House of Representatives
Study Committee on Evaluating Funding for Public Health

Final Report

Chairman Darlene Taylor
Representative, 173rd District

The Honorable Matt Hatchett
Representative, 155th District

The Honorable Angie O'Steen
Representative, 169th District

The Honorable Butch Parrish
Representative, 158th District

The Honorable Dexter Sharper
Representative, 177th District

2025

Prepared by the House Budget and Research Office

Introduction

The House Study Committee on Evaluating Funding for Public Health was created by HR 847 during the 2025 Legislative Session of the Georgia General Assembly. HR 847 acknowledges the need for health security and the crucial role public health holds. This committee is tasked with conducting a thoughtful evaluation of how Georgia's public health system is funded and the services the system provides.

HR 72 provides for the membership of the committee, consisting of five members of the House of Representatives to be appointed by the speaker. Speaker Burns appointed the following members: Representative Darlene Taylor, Chair; Representative Matt Hatchett; Representative Angie O'Steen; Representative Butch Parrish; and Representative Dexter Sharper.

The study committee held three public meetings during 2025, occurring on August 20th at the Coverdell Legislative Office Building, September 17th at Oconee Fall Line Technical College, and October 7th at Lake Lanier Olympic Park. During the three meetings, the committee heard testimony from multiple organizations, agencies, and providers involved across the spectrum of public health. This report provides an overview of the issues discussed by the individuals listed below by meeting.

Wednesday, August 20, 2025 – Coverdell Legislative Office Building (Atlanta, GA)
Dr. Kathleen Toomey – Georgia Department of Public Health
Dr. Chris Rustin – Georgia Department of Public Health, Fulton Department of Health
William Bell – Georgia Department of Public Health
Megan Andrews – Georgia Department of Public Health
Dr. Thomas Craft – Dublin Department of Health
Dr. Zachary Taylor – Gainesville Department of Health
Diane Durance – Georgia Department of Health
Allison Chamberlain – Emory University
Carolyn Mullen – Association of State and Territorial Health Officials

Wednesday, September 17, 2025 – Oconee Fall Line Technical College (Dublin, GA)
Dr. Chris Scoggins – Georgia Rural Health Association
Shelley Spires – Albany Area Primary Health Care
Dr. Keisha Callins – Community Health Care Systems
Katherine Mcleod – First Choice Primary Care
Megan Andrews, Christina Tice, Holly Mobley, and Sandra Gomez-Giron – Georgia Department of Public Health
James Peoples – Georgia Department of Community Health
Callen Wells and Aynsley Hill – Georgia Early Education Alliance for Ready Students
Dr. Thomas Craft and Staff – South Central Health District

Tuesday, October 7, 2025 – Lake Lanier Olympic Park (Gainesville, GA)
Jessica Schwind – Georgia Southern University
Kelly Hughes – National Conference of State Legislatures

Reena Chudgar – Public Health Accreditation Board
Jacob Cooper – Bamboo Health
Callen Wells – Georgia Early Education Alliance for Ready Students
Natasha Taylor – Georgia Watch
Leah Chan – Georgia Policy and Budget Institute

Background

Public health focuses on protecting populations and communities, and Georgia's Department of Public Health (DPH) works to prevent disease, injury and disability; promote health and well-being; and prepare for and respond to disasters. Some specific areas of work include prevention, vaccination, nutrition, maternal and child health services, and addressing social drivers of health.[1] Uniquely, Georgia has a health department in each of its 159 counties, which are grouped into 18 public health districts managed by a district health director who reports to the DPH Commissioner.[2] While Georgia's public health system faces challenges due to complexities in its structure, an urban-rural divide, and workforce issues, there have been many successful public health programs, along with creative solutions that are leveraged to strengthen the health of communities across the state.

[1] Dr. Kathleen Toomey, presentation August 2025.
[2] Dr. Chris Rustin, presentation August 2025.

Committee Findings

There is a wide variance in public health services available in different communities across Georgia. This is largely because there are 159 county health departments organized into 18 public health districts. Currently, Georgia's health departments are using four different electronic medical record (EMR) systems, but DPH is in the process of developing a statewide solution, ultimately bringing all departments online to one centralized database. Having all local health departments on one EMR will allow for a standard of services for available across the state.

The Foundational Public Health Services (FPHS) is a framework that defines the minimum set of services and capabilities every community should have. Some states have integrated FPHS into law, and the Public Health Accreditation Board (PHAB) uses FPHS as a standard in the accreditation process. Georgia currently has four PHAB accredited health departments: Georgia Department of Health; Cobb and Douglas Public Health; District 4 Public Health; and Gwinnett, Newton and Rockdale County Health Department. Most health departments provide the following care: immunizations; women's health services; breast and cervical cancer program services; Women, Infants, and Children (WIC) program services; sexually transmitted disease (STD) services; human immunodeficiency virus (HIV) services; tuberculosis (TB) services; children's services; and environmental health services. However, urban counties may provide additional services such as dental clinics, car seat programs, and mosquito control.[3]

Rural health departments often face challenges which can limit the services they provide. Some common challenges include transportation access, less staff capacity, coordination, and administrative burden. Additionally, rural communities cannot leverage economies of scale as costs increase in rural environments. The fixed costs of providing public health services within a small county do not scale directly with population. With the increased costs in consideration, DPH and the local departments are taking measured steps forward, such as the EMR updates to increase interoperability, telehealth options for certain services, and the integration of the Maternal, Infant, and Early Childhood Home Visiting Program, which addresses transportation barriers.[4]

The Home Visiting Program utilizes public health nurses and trained community health workers to provide care for women during and after pregnancy, as well as for their infants, up to the first birthday. Services are provided at no cost and include clinical assessments for pregnancy and postpartum complications, and infant assessments for feeding, weight, and developmental issues. The program was started as a pilot in FY 2024 with $1.68 million, originally serving 21 counties. Now in FY 2026, the program has expanded to a total of $6.42 million in funding and will serve 75 counties, with 46 staff members and 626 patients enrolled.[5] This program also provides opportunities to leverage the role of community health workers, as there is a large focus on case management and education for patients. The community health workers role includes scheduling appointments (OB/GYN, mental health,

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[3] Dr. Chris Rustin, presentation August 2025.
[4] Dr. Chris Scoggins, presentation September 2025.
[5] Christina Tice, presentation September 2025.

substance use, immunization and health checks, pediatrics), providing referrals and linkages (food, insurance, home safety, housing, transportation, domestic violence, breastfeeding, parenting support, employment), and educating patients and their communities (car seats, feeding resources, Medicaid applications).[6]

The Non-Emergency Medical Transportation (NEMT) program, run through the Department of Community Health (DCH), is also working to address transportation barriers. NEMT provides medically necessary transportation for eligible Medicaid members who lack other means of transportation, and 1.3 million NEMT trips were made in FY 2025. Transports include medical treatment, evaluations, pharmacy visits, and hospital discharges, with different levels of service offered (curb-to-curb, door-to-door, or bed-to-bed). DCH uses a broker model to find providers, and also utilizes ride-share services and volunteers who receive gas reimbursement. Notably, NEMT partners with the Georgia Environmental Management Agency, the Department of Transportation, and DPH to assist the transportation network with information for safety measures.[7]

Babies Can't Wait (BCW), funded by DPH and managed by the Georgia Early Education Alliance for Ready Students (GEEARS), is another program that works for the betterment of public health. BCW is an early intervention program that provides physical, occupational, and speech language therapies, often in the home, for infants and toddlers (birth to age 3) who have a disability or developmental delay. GEEARS presented on opportunities for the state leverage Medicaid for sustainable funding for the BCW program. Currently, therapeutic services can bill Medicaid and private insurance, but special instructors and service coordinators are primarily reimbursed through block grant funding. As case management is a large part of the work needed in the BCW program, GEEARS is interested in partnering with the state to explore options for Medicaid reimbursement for community health workers to leverage this workforce.[8]

Georgia's Prescription Drug Monitoring Program (PDMP), the mandated central database for controlled substance prescriptions, was also highlighted to the committee. Options for enhancing the PDMP include adding information about non-fatal overdose events, tracking prescriptions for buprenorphine to identify potential lapses in care, and notifying health care professionals when an opioid antagonist co-prescription may be beneficial. Additionally, there is a shift towards looking at non-federal funding streams for new funding sources, including opioid settlement dollars and the Rural Health Transformation Fund.[9]

The Emergency Medical Services (EMS) system in Georgia is operated through DPH at the state level, and its responsibilities include issuing EMS agency licenses, issuing EMS provider licenses, and making hospital specialty designations. Structurally, Georgia is divided into 175 emergency zones that mostly align with county borders. Current EMS challenges include an increase in "wall times" at hospitals as ambulances wait for patient transfer and an increase in 911 requests. Additionally, the current system

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[6] Holly Mobley and Sandra Gomez-Giron, presentation September 2025.
[7] James Peoples, presentation September 2025.
[8] Callen Wells, presentation October 2025.
[9] Jacob Cooper, presentation October 2025.

focuses on reimbursement for services provided, such as patient transport, so EMS is working on solutions to include increased reimbursement for on-site care that do not require transportation, as well as options for reimbursement for transport to alternative destinations like urgent care. EMS is experiencing workforce challenges, so there is interest in expanding the use of CHWs to address some of the current challenges.[10]

Federally Qualified Health Centers (FQHCs) serve as a valuable partner in the efforts to bolster public health. They provide primary care, preventative care, school-based care, dental services, and mental health services. FQHCs collaborate with DPH in many ways, such as through the breast cancer and cervical cancer program and during COVID-19 vaccine distribution, as well as a continuum of care for a patient who may receive some services at a health department and primary care services at a FQHC. Another example of partnership between FQHCs and DPH is with HIV/AIDs work, where primary care is provided separately from other aspects of care.[11]

Workforce continues to be a challenge across public health, and all healthcare industries, with staffing recruitment and retention on the forefront. Nursing and environmental health professionals continue to be in high demand, with continual competition between public health, hospitals, and the private sector.[12] Emory University launched its Rollins Epidemiology Fellowship Program in 2020, and it showcases the positive outcomes of the two-year service-learning program for early career epidemiologists. To date, 74 fellows have been placed across six cohorts, and 50% of graduates from the first two cohorts are still in state and local public health one year post fellowship.[13] Additionally, Emory and Morehouse have trained around 1,500 community health workers in the past two years, but many struggle to secure long-term stable employment, making it an under-utilized workforce.[14]

DPH's FY 2026 budget totals $922.5 million, with 50% of their budget from federal funding streams (approximately $464.8 million), 44% appropriated from state general funds (approximately $402.7 million), and the remaining 6% from Trauma Care Trust Funds, Tobacco Settlement Funds, Brain and Spinal Injury Trust Funds, and other funds (approximately $54.9 million). Federal funding is predominately allocated to the counties through programmatic grant-in-aid (PGIA), and about 50% of base federal funds are related to the Women, Infants, and Children (WIC) program. State funds are allocated by DPH to both the general grant-in-aid (GGIA) and PGIA. GGIA funds are distributed to counties based on a formula, last updated in 2011, that considers a county's population share, poverty share, and poverty rate. In addition, all counties are required to contribute funding to their local health departments. The local match requirement has not changed since 1972.[15]

The return on investment (ROI) of public health is evident. The economic benefits of public health investment may include health care savings, productivity gains, value of lives saved, and the quality-of-

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[10] Megan Andrews, presentation September 2025.
[11] Shelley Spires, presentation September 2025.
[12] Panel discussion August 2025.
[13] Allison Chamberlain, presentation August 2025.
[14] Natasha Taylor, presentation October 2025.
[15] William Bell, presentation August 2025.

life years increased. Looking specifically at Georgia, DPH programs addressing maternal and child health have demonstrated returns ranging from $2 to $44 for every $1 invested. Research also shows high ROIs for programs geared towards tobacco control; chronic disease prevention; lead abatement; HIV prevention; and injury prevention, like fall prevention and car seat programs.[16]

Committee Recommendations

Upon review of the information presented, the House Study Committee on Evaluating Funding for Public Health recommends the following:

- Consider updating the county match requirement for county funding contributions to county health departments.
- Update and streamline the public health system structure to create clear lines of authority to the state office, consistent service standards, and transparent accountability measures for local health departments across the state.
- Transition from individual county boards of health to district boards of health, consisting of representation from each county, to consolidate administrative burden on local public health operations.
- Allow local board of health staff to retain their accrued leave when they transition to a state position.
- Provide DPH the authority to update health district composition without requiring unanimous local consent.

[16] Jessica Schwind, presentation October 2025.

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

Respectfully Submitted,

Darlene K Taylor

The Honorable Darlene Taylor,
Representative, 173rd District,
Chairman

The Honorable Matt Hatchet,
Representative, 155th District

The Honorable Angie O'Steen,
Representative, 169th District

The Honorable Butch Parrish,
Representative, 158th District

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