

Georgia on My Mind: A Public Health Laboratory Poised for Change

Elizabeth Franko, director of Georgia's state public health laboratory, often points out to visitors that Georgia is the largest state east of the Mississippi River. "People don't realize that," she said. Nor do they know that the primary state industry is agriculture. "Atlanta is a huge metropolitan area," said Franko, "and people see our big airport; but we have cotton and sorghum and peaches growing all over the state. We are, after all, the peach state."

Franko, a transplant from Trenton, New Jersey, has come to appreciate Georgia's size—ample to accommodate 159 counties, each with its own health department. "Here in Georgia," said Franko, "there is a strong public health tradition; a strong sense of providing to the citizens a safe environment and a modicum of health care. There are parts of Georgia where the health department is the only local health care provider."

The state public health laboratory—100-years-old this year—historically has

maintained close ties to each of those 159 local health departments, which, said Franko, "use us as their laboratory of choice." But after a century of service, perhaps it is inevitable that those relationships evolve. Franko, for one, has overseen several major changes in laboratory practice during her 20-year tenure in Georgia, but expects that the most profound changes are yet to come.

Perhaps the biggest break with tradition will be the institution of fees for laboratory services that used to be funded with state money. Fully three-quarters of the laboratory's workload now comes from county health departments, while the laboratory budget is based almost exclusively on state and federal funding (55% and 45% respectively). "We get about \$80,000-per-year from fee-for-service work. It's not significant to our budget," said Franko.

But as government funding becomes less secure, Franko said, "We need to operate more like a real business." The state

Board of Human Resources has just authorized the laboratory to develop a newborn screening fee system for third-party payers—including county health departments. Franko said this will be "a huge culture shock." And yet she sees it as perhaps the only viable means to support expanded testing and follow-up for the 136,000 infants born in Georgia every year. In January the laboratory added medium chain acetyl dehydrogenase to its panel of ten newborn screening tests, and additional disorders will likely be approved by the Board of Human Resources.

But newborn screening will not be unique. "We're going to charge fees across-the-board," said Franko. "That is what I have been directed to do. And those fees need to be fully burdened for the building, electricity, gas. That is new territory for us; we have never even had to factor personnel costs into our fees before." An associated challenge will be assuring that fee-generated revenues are allocated back to the laboratory budget and not diverted to general state coffers.

This new way of doing business will likely impact the services the laboratory provides, such as syphilis serology and other clinical diagnostic work performed on behalf of county health departments. Franko expects that the laboratory will discontinue some clinical tests "if we cannot do them as cheaply as the private sector can." Speaking generally, she said, "State labs need to figure out which part of the pie is theirs and do it very, very well and charge for it."

The Georgia public health laboratory is actually comprised of three facilities (a fourth fell victim to budget constraints), and the main laboratory—a free-standing, 67,000-square-foot building—sits in close proximity to a panoply of



Laboratory scientists at the Georgia Public Health Laboratory, circa 1914.

Photo Courtesy of Georgia Public Health Laboratory.

potential partners or potential competitors. The laboratory is just east of Atlanta, across the street from a Veterans Administration hospital, two miles from the Centers for Disease Control and Prevention, and not much further from Emory University, Quest Laboratory, and several major tertiary hospitals.

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Already, said Franko, “We are in direct competition for staff.” And the state is at a disadvantage on at least two counts, not being able to match the best private sector salaries and subject to state laws requiring certification for bench scientists. (The CDC and area medical schools are exempt.)

The main public health laboratory currently has 25 vacancies, representing about 16% of its 152 established positions. Not too long ago a full third of its positions were vacant. In the aftermath of several lengthy hiring freezes, Franko said “We’re moving heaven and earth to hire as many people as possible while we can.”

Yet while Franko is working hard to stabilize her budget as resources shrink, she notes that the laboratory has made significant progress in many areas; for example, getting three tandem mass spectrometers in place and up and running for newborn screening and piloting the use of digital camera technology (DPDx) for electronic transmission of parasite specimens. (Atlanta’s large immigrant population is a source of many of the parasitology specimens that come through the laboratory.)

The state-of-the-art Atlanta laboratory complex is just seven-years-old and plans are underway for a new \$12 million, 29,000-square-foot facility to replace the aging regional public health laboratory in Waycross. “We made the suggestion that we need a modern backup laboratory in south Georgia in case this lab is incapacitated for whatever reason,” said Franko, who expects

groundbreaking by fall. (The future of the second regional laboratory facility—in Albany, Georgia—is not yet determined.)

She said that in addition to its usual bacteriology, TB, virology, parasitology, immunology, and infectious disease

work, the public health laboratory has implemented all of the latest protocols for bioterrorism testing and is in the process of adding a chemistry unit. Testing for some of the newest emerging diseases—such as West Nile virus—has become routine.

Last June Franko’s staff was able to stand up a 55-foot, modular BSL-3 laboratory to support the G-8 meeting held on Sea

ready for testing suspicious powders and other samples collected by law enforcement officers in south Georgia.

Reflecting on plans to celebrate the laboratory’s centenary, Franko noted what a difference a 100 years can make. The original Georgia public health laboratory opened New Year’s Day, 1905, in the basement of the capitol building, with a budget of \$3,000 for two years. The first director brought his own microscope to the laboratory and hired a Civil War veteran to help him clean out the basement and set up shop. The workload that first year consisted of 400 specimens that were tested mostly for TB, syphilis and malaria. In the 1930s Director Thomas Sellers developed the Sellers stain for rabies and began a tradition of epidemiology-laboratory cooperation.

Looking back on her own career—spent entirely in the laboratory at either a bench or a desk—Franko observed that change is ever-present. When she was



The Georgia Public Health Laboratory facility at night.

Photo Courtesy of Georgia Public Health Laboratory.

Isle. “It was a big deal,” she said, noting that the unit weighs 30,000 pounds and has a freestanding power supply and its own ventilation system. “We had to move up delivery, installation, licensure and Select Agent inspections by about four months to accommodate the G-8,” Franko explained, “but we did it.” Today the unit provides BSL-3 space for the Waycross regional laboratory and is

doing research at the University of Pennsylvania or syphilis serology in the New Jersey public health laboratory or work at the CDC, Franko never expected that one day her phone number would be on FBI autodial or that the allocation of laboratory fees would weigh on her mind.

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