Description structure organization

PHL is a central part of public health infrastructure. PHL supports public health infrastructure in every three core public health functions. Descriptions of PHL activity in this core function have been previously described by the CDC and ASTPHLD:3, 4, 5 Assessment -- including laboratory tests for infectious diseases, reference tests related to exotic diseases, and highly specialized esoteric tests. PHL often performs tests that are not related to individual but significant treatment for public health reasons, (for example, serotyping bacteria). Other assessment measures include collecting test results, food and water infection documentation, environmental testing, and research. Epidemiological work by public health agencies often depends on the testing and analysis of PHL specimens received from private providers, public health clinics, hospitals, and even private laboratories. Policy Development -- includes consultations in technology, testing, and research requirements for programs and policy development on health issues such as HIV/AIDS, sexually explicit diseases (STDs), and tbs. PHL can play a role in environmental health policy by identifying health hazards through testing and developing policies to solve environmental problems. In some states, PHL is responsible for developing and implementing regulations (for example, CLIA '88) on the operation of private laboratories in the state. The guarantee -- including providing patient testing for the population and indigenous people unable to pay for the tests. PHL states generally provide newborn genetic inspections for state residents, laboratory staff/facilities licensing, laboratory staff training, and environmental monitoring. In addition, PHL has a role in assurance through the measurement of the effectiveness of intervention programs. PHL varies dramatically in both structure and various services. All fifty states and the District of Columbia operate their own PHL.6 states in general, the state PHL operates under the leadership of state health officials; However, the nature of the relationship between health officials and laboratory directors varies by state.4 For example, in Oregon, the Public Health Laboratory Center is one of the five main centers in the Oregon Health Division, and the laboratory director is assistant Administrator of the Health Division. In Tennessee, the Laboratory Services Division is a unit under the supervision of the Tennessee Department of Health Commissioner. In contrast to these separate parts of laboratory services, Washington State has incorporated laboratory services and epidemiological divisions to a central office called Epidemiology, Health Statistics and Public Health Laboratories; this office is one of the five main bureaus of the Washington Department of Health. Size of PHL states in terms of and financing varies by state. For example, in fiscal year 1996, Tennessee State PHL had staff of 186 full-time equivalents (FTEs) and a $9.5 million budget; The Wisconsin state PHL has 280 FTEs with a budget of $23 million; and PHL states of Florida have staff nationwide 354 FTEs and a $21 million budget (budget 1995-96). The state's PHL revenue stream also varies according to the proportion of funding that comes from federal, state, etc. sources. For example, MIchigan and Wisconsin State PHLs receive 60 to 70 percent of their funding from state and federal sources and balances of financing directly from generations of consumer fees. By comparison, the Tennessee State PHL received 95 percent of its funding directly from the state; it collects fees for certain services, but the state PHL approves all revenue through general national administration. Many states also operate regional laboratories that perform certain tests and act as a liaison to send other samples to the central state laboratory. For example, both Maryland and Tennessee operate four regional laboratories in their respective states. Regional laboratories can be an extension of the full service of the central state lab or smaller places. For example, one of the regional laboratories in Tennessee has a small staff of two FTEs and performs exclusive microbiological tests. On the other hand, other states, such as Oregon and Wyoming, operate only one state public health laboratory located in the center. One major difference among the state PHL is the extent to which state laboratories focus resources on directing patient testing for personal health services compared to tests for population-based screening and surveillance. PHL New York is called the Wadsworth Center, and it devotes a third of its sources to laboratory licensing programs for private laboratories; one-third of its sources operate as large base grants funded by research entities; and one-third of its sources for environmental administration, testing, and health monitoring. Other states such as Tennessee have traditionally performed live tests of patient specimens received from local health departments and other public health agencies. Variations in the functions and structures of the state PHL have a direct impact on how laboratories determine their role in public health infrastructure and how current market changes will affect the lab itself. Some state FEL that traditionally performs tests for indigestion patients seeking treatment in local health departments has stated that the number of specimens they receive is decreasing as states develop Medicaid managed care programs. In fact, the company Privately managed ones that bid and receive approval to register Medicaid customers often contract with a large private laboratory for some or all clinical trial services. Therefore, many Medicaid and others patients traditionally treated by the local health department entered a managed care plan where their tests were sent to a private laboratory. Therefore, the state may also receive fewer samples for surveillance purposes. In recent years, the public health community has tried to identify its roles and responsibilities at all levels of government. Healthcare market changes, such as increased managed care penetration, hospital consolidation and other health systems, and privatisation, have stimulated public health agencies to review their community roles and goals. Consolidation in the private laboratory market and the increased presence of managed care in serving Medicaid residents threaten to impose major changes in travel where PHL has traditionally served the community. Three main structures have become the basis of how an organisation is run: works; projected; and matrix. Each structure has an advantage, and if used correctly and in the right environment, the structure can be completed again of the project. Each structure also has disadvantages, but as long as it is understood and good communication exists, the structure can still function properly. Functional organizations are the most common type of three. It works well in small organizations where different parts are geographically close together and that provide only a small number of goods and/or services. In a functional structure, organizations are broken down into different parts based specifically. For example, there may be an area for sales, one for customer service and one for supervisors facing growing problems. The role of the project manager is to ensure the smooth implementation of processes and projects; However, functional managers have the most powers and make final decisions. The advantage to functional structure is the role of functional manager, which means there is only one boss. This reduces or prevents conflicts of interest and makes it easier to manage experts. The disadvantage of this type of structure is that project managers have limited power and limited career path. In the projected structure, all work is seen as a project. Project managers have full control, unlike in the functional structure, and all team members report directly to the project manager. Sometimes members of this team remain, and sometimes they are hired as temporary employees to help the project until it is completed. If the organization takes on a large project, it will have all the resources needed to maintain the project and will act as a versatile small company. Advantages to projected structures including opportunities project for career advancement. In addition, because good communication exists in project work, team members tend to be more committed to, and excel in, in, The weakness of the projected structure is that, as the team broke and dispersed after the completion of the project, there was no long-term goal or a sense of job security for the rest of the workers. Another downside is that organizations basically need to clone the same resources for each project (project manager, work area, administrator). The matrix structure combines both functional and projected structures. Each team member has two bosses; they report both to functional managers and project managers. If the matrix is strong, the power stays more with the project manager. If the matrix is weak, the power stays more with the functions manager. The key is to find a balance where power is shared equally. Due to its complexity, this type of structure can lead to problems if it is not used carefully and properly. Good communication is important to succeed. The advantages of the matrix structure lie in the use of efficient resources due to accessibility facilities. This structure also shows efficient communication vertically and croppetly. Therefore, once the projects have ended, team members may receive jobs elsewhere in the organization. The disadvantage of the matrix structure is the complexity, which can be difficult to manage. For example, if a manager works and a project manager doesn't communicate well, team members can be caught in the middle, causing confusion. Confusion.