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Health and Human Services

A growing cost to counties is the provision of health and human services. In Georgia, the largest expenditures are for uncompensated and indigent health care costs, emergency medical services, hospitals, public health, and public welfare and social services—generally in that order. Other large outlays of county funds are also made for community action agencies, centers for older persons, and behavioral health services, including substance abuse, mental health, and mental retardation.[1] An area of increasing concern and cost for counties is the provision of medical, mental health, and addictive disease services to inmates of county jails.[2]

EMERGENCY MEDICAL SERVICES

Although counties are not required to provide emergency medical services (EMS), many elect to do so for the benefit of their citizens. In most counties, particularly those in rural Georgia, the population density and/or insurance payer mix do not allow for an EMS service to operate at a profit. In these counties, the government often pays a subsidy to the provider of the service. Counties can choose to furnish EMS directly or contract with private providers or neighboring governments; some provide EMS through local public or private hospitals. Because most urban counties in Georgia have a number of private EMS providers located in their jurisdictions, they often leave EMS to the private sector.[3]

Regardless as to the method by which EMS is furnished, all counties that elect to participate must meet or exceed the applicable state statutory and regulatory requirements. Rules and regulations for the EMS program are promulgated and enforced by the State Office of

EMS and Trauma, an agency of the Department of Community Health (DCH). Emergency ambulance services are coordinated by a Regional EMS Council (also referred to as the local coordinating entity), which assigns 9-1-1 zones to ambulance services. In order for an ambulance service to provide emergency EMS care, it must be approved by the regional council.[4]

In order to receive a license, a service provider must meet standards for medical and communications equipment, insurance, and staffing. Each service provider is also required to have a physician medical advisor/director to ensure a high quality of patient care. This requirement can be waived if the county has fewer than 12,000 population, but most counties have made provisions to offer this valuable service.[5]

When providing EMS, a county can choose to provide a basic life support service, advanced life support service, or a combination of both. As the name implies, the advanced life support is the higher level of service and requires paramedics to be aboard the ambulance. At a minimum, each ambulance must be staffed with at least a basic EMT and an intermediate EMT.[6] EMS personnel are also allowed to carry controlled substances (IV fluids and medications). In order to do so, the service provider must have a contract with both a pharmacist and a physician to ensure the appropriate use and storage of such substances.[7]

Counties providing EMS or ambulance services may be considered health care providers who are subject to Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. HIPAA requires EMS to limit the disclosure of a patient's medical and other protected health information. A county that operates an ambulance service is required to pay an annual license fee to the DCH, the amount of which is set by the Board of Community Health and is dedicated to the Indigent Care Trust Fund.[8] DCH is also authorized to enforce laws regarding EMS programs by imposing fines[9] and requiring continuing education of technicians.[10]

Emergency medical services are costly to provide for two reasons. First, fully equipped EMS vehicles are expensive and often require high levels of maintenance. Second, staffing these vehicles with qualified personnel on a 24-hour basis can result in substantial personnel costs, depending on the level of service and prevailing wages. Cost-management measures for ambulance services could include any of the following:

- Limiting subsidies for private providers of services to low-income patients

- Providing vehicle maintenance through county maintenance shops in return for discounts on service subsidies required by private providers
- Combining with other local governments to provide joint overhead for services

Funding for EMS comes from both private payers (i.e., patients and insurance companies) and public payers such as Medicaid and Medicare. Rates for Medicaid reimbursement are set by DCH.

HOSPITALS

As with EMS, counties are not required to provide for local hospital care. However, many counties have public hospitals (see Chapter 4, which describes hospital authorities). Both public and private hospitals are regulated under the Georgia Health Planning and Development Act. This law provides for a health strategies council that recommends state health policy to the governor; health planning and coordination through a state health planning agency that sets guidelines for services, collects data, and administers health services certificates of need; and a health planning review board to hear certificates of need appeals from the planning agency. In order for a hospital to expand its mix of services, it must first secure a certificate of need from the Division of Health Planning of DCH. During this process, a copy of the application for the certificate of need must be provided to the county board of commissioners.

While most public hospitals were built to serve the residents of a particular county and are governed by one county's hospital authority, a number of hospitals have become regional providers of hospital care. The trend toward regional hospitals is due to the impracticality of locating sophisticated and costly medical technology in every local hospital, the inability of small counties to attract physicians, and state and federal incentives for preventing unnecessary duplication of health resources. When combined with static or declining rural populations and the changing climate of health care financing, this trend toward regional hospitals has made small public hospitals less economically viable. Counties that have regional hospitals receive benefits in terms of economic development but incur above-average costs due to increased numbers of uninsured patients coming from outside the county. Counties can contract with hospitals for uninsured patient and other medical care, but they are not required to do so. An as yet unfunded state law autho-

rizes the state to assist counties in paying for the care of nonresident indigent patients. If implemented, the law would require each county to appoint a health care advisory officer to maintain a file of indigent county residents. Upon receipt of a request from a hospital in another county for a determination of a patient's indigency, the advisory officer would determine whether the patient is indigent under state standards and so notify the hospital. For patients found to be indigent, the state pays all or part of the patient's health care costs. If the advisory officer were to fail to respond within 30 days, the county of residence would be liable for these expenses. Since the law is not funded, payment of nonresident indigent health care costs to hospitals is currently voluntary on the part of counties.[11]

Another state law requires a hospital operating an emergency service to provide appropriate and necessary emergency services to any pregnant woman who "presents herself in active labor."[12] If the patient receives health care and claims to be indigent, the hospital must determine if any portion of the cost can be paid by insurance or any federal, state, or local program. It then must communicate its findings, revealing any portion that may be payable from other programs, to the health care advisory officer of the patient's county of residence and request a determination as to whether the patient is indigent under state standards. If the advisory officer concludes that the patient is indigent or fails to respond within 60 days, the county of residence is liable for the patient's costs.[13] Since this law was enacted, a change in Medicaid guidelines has essentially provided for the payment of most of these costs. While state law applies only to pregnant women in active labor, federal "antidumping" regulations prohibit hospitals accepting Medicaid or Medicare from refusing to treat patients who present themselves in emergency condition.[14]

An additional law establishes a state Indigent Care Trust Fund. One of the purposes of this fund is to help defray the cost of uncompensated care at disproportionate share hospitals.[15] DCH[16] is authorized to provide special assistance to hospitals that serve rural communities, with the condition that these hospitals continue to furnish essential health care services to residents in their service areas and engage in long-range planning for cost-effective service delivery.[17] More generally, counties are authorized to levy up to 7 mills on behalf of a hospital authority and are authorized to cover the cost of indigent care. Public hospital authorities have no more legal responsibility to deliver indigent care than do other hospitals. Federal regulations require all hospitals to treat any person, insured or not, who presents him- or herself for emergency care.[18]

The Rural Hospital Authorities Assistance Act provides for the certification of certain rural hospitals (e.g., hospitals operated by a hospital authority, serving indigent patients, maintaining a 24-hour-a-day emergency room, in counties with fewer than 35,000 population) for grant eligibility. However, funding for these grants may not be available due to budget restrictions.[19]

Hospital authorities and nonprofit facilities are, with some exceptions, exempt from ad valorem taxes. Counties with populations of 50,000 or more may tax hospital authorities that have at least 100 beds on real property in which 50 percent of the property is leased to for-profit business or professions. In the case of nonprofit facilities, exceptions include property held for investment purposes that are unrelated to providing health care services, patient care, or training of health professionals.[20]

PUBLIC HEALTH, MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND ADDICTIVE DISEASES

The division of responsibility for administering public health, mental health, developmental disabilities, and addictive diseases services among public organizations involves some overlap. Based on state matching fund formulas, county boards of health (see Chapter 4) are authorized to provide services in four general areas: physical health and disease control, environmental health, mental health and addictive disease, and developmental disabilities.[21] In reality, although county boards of health conduct local assessment of health needs and health planning in all of the four primary and preventive health areas, the actual administration and delivery of mental health, developmental disabilities, and addictive diseases services is provided through the state Department of Behavioral Health and Developmental Disabilities.[22]

County boards of health oversee the delivery of physical and environmental health services and gather valuable information about specific local health risks. Typically, they collect data on key indicators such as infant mortality and low birth weight, teenage pregnancy, health risk behaviors of adults and teens, accident patterns, the West Nile virus, rabies, sexually transmitted diseases, alcohol and substance abuse, and suicides.

The Department of Behavioral Health and Developmental Disabilities operates regional offices that establish, monitor, and evaluate mental health, developmental disabilities, and addictive diseases services in local communities. The regional offices also work with regional planning

boards to provide and facilitate coordinated and comprehensive planning for their regions. Regional planning board members, in partnership with the Department of Behavioral Health and Developmental Disabilities, are charged with planning service delivery systems that focus on a core set of consumer-oriented, community-based values and principles. These principles provide effective and efficient delivery of services to individuals, families, and communities.

The governing authorities of the counties within each of the regions appoint members to the multicounty boards. The county commission, as the governing authority responsible for the appointment of representatives, in collaboration with the regional office and the regional planning board as well as other advocacy organizations, has the duty of ensuring that the most vulnerable citizens of the county are afforded optimal representation. The county governing authorities must ensure that appointments reflect the cultural and social characteristics of the regional and county population. For balance, each disability should be represented on the regional planning board. The regional planning boards meet at least once every two months.[23]

Community service boards, whose members are also appointed by the county governing authorities, have traditionally been the providers of public mental health, developmental disabilities, and addictive diseases services. Reform of the system grants additional authorities to the community service boards and establishes options for them to reorganize. The intent is to provide for an expansion of provider choices. The boards are not required to provide a comprehensive range of services. Along with other providers, they negotiate a contract annually with the Department of Behavioral Health and Developmental Disabilities for the services to be provided.[24]

In addition to these community-based services, the Department of Behavioral Health and Developmental Disabilities operates seven psychiatric hospitals across the state. These psychiatric hospitals serve people who cannot be served in the community. The catchment areas for these hospitals ensures that the people of Georgia have access to such services when they are determined to be a danger to themselves or others because of a disorder of mood or thought.

The Department of Behavioral Health and Developmental Disabilities also provides mental health treatment to defendants who are found to be incompetent to stand trial or not guilty by reason of insanity by a state or superior court. These forensic services have largely been inpatient but are beginning to be offered to nonviolent offenders on an outpatient basis.

In FY 2010, psychiatric hospitals expect to admit more than 9,000 people. The hospitals are located in the following counties:

- Floyd (North West Georgia Regional Hospital in Rome)
- Richmond (East Central Regional Hospital in Augusta, including the Gracewood campus)
- DeKalb (Georgia Regional Hospital Atlanta)
- Baldwin (Central State Hospital in Milledgeville)
- Muscogee (West Central Georgia Regional Hospital in Columbus)
- Thomas (Southwestern State Hospital in Thomasville)
- Chatham (Georgia Regional Hospital Savannah)

Over time, the use of hospitals for treatment of mentally ill, developmentally disabled, and addicted persons will decrease as community options are improved and expanded.

Physical Health and Disease Control

Services offered by the county board of health include family planning, maternal and infant health, immunization, vision, and dental clinics and programs for sexually transmitted disease, AIDS testing and education, and coronary, cardiac, and communicable disease. Generally, about 10 percent of these programs are paid for through patient fees, 50 percent through state and federal grants, and 30 to 40 percent through county funds. These programs serve patients on an occasional basis, but the largest proportion of those being served by all public health programs fall into this category.

Environmental Health

Services provided by the county board of health include inspection of food establishments, water supplies, sewage disposal, swimming pools, and public premises. Most of these services are provided through county funds supplemented by state grant-in-aid funds. The county boards of health in counties with populations of 400,000 or more are also authorized to develop and implement activities for the prevention of injuries and incorporate injury prevention measures in rules and regulations that are within the purview of the county board.[25] Because the county board of health is limited in its enforcement powers, some counties have adopted the board of health's regulations as ordinances and have designated a

board of health code enforcement officer. This arrangement allows the regulations to be enforced as ordinance violations in magistrate court. The magistrate judge may impose penalties and even jail time for code violations.[26]

Mental Health and Addictive Diseases

These services include child, adolescent, and adult counseling and addictive diseases programs and treatment. Most of the funding for these programs is derived from state and federal sources. The counties furnish a small amount, and a very small amount is supplied through fees. These programs serve about 10 percent of those receiving public health services, but they provide more intensive and long-term services than is generally the case with public health.

Developmental Disabilities

These services include early intervention, habilitation, community living, and supported employment programs. The program activities are mostly supported through Medicaid waiver dollars, with some state dollars. Persons with developmental disabilities receive the most intensive services within the service array, usually on a lifetime basis.[27]

Key public health, mental health, developmental disabilities, and addictive diseases issues for county commissioners include the following:

- Developing, in coordination with state and district health systems, preventive and wellness services designed to reduce public health costs in the long run
- Increasing the capacity of the health and mental health systems to use Medicaid programs for revenue maximization. Although state Medicaid plans can change significantly, they have tended to become more supportive of preventive services such as early periodic screening and diagnostic testing for infants and children.
- Increasing participation in PeachCare for Kids, the child health insurance program for low- and middle-income families[28]
- Increasing the capacity to address addictive diseases and mental health problems of county jail and probation populations
- Increasing successful transition from school to adult life for individuals with developmental disabilities through outreach and education to families

- Addressing the waiting list for developmental disabilities services by identifying specific needs by county
- Promoting the use of community-based services to ensure that people with mental illnesses can be served in their home communities as much as possible and defray the costs associated with transporting county residents to psychiatric hospitals
- Ensuring that every county in the state has representation on both the regional planning boards and community service boards
- Providing for the transport of citizens through the sheriff's office from their communities to psychiatric hospitals when involuntary admission has been ordered by a physician or appropriate judge

FAMILY AND CHILDREN SERVICES

Family and children services are the responsibility of the DHS Division of Family and Children Services. At the local level, the board of the county department of family and children services (DFCS) makes recommendations to DHS regarding county policy and appointment of the county director (discussed in Chapter 4).

DFCS has two major areas of responsibility. One area is employability and related assistance programs, which includes the following:

- *Food stamps*. Provides food vouchers for impoverished individuals.
- *Temporary Assistance to Needy Families (TANF)*. Provides up to 48 months of cash assistance to families with dependent children, minimal resources (e.g., less than $1,000 for a mother and two children), and incomes not exceeding approximately 45 percent of federal poverty guidelines. Work activities and a Personal Responsibility and Work Plan are required.
- *Medicaid*. Eligibility varies with programs but generally only covers pregnant women, elderly and disabled adults, and children.
- *Other*. Includes general assistance, transportation vouchers, energy assistance, and child care.

The second area of DFCS responsibility is social services, which includes activities to protect family members from abuse and neglect and to keep families together and children in safe and caring environments. Because these goals are sometimes contradictory, services are usually divided into protective services (child and adult protective services)

and services such as adoption, homemaking, respite, and foster care that promote family functioning.[29]

The department can request the juvenile court to award it the temporary custody of a child who is in danger of abuse or neglect and in more extreme cases, can ask that the court terminate parental rights. Because of the complex nature of abuse and foster care cases, the state has required that counties

1. establish in writing a child abuse protocol, an interagency agreement for clarifying the roles and responsibilities of law enforcement, DFCS, school officials, hospitals, district attorneys, boards of health, and mental health centers in the investigation and processing of child abuse cases;
2. provide for a review of the current status and plans for permanent care of children placed in foster homes.[30] Many juvenile court judges have appointed a foster care review board of citizen volunteers in order to meet the placement review requirement;[31] and
3. establish a Child Fatality Review Committee (as a subcommittee of the child abuse protocol committee) to oversee the local child fatality review process and report to the Child Fatality Review Panel on the incidence of child deaths, with recommendations for prevention.[32]

OTHER SERVICE PROVIDERS

Housing assistance for county residents is provided through a variety of public organizations, which include the following:

- *Public housing authorities*. Although public housing authorities typically have local boards, these authorities are chiefly funded through the federal government and guided by federal regulations related to eligibility and allowable rental rates. Some housing authorities have begun to work with communities to develop affordable homeownership opportunities, and counties will sometimes supplement housing authority funds for special projects.
- *Georgia Housing and Finance Authority*. This state agency operates a program known as Section 8 housing through which an eligible person's rent is partially or fully paid to qualified landlords operating low-income housing.[33]

- *Housing Trust Fund for the Homeless*. Counties can draw from this state trust fund to help remedy local housing problems.[34]

- *Department of Community Affairs*. This state agency operates a First-Time Home Buyers program and provides funding to local governments for projects that assist low-income residents.

Community action agencies are nonprofit organizations that help families that live below poverty level to move toward independence. While these agencies are not tied to local governments, they are the chief recipients of federal Community Services Block Grant funds that are used to provide services such as transportation, housing, nutrition, and promotion of employability. Funds for community action agencies and for initiatives such as homeless programs, welfare reform support, emergency management, and specialized projects are channeled through DHS. Although these funds have traditionally been appropriated to community action agencies, some local governments have developed their own programs in these areas.

Regional commissions (RCs) and Workforce Investment Act boards play a role in regional planning for and technical assistance to (but not provision of) employment and other human services.[35] RCs typically play an administrative role with respect to programs for the elderly and workforce development (e.g., providing staff support to the Workforce Investment Act boards and programs). While RCs are often the lead or area agencies on aging, DHS can designate any appropriate organization as the area agency on aging.[36] Similarly, while RCs often support the work of the Workforce Investment Act boards, these boards are independently established by federal and state legislation.

Although juvenile courts are not social service agencies, they tend to act as brokers and monitors of services supplied by other agencies, such as DFCS and the Department of Juvenile Justice (DJJ), as well as providers of services designed to divert children away from formal court proceedings or prevent them from becoming career offenders. In a majority of counties, basic juvenile court services such as diversion, intake, and probation are provided by the state DJJ. A few counties provide funding or staff in order to augment these state-supplied services. Although the function of the DJJ in all counties is to rehabilitate youth whose behavior warrants commitment to state custody, some urban counties fund basic juvenile court services such as intake and probation on their own. Prior to committing persons to the state DJJ, counties are responsible for covering the cost of any necessary medical examinations

and/or treatment for juveniles upon certification of the expenses by the judge of the court of adjudication, even when the juvenile is housed in another county.[37]

MAJOR ISSUES IN HEALTH AND HUMAN SERVICES

As the cost of providing health and human services continues to grow, counties may have to examine new approaches to effect cost management as well as early intervention activities in order to minimize or even prevent long-term or down-the-line treatment and its associated costs. A number of issues will have to be addressed.

Providing Health Care

Generally, uncompensated health care costs are increasing due to the lack of primary care facilities and an appropriate mechanism for steering patients who need only basic or low-level services away from expensive emergency room care. As a result, there is increased pressure on county governments to subsidize hospitals and other providers. Cost management activities in this area might include the following:

- More use of case management and improved access to and availability of prevention, wellness, and primary care
- Provision of health promotion programs, with increased support for health education, exercise, and nutrition
- Increased education and training of health care practitioners on disability competency issues
- Increased use of Medicaid outreach, clinic, and case management services
- Provision of prenatal care and clinics
- Implementation of programs to manage chronic disease through increased knowledge of how lifestyles affect conditions
- Provision of supplements to physicians for indigent care of patients who would otherwise go to hospitals
- Improved prevention, wellness, and primary care for inmates and persons living with mental illnesses
- Provision of preventive/early detection services not paid for by Medicaid

County commissioners also should be aware of the health needs of children, particularly related to dental care and behavioral health, and of the potential for strategies such as school-based health services to address these needs.[38]

Welfare Reform

While welfare reform has been very successful in reducing the provision of cash public assistance and redirecting the blocked funds to employment support programs such as childcare, economic downturns place the system under severe stress. County governments must be prepared to address a possible gap in funding at least on an emergency basis.

Because the area of family services involves law enforcement and custodial functions, DFCS can become liable for not meeting constitutional and statutory mandates or for not delivering services in accordance with reasonable professional standards. Recent lawsuits, such as *Kenny A. v. Perdue*, have forced several states to address problems relating to excessive worker caseloads, the lack of case responsiveness, the use of emergency care for long-term care, the lack of appropriate placements for foster children, and the absence of specialized placement for troubled children.[39] The root cause of litigation in this area has been the dramatic increase in the demands placed on the family service system without a comparable increase in resources to meet those demands. Due to the downturn in the economy, increased state funding for this system has been reduced, and DFCS has suffered budget reductions of $18 million in FY 10 and FY 11. Many child and family experts and advocates feel that addressing family and child development problems in the state will demand substantially more resources in order to overcome multigenerational problems. Therefore, many counties are recognizing the need for comprehensive early intervention when family and youth crises develop. The Governor's Office for Children and Families[40] provides support to local human services providers for a variety of prevention programs and community-based services.

GEORGIA'S INITIATIVE TO IMPROVE RESULTS FOR CHILDREN AND FAMILIES

Beyond providing the basic level of resources needed to meet legal, professional, and program standards for human services delivery, the key health and human services challenge for the coming decade is twofold: (1) to address the results accountability issue and (2) to create a

solid and efficient system of care—one without service gaps or excess duplication.

With respect to results accountability, some counties are beginning to follow a more proactive strategy for health and human services programming that focuses on return on investment. Such counties appear increasingly willing to provide support for preventive services related to health, housing, behavioral health, and delinquency problems—if these services can demonstrate high net benefits. In order to achieve these net benefits, however, counties must be willing to redirect some resources to areas where the desired impacts are most likely to be realized.

Resources and redirection alone, however, cannot produce the desired benefits. What is needed is a system of care that can exist only when human services organizations and schools work together to provide early identification of problems and family-focused treatments and to share facilities, staff, information, transportation, training experiences, and other resources. Similarly, more systematic and strategic use of Medicaid and other federal funding opportunities is likely to occur only when members of the local human services community work together.

The Family Connection Initiative, a collaborative effort of state agencies (e.g., DHS, the Department of Education, the Department of Juvenile Justice) and local service agencies, provides a model for addressing results accountability[41] and service delivery issues. Most counties in Georgia now have their own Family Connection partnership. In some counties, this partnership has been designated by the county government as the single point of planning and accountability for the human services system in the community. Because many of the partners in The Family Connection are county-operated or county-related organizations, county commissioners should consider assuming significant supporting, coordinating, and leadership roles in such partnerships.

NOTES

1. Interview with ACCG staff, October 1991.
2. Conversation with Suzanne Nieman, ACCG staff member for Health and Human Services, June 2001.
3. Interview with DHR staff member in Emergency Health, October 1991.
4. Official Code of Georgia Annotated (O.C.G.A.) §31-11-3.
5. DCH Regulation 290-5-30-.07; O.C.G.A. §31-11-50.
6. DCH Regulation 290-5-30-.07(c).
7. O.C.G.A. §31-11-60.
8. O.C.G.A. §31-11-31.1.
9. O.C.G.A. §31-11-9.

10. O.C.G.A. §31-11-58.
11. O.C.G.A. tit. 31, ch. 8, art. 2.
12. O.C.G.A. §31-8-42.
13. O.C.G.A. §31-8-43.
14. 42 C.F.R. §482.1(a)(3).
15. O.C.G.A. tit. 31, ch. 8, art. 6.
16. See the Department of Community Health Web site at dch.georgia.gov.
17. O.C.G.A, §31-7-94.1.
18. Excerpted from Ann Marchetti, *Quick Facts* (Atlanta: ACCG, August 1996); O.C.G.A, §31-7-84(b).
19. O.C.G.A. §31-7-94.1.
20. Marchhetti, *Quick Facts*; O.C.G.A, §31-7-72(e).
21. Plan for Financial Assistance to County Boards of Health, based on O.C.G.A. §§31-2-1, 31-2-2; O.C.G.A. tit. 31, ch. 3.
22. Ga. Laws 2002, 1324.
23. O.C.G.A. §§37-2-1–37-2-5.2.
24. O.C.G.A. §37-2-6.
25. O.C.G.A. §31-3-4(8).
26. See O.C.G.A. §§31-3-5.1, 31-3-5.2, 31-3-16.
27. Interviews with ACCG and DHR staff, October 1991.
28. PeachCare for Kids is administered by the Department of Community Health (www.peachcare.org). See also the Covering Kids and Family Initiative in Georgia (www.coveringkidsandfamilies.org/projects/index_StateID=GA.php), which is part of a national health access initiative funded by the Robert Wood Johnson Foundation designed to help local communities identify potentially eligible children and enroll them in available state health insurance programs.
29. Interviews with Clarke County Department of Family and Children Services staff, October 1991.
30. Child Abuse Protocol, O.C.G.A. tit. 19, ch. 15.
31. Foster Care Review, addressed in various sections of O.C.G.A. §15-11-58.
32. See O.C.G.A. §19-15-3 for committee duties and composition; O.C.G.A. §19-15-2, which outlines the requirements for a child abuse protocol committee and a written child abuse protocol; O.C.G.A. §19-15-4, which describes the relationship between the child abuse protocol committee, the county child fatality review subcommittee, and the state child fatality review board.
33. Interview with the director of the Athens Housing Authority, October 1991; O.C.G.A. tit. 50, ch. 26.
34. O.C.G.A. tit. 8, ch. 3, art. 5.
35. O.C.G.A. §§50-8-35, 50-8-36.
36. O.C.G.A. §49-6-63.
37. O.C.G.A. §§15-11-4–15-11-8. For more information on juvenile courts, contact the Council of Juvenile Court Judges.
38. *Child Policy Reports* (Atlanta: Georgia Health Policy Center, School of Policy Studies, Georgia State University, 2001).
39. See Kenny A. v. Perdue, 365 F.Supp. 2d 1353 (N.D. Ga. 2005), in which Children's Rights Inc. sued state and county officials responsible for the foster care system in order to require improvements in systemic deficiencies, including

excessive stays in dangerous emergency shelters, high levels of maltreatment in foster care, and inadequate health care, educational services, and legal representation. A settlement agreement was reached in July 2005 requiring infrastructure changes, service guarantees, and improved oversight of child safety. The state is being monitored in its efforts to meet 31 specific benchmarks in reforming the child welfare system. Two additional settlements were reached with Fulton and DeKalb Counties regarding the right to effective legal representation for children involved in abuse and neglect proceedings.

40. O.C.G.A. §49-5-131 et seq. As of 2008, the former Children and Youth Coordinating Council and the Children's Trust Fund Commission were merged to form the Governor's Office for Children and Families. See O.C.G.A. §§19-14-1, 49-5-155.
41. The Family Connection has a Web-based data repository to help citizens measure community and state progress (www.gafcp.org/index.php).