Georgia Public Health Districts:

Functions and Boundary Considerations

Background:

As the Georgia state budget faces current and potential shortfalls, DHR is considering whether consolidation of some of the 18 district public health offices could save money without losing public health service capacity. In order to consider this option, an understanding of the functions of the district offices and the criteria for defining boundaries needs to be examined. Each current district boundary attempts to balance the various criteria so as to maximize administrative efficiencies while also maintaining a rational public health practice area.

From the April 2008 OPB "Governance and General Grant-in-Aid" Division of Public Health program evaluation:

Responsibility for public heath in Georgia is shared between state government and county boards of health, with the primary enforcement authority residing in the counties. The District Health Director position is the organizational lynchpin allowing Georgia's hybrid public health governance system to work. District directors balance the needs and roles of both the counties and the state by representing the interests of the County Boards to the Division of Public Health, and similarly, the Division's to the Boards. The Master Agreement contract between the Department of Human Resources and the county Boards of Health is the primary management tool for public health in Georgia. Although the Boards are independent entities, the Master Agreement directs the majority of their activities and funding.

Georgia's 18 health districts offer a regional model that provides an element of managerial consistency over the state's 159 counties. There is considerable variation in district size, demographic makeup, and structure…

Rather than building a "practice" with patients accepted for medical care, as most physicians do, the district health director's "practice" is the entire population delimited by health district boundaries. He or she practices public health for the entire district population by assessing health issues and responding to them through the supervised work of district epidemiologists, nurses, environmentalists, nutritionists and others.

Functions of the Health District:

1. Represent the state's public health priorities, interests and obligations to the county Board of Health and to the County Commission;
2. Represent the county Board of Health's public health interests to the state;
3. Provide public health oriented medical services to residents in the health district through: 1) a team of expanded role Registered Nurses following medical protocols under the medical license and medical supervision of the District Health Director; 2) advanced practice nurses, e.g. Nurse Practitioners, working under protocols signed by the District Health Director and 3). LPNs working under the guidance and supervision of public health nurse managers and the District Health Director;

4. Provide medical management and public health response to infectious disease exposures, outbreaks and cases; toxic exposures and hazardous conditions;
5. Provide administrative support, management and supervision to county health department operations;
6. Advocate for leverage of state public health efforts through encouraging county financial support and cooperation of local physicians and medical institutions;
7. Coordinate and provide multi-county public health services, e.g. the sharing of an environmentalist, nurse or nutritionist between counties or the capacity to direct all district nurses to one county in need of emergency surge response;
8. Provide regional emergency preparedness and response capacity. (With the recent emphasis on the need for public health to participate in emergency preparedness, this is effectively an additional function; added since the districts were organized.)
9. Attend to, and promptly manage if necessary, customer and constituent concerns at the local level so that complaints can be avoided, if possible, or addressed without requiring the attention of the Commissioner and/or the Governor.

Note that district public health offices should be differentiated from other typical administrative offices when focusing on administrative efficiencies. The additional medical, public health and community outreach responsibilities require that considerations of optimal span of control or responsibility be evaluated alongside possible efficiencies of scale. Exposure to possible medical liability, timely response to epidemics and emergencies and capacity to build local support and partnerships need to be considered alongside the possible cost savings of administrative consolidation.

Criteria for defining public health district boundaries:

1.) *Population and Population Density*:

Many public health services are provided to all residents of the county. High population density counties have traffic congestion issues which increases travel time**.** Districts should be relatively smaller in land area in densely populated areas.

2.) Geography: *travel distance and travel time as measured by square mileage and mapping of terrain.*

Routine services and response to urgent problems are needed in all parts of each district. Consideration must be given to the costs of travel and the timeliness of response.

3.) *The number of clinical staff needing supervision*:

The higher the number of nurses operating under the medical license of the Health Director, the larger will be the potential exposure to medical liability and the greater the challenge of quality assurance or improvement.

4.) The number of counties:

Each county adds a layer of complexity to the public health practice of the District Health Director. The Board of Health is required to meet at least quarterly. Called and optional meetings can result in the need to meet at least monthly. As the health officer and CEO of each Board of Health, the Health Director is required to actively participate in Board

meetings. *"The scope of services, operating details, contracts, and fees approved by the county board of health shall also be approved by the district director of health." O.C.G.A. §31-3-4 (a) (6)*

Enforcement of health regulations such as food service and on-site sewage inspections resides at the county level and requires coordination with local courts and legal counsel. Also, each county has its own set of leaders and agencies. Health Directors are expected to foster and nurture relationships and partnerships in each county. Most counties voluntarily provide more funding and better facilities than the state requires and these local contributions to the state public health system are often the fruit of the close working relationships between the district health director and county leaders.

5.) *Medical, business and media service patterns*:

Public Health District offices must interact with hospitals, physician organizations, businesses and media outlets within their service areas. Overlapping service areas cannot be avoided but should be minimized in order to enhance efficiencies.

6.) *Historic relationships and groupings*:

Personal relationships and regional organizations have been developed according to historic groupings of counties. Regions or districts have "identities" which contribute to the coordination and support of public health functions.

Additional Considerations:

Each Health District has contractual relationships such as client software systems, medical consultation, radiology services, and laboratory services. Changing health district boundaries would bring additional expenses to county boards of health for purchasing new software systems, data conversion, and software training. Re-negotiating clinical contracts and clinical support systems would risk disruption of services and/or require resources for implementing the changes.

Current Realities:

Population and Population Density:

Georgia's population has doubled since the early 1970's when the 19 health districts were set up. The current 18 districts function with infrastructure designed for the much smaller district populations found more than three decades ago. District populations range from 144,051 persons in the South Central District (Dublin) to about a million persons each in the Fulton and East Metro (Lawrenceville) districts. The average population is about 530,000.

The highest densities are in the DeKalb and Clayton Health Districts (2,698 and 1,902 persons per square mile, respectively) while the lowest are South Central (Dublin) and Southeast (Waycross) with population densities of 39 and 40 persons per square mile.

Geography:

Square mileage ranges from the smaller but population dense metro Atlanta Health Districts (Clayton: 144 sq. miles) to the larger, less dense southern districts (Southeast: 8,611 sq. miles.)

The North Health District, headquartered in Gainesville, has significant terrain issues (mountains and lakes) that increase travel times. Southern districts have fewer terrain barriers.

***The number of clinical staff needing supervision*:**

The total number of nurses (RNs, LPNs and advanced practice nurses) supervised by the district health director ranges from 22 to 117 with the average being 85. Of these, Health directors supervise an average of 61 RNs most of whom operate under Georgia's unique and cost saving nurse protocol law which allows RNs to work expanded roles in delivering public health services. The law requires regular review by the District Health Director of the work of the expanded role nurses.

The number of counties:

Three districts have only one county: Clayton, DeKalb and Fulton; two districts have three or fewer counties: Cobb (2) and Gwinnett (3); and, the remaining thirteen districts have an average of 11.6 counties, ranging from six to 16 counties per health district.

The largest districts, in number of counties, are the Southeast District and the West Central District. The Health Director in each of these districts is required to attend at least 64 Board of Health meetings annually and develop supportive county partnerships in 16 counties. Most health directors report that 8 to 12 counties is the most workable number for a multi-county, less population dense district.

***Medical, business and media service patterns*:**

Overlapping service areas occur across current district boundaries but in most cases the service patterns are centered in the district.

***Historic relationships and groupings**:*

The state has considered changing health district boundaries several times in the past, either to explore cost savings or to align with other state agency regions. The Savannah (two county) and Brunswick (six county) health districts were recently merged as the Coastal Health District to achieve cost savings. This new eight-county district was able to avoid overstretching the District Health Director because geographic size, population, number of supervised nurses, and the number of counties were all close to the median values encountered in other health districts. In addition, the coastal area of Georgia has a regional identity and relatively common medical, business and media service patterns.

The opposite type of change happened in northwest Georgia in 1973 when the original 16 county health district was divided into a ten-county and a six-county district due to the large population covered and the challenge of covering such a large, mountainous geographic area.

Recent attempts to enlarge or redraw other districts have not been successful because many or most of the criteria for defining health district boundaries were found lacking and judged to threaten public health capacity.

Summary:

The current 18 county health district arrangement attempts to balance the need to provide administrative efficiencies and economies of scale with the need to provide locally valued public health services tailored to the unique needs and structures of Georgia's 159 county system. It attempts to strike a balance between state oversight and direction and county support and buy-in. The presence of the current cadre of 18 Health Directors, all licensed physicians, also attempts to strike a balance between minimizing medical costs through the use of expanded role nurses working under the respective medical license and maintaining quality assurance by limiting the number of nurses supervised.

If state revenues were not declining, a strong case could be made for decreasing the size of the larger multi-county health districts (as was done in north Georgia in the 1970s) and/or providing more staff to the rapidly growing metro districts that have more than doubled in population without concomitant state staffing increases.

The reality of Georgia's hybrid state-county public health system, and the district-county relationships required, would make large 20-plus county health districts unmanageable and would result in a likely loss of local financial support, the possible breakdown of the health director- expanded role nurse partnership and the resultant loss of services or increased costs of providing supervised medical/public health services.

In examining the range of values in certain criteria for defining district boundaries, there are several districts that appear to be outliers and possibly candidates for consolidation. However, when the other criteria are examined, the current district boundaries appear rational. The designers of the current arrangement clearly had to balance the various criteria to draw the most rational district boundaries. Any attempt to redraw the district boundaries needs to keep in mind the maxim taught to all aspiring physicians: "First, do no harm."