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House of Representatives
Study Committee on Public Health

Final Report

Chairman Donna Sheldon
Representative, 105th District

Honorable Mickey Channell
Representative, 116th District

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Representative, 152nd District

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Honorable Len Walker
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Prepared by the House Research Office

I. Introduction

The House Study Committee on Public Health was created by House Resolution 1663 during the 2006 Legislative Session of the Georgia General Assembly. HR 1663 acknowledged the need for the Legislature to reexamine the current structure of the state's Public Health establishment, including mission, salaries, and funding formulas. The Committee was tasked with making recommendations regarding how to better serve all of Georgia's citizens with an efficient, modern Public Health system.

House Resolution 1663 provided for the membership of the Committee consisting of five Representatives to be appointed by the Speaker of the House of Representatives, with one Representative to be appointed as Chairman of the House Study Committee for Public Health. The Speaker so appointed the following members: Rep. Donna Sheldon (R-105), Chair; Rep. Mickey Channell (D-116)¹; Rep. Ed Rynders (R-152); Rep. Ron Stephens (R-164); and Rep. Len Walker (R-107).

The Committee held three public meetings at the State Capitol in Atlanta during December 2006; occurring on December 7th, 18th, and 19th, respectively. The Committee heard testimony from various stakeholders and interested parties concerned with the future of Public Health in Georgia, including the Department of Public Health, the Valdosta Health District, the East Metro Health District, the Early/Miller County Health Department, the Archbold Health System, the American Academy of Pediatrics, Heart of Georgia Healthy Start, the Waycross Health District, the Georgia Association for Primary Healthcare, the Georgia Free Clinic Network, the House Study Committee on Pandemic Flu Preparedness, the Office of Emergency Medical Services and Trauma, the Georgia Health Policy Center, the government of Cobb County, the Rome Health District, Dr. Patrick Bernet, the Association of County Commissioners of Georgia, the Warren County Commission, Public Health nurses,² the Equity Group, the Gainesville Health District, the Northeast Health District, the Coastal Health District, and the Georgia Nurses' Association. The Committee's work focused on the mission of the Public Health system, the structure of the Grant-in-Aid allocations to local boards of health, and the situation of Public Health nurses throughout the state.

¹ Became R-116 as of January 8th, 2007.

² Witnesses from Evans, Fulton, DeKalb, Fayette, Bartow, Walton, Gwinnett, Hall, Bartow, and Madison Counties.

II. Background Information

A. Public Health

The World Health Organization defines health as “*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*”³ Public Health is concerned with threats to these areas of well-being across populations. Relating to food poisoning, these populations can be as small as patrons of a single restaurant on a given day. Relating to pandemic flu, this can mean significant portion of the global population. When considering the role of the government in providing healthcare, often most attention is paid to the provision of subsidized medical care to the poor. Currently there is a movement to focus on healthy behaviors in order to save long term costs to the citizens and the state by promoting better diet, exercise, and by discouraging smoking. The traditional and essential role of Public Health is a governmental effort to protect all citizens from environmental contamination, infection, and disease.

Public Health is generally divided into three subcategories: epidemiology, biostatistics, and services. The agency charged with safeguarding the public’s health in Georgia is the Division of Public Health, part of the Department of Human Resources.

The Division of Public Health (hereafter DPH) maintains the health of Georgia’s citizens by focusing on preventing illness through the minimization of external threats, the promotion of healthy personal behaviors, and positive birth outcomes.⁴ It accomplishes this mission by implementing initiatives and tracking outcomes. For example, the epidemiological section tracks the occurrence of a particular disease, investigates any surge in infection, and can recommend measures to combat any further spread. This is only one of the myriad of ways in which DPH acts to safeguard health. Additional methods include intervening in accidents that pose a broad threat to the public’s health, such as the Conyers chemical fire; providing immunizations; ensuring babies are born healthy; and controlling chronic diseases.

Public Health in the United States is composed of a partnership between governments at the Federal, State, and Local levels. In Georgia, the DPH works in conjunction with the local boards of health which operate local public health departments. Federal involvement is primarily through funding, which is channeled through the DPH to the local departments, or directly in the case of the Ryan White program.

The State mandates that local health departments offer a range of services, including environmental services such as monitoring sewage, food service establishments, public swimming pools, tourist accommodations; disease control monitoring for rabies, tuberculosis, sexually transmitted diseases, other notifiable diseases, and providing immunizations; program development consisting of health needs assessments and outcome tracking; as well as administration of emergency medical services and enforcement of all health laws within a specific jurisdiction. O.C.G.A. Title 31 governs the county boards of health and specifies

³ <http://www.who.int/about/en/>

⁴ Dr. Stuart Brown, Director, Division of Public Health

mandated services. Additionally, the Title stipulates that “no population area shall be without health services responsive to their needs.”⁵

B. Public Health Funding

The apparatus of Public Health functions at an annual cost of \$321,513,582.⁶ The funding mechanism for Public Health consists of Federal, State, and locally generated revenues, all at varying levels. Portions of this funding are calculated formulaically, while other portions are budgeted annually by the Legislature, the DPH, and County Commissions; still more is generated locally as fees. This makes for an extremely complicated funding structure as illustrated by Figure 2-1.⁷ Figure 2-2 shows a graphical breakdown of all funding sources.⁸

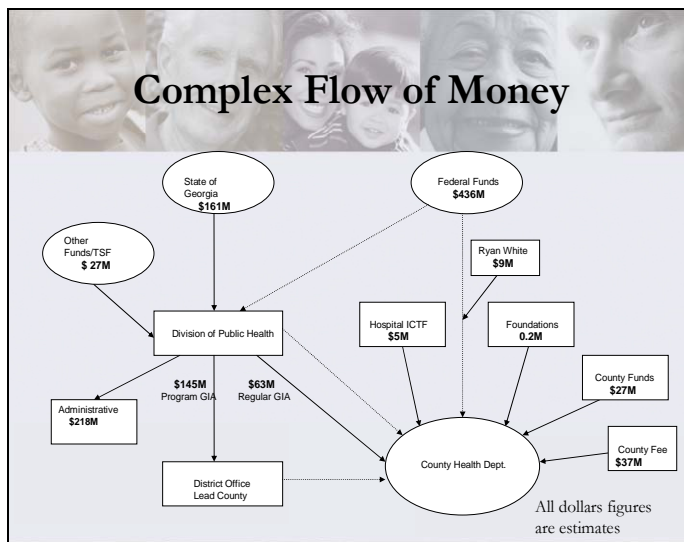


Fig. 2-1

Public Health Funding Sources 2006

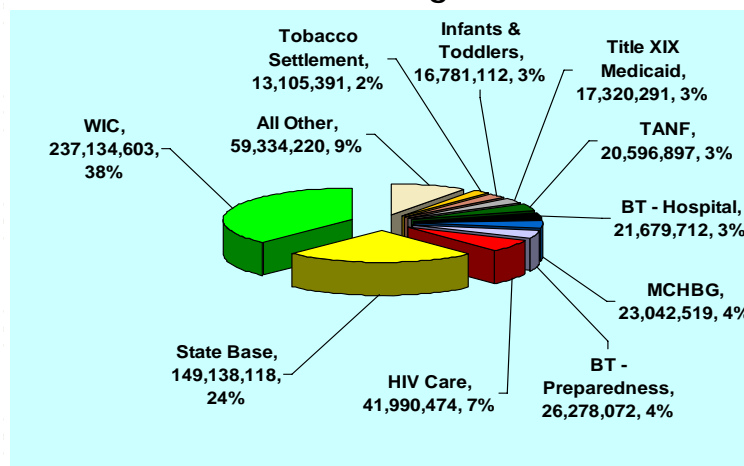


Fig. 2-2

⁵ Amy Fuess, Esq., DHR Dept. of Legal Services

⁶ FY '06 Public Health Base Budget, sum of Federal, State, and TSF

⁷ Dr. Karen Minyard, Georgia Health Policy Center, *What are the Core Business Drivers of Public Health?*

⁸ David Martin, CFO, DHR

As shown in Fig 2-1, County Health Departments receive their funding from upwards of eight separate sources and methods. The core funding allocation underwriting the basic functions of Public Health is the Grant-in-Aid (GIA). There are two forms of GIA, General and Programmatic. Programmatic GIA (hereafter PGIA) is a mixture of Federal and State funds which are disbursed to local departments by the DPH. PGIA is program specific and not discretionary. General GIA (hereafter GGIA) is calculated based on a formula and distributed by the State to the counties via DPH. PGIA is specific in that it can only be used to offer certain services determined by the Federal government, such as WIC.⁹ The Committee was primarily charged with examination of General Grant-in-Aid allocations.

Currently, General GIA underwrites 15% of county board of health spending, taken together across the state. Compare this to the Programmatic GIA at 33%, county funds at 12%, and fees & other funds at 40%.¹⁰ **Since 2000 demographic and financial trends have pressured Public Health budgets as inflation and population growth have outpaced spending.** During that time, the population of Georgia increased from 8.18 million to approximately 9.25 million today. Concurrently, inflationary forces have eroded the purchasing power of one dollar by 15%.¹¹ Since 2000, levels of Programmatic GIA have risen substantially, from a low of \$97,000,000 in 2000 to a high of \$152,000,000 in 2005 to the current level of \$144,000,000. During that same time period the basic allocation of General GIA fell by \$6,000,000 to the current level of \$64,000,000.

The formula governing the allocation of GGIA funds was developed in 1955 and first used in FY1967.¹² Generally, the formula can be described as such:

“One-half the available funds allotted on the basis of, and in proportion to, the latest civilian population for each county (A county with 5% of the state’s population would receive 5% of this half of the available dollars),

One-half of the available funds allotted on the basis of, and in proportion to, the latest civilian population of each county, weighted inversely by an index of financial ability for such county through the application of the Real Property Index as published by the State Auditor.”¹³

⁹ Women, Infants, and Children

¹⁰ DHR, all figures for FY 2006.

¹¹ Ibid, *supra* 10

¹² Department of Public Health, *Plan for Financial Assistance to Health Districts and Local Health Departments*, 1955

¹³ DHR, Division of Public Health, Grant-in-Aid Description, *GIA to Local Boards of Health for Operation of Local County Health Departments*

Expressed mathematically, the formula is:

$$\text{Tax base share} \\ = (\text{Population}_2 / \text{Gross Digest}) \\ / (\Sigma \text{Population}_2 / \Sigma \text{Gross Digest})$$

$$\text{Population share} \\ = (\text{Population} / \Sigma \text{Population})$$

$$\text{Allocation share} \\ = (\text{Tax base share} + \text{Population share}) \\ / (\Sigma (\text{Tax base share} + \text{Population share}))$$

This formula has not been used to adjust allocations since FY1970. Onwards from FY1971 the funds were frozen at the 1970 level. This allocation formed the base amount for future allocations. Changes made to GGIA levels after this were for specific purposes, mainly annual increases in salaries, benefits, and cost of living adjustments.¹⁴ GGIA levels were significantly reduced in FY 1991 through FY 1993 due to economic downturn resulting in insufficient state revenues. In FY 1994, the base allocation was frozen at FY 1993 levels and adjusted on an annual basis.¹⁵

Examining current GGIA allocations provides the best perspective on potential revisions to the GIA formula. GGIA allocations range widely depending on the size and economic performance of each county. Fulton County receives the largest total amount of money (\$6.8 million), while Webster County receives the smallest total allocation (\$65,791).¹⁶ Per capita, Taliaferro County receives the largest allocation, at \$39.12 per resident. Forsyth County receives the smallest per capita amount, at \$2.17 per resident.¹⁷ In total for FY 2006, GGIA totaled \$60.9 million dollars, a rate of \$6.90 per capita statewide. **Under the current funding formula, rural and underdeveloped areas receive significantly more funding per capita than developed urban areas.**

When coupled with the implementation of managed care, local health departments are beginning to see a serious loss of basic operating revenues. The CMOs in Georgia have a heavy focus on pregnancies and infants as an aspect of their case management function; this is reducing fee bases that local departments depend on for the generation of revenues. With an average of 40% of local operating budgets being generated by fees, the financial implications to public health posed by the advent of Georgia Healthy Families cannot be understated.¹⁸ **According to one district health official, revenues lost to CMOs in the first year of care management could equal or exceed the General GIA allocation.** This is especially detrimental to rural districts as a larger percentage of their revenues are dependent on Medicaid.

¹⁴ Ibid, *supra* 12

¹⁵ Ibid, *supra* 13

¹⁶ DHR/OBPS FY 2006 Allocation

¹⁷ Ibid, *supra* 16

¹⁸ Ibid, *supra* 10

III. Committee Findings Concerning Grants-in-Aid

A. General Grant-in-Aid Formula Changes

House Resolution 1663 placed a heavy emphasis on re-examining how grants-in-aid are allocated to county boards of health. To that effect, the Committee heard testimony from Patrick Michael Bernet, PhD., health economist of Florida Atlantic University. Additionally, Dr. Bernet serves on the task force charged with authoring a new GGIA formula. Dr. Bernet testified at length concerning other states' practices as well as how variations of formulae can have policy implications and shape the structure of Georgia's Public Health apparatus.

According to Dr. Bernet, funding formulas should broadly address four main areas: need, fiscal capacity, equity, and efficiency. Funding and staffing levels have a significant effect on the performance of Public Health; and disparities in these account for disparities in performance. Local health department spending is shown to be the most consistent indicator of quality and performance for essential mandated services.

Across the United States, several elements are used within funding formulas to achieve specific policy ends. States embrace various combinations of these principles to shape the type of public health infrastructure desired. Here follows a list of:

Funding Formula Elements¹⁹

1. **Population** – This has a high correlation to need, as higher absolute rates of occurrence are characteristic in more densely populated areas. Additionally, a broader range of services are available to the public in administrative districts with larger populations.
2. **Poverty** – Studies find that poverty is associated with a broader range of public health activity and greater perceived effectiveness among the public. Poverty is also the single best indicator of need. Need has a high and consistent correlation to income.
3. **Local Funding** – Local funding has a disproportionately large impact on the performance and perceived effectiveness of local agencies. Local funding amounts can also have the effect of increasing or decreasing the state allocations, depending on the state's goals.
4. **Consolidation** – Larger systems can achieve greater economies of scale and efficiency. Additionally, larger systems have greater resources and can attract and retain key specialists. Studies also show that large systems are associated with greater performance. With proper incentives, rural districts may be enticed to consolidate into larger health systems covering a wider area and larger population while at the same time avoiding duplication and operating at greater efficiency.
5. **Land Area** – District size is taken into account primarily in western states, especially considering the distances health inspectors must cover between facilities.

¹⁹ Dr. P. Michael Bernet, Florida Atlantic University, testimony delivered 12-18-2006

6. **Hold Harmless** – This is a formulaic provision that would hold county funding at a predetermined (status quo) level regardless of formula. These provisions inevitably reduce the efficacy of formula changes and benefit areas with decreasing need at the expense of areas with increasing need. However hold harmless provisions are often a necessary element in getting formula changes accepted.

7. **Accreditation** – Select states have incorporated measures of accountability and statewide standards into funding formulas. Michigan, Illinois, and Ohio directly tie accreditation standards to funding. Missouri has a voluntary system of accreditation, and Washington, North Carolina, and New Jersey officially encourage accreditation but do not link it to funding.

8. **Minimums** – There is no consensus view on what comprises an ideal public health system. Each state has a unique concept and set of expectations from their respective public health systems. However, it is clear that the single biggest barrier to adequate staffing of governmental health agencies is budget constraints.

9. **Needs** – Depending on the state’s goals, there are several indicators of need, including low birth weight percentages, early mortality rates (ages 0-65), levels of prenatal care, immunization rates, teenage pregnancy rates, population to provider ratio, number of facilities requiring inspection, rates of sexually transmitted diseases, and rates of tuberculosis. **These needs are all interrelated and correspond in a high degree to income. Poverty as a whole is the single best indicator of need.**

The interaction of these elements shapes the public health infrastructure of a given polity. While some methodologies should clearly be embraced, others are controversial and require political consideration and compromise.

B. Funding Formulae in Other States²⁰

1. Missouri

Missouri’s total Public Health budget is \$8.6 million. \$8 million of this is distributed according to a longstanding formula in a fashion similar to Georgia’s current GGIA. The remaining \$565,000 is distributed as a bonus via a new formula that is based on a hold harmless provision (the \$8 million allocation), population score (directly proportional), a poverty score (directly proportional), a bonus for local-self taxation, and a consolidation incentive.

2. Utah

Utah also incorporated hold harmless clauses into a revised formula that is based on consolidation incentives, population, poverty, and land area.

3. Wisconsin

Wisconsin currently utilizes a five factor allocation formula that is based on service level, general population, target population, risk (TB rates, poverty), and geographical factors (area, population density). Each of these five factors is calculated with a basket of ten to fifteen different indicators; next the whole formula is used to determine what is felt to be a

²⁰ Ibid, *supra* 19

reasonable price for a given level of services in an area. This negotiated price the public health agencies can agree to or reject. If the agencies reject the offer, the state can find another provider or renegotiate the price.

C. Grant-in-Aid Considerations

Designing public health systems for homogenous areas is complex, and for the whole of a diverse and large state still more so. Principally, state policymakers must decide first precisely what need and quality measures are crucial to the success of Georgia's public health system. After this, the appropriate elements of a funding formula will be easier to determine.

IV. Trends & Challenges

A. Emerging Threats & Public Safety

Georgia and the wider world have changed radically in the intervening period from when the GIA formula was frozen in place in 1971 up to the present. Globalization and the growth in immigration and international travel have shrunk the planet as they have pulled down old economic and political boundaries. The benefits of increased trade and technological advance have been enormous. Consequently, this increased global traffic has brought new (and old) emergent diseases into our population. One example is the 20% increase in cases of tuberculosis in the United States from 1980 to 1990. Georgia ranks 6th nationally in incidence of tuberculosis and is well above the national average.²¹ This is due to an influx of immigrants, deteriorating public health infrastructure, the spread of HIV, and the spread of TB itself through schools, hospitals, and prisons.

Throughout the 20th Century, public health agencies have had great success in curbing infectious disease, maintaining pure food and water, immunization, and responding to hazardous occurrences (Conyers chemical fire, ect.). During the latter part of the century, the focus of government health measures has shifted to controlling chronic disease, promoting healthy behaviors, and providing care to the under- and un- insured. The difficulty (and merit) of these tasks cannot be understated. However recent trends and events reveal the need to examine the core functions and responsibilities of our national public health resources. The success of public health within its traditional roles has allowed the core mission of government health agencies to be redefined. The threats of a new century may require the return of public health to a more traditional structure and mission, more similar to efforts from the 1930s and 1940s than in the 1980s and 1990s.²²

Perhaps the most essential function of government is to maintain order and protect the public's safety, particularly from threats that the average citizen cannot deter individually. Emergent threats to the public's health, whether from pandemic flu, terrorism, natural disasters, or any mass casualty event are the primary responsibility of Public Health. No other public agency can respond in the critical and specialized manner required to minimize death, injury, disability, and infection during an emergency.

²¹ GA 6.1 cases per 100,000 pop., US 5.1 cases per 100,000 pop.

²² East Metro Health District, *The Challenge of Infectious Diseases*, 2006

After the terrorist incidents in 2001, the Federal government identified public health as one of the weakest links in domestic security. Public health agencies are deficit in critical equipment, training, and operating standards necessary to act in concert with other first responders (Fire & Police). Poor communication and obsolete practices hinder the effectiveness of the public health response.²³ Georgia is no different. A recent report by the Centers for Disease Control's Division of the Strategic National Stockpile shows that the ability of Georgia's Metropolitan Health Districts to dispense emergency resources and medicine has actually deteriorated since the inception of the SNS program. Key deficiencies were listed in requesting SNS support, dispensing, treatment coordination, and lack of coordination amongst the state and the health districts.²⁴

Around the nation, public health is beginning to be seen as a corner of the “Public Safety Triad,” composed of police, fire, and public health/EMS. A public health response is necessary to protect the public from new threats. As resources become scarcer and burdens on our public health infrastructure are increasing, a reassessment of our public health priorities is even more crucial, so as to limit further denudation of the state's capabilities.

B. Stresses and Strains on Public Health Infrastructure

The Committee heard extensive testimony regarding the strains inherent in Georgia's public health system. Significant attention was paid to the role of care management and the ensuing damage caused by Georgia Healthy Families to the budgets of local boards of health. Also cited were delays in contracting agreement and reimbursement. Most importantly, the care management organizations do not reimburse public health for services that Medicaid previously paid for.²⁵

Cited as a detriment to the capability of public health to deal with emerging threats, the sense of mission drift and overload felt by public health employees should not be overlooked. Currently Georgia's public health nurses and staff are required to perform their traditional health monitoring duties as well as devote significant time to disaster preparedness. More than one stakeholder testified that local departments simply cannot perform both tasks at once, and that departments and staff have been overburdened with extra duties and responsibilities.²⁶

C. Public Health Nurses

The third item that the Committee was specifically charged with investigating was the state and role of Georgia's public health nurses. **All testimony concurred with the basic assumption that public health nurses are both the backbone and lynchpin on which our public health system operates.**

²³ Ibid, *supra* 22

²⁴ CDC, Division of the Strategic National Stockpile, *Site Visit Summary Report Atlanta CRI*, 2006

²⁵ Ibid, *supra* 7

²⁶ Capt. Pete Nelms, Fayette Cty. Emergency Management Agency, testimony delivered 12-19-2007
Dr. J. Patrick O'Neal, Director, Office of EMS/Trauma, DPH, DHR
Dr. Wade Sellers, Director, Rome Public Health District

A crisis exists among Georgia’s public health workforce. As the population of our state increases, our numbers of qualified nurses has fallen.

Fig 4-1

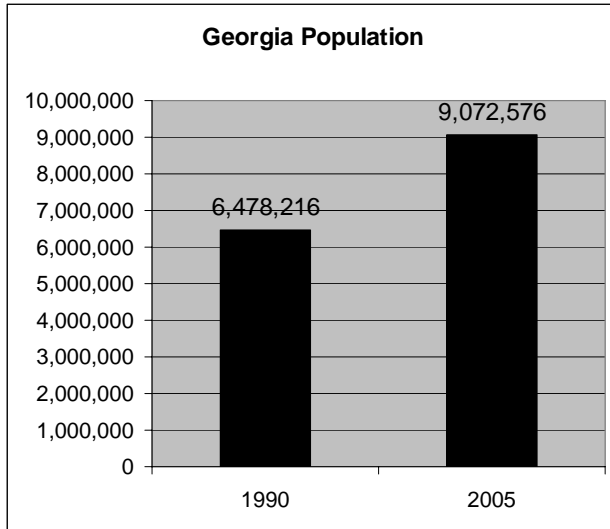
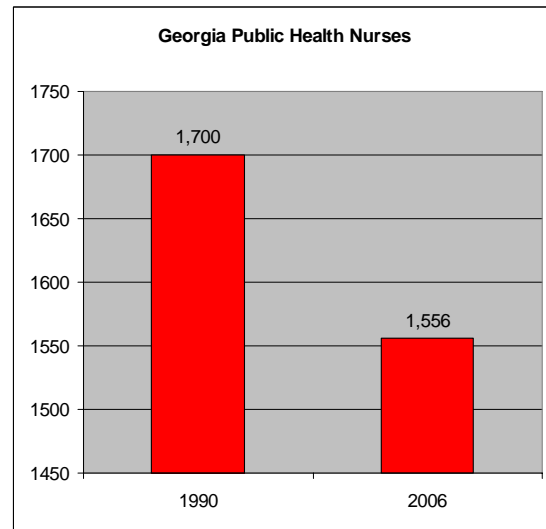


Fig 4-2



The decline in the number of nurses can be easily explained. **Public health nurses are not paid competitively, have little room for advancement, and are being overloaded with extra responsibilities, such as tuberculosis interventions and bioterrorism planning.**²⁷ Table 4-3 illustrates the gaps in pay between public health nurses and their counterparts.

<u>Work Setting</u>	<u>Staff Nurse</u>	<u>Nurse Manager</u>
Public Health	\$36,753	\$51,173
Juvenile Justice	\$46,379	\$55,010
Mental Health	\$42,101	\$56,215
Georgia Market	\$61,206	\$83,040

Table 4-3

The impact of the nursing shortage is currently being felt by Health Districts across the state, however in the event of an emergency incident, the effects of the shortage will be magnified tremendously. Under Georgia law, Emergency Management Agencies (EMA) must be prepared to provide support in several capacities. These are called Emergency Support Functions (ESF).

Public health is responsible for meeting ESF 6 and ESF 8, which are emergency sheltering and health and medical service, respectively. Emergency sheltering of special needs

²⁷ Carol Jakeway, RN, MPH, Chief Nurse, DPH

populations is wholly the purview of public health agencies. Additionally, public health is charged with dispensing the Strategic National Stockpile and the operation of the telephone triage system for use during a pandemic. In a disaster such as pandemic flu, public health nurses will shore up the medical community throughout the state. Indeed, the experience and training public health nurses provide will be invaluable in crisis situations due to the unique set of circumstances that will prevail during a pandemic. Testimony made it clear that due to the current and worsening shortage of public health nurses, during a time of significant medical emergency, Georgia will not be able to perform as is required and expected by the public. **ESF 6 & 8, SNS distribution, telephone triage, and emergency support will not function as designed, and will lead to mass disruption, unavailability and degradation of care, perhaps leading to panic or civil unrest. In the event of pandemic, the medical system in Georgia will collapse due to unprecedented volume without improvement to existing public health infrastructure.**²⁸ If improvements are not made in the specific area of SNS dispensing, the state could lose \$45 million in Federal funding.

Additionally, the cost of turnover for public health nurses is high and increasing. Since 2003, annual turnover costs have increased from \$4.8 million to \$9.5 million in 2005. A significant qualitative loss also occurs with the exit of more experienced nurses who provide crucial institutional knowledge and leadership.

The core crisis in Georgia's public health system is the nursing shortage. Unless corrective action is taken, the nursing problem will continue to grow at significant cost and danger to the health of the public. Remedial actions include competitive pay, a career track, and tuition support for nurses in training.

V. Analysis & Conclusions

Georgia's public health apparatus is at a crossroads. Policymakers can elect to move the system in a different direction to meet new and reemerging challenges, or they may shore up and improve a system that acts as a safety net for the under- and un- insured. The Committee recognizes that Georgia's Public Health system is in a state of crisis due to increasing responsibilities, increasing population, emergent infectious disease, the problems of immigration, the threats of terrorism and pandemic influenza, a shrinking public health workforce, and decreasing funds. It is the intent of this report and any resulting legislation, policy, executive action, rules or regulations so promulgated that the capabilities of Georgia's Public Health system be increased and improved in order to ensure the health and safety of all Georgians from threats both routine and extraordinary.

²⁸ Ibid, *supra* 26

VI. Committee Recommendations

1. Grants-in-Aid

The Committee strongly urges that the current General Grant-in-Aid allocation formula be re-examined and revised. The Committee finds that any new GIA allocation formula should embrace the principles of need, fiscal capacity, consolidation, equity, population, risk, and efficiency. The Committee also embraces the principle of hold harmless, in order to ensure continued operation of rural public health agencies. Additionally, the Committee recognizes that the “actual number of persons in poverty by county” is the best indicator of need for Public Health services; and that, in order to ensure that Georgia is best prepared for a bioterrorist, pandemic flu, or mass casualty event, funding should increase in densely populated areas relative to sparsely populated areas.

2. Care Management Organizations

The Committee finds that the program “Georgia Healthy Families” has had an adverse and unforeseen effect on the budgets of local Public Health departments. Therefore the Committee recommends, either through executive order of the Governor or through legislative action of the General Assembly; that Public Health departments shall be reimbursed by CMOs as if said Public Health departments were Federally Qualified Health Centers, for all services previously provided by and paid for through Medicaid.

3. Reporting Standards

The Committee urges all local and state Public Health organs to adopt the CDC standard HL-7 epidemiological reporting guidelines.

4. Governmental Agencies

The Committee further recommends that:

- a) The Division of Public Health all departments, sections, and offices of the Georgia Department of Human Resources that provision, provide for, or are otherwise concern health or mental health shall be removed from DHR and combined with the existing Department of Community Health, to create a new state agency referred to as the “Department of Health,” which shall have oversight and fiduciary responsibility regarding all government activities concerning healthcare within the State.
- b) The restructuring process should supervised by a Commission of legislative and executive appointees.
- c) From the passage of any act until actual reorganization occurs, the structure and staffing levels for DHR be frozen in place.

5. Health District Staffing

The Committee recommends that the “District Cadre” staff positions currently appropriated to the Division of Public Health shall be moved directly to the District level in terms of assignment and funding, and placed under the direct administration of the respective District Health Directors.

6. Public Health Nursing

The Committee recommends the creation of a competitive career track for Public Health nurses:

Level 1:

- Complete 1 year of PHN experience
- Complete Health Assessment training
- Complete introduction to population health principles
- Complete training to all assigned programs
- Complete all required preceptorships
- Complete Emergency Preparedness training courses: National Incident Management System (NIMS) 100, 200, 700 and 800. Introduction to Emergency Support Functions 6 (mass care) and 8 (health and medical); pandemic influenza plans and American Red Cross Protocols.

Level 2:

- Complete 2 years of PHN experience
- Complete 1 year of practice under Nurse Protocol
- Complete training on community resources
- Complete training on developing community partnerships
- Complete Emergency Preparedness training: Update on NIMS, participate in drills and exercises on pandemic influenza, mass sheltering and mass dispensing; introduction to care of populations with special needs during disasters/emergencies and biological and chemical protocols.

Level 3:

- Complete 3 years of PHN experience
- Complete 2 years of practice under Nurse Protocol
- Complete training on essential services and the application of population health principles to public health
- Experience in collaborating with community partners
- Complete Emergency Preparedness training: Update on NIMS, participate in drills and exercises on pandemic influenza, care of populations with special needs during disasters/emergencies; training in biological and chemical protocols and American Red Cross Protocols; introduction to working with community partners in emergency preparedness planning.

7. Public Health Nursing

The Committee further urges the General Assembly to fund the pay raise appropriated to Public Health Nurses contained within the Governor’s budget recommendations for FY 2008.

8. Grants-in-Aid

The Committee finds that the problem of fund lapsing can be addressed by requiring that 85% of the total Programmatic Grant-in-Aid funds must be allocated to the local boards of health no later than the first quarter following the receipt of such funds by the agency.

9. Federally Qualified Health Centers

The Committee finds that Federally Qualified Health Centers (FQHC) are critical to meeting the health needs of the under- and uninsured. The Committee urges that the General Assembly undertake all necessary measures to support existing FQHCs and to work with the Federal government to increase the number of FQHCs throughout Georgia substantially.

Mr. Speaker, these are the findings and recommendations of your Study Committee on Public Health.

Respectfully submitted,

Honorable Donna Sheldon,
Representative, 105th District,
Chairman

Honorable Mickey Channell,
Representative, 116th District

Honorable Ed Rynders,
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Honorable Ron Stephens,
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