

**PUBLIC HEALTH COMMISSION**

October 18, 2010

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Director

Georgia Health Policy Center

Today I would like to share information about a comprehensive study of public health in Georgia that was conducted in 2005, an analysis of the implications of learnings from 15 years of Georgia Health Policy projects, data from public health organization in other states, and then suggest the implications of that information on Georgia's state organizational structure related to public health (independent, under DCH, under another department, attached to a department).

The 2005 study (with results from interviews, focus groups, and evaluation of archival and documentary evidence) suggested that Georgia's Public Health core business was not aligned with the Essential Services or internal stakeholder preference and that the misalignment between perceived and desired core businesses is not the result of intentional design, but has evolved defacto. In Georgia, inherent systemic challenges such as siloed funding, the number of uninsured and the fraying safety net were found to have more powerful influence over public health activities than the desired drivers such as need and evidence based practices. There was also a call for public health leadership and collaboration – to protect the public's health; to lead the state in the improving the health of all; to provide simple, clear messages; and to build rather than be the safety net. The broad structure of key interrelationships among resources, feedback, rules, goals, and mindsets within the system influenced behavior. **Structure influences behavior.**

An analysis of 15 years of Georgia Health Policy Center research, policy, program, and evaluation projects revealed eight principals that should guide decisions about organizational structure:

1. When consumers interact with state services, they are generally pleased with the services they receive.
2. It is important to create policies that allow consumers to enter the system through any door and access all necessary services.
3. Employees need to be trained in multiple disciplines to facilitate this no wrong door model. Each employee should have a working knowledge of other areas to facilitate easy flow of information and consumers between disciplines.
4. Technology should be integrated to increase efficiency and effectiveness and improve decision making
5. Funding should be linked to outcomes rather than programs.
6. Collaboration should be required and seamless. Coordination and collaboration must be improved among agencies, divisions and departments.
7. Prevention services should be emphasized in all programs
8. The success of public health initiatives hinges on long term planning – transformation should be the ultimate goal of change. When the majority of an organization is busy putting out fires, prevention tend to fall by the wayside.

**Collaboration across departments, agencies, and programs is essential**

The organizational location, structure, and administration of public health varies across states with the majority of state public health agencies operating as independent and free standing. There is not clear evidence regarding the relationships among outcomes, funding, costs, and organizational structure. In Georgia, the Division of Public Health is located within the Department of Community Health, along with Medicaid, Emergency Preparedness and Response, Healthcare Facility Regulation, and the State Health Benefit Plan.<sup>1</sup> The division has a shared relationship with the local public health departments and public health districts in the providing public health services throughout the state. Structurally, the Division of Public Health does not report directly to the governor and is not a cabinet level agency; however, according to state statute, the state health director reports to the Office of the Governor and to the Commissioner.<sup>2</sup> The state health director is the primary statutory public health authority within the State of Georgia. In Georgia, state statutes authorize the Division of Public Health to declare a health emergency, collect health data, manage vital statistics, and conduct health planning.<sup>3</sup> The Georgia legislature has authority to approve the public health budget, adopt public health laws, and establish fees and taxes to generate revenue for public health services.

What clues do these three sets of information provide as to the future organizational structure of public health within Georgia's administrative government? What structure would promote public health leadership and drive desired best public health practice that protects and promotes health. What structure would best promote the kind of collaboration that would be evident to those the state is serving?

In a recent national meeting, leaders of organizations like the Georgia Health Policy Center that span the space between governmental public health and private public health interests were talking about how the governmental organization of public health often impedes best practice. The group agreed the for public health to lead in the protection and promotion of health, the "gold standard" was for public health to be an independent department reporting directly to the governor. I would like for Georgia to have the "gold standard" especially given the health needs in Georgia. While this may not be immediately possible, it can be a long term goal.

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<sup>1</sup> Georgia Department of Community Health. Organizational Chart. Retrieved from [http://dch.georgia.gov/vgn/images/portal/cit\\_1210/52/53/52266428Visio-FY2010orgrev.pdf](http://dch.georgia.gov/vgn/images/portal/cit_1210/52/53/52266428Visio-FY2010orgrev.pdf)

<sup>2</sup> Official Code of Georgia § 31-2-18

<sup>3</sup> ASHTO Profile of State Public Health, Volume One, 2009



## Public Health Organization, Structure, and Administration

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## Principal Findings 1

**Practice Paradox**  
\*Current core business not aligned with "ideal" core business

Essential Service	Current Resource Allocation			Ideal Resource Allocation		
	Low	Moderate	High	Low	Moderate	High
Maintain health status						
Diagnose and treat/diagnose						
Inform, educate and empower						
Mobilize community partnerships						
Develop policies and plans						
Enforce laws and regulations						
Assess needs and Link people to needed personal health services						
Assess a community public health work force						
Evaluate effectiveness, Research						

## Principal Findings 2

**Current drivers not aligned with "ideal" drivers**

- Current Drivers**
  - Money
  - Safety Net
  - Uninsured
  - Performance-based budgeting
  - Regulation
  - Leaders' philosophies
- Ideal Drivers**
  - Need
  - Evidence-based practices
  - State strategy informed by local perspective
  - Local culture



## Principal Findings 3

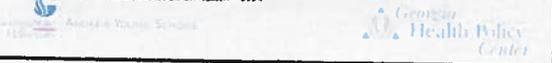
**Call for public health leadership and collaboration**

- The public trust the work of the Division to protect the public's health
- Stakeholders are calling for simple, clear and compelling messages from the Division
- There is a call for the Division to lead to the state in improving the health of all
- Building the Safety Net, not Being the Safety Net.



## Relevant GHPC Programs from the Past 15 Years

- CCSP - 2000
- Single Point of Entry - 2001
- Institutional vs. HCBS Waiver Care - 2004
- Indigent Care Trust Fund - 2004
- Health Care Utilization of Foster Children - 2004
- Peer Support for Older Adults - 2005
- Member and Provider Satisfaction with ACS - 2005
- The Effect of Peer Support on Medicaid Utilization - 2006
- Evaluation of Georgia's CON Programs - 2006
- Evaluation of Georgia's Oral Health Prevention Programs - 2007
- Surveys and Analysis in Support of the State Aging Plan and CCSP Waiver Renewal - 2007
- Evaluation of the Georgia Enhanced Care Program - 2008
- Evaluation of Georgia's Aging and Disability Resource Centers - 2008
- Georgia Population Survey - 2008
- DHR Public Roundtables - 2007
- Covering the Uninsured - A Perspective of Community Leaders - 2006
- Division of Public Health Integrated Family Support Evaluation - 2007
- DHR Policy Impact Council - 2007/2008
- Assessing the Core Business of Georgia's Public Health - 2005
- Medicaid Modernization - 2006
- Georgia State Cancer Plan - 2007
- Legislative Health Policy Certificate Program/Woodruff Legislative Initiative - 2008
- A Summary of Program Activities According to Organizational Functions, prepared for the Governor's Commission on Health - 1994



## Common Themes from Our Work

- **Satisfaction with services**  
At point of service, consumers are generally pleased with the services they receive
- **No wrong door**  
Create policies that allow customers to enter the system through any "door" and access all necessary services
- **Cross-training of workforce**  
Train employees in multiple disciplines to facilitate a single point of access
- **Integration of technology and data sharing**  
Integrate technology to increase efficiency and effectiveness and improve decision making



## Themes, cont.

- **Linked funding**  
Link funding with outcomes rather than programs to avoid turf guarding when serving the same clients.
- **Collaboration**  
Support community/public-private partnerships as a way to develop local capacity to serve individuals and families.  
Improve coordination and collaboration between agencies, divisions and interdepartmentally.
- **Prevention**  
Emphasize prevention services in all levels of DHR.
- **Transformational Change**  
Structures are so complex and problems so immediate, that short term solutions often trump sustainable and transformative solutions.

## Location of State Public Health Agencies

*Fifty-five percent of state public health agencies (28 states) are free-standing, independent agencies, while the remainder are part of a larger agency with other public services*

## Location of State Public Health Agencies

- The remaining 23 state public health agencies are under a "umbrella" or larger agency with one or more of the following public services:
  - Medicaid - 19
  - Public assistance - 17
  - Long-term care - 16
  - State mental health with substance abuse - 14
  - Other - 11
  - Substance abuse - 7
  - State mental health without substance abuse - 5
  - Environmental protection - 1

## State and Local Relationships

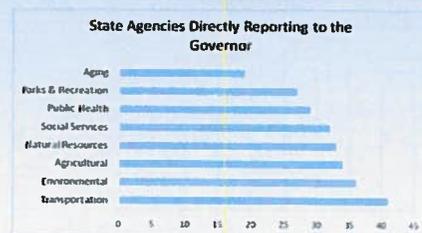
*In about 20% of states, the state public health agency is responsible for providing all local public health services*

## State and Local Relationships

- Ten state public health agencies have centralized control of public health; the state public health agency provides local public health services
- In 19 states, local public health departments often collaborate with the state agency, but operate independently to provide public health services
- Eighteen states have a hybrid system in which there is a shared responsibility in providing public health services among the state agency and the local health departments
- Four states have no local health departments

## Relationship with the Governor

*More than half of the state public health agencies directly report to the governor*

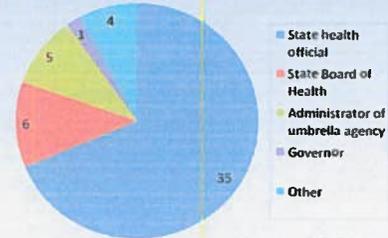


## Relationship with the Governor

- Twenty-nine state public health agencies directly report to the governor
- Thirty-five state public health agencies are cabinet level agencies

## Statutory Authority

*In almost 70% of the states, the primary statutory public health authority is the State Health Official*



## Statutory Authority

- Statutory authority is given to some state public health agencies to do the following:
  - Declare a health emergency - 39
  - Collect health data - 51
  - Manage vital statistics - 51
  - Conduct health planning - 42
  - Issue certificates of need - 27
  - Operate health facilities - 23
  - License health professional - 34
  - Accredit local health agencies - 6
- In 25 states, the state public health agencies can adopt public health laws and regulations

## Funding

*The average state public health agency receives 50% of its funding from federal grants and contracts, with 24% originating from state sources.*

## Fiscal Decision Making in Public Health

	State Public Health Agency	State Board of Health	Governor	State Legislature	Umbrella Agency	Other Entity
Establish Fees for services	33	10	18	44	5	0
Approve the public health budget	10	0	35	46	12	1
Establish laws for public health	0	0	18	45	1	0

Source: ASPPH Profiles of State Public Health, Volume One (2009)

# From Theory to Practice: What Drives the Core Business of Public Health?

Tina Anderson Smith, Karen J. Minyard, Christopher A. Parker, Rachel Ferencik Van Valkenburg, and John A. Shoemaker

In 1994, the Public Health Functions Steering Committee proffered a description of the Essential Public Health Services (Essential Services). Questions remain, however, about the relationship between the roles defined therein and current public health practice at state and local levels. This case study describes the core business of public health in Georgia relative to the theoretical ideal and elucidates the primary drivers of the core business, thus providing data to inform future efforts to strengthen practice in the state. The principal finding was that public health in Georgia is not aligned with the Essential Services. Further analysis revealed that the primary drivers or determinants of public health practice are finance-related rather than based in need or strategy, precluding an integrated and intentional focus on health improvement. This case study provides a systems context for public health financing discussions, suggests leverage points for public health system change, and furthers the examination of applications for systems thinking relative to public health finance, practice, and policy.

**KEY WORDS:** core business of public health, public health finance, public health systems, systems thinking

In 2004, faced with complex systemic and economic challenges and questions from policy makers regarding cost efficiency and duplication of services, Georgia's Division of Public Health (DPH, or "the Division") commissioned an assessment of public health practice within the state. The purpose of the study was to describe the Division's core business, or scope of practice, evaluate its alignment with the Essential Services, and ascertain the drivers of public health practice in the state. Framed within a larger systems context, the findings were intended to inform policy discussions and

strategic planning efforts to strengthen public health practice and improve the health of Georgians within the limits of available resources.

## ● Study Context

Georgia has a growing population of more than 8 million that is relatively young, diverse, poor, unhealthy, and less educated compared to other states.<sup>1</sup> Using the typology developed by Gostin and Hodge, Georgia has an "embedded" public health system,<sup>2</sup> with the DPH being one of four Divisions of the Georgia Department of Human Resources. Like many other southern states,<sup>3</sup> Georgia has an intermediary district structure between state- and local-level public health. There are approximately 6,000 DPH staff, 18 district offices, and local health departments in each of Georgia's 159 counties.

## ● Design and Methods

This study was framed on the basis of an extensive review of the literature on public health practice

This study was supported by the Division of Public Health, Georgia Department of Human Resources.

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assessments and approaches to system change. Multiple data sources and qualitative methods were used to construct a case study of the core business of public health in Georgia. While the basic research questions were practice-based and specific to Georgia's DPH, the study design was based on a holistic orientation—one that considered the Division itself as a complex system embedded within and influenced by even more complex, less well-defined systems related to health and healthcare. This systems perspective significantly impacted the emergent study design, data sources, and analytic methods.

The primary unit of analysis was the state's formal public health agency, while embedded units included state, district, and local infrastructure and activity; the flow of resources through the system; the extent of collaboration; organizational structure; and staff mindset and perceptions. Contextual factors included the political, economic, and regulatory environments, and public financing issues. Perceptions of external stakeholders were also considered in keeping with suggestions that public health systems and practice should value the input of the public to whom the system is accountable.<sup>4</sup>

Data sources included individual interviews, focus groups, and archival documents (ie, financial data, Georgia legal code, prior planning documentation). Using standardized protocols, researchers conducted individual interviews ( $n = 69$ ) and six focus groups ( $n = 86$ ) between June and September 2004 with internal and external stakeholders at the state, district, and local levels. Interview instruments were developed specific for each respondent group. Internal interviewees included district health directors, public health nurses, nurse managers, and state-level staff. A broad range of external stakeholders were chosen on the basis of influence in decision making and representation of the broader system of health: Governor's policy staff, legislators, Department of Human Resources Board, other state agency commissioners, and trade associations. County Boards of Health, healthcare providers, local government, social service providers, educators, and lay citizens participated in the focus groups held in six cities selected on the basis of diversity of geography, rurality, and health system infrastructure. The purpose of the conversations was to understand the perceptions of public health practice, current versus "ideal," including its relationship to the broader system of health.

The qualitative analysis was data-based and inductive, allowing patterns to emerge from the data rather than testing formal hypotheses. Archival documents and transcripts from interviews and focus groups were systematically mined and cross-referenced to define themes. Diverse perspectives and sources made it possible to triangulate the data and test interpretations.

Emergent findings were further tested in discussions with a 12-member Advisory Panel consisting of Division leaders and District Health Directors, a research-practice partnership constructed for the purpose of the study. This combination of methods and data sources helped maintain analytic sensitivity to the relationships, influences, and interdependencies within the Division and the larger public health system.

## ○ Results

### Core business

Interview and focus group participants generally perceived the core business to be dominated by the provision of direct personal medical services, eclipsing critical population-based activities. This theme was substantiated by written descriptions of services provided at the district and local levels, local health department Master Agreements, and documentation of trends in public health funding relative to various programmatic areas. Exceptions to this perspective were related to the fact that many external stakeholders at the state level were unable to describe what they believed to be the scope of public health services in the state beyond "services to the poor." Furthermore, state-level staff felt that their activities were relatively more aligned with the Essential Services than was expressed by district and local health department staff.

Compared with current practice, internal stakeholders generally agreed that a more balanced approach to the Essential Services would constitute the "ideal" core business of public health in Georgia. While district health directors preferred a more balanced allocation of financial and human resources across the Essential Services, they described their present practice as directing more resources toward the provision of personal health services at the expense of population-based services. External stakeholders, while limited in their understanding of the field, agreed with the value of prevention and saw a unique leadership responsibility for the Division in improving health in the state.

### Business drivers

In spite of the fact that not all participants could clearly define the "ideal" core business of public health in practical terms, all agreed that the definition should be driven by three criteria: population need, evidence of effectiveness, and a statewide strategy that is informed by local input. These "ideal" drivers are in stark contrast to the primary drivers of the current core business that the data suggested were predominantly finance-related: the inherent complexity and categorical nature

of public health funding, declining state investments in population-based services, and broader health system financing challenges related to the uninsured and an increasingly fragile safety net.

Considered in combination, results from the interviews and data from financial and legal documents revealed that the nature and extent of funding for state, district, and local health department activities appeared to most significantly influence the scope and level of strategic intent and integration of public health practice in Georgia. A lack of discretionary resources, the predominance of categorical funding, and the acquisition of money from multiple public and private sources at local, state, and district levels appeared to preclude the desired level of planning and integration desired by stakeholders. This flow of resources into and through the system is highly complex. Because no statewide accounting framework exists, the use of resources was difficult to track, and we were unable to cross reference participants' perceptions of resource allocation relative to the Essential Services with actual financial records.

A review of the Division's financial statements revealed the priority-distorting impact of declining public health funding on the practice of public health in Georgia. State appropriations to the Division decreased by 15 percent from FY2003 to FY2005. Internal and external interviewees explained that performance-based budgeting is being used to determine public funding priorities, resulting in relatively less money appropriated for prevention and health promotion activities for which quantifying outcomes, especially in the short term, is difficult. Based on a ranked list of FY2003 DHR funding priorities, public health infrastructure and public safety receive higher priority rankings than most preventive health initiatives, the obvious exception being that of immunizations (the highest ranked public health preventive service). Furthermore, internal respondents explained that county and district health departments utilize local user fees, including Medicaid reimbursement, to subsidize the cost of population-based services.

Internal and external stakeholders also indicated two broader finance-related factors that act as determinants of the core business: the fragility of the safety net and the rising numbers of uninsured in Georgia. Historical documents and interviewee comments reflected that county health departments have served in a safety net role by providing medical services to uninsured and underserved populations throughout the state. Especially during tight economic times, study participants explained that many people look to their local county health departments as the primary safety net provider, especially in rural communities where the demand for medical care outstrips the supply of providers. Further-

more, local and district public health staff described a situation in which the burden of illness borne by much of the state's indigent, uninsured, and immigrant populations continues to be the responsibility of an already overburdened and underresourced public health system.

Although state and local public health officials differed in their opinions as to what the strategic and programmatic focus of the Division should be, all commented on the need for integrated action by public health leaders at local, state, and national levels. Internal and external stakeholders in Georgia identified a need for greater alignment between those who set policy and those responsible for local implementation. Furthermore, they stated that the Division needs to assume a leadership role in convening other parts of the healthcare sector in a collaborative effort to improve the health status of Georgians.

## ● Discussion

In summary, the case study revealed that the Division's current core business is not aligned with the Essential Services or internal stakeholder preferences. The results of the interviews, focus groups, and evaluation of archival and documentary evidence suggested that the misalignment between the perceived and desired core businesses is not the result of intentional design, but has evolved de facto.

Viewed individually, these findings may not be particularly startling. In fact, it is well documented that barriers exist in translating public health theory into practice,<sup>4,5</sup> imbalances occur between the provision of direct patient services and population-based activities,<sup>6-9</sup> and public health financing is complex and may impact performance.<sup>10-12</sup> Our study attempted to move from describing the state of public health practice to understanding the drivers creating these problems so that high-leverage strategies could be devised to improve the effectiveness of the public health system in a sustainable manner.

Our research revealed that there are underlying business drivers, some originating in the larger health-related system beyond the formal purview of the Division, that contribute to the Division's largely unintentional core business. In Georgia, inherent systemic challenges were found to mediate the translation of theory into practice. This finding is consistent with a major systems principle, "structure influences behavior," in which structure refers to key interrelationships among resources, feedback, rules, goals, and mindsets within the system as opposed to the construction of an agency as shown by an organizational chart.<sup>13</sup> Thus, achieving sustained realignment of public health practice with

the Essential Services in Georgia will likely require addressing broader system drivers. System change strategies consistent with this logic might include leading an inclusive process to create a statewide vision and strategy for health improvement; working to “build the safety net rather than be it”; and engaging in local, state, and national efforts to increase access to care and coverage for the un-/underinsured. Such a systemic approach would complement more internally focused, commonly found quality and process improvement strategies internal to the Division.

## Conclusion

Finance-related factors are significant drivers of public health practice. Efforts to further conceptualize public health finance<sup>14,15</sup> should involve understanding its role from a broader systems perspective, creating an opportunity to examine the application of systems thinking and principles to public health policy and practice.<sup>16,17</sup> It is important to note, however, that many barriers to accurate financial analysis of state and local public health systems exist. Specifically, our experience supports others’ call for more accurately tracking public health expenditures, both in general and with reference to the Essential Services.<sup>18–20</sup>

Consideration of our findings within the context of a broader complex system that contributes to public health and provides personal healthcare leads to insights that may be relevant in other states. To use language familiar to public health practitioners, an analogy can be drawn between “upstream” interventions<sup>21</sup> to affect population health and interventions intended to affect drivers of a complex system. Upstream interventions to address drivers of practice may provide higher “leverage points” as a counterpart to more proximal strategies—changes in organizational structure, internal processes, and staff behavior—to improve public health performance.<sup>22</sup> Specifically, efforts to balance the Essential Services, better define the role of public health, and standardize the performance of public agencies through National Public Health Performance Standards<sup>23</sup> and accreditation processes may prove difficult in the absence of broader policy interventions to address drivers specific to each environment.

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## **HHS Task Force Public Hearing Speech FINAL**

Good afternoon. Georgia has undergone a dramatic transformation over the past few decades. Georgians are more abundant, more diverse, more obese and more age-ed than ever.

The health care industry and, more recently, our economy are also changing at a break-neck pace. While it's difficult to see exactly where these changes will take us, one thing is clear -- reform is necessary and urgently needed.

Georgia's rapid changes made a previously suitable set of services more difficult to manage. A reorganization to divide the work into more manageable components just makes sense.

As the HHS task force deliberated on how DHR could evolve to better address the needs of Georgians, they asked the Georgia Health Policy Center to examine the demographics of the state to shed some light on how DHR might be reorganized. They also asked that we re-examine our previous research in the state to identify a few guiding principles to inform the reorganization.

We studied a wide range of data on just how much Georgia and its health care landscape had changed -- and would change. In the year 2000, there were a little over 8 million Georgians. By the year 2030, that number is expected to swell to more than 12 million. And while Georgians over 65 made up about 9.6 percent of the population in 2000, they are expected to comprise nearly 16 percent of Georgia's population by the year 2030.

We pulled from our assessment of core functions of the Division of Public Health, where stakeholders indicated that the primary drivers of the state's public health system were funding requirements, the burden of the uninsured and safety net service provision, out of touch regulation and performance-based budgeting -- instead of the needs of Georgians, evidence-based practices and a state strategy informed by local perspectives.

We also analyzed everything from our work with the Georgia State Cancer Plan and our evaluation of the state's Certificate of Need program to research on the health care use of foster children and analysis and support of the state aging plan.

**We drew upon nearly 15 years of experience, as well as thorough research in the state, to ensure that DHR benefited from lessons learned.**

**For DHR's reorganization to succeed in improving the health of Georgians, we firmly believe that it must adhere to the eight guiding principles we've uncovered from our work. And as we listen to details and opinions about the reorganization, it's important to keep these principals in mind.**

**First, when consumers interact with DHR, they should be generally pleased with the services they receive at the point of service.**

**Second, it's important to create policies that allow consumers to enter the system through any door and access all necessary services. There should be no wrong door.**

**Third, employees need to be trained in multiple disciplines to facilitate this no wrong door model. Each employee should have a working knowledge of other areas to facilitate easy flow of information and consumers between disciplines.**

**Fourth, technology should be integrated to increase efficiency and effectiveness and improve decision making.**

**Fifth, funding should be linked to outcomes rather than programs. This could help avoid turf battles when serving the same clients.**

**Sixth, collaboration should be required AND relatively seamless. Community and public/private partnerships could be supported as a way to develop local capacity, as well as serve individuals and families. Coordination and collaboration must be improved among agencies, divisions and departments.**

**Seventh, prevention services should be emphasized in all levels of DHR. Prevention is key – our research has shown that no matter how a public health initiative is organized, system drivers like poverty, substance abuse and obesity ultimately have more impact.**

**And finally, transformation should be the ultimate goal of change. Structures are so complex, and problems so immediate, that short-term fixes often**

trump sustainable solutions. The success of public health initiatives hinge on long-term planning. But when the majority of an organization is busy putting out fires, prevention tends to fall by the wayside.

From an organizational standpoint, these principals must play out through the reorganization – and seem to do so based on the proposed reorganization plan.

I've been impressed by the thoughtful planning and research that preceded this reorganization plan. Care was taken to examine the best practices of other states and carefully consider the future needs of Georgia. I applaud the committee's willingness to accept input from all parts of the state and impacted state agencies.

In our conversations with the task force, we emphasized the importance of oversight to foster coordination and collaboration – so we support the creation of the Behavioral Health Coordination Council and the HHS Agency Head Alliance.

As the DHR reorganization moves forward, we recommend that it focus on making organizational changes that will create an atmosphere of collaboration and coordination. With all areas communicating, sharing -- and not competing -- for funds, working together and focusing on prevention, DHR should be better able to meet the growing health care needs of Georgians.

Thank you.

Karen Minyard  
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Fall, 2008

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<b>Table 1: Location and Structure of State Public Health Agencies</b>			
<b>Independent State Public Health Agency</b>	<b>Primary Public Health (with MH, SS, DD and/or facility services)</b>	<b>Public Health and Medical (some with MH, SS, DD, facility, and/or aging services)</b>	<b>Health and Human Services (large agency with multiple divisions including PH)</b>
Arkansas (hybrid, governor)	New Mexico (decentralized, governor)	Georgia (hybrid)	Alaska (hybrid)
Arizona (hybrid, governor)	Rhode Island (no LHDs, governor)	Louisiana (centralized)	California (decentralized)
Arkansas (centralized, governor)	Texas (hybrid)	Maryland (hybrid, governor)	Delaware (no LHDs)
Colorado (hybrid, governor)	Vermont (centralized)	Michigan (decentralized, governor)	Idaho (hybrid)
Connecticut (hybrid, governor)		Wisconsin (hybrid)	Kentucky (hybrid)
Florida (centralized, governor)			Maine (decentralized)
Hawaii (no LHDs, governor)			Massachusetts (decentralized)
Illinois (hybrid, governor)			Montana (decentralized, governor)
Indiana (decentralized, governor)			North Carolina (decentralized)
Iowa (decentralized, governor)			Nebraska (hybrid, governor)
Kansas (decentralized, governor)			Nevada (hybrid)
Minnesota (decentralized, governor)			New Hampshire (decentralized)
Missouri (decentralized, governor)			Oregon (decentralized)
Mississippi (centralized)			West Virginia (decentralized)
New Jersey (decentralized, governor)			
New York (hybrid, governor)			
North Dakota (decentralized, governor)			
Ohio (decentralized, governor)			
Oklahoma (hybrid)			
Pennsylvania (hybrid, governor)			
South Carolina (centralized)			
South Dakota (centralized, governor)			
Tennessee (decentralized, governor)			
Utah (decentralized, governor)			
Virginia (hybrid)			
Washington (decentralized, governor)			
Wyoming (hybrid, governor)			
Washington, DC (no LHD, mayor)			

**KEY:** *Centralized* – public health services delivered through state public health agency; *Decentralized* – public health services delivered through local health departments; *hybrid* – shared responsibility in providing public health services among the state and the local health departments; *governor* – state public health agency reports directly to the governor; *No LHDs* – no local health departments

**Table 2: Location of the state public health agency**

Independent public health agency	28
Under an umbrella agency	23

N=51

**Table 3: Other major areas of responsibility of the umbrella agency**

Not under umbrella agency	28
Medicaid	19
Public Assistance	17
Long-Term Care	16
State Mental Health with Substance Abuse	14
Other	11
Substance Abuse	7
State Mental Health without Substance Abuse	5
Environmental Protection	1

\*Items not mutually exclusive

**Table 4: State public health agency directly reports to the governor**

Yes	29
No	22

N=51

**Table 5: Is the state public health agency a cabinet level agency**

Yes	35
No	15
n/a	1

N=51

**Table 6: Relationship between the state public health agency and local health departments**

No local health departments	4
Centralized control	10
Decentralized control	19
Combination or hybrid control	18

N=51

**Table 7: Administrative Responsibilities**

	State Public Health Agency	State Board of Health	Governor	State Legislature	Umbrella Agency
Establish fees for services	21	10	18	44	5
Adopt public health laws & regulations	25	11	19	43	7
Approve state public health budget	10	0	35	46	12
Hire or appoint agency head	1	3	42	6	6
Place public health levy on ballot for general election	1	1	12	36	2
Establish taxes for public health	0	0	18	45	1

\*Items not mutually exclusive

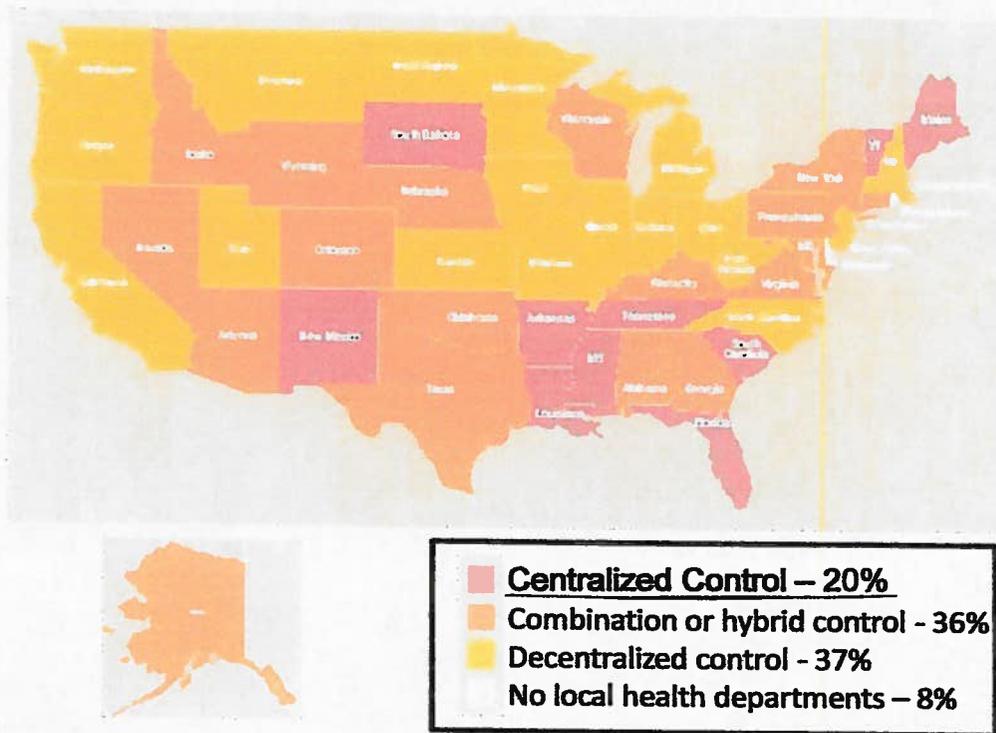
**Table 8: Primary Statutory Public Health Authority within the State**

State health official	35
State board of health	6
HHS secretary or umbrella agency official	5
Governor	1
Other	4

N=51

*(Tables 1-8 Sources: State Public Health Websites and ASTHO Chartbook of State Public Health, Volume One, 2010)*

## State and Local Relationships in Public Health



Source: ASTHO Chartbook of State Public Health, Volume One (2010)

## Georgia

The Division of Public Health is located within the Department of Community Health, along with Medicaid, Emergency Preparedness and Response, Healthcare Facility Regulation, and the State Health Benefit Plan.<sup>1</sup> The division has a shared relationship with the local public health departments and public health districts in the providing public health services throughout the state. Structurally, the Division of Public Health does not report directly to the governor and is not a cabinet level agency; however, according to state statute, the state health director reports to the Office of the Governor and to the Commissioner.<sup>2</sup> The state health director is the primary statutory public health authority within the State of Georgia. In Georgia, state statutes authorize the Division of Public Health to declare a health emergency, collect health data, manage vital statistics, and conduct health planning.<sup>3</sup> The Georgia legislature has authority to approve the public health budget, adopt public health laws, and establish fees and taxes to generate revenue for public health services.

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<sup>1</sup> Georgia Department of Community Health. Organizational Chart. Retrieved from [http://dch.georgia.gov/vgn/images/portal/cit\\_1210/52/53/52266428Visio-FY2010orgrev.pdf](http://dch.georgia.gov/vgn/images/portal/cit_1210/52/53/52266428Visio-FY2010orgrev.pdf)

<sup>2</sup> Official Code of Georgia § 31-2-18

<sup>3</sup> ASHTO Profile of State Public Health, Volume One, 2009