and erroneously purchased 1,200 hypodermic needles that were never used.

The HIG substantiated the allegation that the CHD Attorney has functioned in the role of assistant director of CHD. The HIG also found that a CHD supervisor did not adhere to IT policies governing password protection and installation of computer software. The HIG noted as inconclusive a CHD supervisor's expenditure of federal grant funds, but found specific federal regulations that apply to the instant case and future cases of handling said grant funds.

Recommendations

- CHD Director should work with the Office of General Counsel to take action to appropriately resolve the issue, whether in fact or appearance, of the CHD Attorney functioning as an assistant director.

- CHD management, in conjunction with the DOH IT Office, should take the appropriate action to enforce IT and CHD policy governing employee passwords, centralized coordination of access to DOH information resources through the CHD IT Department, and review and approval of software to be installed on DOH computers.

- CHD Director of Administrative Services should review and take appropriate action on the purchase of the unused hypodermic needles based upon OMB Circular No. A-87 and any other relevant federal regulations governing the expenditure of federal grant funds.

Investigation #05-114
Alleged Unethical Procurement Practices – Miami-Dade/Children's Medical Services

This investigation was predicated upon a complaint alleging that subject contracted provider practiced unethical procurement activities.

The HIG sustained the allegations that the subject inappropriately appeared in an advertisement promoting a specific seating system vendor, and the subject's acceptance of compensation from a vendor appeared to create a conflict of interest. The HIG did not sustain the allegation that the subject was promoting specific vendors and products to CMS clients. However, the HIG found the subject did promote a specific product which one of the vendors that did not carry. The HIG also found the subject had financial ties to the vendor that was receiving the majority of seating system change orders.

Recommendations

- CMS management should take appropriate action toward the subject in this investigation to ensure the integrity of the Orthopedic Clinic at the CMS Office.

- CMS Division Management should apply the same ethical standards found in statute for contracted physicians to non-physician contracted providers, and incorporate these provisions in all provider contracts.

Investigation #05-142
Alleged No Action Taken/Division of DOH

This investigation was initiated based upon a complaint from a citizen who filed a complaint with a division of the department against a licensed practitioner. The initial complaint alleged a breach of confidentiality. The division found probable cause and a formal administrative complaint was filed against the practitioner. The complainant alleged that no action had been taken against the practitioner as of the date of the complaint.

The allegation was substantiated. The attorney assigned to the case had not pursued the case to a resolution and final disposition. The case had been pending for more than three years. The actions already taken by the division appear to be adequate to insure that future cases are concluded in a timely manner.

Investigation #05-145
Alleged Alteration of Final Approval for Septic - Palm Beach CHD

This investigation was based on a complaint pertaining to a drain field repair that reportedly failed prematurely. The complaint alleged that County Health Department (CHD) Environmental Health (EH) employees contributed to the failure by improperly inspecting the contractor's work. The replacement drain field failed six weeks after the CHD's final inspection approval. Subsequent attempts to get the contractor to resolve the problems were unsuccessful. It was believed that the contractor had abandoned his business and left the state. The complainant also sent the complaint to a Congressman.

Allegation 1: County Health Department (CHD) Environmental Health employees improperly classified the drain field as a repair rather than a new installation resulting in a reduced inspection standard being applied to the drain field on permit #04-1901-R. Substantiated

Allegation 2: The Bureau of On-Site Sewage Treatment and Disposal Systems (OSTDS) Inspector, CHD Environmental Health Division, failed to properly inspect permit #04-1901-R, a drain field repair, thus directly contributing to the premature system failure. Partially Substantiated

Allegation 3: County Health Department (CHD) Environmental Health employees improperly altered the final inspection records for permit #04-1901-R. Unsubstantiated

Allegation 4: The inspection report submitted by a Bureau of OSTDS inspector was improperly altered by his supervisory chain. Unsubstantiated

The drain field should have been classified a mound from the beginning and a final cover and stabilization inspection should have been completed prior to final approval. CHD referred the complaint to the Department of Financial Services, Division of Risk Management. The repaired drain field appeared to be in failure as indicated by the complainant. Excavation of the drain field is required to determine the cause of the failure.

Recommendations

- The CHD director should review the evidence presented in this investigation and determine appropriate actions
- The OSTDS Bureau Chief should review the evidence and issues presented in this report and determine if drain field classification and inspection criteria should be changed for established home sites constructed on landfill mounds.

Investigation #05-169
Alleged Failure to Take Action against a Regulated Entity & Alleged Cover Up - Division of DOH

This investigation was based on a complaint made by a former employee indicating that no action was taken on an investigative report that had been submitted to the Bureau of Statewide Pharmaceutical Services (BSPS) in the fall of 2003. The investigation concerned the illegal purchase and resale of prescription drugs by a regulated drug wholesaler.

Allegation 1: The BSPS Pharmaceutical Program Manager allegedly failed to take timely and appropriate action on information contained in an investigative report that was received in the fall of 2003 that indicated the illegal purchase and resale of prescription drugs by a regulated prescription drug wholesaler.

The allegation was substantiated. The manager did not take timely action in processing the investigative report. Consequently, the wholesaler remained permitted to conduct business in Florida from November 2003 until license expiration in June 2005, a period of approximately 19 months.

Recommendations

- The Office of the Deputy Secretary for Health should review the findings presented in this investigation and determine appropriate actions.

- The Bureau Chief, BSPS, should continue the implementation of recommendations established in the Inspector's General audit corrective action plan.

Investigation #05-204
Alleged Misconduct of Testing Employees - Division of DOH - MQA

At an examination committee meeting, the allegation of an inappropriate relationship between a DOH employee and a dentist who provides a dental examination preparation course resulted in confidential examination materials being leaked to the dentist. Documents confiscated from a dental examination candidate at the test site allegedly contained confidential examination material that could only have been leaked by the DOH employee.

Allegation 1: A DOH employee allegedly released confidential examination material and/or information to a former dentist who operates a dental examination preparatory course.

No evidence was found to support the allegations. The employee denied the allegation. However, the appearance of a DOH employee commiserating with a person who provides examination preparatory courses to candidates could be misinterpreted by observers. The allegation is unsubstantiated.

Recommendations

- The Testing Services Unit (TSU) Manager and the Board Executive Director should collaborate in reviewing examination staff enforcement of the instructions contained in the Examination Staff Instruction Booklet giving specific attention to the items candidates can bring to the test site and enforcing candidate compliance.

- The TSU Manager should contact the Northeast Regional Board to determine if the referenced incident report can be found.

- The Board Executive Director should obtain legal counsel to determine if the patient services offered by examination preparation courses rises to the level of "patient brokering."

- The TSU Manager and the Board Executive Director should discuss the viability of cost benefit analysis to determine if the Board should consider benefits of a possible change in the current licensure testing paradigm.

Investigation #05-210
Alleged Inappropriate Duties of Non-Medical Personnel - Division of DOH

This investigation was predicated on a complaint from a therapist who is licensed by the DOH, against the DOH staff responsible for investigating complaints against medical practitioners.

Allegation 1: A medical center filed a complaint with a Division of DOH, against the complainant in error using only a license number without verifying the identity of the license holder. The Division accepted the complaint from the medical center which contained only the license number of the subject of the complaint. Substantiated. Corrective action has been initiated by the Division of DOH.

Allegation 2: The Division provided the medical records of a deceased patient to the complainant without verifying that he was the licensee who treated the deceased patient. Complainant believes that Division personnel violated HIPAA by providing the medical records of a deceased patient that was never treated. Unsubstantiated

Allegation 3: Complainant believes that Division personnel who are not licensed medical personnel should not have access to medical records. Complainant believes there is a law prohibiting non-medical personnel from accessing medical records. Unsubstantiated

Allegation 4: Complainant wants all records of the erroneous complaint filed against removed from the record. Unsubstantiated

Allegation 5: Complainant still has the deceased person's medical records. Division staff stated that they have initiated efforts to recover whatever records were provided to the accused practitioner. Substantiated. Corrective action has been initiated by the Division of DOH.

Investigation #05-225
Alleged Misuse of State Equipment and Information Resources - Division of DOH

This investigation was predicated upon a referral of a complaint call on the Whistle-blower's Hotline. The complaint alleged that a DOH employee and a DOH contracted consultant were misusing computer equipment and network resources.

The HIG substantiated the allegations that the subject employee and the contractor misused DOH computer resources by abusing personal email privileges and by communicating sexually explicit messages.

Recommendations

- Division and Bureau management should take appropriate personnel action toward the subject in this investigation.

- Division and Bureau management should request that Software Architects, Inc., provide another consultant to complete the contract.

Investigation #05-226
Alleged Unhealthy Conditions in Mobile Home Park - CHD

The complaint made by a county resident was about conditions at a mobile home park. The health related issues pertain to the drinking water supply at the park and other park conditions resulting in a poor quality of life for the residents.

Allegation 1: The owner of the mobile home park has failed to maintain a healthy environment for park residents. Unsubstantiated

No evidence was found to support the allegations. There were no actionable issues for the Department identified in this complaint.

Preliminary Inquiry #06-026
Alleged improper billing practices - Medicare Part B – Bay CHD

It was alleged that a county health department was improperly billing Medicare for "incident to" services provided by non-physician providers (NPPs). Investigation substantiated that the county health department (CHD) was improperly interpreting Medicare guidance as it relates to billing for services provided by NPPs. Given the CHD director's statements, it was determined that the initial patient evaluation was not performed by the director; that the director was not personally involved in supervising the treatment plan and was not on the premises and immediately available when the "incident to" services were provided by NPPs. While this billing practice is clearly inconsistent with Medicare guidelines, it may not rise to the level of fraud. Rather, it could be an honest misinterpretation of the guidelines; however, in either case it would appear that the CHD may have an undetermined overpayment debt to Medicare.

Investigation #06-027
Alleged Intimidation by Pharmacy Inspector - Division of DOH

This investigation was based on a telephone complaint from a pharmacy owner who alleged that an Investigator from a division of DOH harassed and threatened the pharmacy staff. The pharmacist also submitted the complaint to the Chief Inspector General's Office and filed a harassment complaint with the local police department.

Allegation 1: A DOH employee allegedly threatened and harassed employees of a pharmacy during the period of December 2005 – February 2006.

Allegation 2: A DOH employee allegedly displayed an unprofessional demeanor during the inspection of regulated pharmacies.

Allegation 3: A DOH employee allegedly took official records from a pharmacy without receipt and without returning the records.

Allegation 4: A DOH employee allegedly accepted meals paid for by a regulated entity.

Allegation 5: A DOH employee allegedly provided guidance that if acted upon by a pharmacist, would constitute an illegal activity.

Allegation 6: A DOH employee allegedly planted expired insulin in a pharmacy refrigerator.

Allegation 7: A DOH employee allegedly practiced racial discrimination in the inspection of a minority owned pharmacy.

Allegation 8: A DOH employee allegedly falsified official pharmacy inspection reports and/or official records.

Allegation 9: A DOH employee allegedly conspired with the owner of another pharmacy to falsify inspection results for a competitor pharmacy.

Allegation 10: A DOH employee allegedly perpetrated a criminal fraud by actions at a pharmacy.

One allegation was substantiated (Allegation #3). Nine allegations were unsubstantiated. No evidence of criminal activity or inappropriate action was found.

Recommendations

- The Director, Medical Quality Assurance should conduct a review to insure that instructions pertaining to the receipting for evidence during inspections are established.
- The Director, Medical Quality Assurance should consider assigning a different investigator to Uniform Complaint Form (UCF) related investigations where resources permit.
- The Executive Director, Board of Pharmacy, should review the complainant's letter and provide a reply.
- The Investigation Manager, MQA-IS Jacksonville should review this report and consider disciplinary action as appropriate.

Investigation #06-043
Alleged Improper Billing – Clay CHD

This investigation was initiated based upon a complaint from the Senior Community Health Nursing Director (SCHND) and Administrator, Clay County Health Department. The SCHND and Administrator contacted the HIG after the resignation of a Healthy Start Case Manager revealed missing documentation in several Healthy Start (HS) case files that were managed by the former employee.

Allegation 1: A former HS Case Manager allegedly failed to properly document numerous encounters with clients that were billed to Medicaid and were found after the employee resigned. Substantiated.

Of the 99 client records found, 86 records lacked professional documentation, and included substantial record keeping on "post-it" notes. With respect to Medicaid billing: 17 infant records were not properly documented. Fifteen months of infant/child services lacked supporting documentation to substantiate Medicaid billing. Eleven months of services were properly documented but never billed to Medicaid. A total of $119.00 was over-billed to Medicaid. Due to the small dollar amount, the Medicaid Fraud Unit will not investigate.

Recommendations

- The former HS Case Manager should not be eligible for rehire.
- The Acting HS Program Manager/Sr. Community Health Nursing Director should be held accountable for violation of DOHP (Poor Performance).
- The Acting HS Program Manager/Sr. Community Health Nursing Director should be held accountable for violation of DOHP (Negligence).
- The Acting HS Program Manager/Sr. Community Health Nursing Director should be held accountable for violation of DOHP (Inefficiency to perform duties).
- The HS Program statewide should adopt the undated QI standards in place at the CHD. The adoption of stricter QI standards will insure a better QI process and eliminate any possibility of billing and or documentation errors in current and future case files.

Investigation #06-069
Alleged Unprofessional Treatment and Care – Orange CHD

This investigation was initiated based upon a written complaint from a County Health Department (CHD) client against a CHD Employee.

Allegation 1: The CHD employee was rude, unprofessional and discriminatory during an initial interview with a client trying to obtain Medicaid eligibility benefits. Substantiated

Allegation 2: The CHD employee did not provide the emergency medical care information to a client during the initial Medicaid eligibility interview delaying the client from seeking care. Substantiated

Investigation #06-082
Alleged Misuse of DOH Endorsement - Division of DOH

This investigation was initiated based upon the observations of a DOH employee. This employee observed that a Los Angeles-based company was using the DOH endorsement on a web site offering CPR services completely on-line.

Allegation 1: The Los Angeles company is allegedly misusing the DOH endorsement.

Allegation 2: This unauthorized use is occurring on a web site promoting on-line CPR training.

The HIG staff viewed the web site and observed the DOH's name being used on the home page. A web viewer would have the impression that the Los Angeles company and all courses offered are endorsed by the DOH. This site allows the viewer/customer to obtain CPR certification completely on-line, without the benefit of hands on instruction.

Per the Los Angeles company, they cannot find the DOH endorsement on their web site. Another look at the web site revealed that in fact, the DOH endorsement had been removed. Time elapsed between e-mails and the removal of the endorsement was eleven days. The HIG retained a copy of the sourcing on the Los Angeles company's web site, showing the DOH endorsement was being displayed on May 19, 2006.

MANAGEMENT REVIEW SUMMARIES

BUREAU OF LABORATORIES - HIG-06-001MR

The review was conducted at the request of the Deputy Secretary for Health, to assist in Bureau of Laboratories (BOL) reorganization efforts and provide strategic information to new BOL leadership. The methodology involved conducting staff and management interviews at Jacksonville, Lantana, and Miami Laboratories; administering a stakeholder survey; and reviewing personnel and related documents and records. The framework utilized was the Sterling Criteria for Organizational Performance Excellence. Recommendations resulting from this management review were as follows:

Leadership

1. Bureau management should promote teamwork and seamless provision of services throughout the organization.
2. Department management should ensure and monitor the implementation of Sterling organizational excellence principals throughout each of the five laboratories, with emphasis on effective statewide communication strategies that reach every level of the organization.

Strategic Planning

3. Bureau management should update strategic plans on a regular basis, and include employees in the planning process at every level of the organization.

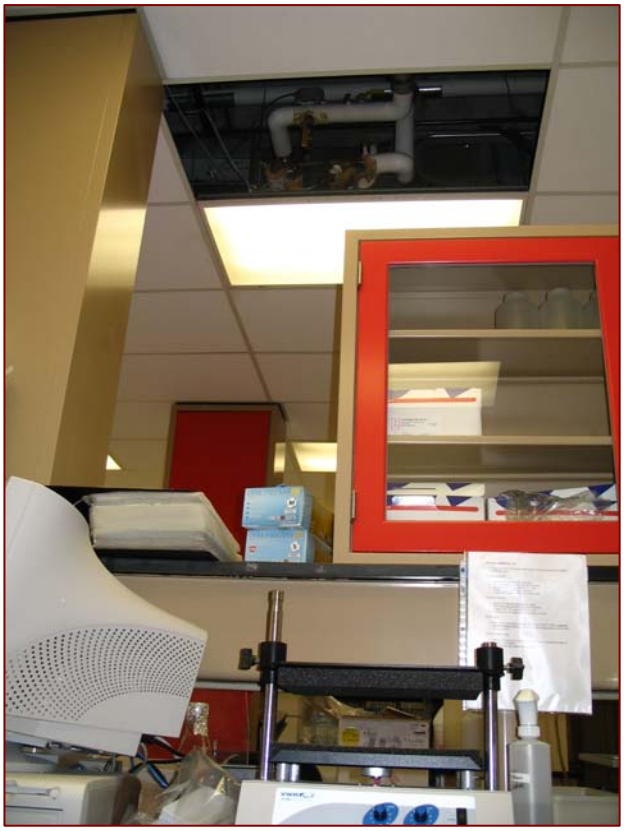
Customer and Market Focus

4. The BOL should develop a standardized system to track customer feedback at all five laboratories to improve BOL operations and document changes resulting from the feedback process.

Human Resource Focus

5. Bureau management should assess individual personnel issues at each laboratory based upon the findings of this report, and take the appropriate action to resolve these issues.

6. Bureau management should institute an employee recognition system bureau-wide and task each laboratory director with implementing the employee recognition system at his or her laboratory.
7. Bureau management should review employee evaluation practices, and ensure adherence to the DOH employee performance evaluation process at DOHP 60-22-02.
8. Bureau management should promote innovative and cost effective training opportunities for all BOL employees through the use of technology, and ensure that current staff has been properly trained in all facets of their positions.
9. Bureau management should institute uniform policies for orientation of all new employees to include, but not be limited to, safety policies and practices. Further, bureau management should require annual updates for training on safety policies and practices for all employees.



Process Management

10. DOH and BOL management should identify all available fixed capital outlay and operating capital outlay funding allocated to BOL, and secure the necessary spending authority to access these funds for the purpose of building repair, renovation, mold/mildew eradication, and equipment replacement.
11. BOL management should prioritize key process requirements, such as the hiring of a Safety Officer and the acquisition of a new billing system.
12. BOL management should resolve the issue of late courier deliveries resulting in delayed specimen testing.

Organizational Performance Results

13. BOL management should monitor and document performance results.

14. DOH and BOL management should incorporate CHD director and administrator priorities and action items expressed in this report into the BOL strategic and transition plans, and develop strategies to implement the priorities and actions.

Other Recommendations

15. Bureau management should promote cultural diversity throughout the organization and encourage appropriate activities that do not interfere with laboratory workflow or productivity.

CENTRAL PHARMACY - HIG-06-002MR

This review was conducted at the request of the Deputy Secretary for Health to assist the Bureau of Statewide Pharmaceutical Services (BSPS), also referred to as Central Pharmacy (CP), in reorganization efforts and to provide strategic information to new CP leadership. Results of the review were as follows:

Strengths

Employees generally liked and respected executive leadership, and liked working with their colleagues. CP has a customer survey process that is administered quarterly to each section's customers. Survey results have been very positive regarding CP performance.

Executive leadership is identifying problems and working to resolve them. CP is currently going through the Sterling self-assessment process to promote organizational excellence. Executive leadership is identifying service and employee satisfaction concerns and is moving to address these issues.

Opportunities for Improvement

Leadership: Employees expressed that two supervisors are condescending and unprofessional, and should attend management training on how to professionally interact with employees.

Strategic Planning: Employees expressed that they are not included in the planning process, and are not familiar with the CP mission, vision, and goals.

Human Resource Focus: Employees stated they are not adequately recognized, not paid enough, and not evaluated on a timely basis.

Process Management: Employees stated there is inadequate space for their supplies, causing hazards with operating the forklift; the quarantine room frequently overflows into the front office area, making it difficult to navigate and properly perform office duties; they lack adequate office supplies; computers and peripherals are outdated; the monthly inventory is a manual process, causing unnecessary delays and potential mistakes in tracking inventory; and the building has numerous leaks from the roof that have caused mold to grow in several areas inside.

Recommendations

1. DOH Management should consider a Bureau Chief who has a Pharmacy background, is experienced in management of diverse employees, is familiar with state policies, and is a good communicator.

2. Bureau Management should hold regular staff meetings, and ensure middle management's fair and equitable implementation of personnel policies and practices.

3. Bureau Management should continue with the Sterling Challenge and incorporate employees into the strategic planning process. Strategic planning should include facility issues.

4. Bureau Management should post customer survey results from each CP section and utilize them to promote organizational improvement.

5. Bureau Management should promote a fair employee recognition process, and employee access to job-specific training.

6. Bureau Management should ensure CP adherence to DOH employee evaluation policies.

7. Bureau Management should automate the shipping and receiving system to one having bar coding capabilities to enable CP to operate without interruptions caused by manual operations.

8. Bureau Management should inspect and make feasible repairs and adjustments to current facilities, until renovation or site relocation can be accomplished.

9. Bureau Management should require a position for fiscal monitoring and a separate position for program monitoring to ensure contract integrity and compliance, and to oversee the current CP contracts with, but not limited to, Department of Health, Department of Corrections, and Department of Children and Families.

10. DOH and Bureau Management should incorporate CHD Directors, Administrators and Pharmacy Managers results from the survey into their strategic planning process, and remain proactive with all Central Pharmacy stakeholders.

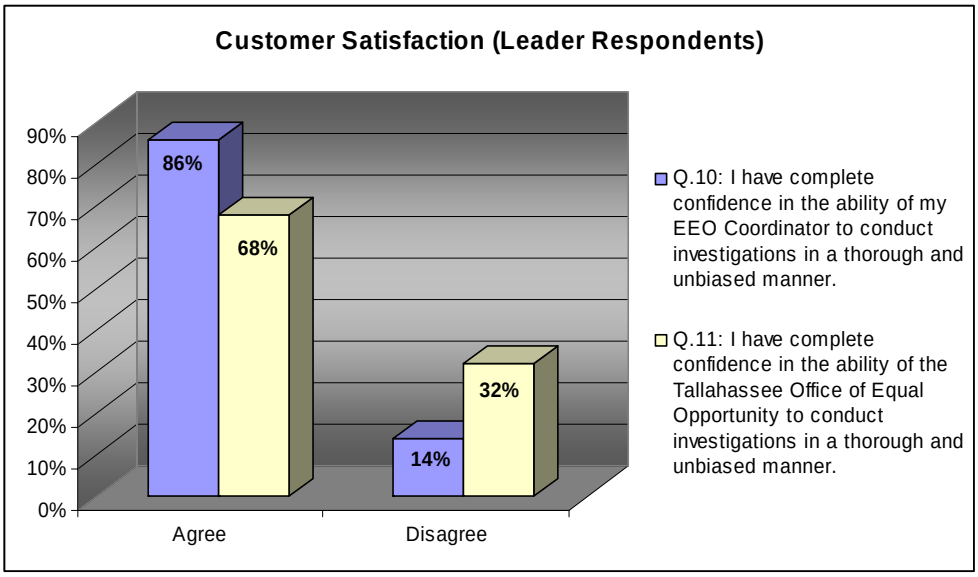
OTHER ACCOUNTABILITY PRODUCTS

Program Review of the Equal Opportunity Program

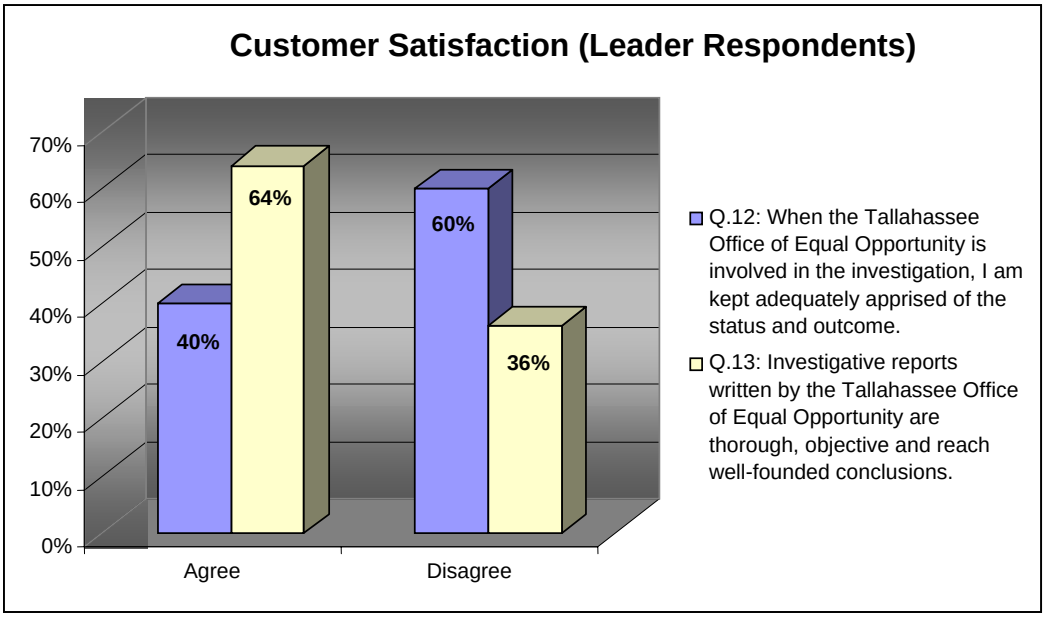
By action of the prior DOH Secretary in late 2005, the Equal Opportunity (EO) Program was transferred to the HIG. Physical re-location did not occur until February 2006. Prior to the merger, a program review was undertaken by HIG staff to provide information useful to the merger process and to identify improvements in processes and operations. The methodology for the program review included interviews of central office and local staff, document review, and on-line surveys of field staff and leadership.

Results from the on-line surveys reflected the perceptions and knowledge base of field staff and leadership. A majority of coordinators reported not having been trained in required duties, nor receiving written descriptions of those duties. Twenty-seven percent (27%) of coordinators indicated they did not know who/what office was responsible for conducting investigations in their jurisdictions and the majority reported they had not been trained in conducting investigations. A portion of coordinators and leaders indicated they conduct investigations with no involvement of, or coordination with the Tallahassee EO Office.

Most leaders (86%) expressed complete confidence in their coordinators to conduct thorough and unbiased investigations. Approximately two-thirds of leaders (68%) expressed confidence in the ability of the Tallahassee EO Office to conduct thorough and unbiased investigations.



Over one-half of leaders (60%) indicated they were not kept adequately apprised of investigation status, and slightly over one-third (36%) expressed concerns about the thoroughness and objectivity of EO investigative reports. The majority of leaders (83%) reported Tallahassee EO staff to be professional and courteous. Some leaders (37%) expressed concerns about timeliness and 44% expressed concerns about responsiveness and usefulness of information provided by staff.



Among EEO coordinator respondents, those who reported a longer length of service, cover multiple counties and/or devoted a significant amount of time to EEO duties, were more likely to express dissatisfaction with services provided by the Tallahassee EO Office. Seventy-eight percent (78%) of coordinators reported they have never felt pressure from management to reach certain conclusions when dealing with EEO complaints, while 22% reported they have felt some level of pressure. Those reporting a longer length of service and/or those covering multiple counties were more likely to report having experienced pressure from management to reach certain conclusions.

The report also included an exploration of investigative and mediation process issues such as the potential for conflict of interest between the roles of investigator and mediator, when those roles are assumed by the same staff and/or office, at different points in time within the same case. A related issue involves the potential liability incurred by the department when an investigation is abandoned due to the resignation or termination of the alleged discriminatory official.

From this information, combined with a summary of the 2005 EEO Committee activities and recommendations, key areas emerged where opportunities exist. Actions recommended from the results of this program review included:

- Implement improved, cost and time-efficient mechanisms of providing initial and regularly recurring EO training to all department employees and supervisors.
- Clearly delineate the complaint intake and investigatory processes whereby the roles of field and central office staff are clearly defined, effectively communicated and staff is properly trained to perform those roles.
- Clearly define and distinguish between those who investigate and those who are authorized to mediate for the department as well as for determining thresholds for pursuing mediation, discontinuing investigations and/or resuming investigations. This distinction may be facilitated by organizational restructuring to further separate the investigatory and mediation functions.
- Conduct a detailed review of requirements for compliance data collection with the aim of reducing redundant data collection and providing standardized data element definitions and sources.

- Customer service should be the driving principle behind program changes and future operations. This will require the continuous awareness of and responsiveness to the unique needs of the various customer groups including complainants, alleged discriminatory officials, supervisors/administrators, department senior leadership, all non-supervisory employees, and clients of the department and the department's contractors.

HIG staff devoted much of the second half of FY 2005-2006 to beginning the process of implementing these recommendations within the merged EO/HIG functions.

Program Review of the Child Care Food Program Audit Section

With the departure of the supervisor of the Child Care Food Program (CCFP) Audit Section, Linda Keen, Inspector General, directed a thorough review be conducted of the HIG CCFP Audit Section, including its organization, duties and responsibilities. Recommendations resulting from the review:

- The mission of the CCFP Audit Section should be clearly established in writing and provided to the staff and other concerned persons. The mission statement should make it clear that the reviews conducted by the CCFP Audit Section are administrative compliance reviews, not audits or agreed upon procedures reviews. All forms and documents related to the review of sub-grantees should clearly state that the reviews conducted are administrative compliance reviews and not audits or agreed upon procedures reviews. The position descriptions of the staff of the CCFP Audit Section should be updated to more accurately reflect the mission of the CCFP Financial Review Section and the duties of its staff.

- The title of the CCFP Audit Section should be changed to CCFP Administrative Compliance Review Section to more accurately reflect its mission, duties and responsibilities.

- In the absence of a documented requirement or need for the CCFP Audit Section to conduct audits or reviews independent of the BCNP, the Section staff, along with its duties and responsibilities, should be transferred to the BCNP.

- If the decision is made for the proposed CCFP Administrative Compliance Review Section to remain in the OIG, the supervisor should report directly to the Inspector General rather than the Director of Internal Audit in order to avoid any appearance that the section is conducting audits.

- The scope of program reviews and the related workload should be reviewed and adjusted as necessary to establish achievable goals that can be accomplished by available staff. Field staff should be provided with high speed internet connections as quickly as possible, to replace any current modem connections.

- In the absence of any Federal regulation establishing standards for administrative compliance reviews conducted by the CCFP Audit Section or the BCNP, the BCNP should determine the scope and standards of reviews conducted and the reports issued. This would allow for the most efficient and effective use of available funds.

- In the absence of a requirement for the CCFP Audit Section or the BCNP to conduct any audits or Agreed Upon Procedures Reviews of sub-grantees expending less than $500,000, the BCNP and the CCFP Audit Section should work together to use the available 2% audit funding to

design and conduct administrative compliance reviews that provide the maximum benefit to the program review effort of the department.

- Written policies, procedures and guidelines should be developed to clearly establish and define the duties and responsibilities of staff in the conduct of administrative compliance reviews. After written policies, procedures and guidelines are developed, the need for training of field staff should be assessed and any necessary training provided.

5. Human Resource Focus

"I see an investment in training as an investment in staff competence and mission accomplishment."

Linda Keen
Inspector General

Management support continued for HIG staff to pursue diverse and relevant training. Such training not only aids personal and professional growth, it is a key to enhancing our products and underscoring the credibility of our staff. A sampling of training HIG staff has attended includes:

Audit staff

Creative Problem Solving for Internal Auditors, The Changing Role of the Professional Auditor, Project Management Skills for the Auditor, Information Technology Audit Perspectives, Fraud Investigation for Internal Auditors, State and Local Government Accounting Conference, CDC/AEA Summer Evaluation Institute, Going Wireless – How Not to be Left Behind in Your Audits, Certified Government Auditing Professional Review Course.

Investigative staff

Investigative Training for Medical Quality Assurance Investigators, Equal Opportunity Investigative Training, Association of Inspectors General Annual Conference, National Network of Public Health Institutes Conference, Southeast Evaluation Association Workshop on Qualitative Data Analysis, Issues in Contract Management.

The allowance of flexible working hours continued during this fiscal year. 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.

Key HIG Processes:

- Audits
- Investigations
- Management Reviews
- Risk Reviews
- Other Accountability Products (e.g., Program Reviews))
- Administration

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. Process modifications this year included revision of the Investigative Manual to address changes in processes related to whistle-blower cases.

Two complaint classifications were added this year necessitated by our acquisition of Equal Opportunity investigative responsibilities: EO Internal Complaints, for those complaints filed by a department employee, and EO External Complaints for those filed with an external agency such as the Florida Commission on Human Relations or the Equal Employment Opportunity Commission.

Additionally, new processes were developed and existing processes were modified to encompass our expanded responsibility of the EO program. An extensive workplan was developed based on results from the EO Program Review Report. Pursuit of implementation required a great deal of time from both audit and investigative staff.

Plans were also developed to update the software utilized in our complaint and investigation status tracking system. Efforts in this area were focused primarily on concept development and vendor selection.

Complaint Classifications

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

Refer to the Appendix for a complete listing of 2005-2006 closed complaints.

7. Results

We assess our performance as an organization through quarterly performance indicators, customer and employee satisfaction indicators and external review results. Our performance over 2005-2006 reflects both successes and improvement opportunities.

- ***"Professional and just service."***
- ***"All issues raised were addressed by the investigation and report."***

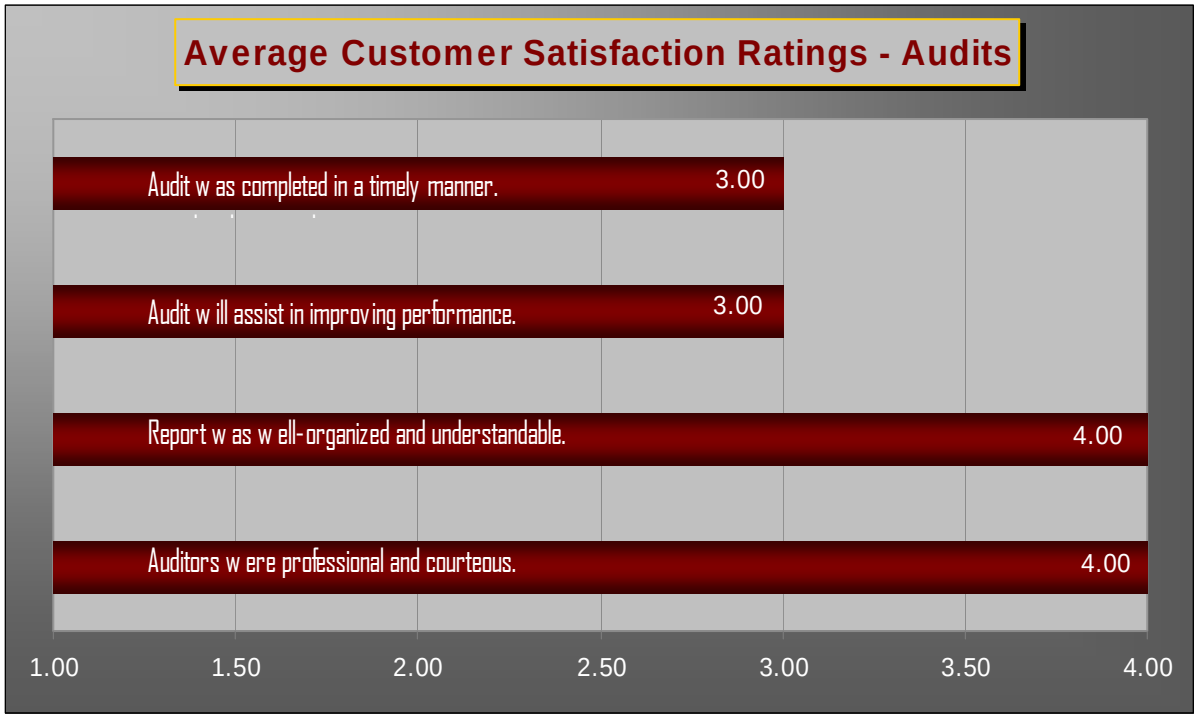
- Respondents to investigative quality survey

Customer-Focused Results

We continue use of a web-based process of assessing customer needs and satisfaction. Our customers consist of Headquarters and CHD managers and staff, who consistently rank our services highly.

In the Investigations area, our overall average customer satisfaction rating was **3.4** on a scale of 1 through 4 with 4 reflecting the most positive ranking of "strongly agree." Additionally, all customers responding to the survey reported they either "strongly agreed" or "agreed" with the four quality measures listed on the chart below.

In the Audit area, the average customer satisfaction was **3.5** on a scale of 1 through 4 with 4 reflecting the positive end of the scale. As with Investigations, all audit customers responding to the survey reported they either "strongly agreed" or "agreed" with the four quality measures.



"Even though we expected to receive several of the recommendations made in the audit, the review also identified other areas that we had not considered."

- Respondent to Audit quality survey

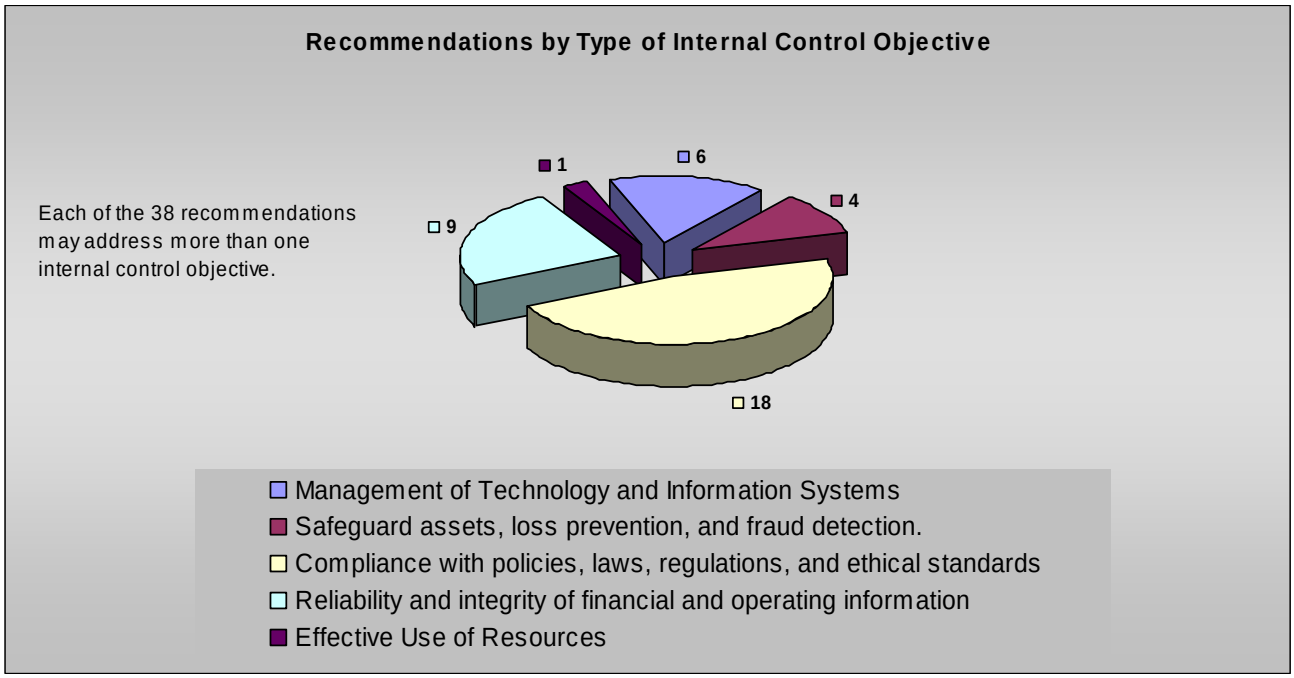
Human Resource Results

In FY 2005-2006, our turnover rate at central office was only 7% with the loss of two staff persons. The department's employee satisfaction survey conducted during the fiscal year yielded results that were in line with all headquarters employee responses.

Organizational Effectiveness Results

Internal Audit

The HIG Internal Audit unit performed four comprehensive audits and one follow-up review of audit findings and recommendations from prior years. Of 38 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.

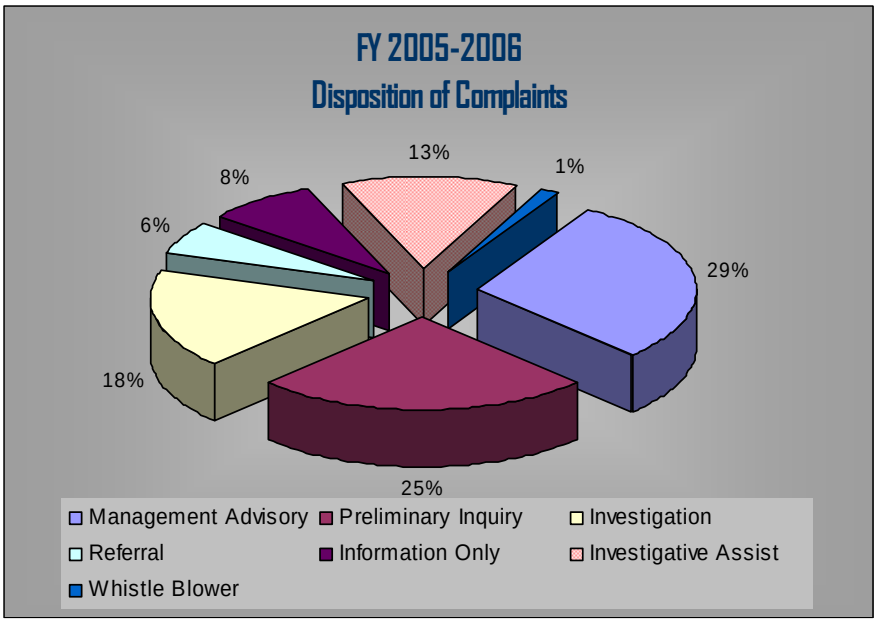


CCFP Administrative Compliance Reviews

The Child Care Food Program (CCFP) administrative compliance review section issued 250 reports and identified $1,961,791 in questioned costs. Pursuant to recommendations from the CCFP program review (see page 36), the CCFP administrative compliance review function and staff will be transferred to the Bureau of Child Nutrition Programs during FY 2006-2007.

Investigations

Investigative staff received a total of 232 complaints in 2005-2006 and closed a total of 222 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 working days, completed 77% of our preliminary investigations within 30 days and 85% of full investigations within planned timeframes. Refer to the appendix for a complete listing of FY 2005-2006 closed complaints.



Management Reviews and Other Accountability Products

Two management reviews and two program reviews were conducted this fiscal year. The Equal Opportunity Program Review identified numerous opportunities for program improvement and made five overarching recommendations to guide those improvement efforts. The program review of the HIG Child Care Food Program Audit Section produced eight recommendations for program improvement. The management review of the Bureau of Labs produced 15 recommendations and the Central Pharmacy management review resulted in 10 recommendations.

External Reviews of HIG

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 U.S. Attorney's Office and law enforcement organizations.

Davis Productivity Award

In 2006 the HIG Hurricane After Action Review Team that produced the department's after action report for the 2004 hurricane season was selected to receive a Davis Productivity Award (plaque level recognition). This honor further reinforced the extraordinary effort required of staff to produce the report, which continues to guide improvements in the department's hurricane response planning and to serve as a comprehensive reference document for researchers in the area of public health emergency preparedness.

Concluding Comments

This was a year of change and transition for the HIG. For approximately the first six months of the year our Director of Investigations served as Acting Inspector General, while the Inspector General was assigned to serve in an Acting Deputy Secretary position. During the last six months of the fiscal year, much effort was focused on integrating the Equal Opportunity staff and functions within the HIG and on making program improvements where possible. There was a leadership change in the Child Care Food Program Audit Section of the HIG and a subsequent program review that recommended organizational restructuring, planned to occur in FY 2006-2007. These changes evolved against the backdrop of routine investigative, audit and management review workloads. All areas offered significant recommendations for operational improvements and cost-saving measures in our ongoing effort to make indispensable contributions to the department.

APPENDIX

Department of Health
Office of the Inspector General
Closed Complaints 2005-2006

Number	Type	Alleged Subject	Disposition
03-019	PI	Alleged fraudulent Medicaid billing	Referred to AHCA
04-201	IN	Alleged contractual services by former employees	Partially Substantiated
04-230	MA	Alleged intentional improper Medicaid/Ryan White Billing Practice	Referred to Management
04-237	IN	Alleged abuse of state time & equipment	Substantiated
05-029	MA	Alleged patient abuse	Referred to Management
05-037	INA	Alleged breach of confidential medical information	Assisted Law Enforcement
05-039	IN	Alleged discrimination by Wakulla CHD Septic Inspector	Unsubstantiated
05-042	MA	Alleged violations of professional, legal & due process rights	Referred to Management
05-045	INA	Alleged breach of confidential medical records	Assisted CHD
05-068	IN	Alleged fraudulent septic tank permitting	Substantiated
05-076	NF	Alleged concerns with School Readiness	Information only
05-089	MA	Alleged abuse of state time	Referred to Management
05-091	INA	Alleged breach of confidential patient information	Assisted CHD
05-093	INA	Alleged security breach of medical record	Assisted CHD
05-094	INA	Alleged security breach of medical records	Assisted CHD
05-095	PI	Alleged incorrect test result reporting	Unsubstantiated
05-098	PI	Alleged unauthorized access to computer workstation	Unsubstantiated
05-099	PI	Alleged possible threatening utterance	Unsubstantiated
05-102	IN	Alleged breach of confidential information	Unsubstantiated
05-107	INA	Alleged threat	Assisted Law Enforcement
05-109	PI	Alleged threats and adverse statement by supervisor	Unsubstantiated
05-111	IN	Alleged mismanagement	Substantiated
05-112	IN	Alleged missing back-up tapes	Substantiated
05-114	IN	Alleged issues with CMS by vendor	Partially Substantiated
05-115	MA	Alleged concern regarding distribution of funds	Referred to Management
05-119	PI	Alleged misconduct	Information recorded for possible future use
05-120	MA	Alleged deliberate delay of SS benefits	Referred to Management
05-121	PI	Alleged HIPAA violation	Information recorded for possible future use
05-122	PI	Alleged solicitation by EH employee	Unsubstantiated
05-123	MA	Alleged nonreferral of criminal violations per FS	Referred to Management
05-124	PI	Alleged impersonation of Orlando investigator	Referred to Management
05-125	PI	Alleged HIPAA violation	Unsubstantiated
05-126	MA	Alleged irregularities in variance application	Referred to Management
05-127	INA	Alleged misconduct	Assisted Agency for Work Force Innovations
05-128	MA	Alleged fraud and discrimination	Referred to Management
05-129	MA	Alleged abandonment	Referred to Management

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
05-130	PI	Alleged inappropriate behavior by physician	Substantiated
05-131	PI	Alleged breach of confidential information	Referred to Management
05-132	IN	Alleged mismanagement and conduct unbecoming a state employee	Substantiated
05-133	MA	Alleged abuse of state time	Referred to Management
05-134	MA	Alleged rudeness by state employee	Referred to Management
05-135	NF	Alleged consideration of disciplinary action	Information only
05-136	MA	Alleged misconduct and mismanagement	Referred to Management
05-137	MA	Alleged inequitable referrals	Referred to Management
05-138	MA	Alleged improper fee charges	Referred to Management
05-139	RF	Alleged poor health conditions at motel	Referred to DBPR
05-140	MA	Alleged abuse of state time	Referred to Management
05-141	PI	Alleged violation of investigative procedures	Unsubstantiated
05-142	IN	Alleged no action taken	Substantiated
05-143	PI	Alleged security breach	Substantiated
05-144	INA	Alleged confidentiality breach	Substantiated
05-145	IN	Alleged alteration of final approval for septic	Partially Substantiated
05-146	PI	Alleged illegal written prescriptions	Information recorded for possible future use
05-147	PI	Alleged failure to provide services	Information recorded for possible future use
05-148	INA	Alleged misplaced lab samples	Assisted CHD
05-149	IN	Alleged instant messaging	Substantiated
05-150	PI	Alleged favoritism by EH Director	Unsubstantiated
05-151	INA	Alleged installation of unauthorized software	Assisted IT
05-152	MA	Alleged misuse of email	Referred to Management
05-153	MA	Alleged mismanagement and conduct unbecoming a state employee	Referred to Management
05-154	IN	Alleged Medicaid fraud	Unsubstantiated
05-155	NF	Alleged sexual harassment	Information only
05-156	IN	Alleged breach of confidential information	Unsubstantiated
05-157	INA	Alleged HIPAA violation	Assisted CHD
05-158	INA	Alleged stolen confidential information	Referred to Management
05-159	INA	Alleged theft of money	Assisted Law Enforcement
05-160	MA	Alleged intoxication of call center employees	Referred to Management
05-161	PI	Alleged abuse of state time	Substantiated
05-162	IN	Alleged refusal to pay for client's injuries	Unsubstantiated
05-163	NF	Alleged behavior unbecoming a state employee	Information only
05-164	PI	Alleged cheating on Optometry Exam	Information recorded for possible future use
05-165	MA	Alleged mismanagement	Referred to Management
05-166	IN	Alleged problems with renewal license	Substantiated
05-167	RF	Alleged failure to maintain proper procedures	Referred to AHCA
05-168	MA	Alleged inappropriate use of email	Referred to Management
05-169	IN	Alleged failure to take action against a regulated entity & alleged cover up	Substantiated
05-170	MA	Alleged improper denial of disability benefits	Referred to Management
05-171	IN	Alleged impropriety	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
05-172	NF	Alleged problem with refund	Information only
05-173	PI	Alleged no inspections of schools	Substantiated
05-175	MA	Alleged unprofessional conduct by state employee	Referred to Management
05-176	MA	Alleged misconduct by employees	Referred to Management
05-177	MA	Alleged release of confidential information	Referred to Management
05-178	MA	Alleged breach of medical records	Referred to Management
05-179	INA	Alleged denial of medical records	Assisted CHD
05-180	PI	Alleged breach of client information	Referred to C&F
05-181	PI	Alleged theft of social security numbers	Substantiated
05-182	MA	Alleged discrimination	Referred to Management
05-183	PI	Alleged security breach	Substantiated
05-184	MA	Alleged toxic mold	Referred to Management
05-185	IN	Alleged high risk situations	Partially Substantiated
05-186	PI	Alleged procurement fraud	Information recorded for possible future use
05-187	PI	Alleged breach of confidential client information	Information recorded for possible future use
05-188	INA	Alleged missing medical records	Assisted CHD
05-189	MA	Alleged problem making appointment	Referred to Management
05-191	PI	Alleged misconduct by employees	Substantiated
05-193	INA	Alleged breach of confidential client information	Assisted CHD
05-194	INA	Alleged ineligibility for services	Assisted CHD
05-196	MA	Alleged misuse of email	Referred to Management
05-197	PI	Alleged disciplinary action against a physician	Unsubstantiated
05-198	IN	Alleged HIPAA violation	Substantiated
05-199	PI	Alleged denial of medical records	Unsubstantiated
05-200	PI	Alleged harassment, discrimination & retaliation	Referred to EEO
05-201	MA	Alleged various discrepancies against DOH	Referred to Management
05-202	NF	Alleged violation of HIPAA	Information only
05-203	RF	Alleged concerns re: medical treatment and HMO	Referred to the Department of Insurance
05-204	IN	Alleged misconduct of testing employees	Unsubstantiated
05-205	MA	Alleged moral, morale and fraud problems	Referred to Management
05-206	PI	Alleged unlicensed activity & homicide	Unsubstantiated
05-207	MA	Alleged concerns with former employer, Jackson Memorial Hospital	Referred to Management
05-208	PI	Alleged breach of confidential medical information	Unsubstantiated
05-209	PI	Alleged HICFA security incident	Information recorded for possible future use
05-210	IN	Alleged inappropriate duties of non-medical personnel	Partially Substantiated
05-211	PI	Alleged fraud regarding CNAs	Unsubstantiated
05-212	NF	Alleged refusal of medical care	Information only
05-213	MA	Alleged discrimination per USMLE exam	Referred to Management
05-214	IN	Alleged failure to take action against an impaired licensed physician	Unsubstantiated
05-215	MA	Alleged misuse of email	Referred to Management
05-216	MA	Alleged cover-up	Referred to Management
05-217	RF	Alleged sale of spoiled meat	Referred to the Department of Agriculture

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
05-219	INA	Alleged threats by DDD claimant	Assisted Law Enforcement
05-220	MA	Alleged inappropriate email	Referred to Management
05-221	INA	Alleged missing lab reports	Assisted CHD
05-222	INA	Alleged wrong labs given to client	Assisted CHD
05-223	RF	Alleged unsanitary conditions at bar/restaurant	Referred to DBPR
05-224	NF	Alleged concern with MQA employee	Information only
05-225	IN	Alleged misuse of state equipment & state resources	Substantiated
05-226	IN	Alleged unhealthy conditions in mobile home park	Unsubstantiated
05-227	MA	Alleged falsification of educational documentation	Referred to Management
05-228	PI	Alleged various acts of misconduct	Unsubstantiated
05-229	RF	Alleged unethical behavior	Referred to DMS
05-230	PI	Alleged possible wrongful termination	Unsubstantiated
05-232	MA	Alleged cancer cure	Referred to Management
06-001	INA	Alleged HIPAA violation	Assisted CHD
06-002	MA	Alleged flu vaccine shortage	Referred to Management
06-003	WB	Alleged wrongful termination	Substantiated (violation of law)
06-005	RF	Alleged HIPPA violation	Referred to Health and Human Services Office for Civil Rights (Atlanta, Georgia)
06-006	PI	Alleged no response from Board of Nursing	Unsubstantiated
06-007	INA	Alleged fraud by employee	Assited US Attorney's Office
06-008	INA	Alleged sell of county equipment	Assisted CHD
06-009	IN	Alleged theft of state property	Unsubstantiated
06-010	MA	Alleged misuse of state phone	Referred to Management
06-012	NF	Alleged problem with lab	Information only
06-013	NF	Alleged possible cover up	Information only
06-015	MA	Alleged unprofessional practices	Referred to Management
06-017	MA	Alleged employee misconduct	Referred to Management
06-018	PI	Alleged HIPAA violation	Unsubstantiated
06-019	INA	Alleged issuance of birth certificates without fee	Assisted CHD
06-020	NF	Alleged unethical/unprofessional actions	Information only
06-022	NF	Alleged inappropriate behavior of CHD employee	Information only
06-023	MA	Alleged possible misconduct by employees	Referred to Management
06-024	IN	Alleged wrongful termination	Unsubstantiated
06-025	INA	Alleged theft of prescription forms	Assisted CHD/Law Enforcement
06-026	PI	Alleged improper billing practices - Medicare Part B	Substantiated
06-027	IN	Alleged intimidation by pharmacy inspector	Partially Substantiated
06-028	PI	Alleged stolen prescription pad	Substantiated
06-029	IN	Alleged security violation	Substantiated
06-030	RF	Alleged TB positive inmates in courtrooms	Referred to Miami Dade IG
06-031	MA	Alleged breach of confidential medical information	Referred to Management
06-032	PI	Alleged breach of confidential medical information	Referred to MQA
06-033	NF	Alleged concerns with Baker Act commitment	Information only
06-034	RF	Alleged problems with clinic	Referred to AHCA
06-035	MA	Alleged mismanagement & threats in the work place	Referred to Management

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
06-036	MA	Alleged unfair cost for medical records	Referred to AHCA
06-039	PI	Alleged inappropriate behavior by state employee	Substantiated
06-041	NF	Alleged poor service	Information only
06-042	PI	Alleged mistreatment of client	Unsubstantiated
06-043	IN	Alleged improper billing	Substantiated
06-044	PI	Alleged contract fraud	Substantiated
06-045	INA	Alleged stolen laptop	Assisted Law Enforcement
06-046	PI	Alleged concern regarding immunizations	Unsubstantiated
06-047	IN	Alleged inappropriate use of email	Substantiated
06-048	RF	Alleged dirty public restroom	Referred to Department of Agriculture/Consumer Services
06-049	MA	Alleged confiscation of nursing licenses	Referred to Management
06-050	NF	Alleged problem with Express Care	Information only
06-052	MA	Alleged poor service from CHD	Referred to Management
06-053	MA	Alleged mismanagement	Referred to Management
06-054	PI	Alleged battery	Unsubstantiated
06-055	IN	Alleged security violation	Substantiated
06-056	MA	Alleged unprofessional leadership/outside employment	Referred to Management
06-057	RF	Alleged breach of confidential employee information	Referred to Department of Financial Services
06-058	IN	Alleged private recruitment of CMS clients	Partially Substantiated
06-059	PI	Alleged violations of guidelines	Partially Substantiated
06-061	MA	Alleged mismanagement	Referred to Management
06-062	PI	Alleged unlawful laboratory marketing by DOH	Unsubstantiated
06-063	IN	Alleged illegal taping	Partially Substantiated
06-064	INA	Alleged sell of prescriptions	Assisted Law Enforcement
06-065	IN	Alleged unbecoming behavior of state employee	Unsubstantiated
06-067	MA	Alleged misuse of DOH computer/HIPAA violation	Referred to Management
06-069	IN	Alleged unprofessional treatment and care at CHD	Substantiated
06-072	MA	Alleged neglect of child's dental health	Referred to Management
06-074	WB	Alleged retaliation	Unsubstantiated
06-075	PI	Alleged refusal of treatment	Information recorded for possible future use
06-076	PI	Alleged mismanagement	Referred to HRM
06-077	MA	Alleged sell of sample use drugs	Referred to Management
06-078	MA	Alleged school bus drop at CHD	Referred to Management
06-082	IN	Alleged misuse of DOH endorsement	Substantiated
06-083	RF	Alleged erroneous information on medical record	Referred to AHCA
06-084	MA	Alleged discrimination & harassment	Referred to Management
06-085	IN	Alleged battery	Substantiated
06-086	PI	Alleged failure to safeguard information	Unsubstantiated
06-087	INA	Alleged theft	Assisted Law Enforcement
06-088	MA	Alleged unsanitary conditions in waiting room	Referred to Management
06-089	IN	Alleged breach of medical information	Unsubstantiated
06-090	WB	Alleged retaliation	Unsubstantiated
06-091	PI	Alleged fraud and waste	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
06-094	PI	Alleged substance abuse	Referred to Law Enforcement
06-095	MA	Alleged rudeness by CHD employee	Referred to Management
06-096	PI	Alleged cost due to DOH error	Unsubstantiated
06-098	MA	Alleged misuse of state vehicle	Referred to Management
06-099	PI	Alleged withhold of medical information	Unsubstantiated
06-101	NF	Alleged violation of rights to confidentiality	Information only
06-102	NF	Alleged advised to resign	Information only
06-103	MA	Alleged suspension of nursing license	Referred to Management
06-104	INA	Alleged misuse of state computer	Assisted CHD
06-105	RF	Alleged unjust increase of premiums	Referred to the Dispute Resolution Office
06-107	NF	Alleged order to harm child	Information only
06-109	PI	Alleged breach of medical information	Unsubstantiated
06-111	MA	Alleged mandated dress attire without policy & nepotism	Referred to Management
06-115	MA	Alleged unsanitary conditions	Referred to Management
06-116	MA	Alleged dishonest nursing staff	Referred to Management
06-118	MA	Alleged listing of wrong address	Referred to Management

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

Florida Department of Health

OFFICE OF THE INSPECTOR GENERAL

4052 Bald Cypress Way, Bin #A03
Tallahassee, FL 32399-1704

Report Fraud, Waste, Mismanagement, Illegal or Unethical Conduct, Discrimination:

Department of Health IG	(850) 245-4141
Whistle-blower's Hotline	(800) 543-5353
Discrimination Complaints	(866) 779-6118
TTY (for hearing impaired)	(850) 410-1451