GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Clyde L. Reese, III, Esq., Commissioner *Sonny Perdue, Governor*

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MINUTES OF THE MEETING OF
PUBLIC HEALTH COMMISSION
Department of Community Health, Division of Public Health
2 Peachtree Street, 5th Floor Board Room
Atlanta, Georgia 30303
Monday, August 9, 2010
8:30 am-12:00 pm

DR. PHILLIP WILLIAMS, CHAIR, PRESIDING

MEMBERS PRESENT
Deb Bailey
Jimmy Burnsed
Jack Chapman, Jr., M.D.
Greg Dent
Lynne Feldman, M.D
Ted Holloway, M.D.
Jim Peak
Diane Weems, M.D.

GUESTS PRESENT
Tom Andrews, St. Joseph's Mercy Care
David Bayne, Senate Budget and Evaluation Office
Fay Brown, GA Academy of Family Physicians
Paula Brown, Office of Planning and Budget
Whitney Brown, Voices for Georgia's Children
Seema Csukas, Children's Healthcare of Atlanta
Dr. Sandra Ford, DeKalb County Board of Health
Patrick Harry, District 3-2
Charles Hayslett, Hayslett Group
M. Henderson, GRN CSB
Lloyd Hofer, East Metro Health District
Linda Lowe, Families First
Terry Mathews, Mathews & Maxwell, Inc
Scott Maxwell, Georgia Public Health Association, Inc.
Terri Mc Fadden, Georgia Chapter AAP
Brian Noyes, Brock Clay Government and Public Affairs, Inc.
Ebony Simpson, DHHS, Region IV
Keir Sims, DeKalb County Board of Health
Helen Sloat, Nelson Mullins
Robert Stolarick, Georgia Public Health Association, Inc.
Cathalene Teahan, Georgia AIDS Coalition
Jacqueline Taylor, DHHS, OPHS, Region IV
Russ Toal, Georgia Public Health Association, Inc.
Rick Ward, Georgia Chapter AAP
Stanley Wei, East Metro Health District
Karen Williams, West End Medical Center

STAFF PRESENT
Clyde Reese, III, Esq.
Rony Francois, M.D.
Brittany Bennett
Janie Broadnax
Cathy Brown
Claude Burnett
Andrea Fuller Ruffin
Carole Jakeway
Rhonda Page
Nancy Pisor
Joyce Slade
Tom Wade

WELCOME AND CALL TO ORDER

Dr. Williams welcomed Commission members and guests and called the meeting of the Public Health Commission to order at 8:30 am. The Commission approved the minutes of the July 12, 2010 meeting by unanimous vote. Dr. Williams identified the objective of the meeting, which was to gain insight into the proposed organizational structures. The presenters scheduled would lead discussion on the advantages and disadvantages of the proposed organizational options and how each might impact the unique infrastructural needs of Georgia's public health system.

Dr. Williams called on DCH Commissioner, Clyde Reese, to provide an overview of the organizational considerations before the Commission. Commissioner Reese briefly explained that the Commission was charged with making a recommendation as to whether the Division of Public Health is better served as a part of DCH, incorporated into another agency within the Executive Branch ("umbrella agency"), as an attached agency or as an independent agency. Commissioner Reese briefly discussed what it means to be an attached agency, as the least clearly defined of the structures. The Commissioner explained that the relative size, infrastructure and overall resources for administration of these agencies may be small, creating a practical need to attach to a larger agency within the Executive Branch that would handle administrative duties for the attached entity as needed. Commissioner Reese went on to say that those bodies that are currently attached to DCH retain their full independent rule and policy making authority for their functions, which, generally, have a more narrow focus. In terms of budgetary considerations, the Commissioner explained that the attached agency's budget is typically presented to the General Assembly as a component of the larger agency. Commissioner Reese followed with a brief discussion of the old Division of Mental Health to provide an overview of a stand alone agency structure.

Dr. Williams invited Debbie Hall, Chief Operating Officer of DCH, to discuss the transition of Public Health to the Department.

Ms. Hall discussed the priority goals of the overall transition effort with respect to the following core functions:

<u>People</u>
Ms. Hall indicated that DCH had to ensure that the people who would be impacted by the transition would not be disturbed with respect to payroll and individual jobs and responsibilities. The focus was on not creating gaps or loose ends in the transfer of personnel and budgetary resources but to identify and optimize administrative services in the transition effort.

<u>Budget</u>
Ms. Hall indicated that the budget component of the transition was critical particularly in developing a framework for mapping the current organizational structure into the new, post-transition structure, an effort that was further compounded by the uncertainty of what the new structure would be. Ms. Hall indicated that management knew some of the fundamental components that had to be in place and began forging the transition of budgetary considerations in those areas.

<u>Communications</u>
Ms. Hall discussed the importance of communication not just with employees, which was foremost, but also with the Governor's Office, legislators and the public, in general. Ensuring consistent, transparent and coordinated communication with all stakeholders was critical in keeping them apprised of the direction of the Department.

<u>Finance and Accounting</u>

Ms. Hall indicated that the Department sought the help of the State Accounting Office to assist in establishing the account codes under which the new organizational structure would operate. Additionally, they worked to ensure the Department maintained the appropriate alignment related to funding authorities and institutions as to not disrupt funding streams.

Cost Allocation Plan

Ms. Hall discussed the chore of evaluating the enterprise, which is the structure in the old DHR that administered the services for Public Health. DCH had to determine the requirements of supporting Public Health from a human resource perspective, finance and accounting, payroll and various other services that would be required on an enterprise level. The Department had to ensure that a structure was in place that could accommodate and support the new division.

Funding Sources

Ms. Hall discussed the importance of identifying the funding streams, most from federal partners, USDA, HHS, CDC and ensuring the appropriate structure was in place to administer and manage them. She also discussed several grants that were in process or required routine application which the Department could not afford to jeopardize as a result of organizational, programmatic or other changes associated with the transition. The Department was committed to safeguarding against the interruption of services.

Change Management

Ms. Hall discussed the task of devising a Departmental strategy that would allow people, internal and external to DCH and Division of Public Health, to accept the transition and recognize their shared mission of protecting the people they serve and safeguarding against the loss of service.

Service

Ms. Hall discussed the Department's priority goal of maintaining optimal service levels or, at a minimum, not disrupting services.

Ms. Hall followed with a discussion of the high level accomplishments by work stream.

Accounting and Finance

This work stream ensured the transition of several fiscal operations efficiently and accounted for all facets of operations to ensure no interruptions.

Audits

Ms. Hall indicated that there were external and internal audits that needed to be accounted for and monitored to ensure that progress was being made on any required correction action plan as to not risk an interruption of funding or services. The Audits work stream transitioned all Public Health audit functions to DCH and ensured uninterrupted access to Public Health financial systems.

Legal Services

This group ensured that transition activities were aligned with the legislative mandate. Ms. Hall indicated the Legal Services work stream was quickly aligned throughout the legislative process especially when the session began. They were very engaged in tracking the legislation and explaining the impact on the Department. This work stream was also required to execute Memorandums of Understanding (MOUs), for those instances where it made sense to share services with DHS, as in the case of mailroom services, for example.

Contract Life Cycle

Ms. Hall indicated that the beginning of transformational activities was initiated with the Contract Life Cycle work stream as this process could not be effectively transitioned as it previously existed. Towards the end of the transition, several work streams were combined to develop a process flow that included Procurement,

Legal, Contracts Administration, and Accounting. Both entities, DCH and Public Health, depend on third parties for the administration of services which is captured in a contract agreement. This work stream ensured that processes were followed in accordance with appropriate rules governing each activity. Ms. Hall suggested the focus was on implementing a process that would be functional in new environment.

Human Resources
This work stream integrated Public Health into the DCH human resources infrastructure. Ms. Hall indicated that this group was very engaged in ensuring the core DCH policies were provided to the transitioned employees and that there was no interruption in employee benefits. With approximately 1600 people transitioning, Ms. Hall discussed the complexities that existed and the various entities that had to coordinate their efforts for successful integration.

Information Systems
This work stream transitioned the Public Health information systems to DCH and developed a temporary IT solution to facilitate communication across the different systems used by each entity. Ms. Hall indicated that the Department was in the midst of a massive IT transition with GAIT, IBM and AT&T. The focus was ensuring that those systems transitioned accordingly and that Public Health would at least be able to communicate and utilize those systems. Ms. Hall also discussed the importance of keeping accessible those information systems utilized by the public.

Facilities and Property
Ms. Hall discussed the many different service lines and facilities that exist in Public Health, many of which are very old. She described challenges with structural maintenance given the limited funding. Ms. Hall also discussed the need for accounting of facilities that existed for the proper transfer of leases and assets.

Business Continuity
Ms. Hall indicated this effort resulted from wanting to ensure that any interruption, either during transition or beyond, was reinforced by an effective communication crisis management plan and structure that could safeguard the maintenance of operations. Ms. Hall said these efforts were further compounded by the simultaneous need to address the H1N1 pandemic. The Department was able to develop plans for countering massive absenteeism such as working from home and cross training strategies.

Communications
The Communications work stream worked to identify the key stakeholders and a process for delivering consistent and transparent communication.

Ms. Hall discussed the significant opportunities, issues and challenges broached during the transition.

Opportunities

Organizational Design

Ms. Hall discussed the changes DCH made administratively in the alignment of specific programs to foster more efficient administration. She discussed the importance of creating a vendor management unit within Public Health to effectively monitor the contract performance inconsideration of the contract terms, which was critical given the number of Public Health contracts that needed support.

Additionally, Ms. Hall discussed the creation of a separate division for Emergency Preparedness and Response. The imminent threat of the H1N1 pandemic, according to Ms. Hall, required the Department to shift its priorities to this area immediately.

Asset management

Ms. Hall discussed the opportunity afforded from reconciling the assets converted from Public Health to DCH with the actual on hand physical inventory. Ms. Hall indicated that these assets are located throughout the state and many were acquired with federal funds and are subject to rules associated with how they are administered in the system. A review of this overall process enabled the Department to ensure that current practice is consistent with the guidelines.

Performance Based Contracting

In FY 2008 DCH established a policy requiring that all agreements be performance based. The transition of Public Health afforded the opportunity to update Public Health contracts to reflect this change in policy and ultimately in the delivery of services. Ms. Hall discussed the importance of holding contractors accountable for the delivery of services in the manner agreed. She went on to say that many of the agreements transitioned from DHR were not performance based and required amending upon expiration. Consistent with current policy going forward, Ms. Hall indicated that contracts would not be executed unless they are performance based.

Issues

Antiquated Information Systems major challenges so far.

Ms. Hall indicated that the Department is currently developing, and in some cases implementing, updates to some of the critical IS functionality on which the state depends, particularly with respect to Vital Records, the Georgia Immunization Registry (GRITS) and Babies Can't Wait programs, where multiple disparate systems may exist. The Department is in the planning stage to determine the best system to meet the demands of the Public Health service delivery model. Additionally, Ms. Hall discussed the associated security and privacy issues and limited bandwidth. She mentioned the different email systems that exist within the Department and the difficulty of communicating with all employees concurrently.

Documentation Management

Ms. Hall discussed issues with the process for managing the large volume (400) of contracts associated with Public Health, which usually resulted in delays. Initial measures that have been taken since transition have included developing a Sharepoint database for monitoring and electronically routing documents for the appropriate oversight. Ms. Hall indicated efficiencies in administering the contracts have been gained particularly with respect to timely processing.

Increased Demand for Services

Ms. Hall discussed the impact of the current state of the economy on the public health infrastructure and indicated the demand for services in Georgia is at an all time high.

Facility Improvements

Ms. Hall discussed the age of several Health District offices and the need to implement modernization efforts or at minimum provide maintenance and repair.

Challenges

Customer Relationship Management

Ms. Hall discussed the challenges resulting from a lack of a centralized system for managing the volume of inquiries and requests for information. She indicated a need to be able to route identified issues to the appropriate area and monitor that they are addressed.

Operational

Ms. Hall discussed challenges inherent to operating mission critical programs with disparate and obsolete information systems and the resulting audit risks and inefficiencies.

Ms. Hall followed with a discussion of the Department's Transformation Strategy post transition for those areas that needed improvement. Overall, the Department utilized work teams, which allowed people with the skills and competencies to improve the processes to participate in implementing the strategy for addressing those areas of concern.

Ms. Hall went on to discuss some of the priorities of the transformation.

Transformation Priorities

Design Cost Allocation System
The Department identified flaws in the random moment sampling methodology that was previously used. The Department engaged federal partners to design a new plan which is currently in place.

Finalize Intentions on FY2010 Inter-Agency Agreements
Need assessment and overall review performed on those MOUs that had been developed with DHS during the transition.

Document Management
Significant challenges with physical plant of many older state facilities, which is particularly concerning for safeguarding vital records. Ms. Hall indicated that the Department is currently reviewing how the process can be improved through technology.

Team Georgia Marketplace
Ms. Hall provided insight into the Team Georgia Marketplace initiative of the Department of Administrative Services, where purchasing could be electronically administered to improve efficiency. She indicated the Department is moving ahead with implementation.

E-Performance
The Department recently completed training in performance management systems. Ms. Hall indicated that DCH had gone live with e-performance and wanted to get Public Health on board to have a centralized process for managing the performance of employees.

Rewrite of DHR Master Agreement
Ms. Hall indicated that this interagency agreement with the former DHR was scheduled to expire at the end of FY2010. The Department successfully initiated a new agreement timely and without interruption.

Asset Management
Ms. Hall indicated that while asset conversion had been completed during the transition process, reconciliation and verification of current assets were currently being performed.

Health District Facility Improvements
The Department is currently assessing the costs and benefits of repairing, replacing or relocating older, state offices with significant levels of deferred maintenance. Further technological upgrades are being considered to support Vital Records.

Workforce Development
Ms. Hall indicated that this is the first year workforce development has been elevated as an agency-wide strategic priority and goal largely because of its increasing importance in the current

environment. She went on to say that current budget challenges and increased competition for staff, particularly with the Department's federal partners have resulted in a diminished agency workforce. In order to ensure the Department has the staff necessary to accomplish its mission and goals, targeted recruitment strategies are currently being developed, including health fairs and elevating the Team DCH website. Additionally, Ms. Hall discussed the launch of "DCH Jobs".

Performance Based Contracting/Vendor Management
Ms. Hall discussed the task of updating the contracts transitioned from Public Health to be performance based. She also discussed monitoring accountability of the parties involved.

Grant Administration
Ms. Hall discussed the importance of establishing a fair and open process for administering grants.

In closing, Ms. Hall reviewed the Department's current organizational charts and opened the floor to questions. A handout was provided to the Commission.

Commission member Dr. Lynne Feldman commented that when Public Health was a part of the former DHR, several critical Public Health infrastructure functions were incorporated into the larger DHR system such as financial and personnel management and IT. Dr. Feldman inquired how the Department ensured that the functions that were supposed to go with Public Health during its transition to DCH actually did.

Ms. Hall responded that much of this determination depended on the Allocations Study conducted by Nichols and Cauley and Associates, LLC, which identified those areas that were a part of Public Health and appropriate for transition or were the responsibility of the DHR. The study identified a total of 57 positions which were subsequently divided among the departmental areas. She went on to say that the Department reviewed how the entire structure was designed and how DCH and its administrative structure could be aligned to support the Public Health employees who were transitioning. She said that while efforts were made to keep the core Public Health responsibilities separate, this was not always possible as some of the positions that transitioned over were vacant.

Dr. Feldman then questioned if this same issue would exist if Public Health were to no longer be a part of DCH, as some of its core functions have been assimilated into DCH.

Ms. Hall agreed.

Dr. Feldman followed with an inquiry about the 1,631 Public Health employees previously identified by Ms. Hall, specifically, whether this total included county health department employees. She indicated that these employees create the core staff at the district level and certainly at the county level and are impacted by DCH policy, directions and priorities and yet they seem to be out in "limbo". She inquired about DCH's philosophy regarding these employees.

Ms. Hall acknowledged that the Public Health employee total did not include county level employees. She indicated that DCH continues to work to align communication and support for these employees. Further, she explained that the location of these employees throughout the state presents a challenge as they have their own set of leadership and established processes in place. Ms. Hall indicated that DCH has made strides with respect to leadership moving forward and feeling a part of DCH. Reviewing the agreements between each of those entities helped county level employees develop a common understanding of how they are positioned within DCH. Ms. Hall says the department has a long way to go but continues to make positive strides.

Dr. Feldman suggested this as a potentially weak area of the Department as there is still uncertainty about how the larger DCH views county level staff. Dr. Feldman emphasized the importance of making these

employees feel a part of the DCH system because it is as this level that the policies and the actual public health work gets done. Dr. Feldman then inquired about the cost of the transition.

Ms. Hall indicated that the direct costs of the transition as well as those incurred related to facilities, including employee relocation, could be provided to the Commission.

Dr. Feldman inquired about Public Health staff's involvement in deciding what the needs and priorities were for any transformation efforts.

Ms. Hall indicated that Public Health staff was involved in the process from the beginning.

Dr. Williams inquired about the entity responsible for renegotiating the Master Agreement, specifically if renegotiation is done by Public Health or at the DCH level. He indicated that the Master Agreement was based on a 1970s calculation based on population and wealth in a county but that there had been discussion on modifying.

Ms. Hall responded that the execution of the agreement is done at the DCH level. Any changes to the formula, she indicated, would require the involvement of additional stakeholders.

Dr. Feldman suggested that "negotiation" of the Master Agreement was too strong a term to use as there is no true negotiation involved. Once the agreement and the funds associated are matriculated down to the county level, it is accepted or refused.

Dr. Francois, the Director of Public Health, indicated that a work group has been put together to review the Grant and Aid formula and includes various stakeholders.

Commissioner Reese requested that Dr. Williams permit him to clarify several points. First, Commissioner Reese indicated that the term "Master Agreement" is used to reference two different agreements. The Formula for Grant and Aid, which some may be familiar with as a "master agreement", dates back to the 1970s with regard to how Public Health funds are allocated and as Dr. Francois indicated, a work group has been assigned to review. Commissioner Reese went on to say that a different master agreement is referenced administratively between DCH and the old DHR. He indicated that when DCH was created, one of its largest components was the old Medicaid agency and DHR, through the Department of Family and Children Services, acted as the on the ground eligibility function for Medicaid member enrollment. The old Department of Medical Assistance in DHR and the newly created DCH had a lot of infrastructure administrative functions intertwined between agencies. Separate and apart from the Grant And Aid Formula for Public Health, there is a very large administrative agreement that DCH and the current DHS has with regard to different administrative functions across different entities and requires renegotiation to bring into line with current reality which includes Public Health and licensure functions that transitioned to DCH.

Second, Commissioner Reese wanted to clarify the issue of county board of health employees. He indicated that he agreed and had also come to discern this issue as a major organizational weakness in the administration of the public health system in the state. He went on to say that there are components of the issue that must be addressed from a statutory point of view because as the law is written, the employees of the Boards of Health are employed by the various counties, not by DCH, for the most part. District Health directors are employees of the Department as well as assorted other staff, which creates issues at the administrative level for the state. He indicated that the Department has taken the position that it does not have daily authority over the employees of the county board of health based on current statute. The Commissioner discussed issues of whether or not DCH ethics and personnel policies apply to county boards of health. DCH has taken the position that they do not. The Commissioner emphasized the challenge of the state trying to administer Public Health programs that, as has been recognized, cannot be done without the work of county employees over whom the state does not have jurisdiction. The dichotomies that exist, in

large part, begin with how the law is written, he said. While this ongoing issue may not be within the purview of this Commission, he indicated that it may be an important part and parcel of its deliberation and thoughts on how to create the most effective Public Health structure.

As a recognized strength for Georgia's public health system, Dr. Feldman indicated her hesitation in having the work of the Commission in any way interfere with the grass root effort of the county Board of Health system. She explained that the weakness of the system lies within the Department.

Commissioner Reese clarified his position that the weakness with the county board of health is administrative and is a question of how DCH interacts with the district and county level system and how the law is interpreted to determine the extent of DCH's authority. He emphasized that the flaw is in how the law is written and how the Department is required to administer it.

Vice Chair, Dr. Diane Weems, agreed that the District and county system is the strength of Georgia public health. She referenced, most recently, the local approach to addressing H1N1 pandemic, where the response was based on local resources and local needs. Because the state has a system of county health departments, commonly supported by District Health Directors who link back to the state, Dr. Weems reasoned that the coordinated effort that is public health was meant to be uniquely designed in each county to meet their specific needs.

Commissioner Reese agreed. He indicated the key is finding a way for the state to better serve at the district and county level. To the extent that this Commission can address, he indicated that it would contribute to the overall strength of the public health system in the state.

Dr. Williams called recess at 9:42 a.m. in anticipation of the U.S. Surgeon Address.

Dr. Williams resumed the meeting of the Public Health Commission by a call to order at 10:29 a.m.

Dr. Frank E. Shelp, Commissioner of the Department of Behavioral Health and Developmental Disabilities was called to present the independent agency perspective to the Commission.

Dr. Shelp provided an overview of the DBHDD, a department of approximately 9,000 employees, encompassing 20 hospitals and a large and diverse number of constituency groups. The Department has three attached agencies, all small in size, more predictable (transactional) in what they do, and can predict costs fairly easily. Revenues usually come from fees/federal funds. The Department also has 26 Community Service Boards. Dr. Shelp discussed some of the advantages of the independent agency structure. The most important advantage was with respect to visibility, and the ability to engage the legislature directly. Other advantages were direct access to key stakeholders and flexibility, specifically the ability to respond quickly to situations as they arise. As an independent agency, the Department has enhanced its recruiting capabilities, and has allowed recruitment from a different pool of individuals. Benefits of being directly accountable to stakeholders and flexible to establish departmental priorities and alter resources were also discussed.

Dr. Shelp invited questions from Commission members.

Dr. Weems inquired about the cost of the transition to a separate department.

Dr. Shelp indicated that no specific allocations were made for the transition.

Dr. Feldman inquired about some of the disadvantages of the transition.

Dr. Shelp discussed the responsibility of the Department in being completely accountable for its actions.

Jim Peak inquired about differences in the ongoing administrative costs as a separate department and previously as a division.

Dr. Shelp suggested that administrative costs before and after are impacted by several, distinct factors, thus it would be difficult to determine without further review.

Dr. Williams called Dr. W. Douglas Skelton, current District Health Director for the Coastal Health District, former commissioner of the Department of Human Resources and former director of the Division of Mental Health in the Department of Human Resources to discuss the umbrella agency perspective.

Dr. Skelton indicated that the initial Department of Health in Georgia was created at the urging of the Medical Association of Georgia. He said it did not include mental health services until 1959 when an expose of inhumane care at Central State Hospital in Milledgeville culminated in transferring the state psychiatric hospitals from the Department of Welfare to the Department of Health. By the time of the Carter Administration the mental health component of the Department of Health budget was around 80%, and advocates were urging Governor Carter to free mental health from a perceived dominance by public health. He did so by creating the Department of Human Resources with separate divisions of public health, labeled as physical health, and mental health. A similar problem would be created today if Public Health was merged with Behavioral Health, plus the problems in the behavioral health system, including potential oversight by a federal court likely would leave public health struggling to be heard.

Dr. Skelton went on to discuss his experience as a Division Director of mental health in an "umbrella agency", which he indicated was positive overall. Dr. Skelton attributed the success of his directorship to the strong support provided by then Governor Carter and Mrs. Carter who were personally involved in his efforts. Dr. Skelton indicated that he was responsible for personally updating the Governor on the changes being made, which fueled the Governor's support for moving the division's budget priorities higher.

Dr. Skelton argued that if a division director in an umbrella agency has the governor's support the agency will be supported. If, on the other hand, the governor is disinterested or even non-supportive, the division director will have to convince his or her superior or superiors of the agency's needs and to depend upon others to make the agency's needs known. The recent advocacy to split DHR by creating separate departments of behavioral health, public health, and aging testifies to the views of advocates that the umbrella structure was not meeting the needs of those served by the three divisions.

Properly supported, a division can succeed, but support will wax or wane with changes in the departmental leadership and the office of governor. One advantage is that a division director may survive a change in administrations, cabinet officials usually do not.

With respect to the independent agency perspective, Dr. Skelton agreed that the advantages for the agency is the agency's leader has direct access to the Governor, the General Assembly, the Office of Planning and Budget, the Legislative Budget Office, the Senate Budget Office, the media, and advocacy groups. Successful advocacy and leadership moves the agency forward, lack of success usually, and should, leads to dismissal. The only negative he identified was that the agency leader, as a Governor's cabinet officer, usually leaves with a change in administration.

Dr. Williams called on Russ Toal, the Clinical Associate Professor of Health Policy and Management at the Jiann-Ping Hsu College of Public Health at Georgia Southern University, Executive Secretary for the

Georgia Public Health Association, Inc. and former Commissioner of DCH, to lead a discussion on the impact of organizational structure on the efficacy of the Division of Public Health.

Early in his discussion, Mr. Toal discussed the creation of the Georgia Department of Community Health by in 1999. The General Assembly created DCH by consolidating four agencies involved in purchasing, planning and regulating health care. Mr. Toal provided a historical perspective for the possible reasons the General Assembly did not include Public Health into DCH at that time. First, he indicated that DCH was created as a purchaser and regulator of health services not as a direct provider which is what Public Health is. Second, the general approach to doing business is different for both entities as DCH takes a more centralized, top down approach. Much of the work in Public Health, in contrast, occurs at the local level. He also discussed general practical concerns.

Mr. Toal opined that of the four structural options before the Commission, the "umbrella" structure would provide Public Health no autonomy or authority and should be the lowest priority.

Mr. Toal discussed the principles that guided the GAPHA position on reorganization. These principles, he went on, were based on a need for autonomy, access and authority

Autonomy

He indicated Public Health needs the autonomy to get the best information and expertise and the freedom to act on that information in times of emergency or impending crisis. Having to get permission to talk to scientific experts or federal agencies is dysfunctional. Local autonomy, he suggested, is equally essential. Public Health at its core is local and it must have the ability to respond to local concerns immediately without having to work through a decision making chain.

Access

Mr. Toal discussed the importance of access as it follows autonomy. Public Health needs to be positioned so it may access scientists, federal offices, the Governor and certainly the members of the General Assembly. It needs to be able to directly access and respond to legislative questions without restraint from those who don't understand the need for Public Health actions or responsiveness. He also discussed the importance of visibility of Public Health. Within the former DHR, Mr. Toal, indicated that Public Health did not have that visibility.

Authority

Mr. Toal also discussed the statutory, regulatory and administrative authority to take action to prevent or respond to Public Health crises, man made or natural. Whether food borne, viral, terrorist or hurricane driven, Public Health needs both autonomy and authority to act decisively and immediately without restraint. He suggested that Public Health does not have the ability to act or respond in such a manner today.

Mr. Toal went on to suggest that these issues would not necessarily require Public Health to be a separate agency. He said as an attached agency Public Health could still take advantage of the administrative efficiencies of being associated with or a part of DHC and the opportunity to direct Medicaid funds to Public Health could still exist, an opportunity he suggests that should not be minimized. According to Toal, Public Health as an attached agency could also provide population health expertise to DCH on Medicaid, Peach Care and the State Health Benefit Plan (SHBP) programs. He said both as an attached agency and an independent or standalone agency for that matter, autonomy, access and authority could be addressed up front.

Mr. Toal concluded his discussion with three critical points. First, he indicated that the one structure does not need to be changed is the successful operation of the districts and local county board. He said over the past 20-30 years, they have repeatedly proven their utility and value and achieved a level of cost efficiency that did not exist before those districts were put in place. He cautioned the Commission on entering into

discussions about making county health staff state employees as he suggested this was not needed and emphasized this area of Public Health as not needing revision.

Second, Mr. Toal noted the Commission's charge is to determine how best to served the interests of the *state*. The structure that serves the state best, he argued, is the one that reinforces local Public Health autonomy the most. Public Health does not need a large state office, more centralization or the type of control that would be required in an agency like DCH.

Finally, Mr. Toal discussed the existence of eight MPH programs in the state. These programs, he suggested, have the ability to assist and be a part of the Public Health mission in ways that have never been tapped. He encouraged Commission members to include strategies for taking advantage of the state's own investment in Public Health training in its final comments and recommendations.

Mr. Toal closed by congratulating Commissioner Reese on a job well done, given the tough position and challenges facing the Department. He indicated that much progress has been made in the transition, which he encouraged the Commission to note in its report. He then invited questions from the Commission.

Dr. Ted Holloway asked if there were any attached agencies as large as Public Health.

Mr. Toal responded that the size of Public Health, in this context, should be considered in terms of the number of people in the state office of Public Health, which is a much smaller number and should always be small. The attractiveness of having an attached structure is that it helps resist the temptation to build a big state bureaucracy in Atlanta, which is not what Public Health needs. He suggested that Public Health needs a structure that reinforces and bolsters the local delivery capacity, which can be accomplished in an attached agency.

Dr. Feldman expressed her concern about another agency having control of areas like budget, personnel and public relations because they've already experience some difficulties with PR systems in issuing press releases addressing Public Health issues in a timely way and composed by people who are knowledgeable about the Public Health experience. She continued to say that this other agency would not consist of Public Health people and the Public Health budget, at the very least, would be at risk in this type of situation.

Mr. Toal responded that the attached structure would not necessarily create those challenges. He indicated that it would be critical that an administratively attached agency have its autonomy and authority so in addition to having a press office with DCH, for example, Public Health would need to maintain its own press office person who understands and knows Public Health. Similarly, Public Health would not need its own budget office but should have its own budget person. He went further to say that Public Health needs to have its own Board and the ability to create its own scientific advisory panels. He said this could be accomplished in either a standalone agency or as an attached agency.

Dr. Feldman questioned Public Health's ability to maintain these functions as Mr. Toal described in an attached structure, largely concerned that this ability would be based on the willingness of the Commissioner of the agency to which it is attached.

Mr. Toal indicated that it would depend on how the legislation is written. If the Board and State Health Officer report directly to the Governor, then they have autonomy in that regard. The decision making for Public Health policy matters, in this case, would clearly reside within that attached agency.

Dr. Feldman asked Mr. Toal if he was advocating for this alternative.

Mr. Toal responded the attached structure is one that should be considered. He said he is an advocate for a structure that addresses issue of autonomy, access and authority. He suggested that these principles could

not be accomplished in the divisional structure. He said realistically, the attached or standalone agency may present more feasible options. He went on to say that the standalone model creates a lot of challenges, which he opined would make the division between Medicaid, SHBP and Public health more stark. He discussed a need to have more of Public Health embodied within Medicaid, Peachcare and SHBP than what exists today. Mr. Toal provided an example of the Family Planning Waiver, which is perceived as a Medicaid issue but Public Health provides a significant amount of family planning services and yet are not actively engaged in the decision making process. He suggested that creating two separate departments would worsen this and similar issues.

Dr. Feldman inquired how this issue would be improved in the attached agency structure.

Mr. Toal responded that the agency would have more autonomy. The DCH Commissioner would not have authority over how business is done in the attached agency. He indicated that the attached agency could be structured in a way that would enable it to reap the benefits of Medicaid funding, SHBP, for example, that exist within DCH and the administrative structures that would be required in a separate agency.

Dr. Williams indicated that he recognized the benefits of shared resources that might be gained from being an attached agency but expressed concern with respect to access. In terms of budgets, he inquired how an attached agency would be able to present their own independent budget from the organization to which it is attached.

Mr. Toal responded that it would have its own budget personnel. The legislation could be written in a way to make it clear that the attached agency presents its own budget. He suggested, however, that there would be no harm in having budget reviewed or tracked with the DCH budget.

Dr. Williams questioned if legislators would be more impressed by a Commissioner presentation of a budget than a representative of an attached agency and the potential implications on the funding approved for that agency.

Mr. Toal explained that the legislators would want to hear from the State Health Officer who was appointed by the Governor and has the statutory responsibility for Public Health.

Dr. Williams inquired about the Commission's ability to propose a change that would require legislation given its charge to consider the four organizational options.

Mr. Toal indicated that it was within the Commission's authority.

Dr. Feldman's review of the DCH organizational chart prompted her inquiry about the input of the Commissioner within attached agencies.

Mr. Toal emphasized that input would depend entirely on how the law is written. Ironically, he said, the bill for the reorganization of Public Health that passed was a strong piece of legislation and is a solid foundation for any proposed changes. Mr. Toal went on to say that it would not be ideal for DCH, with its centralized way of doing business to dictate terms within Public Health, an issue that he suggested may not be avoidable in a divisional setting. An attached agency, he concluded, is a different phenomenon.

Dr. Williams called on Dr. Robert Stolarick, Executive Director of Georgia Public Health Association to discuss the relationship between state health ranking and organizational structure.

Dr. Stolarick thanked the Commission for its invitation to present.

Dr. Stolarick began with a discussion of The Trust for America's Health classification of state public health departments or agencies as Stand Alone, Mixed Function, or Umbrella, which he indicated could be represented by a continuum with Stand Alone at one end and Umbrella at the other. In between, would be Mixed Function and other variations. He indicated that, currently, there are 27 stand alone state public health agencies, 8 mixed function state agencies, and 16 umbrella state agencies. Dr. Stolarick's discussion included detailing of several reports of health ranking and overall outcomes based on these organizational structures.

The *State Scoreboard on Health System Performance* report was published by the Commonwealth Fund in 2009. This report included measures for access, prevention and treatment, avoidable hospital use and costs, equity, and healthy lives. Access **i**ncludes: % 18-64 insured, % of children 0-17 insured, % of at-risk adults who visited the Doctor for a routine checkup in the last 2 years, % of adults who need to see a doctor but could not because of cost. Prevention and treatment includes: % of adults age >= 50 who received recommended screenings and preventive care, % of adult diabetics who received recommended preventive care, % of children 19-35 months who received all recommended doses of 5 key vaccines, % of children with both a dental and medical preventive visit in the last 12 months, and % of children with a medical home. Avoidable hospital use and costs includes**:** pediatric asthma admits per 100,000 children, Medicare admits for ACSCs, and Medicare 30 day re-admits. Equity includes: % uninsured ages 0-64 by FPL, % of adults without a usual source of care by FPL, and % of children without a medical home by FPL.

Results:

Stand Alone	Mixed Function	Umbrella
24.48	27.38	26.81
N=27	N=8	N=16

Also in 2009 The United Health Foundation published the report *American's Health Rankings*. This report had measures that are grouped as health determinants and health outcomes. Determinants include: behaviors such as smoking, binge drinking, obesity, and HS graduation; community and environment such as violent crime, occupational fatalities, infectious disease, children in poverty, air pollution; public and health policies such as the lack of health insurance, public health funding (per capita), and immunization coverage % children 19-35 months properly immunized; clinical care such as prenatal care, primary care physicians per 100,000 population, and preventable hospitalizations per 1,000 Medicare enrollees.

Health Outcomes include**:** poor mental health days, poor physical health days, geographic disparity, infant mortality, cardiovascular deaths, cancer deaths, and premature death.

Results:

Stand Alone	Mixed Function	Umbrella
24.46	23.00	27.69
N=27	N=8	N=16

The next table shows state funding per capita by structure type.

Per Capita State Funding

Stand Alone	Mixed Function	Umbrella	Georgia
$46.06	$32.65	$34.25	$19.66

The next table shows federal funding (CDC + HRSA) funding per capita by structure type.

Per Capita Federal Funding

Stand Alone	Mixed Function	Umbrella	Georgia
$48.07	$51.06	$56.15	$39.29

In 2010, Klaiman and Ibrahim found, "State health department structure seems to have some impact on pandemic planning, and there are simple steps health departments can take to address and improve their functioning including increasing professional development, reducing layers of hierarchy, and increasing communication and collaboration with external partners."

Finally, Dr. Stolarick suggested that, based on his research, a state's investment in public health affects the amount of federal funding that states receive. He presented a calculation of the average funding for the top 20 states and the average federal funding they received using 2009 data. In addition, he included the average of all states (including the top 20) and of Georgia in the next table.

Public Health Funding

	State per Capita	Federal per Capita	Total per Capita
Top 20	$64.87	$59.58	$124.45
All States	$28.92	$43.94	$ 72.86
Georgia	$19.66	$39.29	$ 58.95

His calculations yielded an additional $91,018,494 for public health in Georgia would be received if the State of Georgia funded public health at the average per capita of all states (assuming a Georgia population of 9,829,211). If the State of Georgia funded public health at the average per capita of states with a stand alone structure, this would mean an additional $250,000,000 annually for public health in Georgia.

Dr. Stolarick indicated the limitations of his research as there is not adequate information available on which of the structures create economies of scale or were the most efficient.

He provided the following concluding points:

- Structure should follow strategy
- You have to spend money to make money
- Listen to what Public Health Employees have to say
- This is data and needs more analysis (P and R values)
- A move toward "stand alone seems reasonable" if feasible, sustainable, and timely.

Dr. Stolarick invited questions from the Commission. A handout was provided.

Jimmy Burnsed inquired about the impact of the size of the state on the funding data.

Dr. Stolarick responded that size of the health departments are generally a positive factor for areas like accreditation.

Jimmy Burnsed questioned if that would attract more funding as a standalone agency.

Dr. Stolarick indicated that it doesn't always.

In an attempt to identify logical explanations for the disparity in the data, Jim Peak inquired about the number of states that employ local nurses.

In his response, Dr. Stolarick referenced the state of Tennessee with which he is most familiar. After some discussion about the complexity of the employee arrangement, Dr. Stolarick indicated that the local nurses are all state employees. He also indicated the need for more research to explain the disparities.

Dr. Weems noted that the discussion about reorganization and structure has been in terms of Public Health as it exists today. In consideration of how health care reform will impact changes and the overall expansion of Medicaid in the near future, Dr. Weems inquired about the implications on the determination of the best structure for Public Health. Further she questioned how the Commission should consider health care reform and maximizing Medicaid given that Public Health is not expected to grow as a primary care provider itself. Dr. Weems said the Public Health structure is an important partner in local communities. Although they are facilitators and ensure access they are not the provider. She invited thoughts from any of the speakers.

Commissioner Reese responded that in order to retain a link between Medicaid and Public Health, a recommendation to either maintain the divisional structure within DCH or to attach it to the agency would create a stronger link than if it were a separate agency.

Russ Toal also responded that Medicaid has, based on federal rules and regulations, the ability define what preventive health services it wants to cover and who will pay for these services. He indicated that there is no language in the regulations restricting these services to personal health services. He went further to say that the thinks the new emphasis is not only on coverage for everyone but also on a push toward prevention and wellness. This, he argued, presents tremendous opportunity for Public Health to use Medicaid as a building tool. Mr. Toal suggested that Medicaid, the SHBP and Peachcare could also improve their own operations with a Public Health type of approach where the wellness of a population is considered. Public Health, he said, has a lot to teach the insurance world about who is at risk, how to identify risks and how to successfully intervene to mitigate that risk. With the right organizational structure, argued that Public Health can have a profound impact and suggested that this could not be accomplished with the assistance of federal funds if it is aligned with DCH.

Jimmy Burnsed noted that the data presented suggests that standalone agencies get more money form federal and state governments.

Mr. Toal cautioned Commission members about arriving at that conclusion as the chart only measures direct state funds and does not include, for example, Medicaid revenue, county funds and a lot of other revenue sources that affect the delivery of Public Health.

Dr. Skelton followed that Public Health, in his definition throughout the years, has included primary, secondary and tertiary prevention. Primary being the preventive piece, secondary being the "laying of hands", principally in the private sector, and tertiary being chronic disease management. He said health reform is attempting to get those health promotion and disease prevention principles into all parts of the health care system, and suggested this can be accomplished within the state through the current divisional model or as an attached agency.

Jim Peak asked Commissioner Reese if the federally matched funds for Medicaid have been fully utilized.

The Commissioner indicated that they had not.

Dr. Williams discussed having a public comment opportunity both in terms of people being able to submit comments and having a portion of one of the Commission's meetings dedicated to a presentation of comments.

Dr. Weems indicated that the Commission discussed apportioning a good part of the October meeting for public comment and is willing, with staff support, to get that message out across the state. In the interim, however, she discussed providing an ability to comment via email.

Dr. Williams discussed dividing the Commission into four subcommittees to discuss the structural options under consideration with the hope that members would, as pairs, review the pros and cons and gather information that can be used to evaluate each of the four options. He indicated the expectation that written material would be presented to assist with the Commission's deliberations.

Sub-Committee Assignment

- Diane Weems and Jimmy Burnsed-Stand Alone Agency Structure
- Jack Chapman and Deb Bailey-Current Divisional Structure
- Greg Dent and Ted Holloway-Reorganization under another Agency
- Dr. Lynne Feldman and Jim Peak-Attached Agency Structure

Dr. Feldman inquired about the agenda for the September meeting.

Dr. Weems indicated the meeting would focus on the financial aspects the division, specifically past and future funding. She indicated the Commission would be interested in hearing presentations from legislators and representatives from the Office of Planning and Budget as they provided leadership on the task force that ultimately led to the development of the legislation for reorganization. Representatives from an attached agency and the Georgia Budget and Policy Institute were also discussed.

NEXT MEETING DATE

The next meeting of the Commission is scheduled for Monday, September 13, 2010 from 8:30 to noon.

PUBLIC COMMENTS AND OTHER BUSINESS

There being no further business, the meeting adjourned at 12:28 p.m.

Minutes taken by Karesha Berkeley Laing and Tamika Matthews on behalf of Chair.

Respectfully Submitted,

Dr. Phillip Williams, Chair

To obtain a digital recording of this meeting, please contact the Division Public Health.

Attachments
1—Department of Community Health: Transition and Transformation Update (presentation)
2—Written Testimony of Dr. W. Douglas Skelton
3—Written Testimony of Russ Toal
4—Written Testimony of Dr. Robert Stolarick
5—Relationship Between State Health Rankings and Organizational Structure (presentation)