



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, October 18, 2010
8:30 am-2:30 pm
Extended Session

DR. PHILLIP WILLIAMS, CHAIR, PRESIDING

MEMBERS PRESENT

Deb Bailey
Jack Chapman, Jr., M.D.
Greg Dent
Lynne Feldman, M.D.
Ted Holloway, M.D.
Jim Peak
Diane Weems, M.D.
Phillip Williams, M.D.

MEMBERS ABSENT

Jimmy Burnsed

GUESTS PRESENT

Paula Brown, Office of Planning and Budget
Representative Mickey Channell, Georgia House of Representatives
Mike Chaney, GAAAP
Jeff Cornett, Hemophilia of Georgia
Eric Klein, Glaxo Smith Kline
Terry Mathews, Mathews & Maxwell, Inc
John Powers, GSU
Helen Sloat, Nelson Mullins
Robert Stolarick, Georgia Public Health Association

STAFF PRESENT

Rony Francois, MD
Karesha Berkeley Laing
Karen Davis
Elizabeth Franko
James Howgate
Tamika Matthews
Charles Owen

WELCOME AND CALL TO ORDER

Dr. Williams welcomed Commission members and guests and called the meeting of the Public Health Commission to order at 8:44 a.m. The Commission voted to approve the minutes of the September 13, 2010 meeting. Dr. Williams identified the objective of the meeting, which was to gain insight into the state of Georgia's public health system. Additionally, the presenters would provide direction on what is needed to create an effective public health system in the state. The Commission apportioned part of the meeting for public comments from parties interested in making suggestions about the organizational options under consideration.

Dr. Williams called on Dr. Karen Minyard, Director of the Georgia Health Policy Center to discuss the Center's recent assessment of Georgia's public health system and its implication on the ideal organizational structure for Public Health.

Dr. Minyard indicated that her presentation would rely on data from several different sources, including the 2005 Public Health study, the historical work of the Georgia Health Policy Center and the organizational trends for public health in other states, to discuss the overarching implications on the most effective structure for Georgia.

The 2005 study of Georgia's public health system, which included stakeholders, Public Health directors, focus groups and communities, and a review of archival documents, yielded the following three principle findings:

- Current core business is not aligned with the "ideal" core business. The study suggested the practice of public health was not being performed according to stakeholder preferences.
- Current drivers are not aligned with "ideal" drivers. The real systemic challenges such as the uninsured, siloed funding and the fraying safety net were found to have more influence over public health activities than the ideal drivers which would be need, evidence based practice, state strategies informed by local perspective and culture.
- There is a need for greater public health leadership and collaboration. Dr. Minyard indicated that there was significant support and interest from stakeholders, leaders and communities, in Public Health leading the state from where it is to where it should be.

Dr. Minyard went on to say that one of the culminating events of this study was a Health Summit in Georgia that included approximately 800 people from across the state. The group identified several inter-disciplinary goals for Public Health and examined the relationship between health and a variety of contributory factors such as education, safety and transportation to develop key objectives for the state. Dr. Minyard indicated that there was a focus on both leadership and inter-disciplinary collaboration in order to improve the public's health.

Dr. Minyard followed with a discussion of knowledge gained from the historical work of the Georgia Health Policy Center from a number of projects it has done in evaluation, research, policy and practice to which she deferred for key principles about organization. She identified the following common themes:

- Satisfaction with services. She indicated that when consumers interact with state services they are generally pleased with the services they receive.
- No Wrong Door. People want ready access to all of the necessary services.
- Cross Training of Workforce. Train employees in multiple disciplines so they understand what services would be available to consumers.
- Integration of Technology and Data Sharing. Consumers, she said, want greater technological integration and funding that is linked to outcomes rather than individually siloed programs. They

want collaboration across divisions and departments. They want to see prevention services emphasized not just in public health but also in other parts of the system.

Dr. Minyard then discussed the location, structure and administration of public health across states, with the majority of states having independent public health departments. She noted that there is not clear evidence regarding the relationships between outcomes, funding, costs, and organizational structure.

Dr. Minyard discussed the need for collaboration and coordination between state agencies no matter the structure. She advised the Commission to address the issue of coordination across the different parts of the state government in its recommendation as this is clearly an area of need for public health as suggested by the data.

Dr. Minyard concluded with a discussion of a recent national meeting of leaders of governmental and private public health organizations where it was suggested that the “gold standard” for Public Health to lead in the protection and promotion of health is for it to be an independent department. She indicated that she would like to see Georgia have the gold standard. In light of the limitations on how this transformation could occur, however, she cautioned that an immediate organizational change may not be possible. Instead, she suggested that a longer term transition plan might be a reasonable alternative.

Handouts were provided.

Dr. Williams invited questions from the Commission.

In response to her closing comments, Jim Peak asked Dr. Minyard to expound on the interim steps she referenced.

Dr. Minyard responded that while she was not recommending any particular interim step, among the Commission’s organizational options are maintaining the divisional structure or transitioning to an attached structure. She concluded that these types of steps are what she would imagine the Commission would consider as they deliberate about potentially moving toward an independent organization.

Dr. Williams asked for insight as to how organization within a state impacts the effectiveness of public health in terms of performance of health indices in the state structures that were reviewed.

Dr. Minyard indicated that there is currently no known data that ties organizational structure to effective outcomes. A lot of the outcomes of public health, she said are tied to leadership.

Greg Dent requested more information about the principle findings of the Health convening in 2005 and the call for the division to lead in improving health and in particular building the safety net instead of being the safety net.

Dr. Minyard, said one of the reasons Public Health has had to focus on access and care issues at the individual level, at times to the detriment of the bigger public health picture, is because the needs of the uninsured are so pressing and the communities look at Public Health as their safety net; their place of last resort. She discussed the call for leadership to figure out how to help build a system that uses all of the resources in a community and doesn’t depend solely on Public Health to meet its needs.

Dr. Williams invited Dr. James Curran, Dean of the Emory University, Rollins School of Public Health to provide insight on developing an effective public health structure in Georgia.

Dr. Curran began his presentation by commending the public health training programs available in the state. He indicated that Atlanta is often regarded as one of the most prized places in the world for public

health, largely because of the Centers for Disease Control and Prevention. Atlanta, he said, is sometimes referred to as the “public health capital of the world”. For this reason, he said, the state has an opportunity for to be the healthiest in the country and that should be the unabashed goal.

Dr. Curran followed by inquiring about the definition of public health, which is an important consideration when you think about placement, he said, because in general it is seldom understood. He said the Institute of Medicine (“IOM”) of the National Academy of Sciences has defined public health as “what we, as a society, do collectively to assure the conditions in which people can be healthy...” Dr. Curran noted that this is not the same as public medicine or public hospitals nor public health financing but rather public health is more inclusive of all factors contributing to or detracting from health including the healthcare system and health financing, education, agriculture, transportation and various economic solutions to poverty reduction since education and economic status are themselves social determinants of health.

Dr. Curran said in order to be effective public health usually begins with a population perspective instead of an individual perspective. The population perspective is broader and tends to emphasize prevention first, which allows opportunities to improve health and reduce important health disparities. He continued that health disparities are perhaps the greatest link to understanding the poor ranking of the state.

Dr. Curran referenced the IOM’s definition of the core functions of public health, which are assessment, policy development and assurance. To provide examples, he said, assessment involves surveillance of new or potential threats, H1N1, West Nile, salmonella in peanut butter as well as tracking the status of other modifiable causes of death or illness throughout the state, such as cancer mortality, cardiovascular disease or HIV infection. It also includes an assessment of modifiable risk factors such as substance abuse trends, smoking, alcohol, sexual behavior and unintended pregnancy rates. It is only when the state possesses accurate information through assessment that the sound function of policy development can be addressed. Dr. Curran said once public health priorities are identified through accurate assessment then policies to improve the health of Georgians can be proposed and established. For the third function, assurance, Dr. Curran indicated that it is not enough to recommend effective policies if they are not implemented due to a lack of coordination in the state or with the private sector or due to insufficient resources. The assurance function, he said, involves the important contributions of public health nurses and others as providers of essential prevention and care services throughout the state.

Dr. Curran continued with a discussion of how Georgia is performing in terms of public health. In most surveys, he said, Georgia ranks somewhere in the 40s among the 50 states. He noted, though, that these rankings are difficult to determine. Dr. Curran indicated that Georgia ranks 40th in per capita income which is a factor in determining health. He went on to say that there continues to be large disparities by geographic region, race and ethnicity in terms of health outcomes and behaviors throughout Georgia. Most of these disparities and poor rankings, he said, are not largely related to health insurance, although adequate health insurance is important. Addressing issues of health insurance will not necessarily improve public health in Georgia, in and of itself.

Dr. Curran identified the following as reasons for the high vulnerability of funding for public health in Georgia:

1. State budgets are very tight;
2. Healthcare costs continue to escalate rapidly;
3. The core public health budget is relatively small and can be treated as discretionary compared to other entitlement expenditures;
4. When prevention is successful, public health problems become invisible. When public health is successful, he said, it is usually taken for granted.

Dr. Curran concluded that the most important factor in Georgia accomplishing the assessment, policy development and assurance functions of Public Health is having an informed, strong, independent voice to advise the Governor and Legislature on how best to improve the health of Georgians. The voice, he suggested, needs to be independent of health financing, not subservient to it. He discussed the importance of Public Health and Public Health Preparedness being aligned very closely in one agency since the capacity to respond to new public health or terrorist threats requires close synergy and habitual collaboration. For these reasons, he suggested that public health would be best served by a direct reporting relationship to the Governor and Legislature.

Dr. Williams opened the floor to questions.

Dr. Ted Holloway inquired about the status of accreditation of local health departments.

Dr. Curran responding that, in general, accreditation of local health departments will be a good thing as it would let people know what is expected and what is ideal. He opined that many states suffer in public health from the federal system. He said while there are many beneficial aspects of the system such as state independence, assuring that there is adequate public health professionalism and framework often suffers from this independence. The federal government works its magic through funding mandates rather than any concern in terms of adequacy of professionalism and specific standards for public health. He said it would be beneficial for Georgia to get involved in the process during this early stage.

In reference to Georgia being regarded as the center of public health knowledge in the world, Greg Dent questioned what critical component is missing that would allow the state to take advantage of its position and improve its national ranking.

Dr. Curran suggested that the answer lies, at least in part, in structure and function. He indicated that strong leadership from the Governor down would be needed. He discussed the importance of establishing a statewide commitment to work towards being the healthiest state and assessing those areas that are vulnerable to improve. Dr. Curran also said that it was important to recognize that many problems with health are mired in social determinants. He referenced increased disparities in income and racial inequalities in health outcomes, as examples. Identifying the areas that can be improved is critical to improving the state's overall health rankings.

Dr. Lynne Feldman indicated that one of the areas she has been interested in for a long time is fostering a productive relationship between governmental public health and the many schools of public health in Georgia. She suggested that this was the missing piece in the state's public health structure and inquired about any perceived barriers to fostering such relationships and if there are any particular structures under consideration that would be more or less helpful.

Dr. Curran responded that the focus should be on how to develop these relationships more so than any perceived barriers. He mentioned internships as a way the government and schools can begin to work together.

There being no further questions, Dr. Williams called on Georgia Representative Mickey Channell to discuss House Bill 228 ("HB 228") and Georgia's public health infrastructure.

Representative Channell began his discussion by suggesting that the fundamental question to the Commission's charge is if "bigger is better" or if a smaller, more focused organization would better serve Georgia and be less wasteful of resources. He provided a historical background of the reorganization of the former Department of Human Resources ("DHR"), which was the largest agency within state government and marked by several notable challenges. Representative Channell said HB 228 began the process of transforming DHR into smaller, more focused organizations. He went on to say that attention

to Public Health and its core functions within the larger DHR was not adequate for optimal effectiveness. Representative Channell suggested that Georgia's public health system, as a whole, has similarly veered off course amidst a lack of certainty about the role and function of Public Health.

Representative Channell opined that Public Health needs a high profile and not to simply be a small part of a larger agency. He discussed his advocacy for Public Health as a standalone agency during the recent reorganization. He went further to say that DCH does a good job in fulfilling its core mission, which is paying for healthcare services that are provided by another entity. He challenged the Commission to identify how Public Health fits into that mission, suggesting that it does not. Representative Channell discussed the difficulty of one commissioner being able to effectively carry out the distinct missions of DCH and Public Health and referenced the previous DHR experience as the potential outcome of this structure.

Representative Channell went on to suggest that a standalone agency would be the best structure for Public Health. To quell concerns that Public Health is not large enough to be an independent agency, Representative Channell listed several stand alone state agencies that are currently smaller than what Public Health would be as an independent agency. He suggested that Commission members consider the private sector's transition from conglomerate structures to more focused industries as it moves forward in its deliberation.

Dr. Williams invited questions from the Commission.

In consideration of previous testimony suggesting that Public Health's transition into an independent agency this year would be virtually impossible, Dr. Feldman requested Representative Channell's perspective on the feasibility of this recommendation.

Representative Channell responded that he didn't share the opinion represented in the previous testimony, in light of the facts. He referenced the poor state health outcomes as evidence of a need to question the effectiveness of Public Health's historical and current structure. If the Commission, he said, is trying to identify the most efficient way to run public health in the state the answer is clear—as a stand alone agency. Whether or not the recommendation is implemented in the upcoming session cannot be determined at this point.

Dr. Feldman followed with a request for the Representative's opinion on Public Health being an attached agency as an alternative.

Representative Channell indicated that the attached structure would be his second choice as many of the same advantages of the independent structure in terms of having a high profile, would be attainable.

Dr. Chapman questioned the budgetary feasibility of establishing Public Health as an independent agency.

Representative Channell encouraged the Commission to focus on its charge, which is to identify the best structure. The prospects for implementing any proposed standalone agency is best left for the General Assembly to figure out.

Dr. Williams requested insight on the re-integration of Emergency Response and Preparedness.

Representative Channell indicated that he didn't have an opinion on the issue.

Dr. Williams requested guidance on whether the Commission should evaluate the financial aspects of each structural option under consideration.

Representative Channell responded that the financial feasibility will be “the” question for the General Assembly to consider and the Commission should not be expected to address the issue.

Greg Dent questioned how Public Health should better communicate its mission and vision to effectively obtain resources from the General Assembly.

Representative Channell responded that a highly visible, independent Public Health agency focused on its core mission will speak well not only to members of the General Assembly but also to the general public.

Dr. Williams called on James Peoples, Executive Director of the Office of Health Improvement to discuss its collaboration with Public Health.

Mr. Peoples indicated that the Office of Health Improvement (“OHI”) is comprised of three units, the Office of Minority Health, the Commission of Men’s Health and the Office of Women’s Health, which are collectively tasked with promoting and providing preventive measures for more healthy living. His presentation, he indicated, would describe the specific focus of each unit and how they interact with Public Health.

The Office of Minority Health (“OMH”) was established to focus on issues of health disparities with the goal of achieving health equity. Mr. Peoples noted the significant health disparities that exist in Georgia between rural and urban areas, races and gender. He indicated that OMH participates in community outreach projects and assists community partners across the state in their service to populations with no or limited access to health care, including health screenings and preventive measures. Mr. Peoples also discussed the importance of the OMH’s work to keep people informed about the health disparity statistics that exist within the state. OMH’s 2009 *Health Disparities Report*, for example, detailed health disparity data by county. The support of Public Health’s data components, he said, was a necessary factor in developing the report. The Minority Health Advisory Council advises the Commissioner and OMH on specific minority health issues that may arise in the state.

The Commission on Men’s Health, he continued, focuses on educating Georgia’s men on their health status and how to prevent long term illness and premature death. Mr. Peoples indicated the sole purpose of the Commission is to inform. Consequently, its mission relies heavily on Public Health to implement some of the ideas and strategies that the Commission develops.

The Office of Women’s Health focuses on educating Georgians on the health status of women in the state. It uses Public Health to implement the recommendations of the Women’s Health Advisory Council.

Mr. Peoples indicated that these units are collectively intended to provide a resource and raise educational awareness across the state on those issues that impact women, men and minorities.

Mr. Peoples continued that Public Health is a vital partner in OHI’s work. He discussed the OHI’s current partnership with Public Health’s Breast and Cervical Cancer Program. OHI works to locate resources to assist the program in its work. Mr. Peoples indicated that utilizing some of the proceeds from the breast cancer license tag, for example, will allow OHI to aid the program in increasing the number of indigent women it can accommodate.

Dr. Williams invited questions from the Commission.

Dr. Diane Weems indicated her familiarity with OHI’s work within the Savannah region. In consideration of the work OHI has done in partnership with Public Health, Dr. Weems questioned the reasonableness of OHI being a part of Public Health. She referenced the many close ties between the programs, including a shared focus on women’s health issues and improving health outcomes, which

includes addressing issues of health disparity, an area in which Georgia has made very little progress. She discussed the potential for greater synergy and effectiveness in meeting their common goals.

Mr. Peoples acknowledged the benefit of having some of the offices and functions of OHI to be more closely aligned with Public Health, provided that the mission and work of the offices, in terms of health disparities, are preserved and the legislative requirements are met.

Dr. Feldman inquired about the reason for the placement of OHI within DCH.

Mr. Peoples explained that the Office of Minority Health was originally a part of Public Health. The authorizing legislation that subsequently created DCH, however, moved Minority Health to the Department and created the Office of Women's Health. The Commission on Men's Health was legislatively created within DCH several years later.

Dr. Williams called on Charles Owns, Executive Director of the State Office of Rural Health to discuss its collaboration with Public Health.

Mr. Owens explained that the State Office of Rural Health ("SORH") is a collaboration of programs working to facilitate access to healthcare across the continuum of services. He said the goal of SORH is to develop financially viable regional systems of care. SORH promotes and encourages communities to take action in identifying the services they need and how to deliver these services independently or through partnerships with others.

Mr. Owens followed with a discussion of the components of the SORH, including:

- Primary Care Office ("PCO"), which assists communities in improving access to primary health care in Georgia's rural and urban underserved areas. Mr. Owens discussed the Foreign Physician Program and the National Service Corps, which are designed to assist Health Professional Shortage Area communities in the development, recruitment, and retention of physicians and other allied-healthcare personnel through various incentives. In exchange, participants work in underserved areas and provide services on a sliding scale. A charge of this work, he said is the promotion of federally qualified health centers, which are federally funded clinics for primary and preventive health services, including dental and mental health services. These centers also use a sliding scale in exchange for federal subsidies. Mr. Owens noted that the Legislature has been supportive of the advancement of federally qualified health centers over the past few years.
- Health Professional Shortage Area ("HPSA") Designations. Aided by the PCO, the HPSA designation program assists communities in applying for this federal designation, which affords access to assistance with recruiting health care providers. Based on a community's qualifications, Mr. Owens said, a variety of resources and opportunities such as scholarships and loan repayment incentives may be available to support these efforts.
- Hospital Services program. This program provides technical assistance/resources to rural hospitals to continue health care services to Georgia's rural residents.

Mr. Owens briefly mentioned several special programs and projects:

- The Georgia Farm Worker Program. SORH is responsible for managing this program, routing grant funds received to providers serving this population.
- Healthcare for the Homeless Program. This state appropriated program is intended to provide primary health care services to the homeless population at such sites as shelters and soup

kitchens. Originally centered in Atlanta and Savannah, recent budget reductions have limited the program to the Atlanta location.

- Statewide Area Health Education Centers. SORH is the conduit for finances for statewide area health education centers, which are administered through the Medical College of Georgia (“MCG”). Mr. Owen explained that the state appropriation is routed to the Department which then executes the grant to MCG. There are currently six centers scattered through state.
- Rural Health Network. Mr. Owens discussed SORH’s promotion of networks for rural health that can focus on specific issues impacting the community and identify ways to address them.

In closing, Mr. Owens indicated that 157 of the 159 counties in Georgia benefit from programs administered by SORH. Additionally, 145 counties benefit from three or more these programs. He attributed these statistics to the longstanding needs of the state.

Dr. Williams invited questions from the Commission.

Dr. Holloway inquired about the breakdown of state and federal funding for SORH.

Mr. Owens indicated a 7.9 million dollar budget, equally matched by federal and state dollars. He noted the fluctuation inherent in SORH’s budget due to differences in grant cycles.

Dr. Feldman inquired about the history of SORH within DCH, specifically if it were ever a part of Public Health.

Mr. Owens responded that SORH programs were initially housed within Public Health but were re-organized in the authorizing legislation for DCH.

Dr. Feldman followed with a request for insight as to why SORH was transitioned to DCH which is more of a financial institution.

Mr. Owens explained that one of SORH’s primary charges is to identify need. All of the SORH’s funds are used to support community advancement of their health system. He said grant funds are routed to the community for the actual performance of the provider or community development work. He mentioned a 2.5 million dollar ER Diversion Grant that SORH distributed to providers and the funding provided to public health departments for the provision of service to migrant, seasonal workers, as examples. Many of the grant programs, he said, function in this same way.

Suggesting that SORH falls within an apparent “gray area” between being a direct provider of services and a financier, Dr. Feldman requested Mr. Owens’ opinion on where SORH should be aligned with any recommendation for Public Health to be an independent agency.

Mr. Owens suggested that SORH should remain with DCH. He went on to say that Public Health is a recognized provider of care in the state. SORH, he said, has tried to maintain the position that it facilitates communities in developing their own system of care. SORH is very cautious about not dictating how care is to be provided, he said.

In follow up, Dr. Williams questioned the impact of not having a component such as SORH in any recommended independent agency for Public Health, in terms of a missed opportunity for a concerted effort in improving health outcomes and efficiency.

Mr. Owens responded that SORH contributes heavily to the improvement of health for Georgians. In the current environment, he said, SORH funds opportunities and collaboratives for communities to create their own health care solutions. The efforts of SORH and Public Health, he continued, are complementary and he expects both programs to be supportive of each other's work in the future as they have been historically.

Dr. Williams opened the meeting to comments from the public. There being no response to a request for public comment, Dr. Williams called for a short break.

The meeting reconvened with a Commission work session to further discuss the organizational options in the context of the testimony heard.

PUBLIC COMMENTS AND OTHER BUSINESS

There being no further business, the meeting adjourned at 11:55 a.m.

NEXT MEETING DATE

The next meeting of the Commission is scheduled for Monday, November 15, 2010 from 8:30 to noon.

Minutes taken by Karesha Berkeley Laing 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—Testimony of Dr. Karen Minyard, Director, Georgia Health Policy Center

2—Improving Public Health and Establishing an Effective Public Health Structure in Georgia (Dr. James Curran)

3—Division of Operations (Handout)