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**State of Georgia
DRAFT**

**Health Improvement Plan
2016-2021**



15 **Executive Summary**

16 The State Health Improvement Plan (SHIP) is the result of a collaborative effort to assess the most
17 pressing health needs in the state and create an actionable plan to improve health for all Georgians. The
18 Mission of the Georgia Department of Public Health (DPH) is to prevent disease, injury and disability;
19 promote health and well-being; and prepare for and respond to disasters. As the lead agency in the state to
20 prevent disease and promote health, DPH is committed to leading and coordinating the SHIP. While
21 several of the objectives and strategies outlined in this plan are coordinated with activities listed in DPH's
22 strategic plan, the SHIP is intended to reflect activities that extend beyond the capacity of any one
23 organization to accomplish. Instead, the SHIP is a reflection of statewide efforts involving multiple
24 stakeholders. Ultimately, all stakeholders in Georgia are responsible for the content of the plan and for the
25 successful completion of activities.

26 The SHIP builds upon findings from the Community Health Assessment conducted by the Department of
27 Public Health. The Community Health Assessment involved input from stakeholders throughout the state,
28 who identified three priority focus areas for the state: Maternal and Child Health, Chronic Disease
29 Prevention and Access to Care. These three focus areas were used as the overarching framework for
30 organizing and developing the SHIP.

31 During a conference held in April 2016, stakeholders gathered together to review the Community Health
32 Assessment findings and develop the outline of the SHIP based on the three priority areas identified.
33 Stakeholders were divided into the three work groups based on their expertise and the functions of the
34 agency they represent. These work groups both built upon existing plans and developed new and
35 innovative strategies to improve the objectives that were developed for each focus area, all while applying
36 a framework of health equity and improving the social determinants of health. Chronic Disease
37 Prevention and Maternal and Child Health utilized existing advisory groups, while Access to Care
38 convened and established a new advisory group.

39 The goals listed in this plan are achievable, yet aggressive, and reflect best practices to give the citizens of
40 Georgia access to the best system of care possible. To capture the activities that will be conducted, the
41 document contains measurable objectives with data sources routinely collected to assess progress
42 throughout the reporting years of the plan. The document also contains evidence-based or promising
43 strategies. Activities listed are measurable and timely, specific actions to be taken.

44 Moving forward, the SHIP is intended to be a living document, reflective of emerging priorities, changes
45 in the evidence-base for strategies, and successes and challenges in implementing the plan. This plan is to
46 serve as a tool and resource for providers, government agencies, community-based organizations,
47 advocates, academics, legislators and other stakeholders to understand the activities being carried out
48 throughout Georgia and influence strategies moving forward.

49 Implementing the SHIP will require organizations to partner together and work collaboratively to improve
50 health throughout the state. To achieve these goals will be to achieve collaboration and to promote health
51 equity for all Georgia's citizens.

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53

54

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131 thanks the following partners for their participation in the development of this State Health Improvement
132 Plan and thanks them for their support as we move forward with implementation:

133

- | | |
|--|---|
| 134 Alliant Quality | 169 Mental Health Association of Georgia |
| 135 Anthem/Blue Cross Blue Shield of Georgia | 170 Morehouse School of Medicine |
| 136 Center for Black Women's Wellness | 171 Navicent Health |
| 137 Centers for Disease Control and Prevention | 172 North Central Health District 5-2 |
| 138 Children’s Healthcare of Atlanta | 173 Northeast Health District |
| 139 Community Health Works | 174 Parent to Parent of Georgia |
| 140 Emory University | 175 Sickle Cell Foundation of Georgia, Inc. |
| 141 Emory PRC | 176 Voices for Georgia's Children |
| 142 Emory Center of Excellence in Maternal and Child
143 Health | |
| 144 Employers Like Me | |
| 145 Fulton County Department of Health and Wellness | |
| 146 Fulton County School System | |
| 147 Georgia American College Physicians | |
| 148 Georgia Association of Nursing Students | |
| 149 Georgia Chapter American Association of
150 Pediatricians | |
| 151 Georgia Core | |
| 152 Georgia Dental Association | |
| 153 Georgia Department of Education | |
| 154 Georgia Department of Juvenile Justice | |
| 155 Georgia Health Policy Center | |
| 156 Georgia Hospital Association | |
| 157 Georgia Institute of Technology | |
| 158 Georgia Nursing Leadership Coalition | |
| 159 Georgia OBGyn Society | |
| 160 Georgia Parent Teacher Association | |
| 161 Georgia Partnership for Telehealth | |
| 162 Georgia State Perimeter College Nursing School | |
| 163 Georgia State University | |
| 164 Georgians for a Healthy Future | |
| 165 Grady Health System | |
| 166 Gwinnett Newton Rockdale Health District | |
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212 **Introduction and Background**

213 The Georgia Department of Health’s (DPH) mission is “To prevent disease, injury and disability: promote
214 health and well-being: and prepare for and respond to disasters.” Through its State Health Improvement
215 Plan (SHIP), the DPH works to achieve its stated mission. The SHIP is one of the instruments used to
216 describe and promote the strategies in place to accomplish statewide health improvement goals. Using
217 innovative strategies, evidence based and promising practices, the DPH is committed to leading efficient
218 and effective initiatives with multidisciplinary partners statewide to improve the health of all Georgians.
219

220 DPH used a comprehensive approach that included developing specific objectives and targeted measures
221 aligned with the needs of the state’s diverse population. The Georgia State Health Assessment laid the
222 groundwork for DPH’s engagement with public health system partners, provision of data and information
223 to multidisciplinary stakeholders, and for the overall state health improvement planning process.
224

225 The development of Georgia’s SHIP was the result of a process that reflects input from a diverse group of
226 DPH stakeholders. Through this process, DPH provided state health assessment data, analysis, and
227 leadership, and facilitated stakeholder workgroups to gain consensus on high-priority health issues. With
228 stakeholder consensus, strategies and actions were identified for implementation to help improve health in
229 these health priority areas.
230

231 The Georgia SHIP promotes collaboration across sectors and guides DPH investment in state initiatives.
232 The SHIP is an actionable document that allows for surveillance, evaluation, and subsequent revisions
233 and adjustments to plans as needed. This flexibility helps ensure that the assessment of objectives,
234 strategies and priorities occur regularly during designated periods of time and accommodation for
235 changes related to emerging health issues and trends. DPH’s dissemination of population health data and
236 sharing of best practices will provide Georgians with information and tools necessary to improve health
237 statewide.
238

239

240 **Purpose of the Plan**

241 The SHIP is an action-oriented plan that outlines the key health priority areas for the state, and how these
242 priority areas will be addressed to ultimately improve the health of all people in the State. The SHIP was
243 created through a statewide, collaborative planning process that engages partners and organizations to
244 develop, support, and implement the plan. This development process enables loosely-networked system
245 partners to coordinate for more efficient, targeted and integrated health improvement efforts. The SHIP
246 serves as a vision for health and a framework for organizations to use in leveraging resources, engaging
247 partners, and identifying priorities and strategies for collective action towards improving community
248 health and achieving health equity.

249
250 This SHIP was developed to establish a vision, direction, and outline with clear priorities and
251 measureable objectives to improve health in the state of Georgia. The SHIP serves as a tool not just for
252 DPH, but also for health providers, government agencies, community-based organizations, advocates,
253 academics, policy makers, and other stakeholders committed to health equity and improvement.

254
255 Georgia’s SHIP addresses the overall health of the state’s population and provides a frame of reference to
256 guide policy making and resource allocation. It demonstrates how public health prevention efforts can be
257 instrumental to achieving health care objectives. It offers detailed objectives and strategies for addressing
258 three health priority areas identified through assessment of population health data. Addressing the SHIP
259 priorities requires coordinated action involving not only health care providers and public health
260 specialists, but also partners outside of the traditional health sphere whose activities influence population
261 health.

262
263 A team of subject matter experts from within DPH and dedicated representatives of community-based
264 organizations throughout the state developed the SHIP. Collaboratively, these public health leaders
265 evaluated the 2015 Georgia State Health Assessment report and additional data sources, as well as the
266 goals of the Healthy People 2020 and National Prevention Strategy to identify public health priorities that
267 demonstrate achievable opportunity for improvement.

268
269 Georgia’s SHIP emphasizes that health equity is a major priority in all health areas, that involvement of
270 health partnership to leverage resources and that a strong public health infrastructure is essential to
271 achieve the health priority outcomes.

272

273

274 **SHIP and Strategic Planning**

275 DPH collaborates with hospital, public and private health organizations, state and local agencies, and
276 other stakeholders throughout the state to develop and implement programs and strategies. Keeping in
277 alignment with statewide goals, these strategies address local needs to improve the health of our
278 communities. DPH solicited community input in establishing the Georgia Department of Public Health
279 Strategic Plan. The overarching goals of the SHIP are tied to the DPH’s Strategic Plan.

280

281 The SHIP aligns with the following DPH Strategic Plan objectives:

282

283 • Objective 1.1: Increase the percentage of Georgia’s Fitnessgram assessed student populations that
284 fall in the Healthy Fitness Zone (HFZ) for Body Mass Index (BMI) by 1% each year for 4 Years.
285 By 2019, 64% of Georgia’s students will fall inside the HFZ for BMI.

286

287 • Objective 1.2: By 2019, eliminate all pediatric asthma deaths in Georgia.

288

289 • Objective 1.3: By 2019, reduce the preventable infant mortality rate from 6.3 (2013) to 5.3 per
290 1,000 births.

291

292 • Objective 1.4: By 2019, decrease the annual rate of hospitalizations for diabetes by 25% (from
293 180.2 to 135) and for hypertension by 10% (from 73.3 to 65.7) over 2013 rates.

294

295 • Objective 2.1: By 2019, identify, establish and maintain programs and services to increase
296 healthcare access and access to primary care.

297

298 • Objective 2.2: By 2019, improve technological infrastructure to promote health and wellbeing by
299 collecting, analyzing and reporting health data, tracking disease and health determinants and
300 applying science and epidemiological principles to support decisions.

301

302 The SHIP advances the strategic planning goals of the department. The SHIP focuses on the importance
303 of communicating the value of Public Health Programs, evaluating outcomes to guide future investments
304 in DPH programming; and ensuring Department program investments focus on improving health
305 conditions of all Georgians.

306

307

308 **State Health Improvement Plan Process**

309 The Georgia Department of Public Health used a participatory, community driven approach guided by a
310 modified Mobilizing Action through Planning and Partnership (MAPP) assessment process to develop the
311 Georgia Statewide Health Assessment (SHA).The MAPP model outlines a series of assessments that form
312 the basis for collaborative planning.

313
314 DPH conducted four MAPP assessments. Each MAPP assessment contributed important information in
315 the development of the Georgia SHA. The community health status assessment was the primary focus of
316 the Georgia SHA report. Forces of change sessions identified factors that could affect implementation of
317 the plan. A state public health system assessment survey was distributed to core public health system
318 partners to identify strengths and weaknesses, and opportunities for improvement toward providing public
319 health services. Community themes and strengths were gathered during regional focus group forums and
320 work group planning sessions. Forum and work group members identified potential resources and
321 partners that could be leveraged and engaged for particular priorities of the plan.

322
323 The result of these conversations is included in each of the goal areas of this document. Local public
324 health agencies participated in both the regional forums and work group sessions, and provided important
325 perspectives on systems capacity from various regions of the state. As this is a “living” document, DPH
326 expects that information gathering and sharing will be an ongoing process that will be facilitated by DPH
327 during Plan implementation.

328
329 **Statewide Health Status Assessment**
330 DPH utilizes the DPH Online Analytical Statistical Information System (OASIS) <https://oasis.state.ga.us>
331 as a web-based tool that allows access to publicly available health data and statistics for the state of
332 Georgia. OASIS contains both primary and secondary data from a variety of sources. Selected Measures
333 of Health Status for 2015 were identified by a diverse group of public health professionals. This
334 information was the primary focus of the Georgia SHA report and was provided to public health partners.

335
336 **State Public Health System Assessment**
337 DPH utilized the National Public Health Performance Standards Program (NPHPSP) Local Public Health
338 System Assessment (LPHS) as a guide for developing a DPH Public Health System Survey. The survey
339 assessed DPH’s activities related to providing the 10 Essential Public Health Services (EPHS).The
340 Georgia Public Health System Assessment focuses on how well the 10 essential public health services are
341 being provided. The survey looks at the components, activities, competencies, and capacities of our
342 Georgia public health system. The public health system survey was distributed to state, district and county
343 health department staff. In addition, surveys were distributed to county board of health members. The
344 survey is intended to help the DPH gain an understanding of its performance by identifying strengths,
345 weaknesses, and opportunities for improvement.

346
347 **Forces of Change Assessment**
348 The DPH in conjunction with the University of Georgia School of Public Health outreach center held a
349 session on future issues facing public health at the UGA State of Public Health conference on October 6,
350 2015.This conference was attended by a diverse group of public health professionals. In addition, the

351 DPH held a forces of change session with State and District Health Directors and staff in 2015. Information
352 from these sessions identified factors that could affect implementation of the health improvement plan.

353
354 The most significant external trends that will have the greatest impact on Public Health can be categorized
355 into four major areas: demographics, economics, policy, and health. Since each of these areas is vast and
356 complex, they are being summarized, with those factor shaving the largest effect in the near and
357 intermediate future being highlighted.

358
359 Georgia Demographics

- 360 • In just three decades—from 2000 to 2030—Georgia’s elderly population (over 65) will increase
361 by over 140%, one of the fastest rates of increase in the country.
- 362 • While the population is aging, the number of working age residents will decline from about 6
363 persons per elderly resident to around 3.5 in 2030.
- 364 • An aging population will place a heavy burden on healthcare resources, including those that are
365 provided by the state.
- 366 • Georgia’s population has been growing at twice the national average.
- 367 • More counties are becoming “majority minority”; since 2000, five counties, including four in
368 Metro Atlanta, have undergone this change.

369
370 Key Economic Issues

- 371 • The economy at the state and national levels is showing steady improvement.
- 372 • Between 2008 and 2012, the percentage of children in poverty increased from 20% to 27% of
373 persons under age 18.
- 374 • While unemployment has dropped from over 10% to 6.3%, the state still has not regained all the
375 jobs lost in the Great Recession.
- 376 • State revenue collections have been growing steadily in recent years. Three quarters of the way
377 through FY 2015, there has been a 6.1% increase.

378
379 Health Policy Considerations

- 380 • The Patient Protection and Affordable Care Act took effect in 2014 and will result in the
381 following changes in the healthcare landscape.
- 382 • All insurance plans will provide for expanded services encompassing prevention, chronic disease
383 management, tobacco cessation, maternal and newborn care, and prescription drugs.
- 384 • Before implementation of the ACA, Georgia had the fifth highest number of uninsured in the U.S.
385 with 19% of the population (1.67 million individuals) lacking coverage. According to an August
386 Gallup poll, 20% of the state’s residents are uninsured, the third highest rate in the country.
- 387 • An increase in Medicaid eligible population, coupled with a decrease in the number of providers
388 accepting Medicaid patients could result in a significant increase in demand for local public
389 health services.
- 390 • In 2013, 69.8% of children 19-35 months were fully immunized a slight decline from previous
391 years.

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- Throughout the state, there are significant health disparities by race, ethnicity, population density, education, and county of residence. According to the UHF, the difference between the healthiest and unhealthiest counties in terms of overall mortality rates within Georgia is getting worse.
 - There are substantial shortages of health professionals in the state especially in rural areas.

397 **Community Themes and Strengths Assessment**

398 DPH held 5 regional focus group forums with public health partners across the state. The forums were
399 facilitated by Georgia Southern University Jiann-Ping Hsu College of Public Health, to gain feedback on
400 health data, identify priority health issues, identification of available assets and resources. DPH subject
401 matter experts presented the Selected Measures of Health Status 2015. Participants were asked to provide
402 feedback on important health issues in their area, what actions should DPH take to address these health
403 issues, and what assets are available to assist the DPH in addressing these health issues.

404 In addition, DPH presented the Selected Measures of Health Status 2015 to the Board of Public Health
405 and the District Health Directors, who serve as executive directors of the county boards of health. Local
406 public health agencies participated in the focus group forums and in workgroup sessions to provide
407 important perspectives on systems capacity from various regions of the state.

408
409 Feedback from these forums identified three priority areas for health improvement: Access to Health
410 Care; Chronic Disease; and Maternal and Child Health. On April 28, 2016, DPH staff and public health
411 partners met around these three focus areas to establish priorities, identify strategies and resources, and
412 establish performance metrics. This meeting formed the basis for the Georgia SHIP.

413
414

415 **Role of Partners in Plan Development Process**

416 DPH invited public health partners to participate in the development of the Georgia SHIP. All DPH
417 partners received an invitation to attend the 5 regional focus group forums. Public Health District offices
418 and local health departments were encouraged to attend and invite local partners to the regional forum in
419 their area. Once health priorities were identified from the focus group forums, DPH invited public health
420 partners to participate in the development of the Georgia SHIP around the three health priority focus
421 areas. See Appendix A for a list of participants of the SHIP development meeting.

422

423 **Selection of Priority Areas**

424 DPH invited all public health partners (list is provided in the Georgia SHA) to participate in five regional
425 forums. Each forum lasted three hours including a one hour presentation by the Georgia Department of
426 Public Health (DPH) followed by a two hour open discussion of regional health needs. The open forum
427 discussion was facilitated by the Georgia Southern University Jiann-Ping Hsu College Center for Public
428 Health Practice and Research (CPHPR) team members. The discussions were guided by three overarching
429 questions: 1) *What are the top health issues in your community?* 2) *What are the community assets*
430 *available to help tackle these problems?*, and 3) *What do you think the DPH should be doing to address*
431 *the top health issues.* During each forum, the facilitators used large and small group discussions to illicit
432 as much discussion as possible. Lead team member, Dr. Ashley Walker, followed Nominal Group
433 Technique principles to ensure that all participants were given an opportunity to speak. On average, each
434 question was discussed for approximately 20-25 minutes.

435

436 After the open discussion of questions one and three, participants were given the opportunity to vote. For
437 question one, *what are the top health issues in your community?* Participants voted for three of the health
438 issues discussed by the entire group. These votes were tallied in order to determine the top health issues
439 for each forum. The results of this process guided the discussion of both questions two and three. For
440 question two, *what are the community assets available to help tackle these problems?* Participants first
441 discussed community assets and then determined which health issues the community asset could address.
442 Following this discussion, the group briefly discussed possible interventions. This discussion prepared the
443 group for the final question of the forum, *what do you think the DPH should be doing to address the top*
444 *three health issues?* This discussion was completed in small groups followed by a large group sharing
445 session. After the sharing session, each participant voted using for their top five action items. The voting
446 process aided in the prioritization of health issues and action items for each forum and also allowed the
447 CPHPR team to determine overall state issues.

448

449 **Health Priority Area Workgroups**

450 Public health partners were invited to attend a SHIP development session, held on April 28, 2016, around
451 the three health priority areas: Access to Health Care, Chronic Disease and Maternal and Child Health.
452 Three work groups were established around the 3 priority areas. Chronic disease and Maternal & Child
453 Health built around existing partner advisory groups. Access to Health Care is a new advisory partner
454 group established. These workgroups met to identify priorities, identify evidence based or promising
455 practices as strategies for improving health, and establish performance measures in these priority areas. In
456 addition, assets were identified where resources can be leveraged to address specific health issues. Work
457 groups continue to meet to evaluate progress, review new data and information, and make adjustments to
458 plan strategies to achieve goals and objectives.

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The work group sessions were facilitated by a consultant, in collaboration with work group chairs and DPH staff. Work groups selected indicators that were relevant to the specific areas of concentration and goals; that represented long-term performance metrics; and for which surveillance systems existed. Objective targets were determined by reviewing historical data for each indicator. Once the objectives were developed, each work group identified evidence-based strategies from authoritative sources. Responsible parties for implementation of strategies are established in the plan.

Community engagement at multiple levels is critical throughout all components of a health improvement planning process, from conducting the state health assessment, to developing and implementing the state health improvement plan. Involving a broad range of stakeholders and developing multi-sector partnerships led to the creation of this actionable and sustainable Plan. In addition to being involved on the regional forums and serving in focus area work groups, community partners were invited to provide input and feedback as the Plan was drafted.

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476 **Themes Identified Through the Planning Process**

477

478 During the SHIP planning process, the relationships between some of the priority areas was noted. In
479 addition, several cross-cutting themes or needs were identified that impact the ability of the State of
480 Georgia, DPH, and partners across the state to achieve change on the priorities listed in the plan. These
481 themes were--

- 482 • Social Determinants of Health
- 483 • Cross-Sector Collaborations
- 484 • Health Equity
- 485 • Funding

486 **Social Determinants of Health (SHD)**

487 According to the World Health Organization, the social determinants of health (SDH) are “the conditions
488 in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the
489 conditions of daily life.” These include education, level of income, housing, and access to health care.
490 The participants in the planning process noted that Georgia’s Health Assessment indicates that persons
491 living in Georgia, especially children, experience higher rates of poverty than in the U.S. as a whole,
492 which influences lifelong health outcomes, and thus might make it more challenging and also all the more
493 important to achieve the objectives listed in this plan.

494

495 **Cross or Multi-Sector Collaborations (MSC)**

496 The health care delivery system and governmental public health alone or together cannot achieve the
497 improvements in outcomes described in this plan; cross-sector or multi-sector collaborations are
498 essential. Other sectors essential to the achievement of the goals in this plan include but are not limited to
499 housing, education, business, and transportation. To be most effective, these collaborations need
500 leadership support, clear communication, and common metrics. Participants in the process discussed the
501 need for collaborations in order to support the ideas reflected in this plan.

502

503 **Health Disparities and Health Equity (HD/HE)**

504 Georgia is a diverse state, and according to the Georgia Health Assessment, various populations face
505 significant health disparities across different health outcome areas. For example, African American
506 women are more likely to die of breast cancer than white women in Georgia. Low income children are
507 more likely to be overweight or obese. And, white males in rural communities are more likely to use
508 tobacco products than other population groups in Georgia. Health equity is the idea that, in addition to
509 addressing these disparities, Georgia could create the conditions in which all individuals have an equal
510 opportunity to achieve health, regardless of race, ethnicity, income, childhood experiences, education
511 level, or geography. Participants felt that health equity was an important consideration in both the
512 priorities areas selected as well an important framework for action on many of the priority areas.

513

514 **Funding(\$)**

515 Given Georgia’s ranking of 40th among all states for health outcomes by the America’s Health Rankings
516 in 2015, participants note that funding was an important consideration and potential barrier for achieving
517 the objectives in the plan. While not all priorities require additional funding in order to make measureable
518 progress and low-cost policy and environmental changes exist for several priority areas, some areas have

519 no current funding and/or are funded solely by grants and cooperative agreements with the federal
520 government. Funding considerations, therefore, was something participants noted might be important to
521 identify in the final plan.

522

523 To reflect where these themes or issues are most relevant to a priority, the topics are indicated within the
524 plan near the title of each priority using the symbols below. In addition, within the plan, the relationship
525 between topics is noted in the text of each priority.

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529 **Focus Area: Access to Care**

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533 **Access to Health Care**

534

OBJECTIVE: INCREASE THE NUMBER OF ACCESS TO CARE PARTNERSHIPS.

2016 Baseline	2020 Target
0 Total	5 Total

535

536 **BACKGROUND**

537 Access to care was identified as a statewide health priority through the Community Health Assessment. During the assessment, stakeholders,
538 including members of the community, were able to express the health needs in their region and prioritize these needs. Access to care was identified
539 as a top health issue in each regional forum because of its influence on overall health, its intersection with the majority of other health issues
540 identified in each regional forum, and because lack of access to care increases health disparities already present in communities.

541 According to the Georgia Department of Community Health, approximately 80% of the 159 counties in Georgia meet the definition of a primary
542 care health professional shortage. Hospital closures are also on the rise throughout rural parts of the state. The Georgia Department of Public
543 Health recognizes the personal and societal cost related to poor access to care, and addressing this is a statewide health priority.

544 National Healthcare Disparities Reports published by the Agency for Healthcare Research and Quality (AHRQ), reveal that a disparity exists
545 among racial and ethnic minorities and people of low socioeconomic status (SES) and those who have access to health care. A recommendation of
546 the National Prevention Strategy is to reduce barriers to accessing clinical and community preventive services, especially among populations at
547 greatest risk.

548

549 Healthy People 2020 acknowledges that improving health care services includes increasing access to and use of evidence-based preventive
550 services. These are services that prevent illness by detecting early warning signs or symptoms before they develop into a disease (primary
551 prevention), and detecting a disease at an earlier and often more treatable stage (secondary prevention). Similarly, the 2012 Institute of Medicine
552 Report, Primary Care and Public Health: Exploring Integration to Improve Population Health, established that improving population health will
553 require activities in three domains: (1) efforts to address social and environmental conditions that are the primary determinants of health, (2) health
554 care services directed at individuals, and (3) public health activities operating at the population level to address health behaviors and exposures.

555 The Centers for Disease Control and Prevention’s Practical Playbook: Public Health and Primary Care Together, makes the case that strong
 556 partnerships can increase public health’s effectiveness in critical ways, such as increasing public health access to individual level data,
 557 strengthening public health efforts to achieve health equity, maximizing funding opportunities, co-locating services and linking individuals to
 558 services.

559
 560 **PLAN OF ACTION**

Strategies	Activities	Partners
Support legislative changes to maximize the health care workforce.	Enhance partnerships to initiate and advocate for legislation that would allow Advanced Practice Registered Nurses to operate within their full scope of practice each legislative session.	Department of Public Health Georgia Nursing Leadership Coalition Advanced Practice Registered Nurse Consultants
Increase access to primary care through comprehensive school-based health centers throughout Georgia.	Increase the number of comprehensive school-based health centers throughout Georgia by 10% each year.	Department of Juvenile Justice Children’s Healthcare of Atlanta Department of Education GA Association of School Nurses Emory School Based-Health Alliance
Develop a statewide infrastructure for health information technology (HIT)/community patient health records	Foster partnerships to advocate for school nurse funding and legislative changes to facilitate the placement of one full-time Registered Nurse (RN) in every school district.	
	Collaborate with the Division of Information in developing a statewide patient health record as part of the Enterprise System Modernization initiative.	Morehouse School of Medicine Department of Public Health Department of Community Health
	Hold local community meetings with	

DRAFT

Improve local community engagement, collaboration and partnerships aimed at improving access to care

providers to discuss patient health records and the importance of collaboration and sharing annually.

Convene annual meetings to enhance and foster partnerships between non-profit organizations, government agencies, health care providers, hospitals, schools and school nurses, religious and community organizations, businesses and the Chamber of Commerce in local communities to promote access to care.

GA Hospital Association
Department of Juvenile Justice
GA Dental Association
Department of Public Health
Chamber of Commerce

Develop one resource database to include available community services by county, evidence-based interventions and a dashboard for community health improvement reports.

Ensure comprehensive medical coverage for all Georgia's citizens through promoting awareness, utilization and increase of coverage options.

Develop and implement one collaborative approach to ensure eligible individuals are enrolled in coverage.

Department of Public Health
Voices for Georgia's Children
Department of Community Health,
Office of Rural Health

Develop partnerships to advocate for options to close the coverage gap in Georgia during each legislative session.

<p>Identify opportunities to embed telehealth into systems of care, including ensuring integrated strategies for increasing access to specialty care services, to enhance patient experience while creating supportive environments, particularly in rural areas</p>	<p>Increase funding for telehealth capabilities through grant opportunities and advocacy for state funding each legislative session.</p> <p>Increase the number of comprehensive school-based health centers utilizing telehealth services by ensuring placement of technology and providers in the centers by 10%.</p> <p>Conduct one statewide communications awareness plan for existing telehealth capabilities.</p>	<p>GA Partnership for Telehealth Department of Public Health Emory, School-Based Health Alliance Voices for Georgia’s Children Department of Behavioral Health and Developmental Disabilities Department of Juvenile Justice Department of Community Health</p>
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SOCIAL DETERMINANTS OF HEALTH

Access to care is largely determined by the social determinants of health. Factors such as education, employment, race and SES all impact one’s ability to access care. An inability to access care can further propel disparities. The strategies outlined in the state plan seek to increase access to care for all populations, particularly those most affected by the social determinants of health, by increasing access to care in schools and utilizing telehealth.

Georgia has consistently ranked low on health status and socioeconomic measures compared to the other states. In the latest United Health Foundation report (2015) Georgia is 40th for overall health among all states. The Georgia Department of Labor indicates that the unemployment rate is 5.1%. However, 30.5% of Georgia’s population is African American, who fare worse in measures such as poverty, home ownership, high school graduation rates and unemployment. Furthermore, the unemployed population experiences worse health and higher mortality rates than the employed population.

According to the 2016 County Health Ranking and Roadmap data, Georgia has an overall high school graduation rate of 73% with a minimum range of 42%. Evidence links maternal education with the health of children, as education levels often determine the resources available to the children and the quality of schools that the children attend.

578 People living in poverty or with lower socioeconomic position are more likely to have worse access to healthcare, and children living in poverty
579 are especially vulnerable. The United States Census Bureau’s 2014 data indicates that 18.3 percent of Georgia’s population met the national
580 poverty level. According to the 2016 County Health Rankings and Roadmaps, 26 percent of children under age 18 in Georgia are currently in
581 poverty, which is the equivalent of 1 in 5 children.

582
583 While negative health effects resulting from poverty are present at all ages, children in poverty experience greater morbidity and mortality than
584 adults due to increased risk of accidental injury and lack of health care access. Healthy People 2020 recommends a full-time registered school
585 nurse-to-student ratio of at least 1:750. However, unofficial numbers from the 2014-2015 school year indicate that the ratio of nurse, both licensed
586 practical nurses and registered nurses, is closer to 1 to 1,245 students. Furthermore, the 15 comprehensive school based health centers in the state
587 of Georgia are not sufficient enough to support the many students and communities with significant barriers to healthcare.

588
589 **POLICY CHANGES NEEDED**

590 Although several of the strategies and activities listed in the state plan include policy/legislative changes that alleviate causes of health inequity,
591 the following issues need to be addressed:

- 592 • Changes in scope of practice for health care practitioners
- 593 • Reimbursement for services provided
- 594 • Increases in reimbursement rates
- 595 • Reductions in the administrative burden for providers
- 596 • Policies to increase the number of providers, particularly in rural areas, including loan repayment programs for providers

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Focus Area: Maternal and Child Health

1. Infant Mortality
2. Pediatric Oral Health
3. Maternal Mortality
4. Systems of Care for Children with Special Health Care Needs
5. Congenital Syphilis

DRAFT

607 **Infant Mortality**

608

OBJECTIVE: BY 2019, REDUCE THE PREVENTABLE INFANT MORTALITY RATE FROM 6.3 (2016) TO 5.3 PER 1,000 BIRTHS

2016 Baseline	2020 Target
6.3 per 1,000 births	5.3 per 1,000 births

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610

611 **BACKGROUND**

612 Infant mortality is the death of a baby before his or her first birthday. The state infant mortality rate, number of infant deaths per 1,000 live births,
613 is indicative of the health and well-being of that state. Infant death is most often a result of genetic and congenital anomalies but equally is a result
614 of social determinants of health such as education and poverty.

615

616 Georgia’s infant mortality rate declined from 2008 to 2010 by more than 25%. From 2010 to 2013, the infant mortality rate increased from 6.3 to
617 7.2. The infant mortality rate among Hispanics and non-Hispanic Blacks increased during this period, each by 1.3 deaths per 1,000 live births. The
618 Healthy People 2020 objective for the infant mortality rate is 6.0. Georgia’s infant mortality rate among non-Hispanic Blacks (11.2) is twice as
619 high compared to non-Hispanic Whites (5.5). Both non-Hispanic Whites and Hispanics exceeded the Healthy People 2020 objective in 2013.

620 Approximately half (53.1%) of Georgia’s infants were placed to sleep on their back in 2011. The Healthy People 2020 objective for this measure
621 is 75.9%. More mothers who were over the age of 24 and non-Hispanic White placed their infant on the back to sleep than mothers 24 years of age
622 or less and mothers of other racial/ethnic groups. Over half of mothers less than 20 years old reported placing their infant on its side or stomach to
623 sleep. Only 38.8% of White mothers reported placing their infant on their side or stomach while approximately 57.0% of Black and Hispanic
624 mothers did.

625

626 Infant mortality is caused by a multitude of factors including genetics, congenital anomalies, injury, maternal complications and preterm birth.

627 Preterm and low-birth weight are the number one causes of infant mortality in Georgia. Both preterm birth and low-birth weight are strongly

628 correlated with the individual environment, health status and socio-economic status of the infant’s birth mother. Studies have shown that
 629 preventing sleep related deaths and reducing preterm birth are strategies that may result in lower infant mortality rates.

630

631 **PLAN OF ACTION**

Evidence-Based Strategies	Activities	Partners
<p>Increase the number of birthing hospitals participating in the 5-STAR Hospital Initiative, a Georgia Hospital Association and DPH designation for hospitals that have revised policies, practices and environmental changes that encourages and supports breastfeeding</p>	<p>Recruit hospitals through in-person presentations on the 5-STAR Hospital Initiative</p> <p>Provide in-person trainings to hospitals participating in the initiative</p> <p>Recognize hospitals for participating in the 5-STAR Hospital initiative. The hospital recognized will receive a 5-STAR plaque for meeting the Baby friendly requirements.</p> <p>Recruit birthing hospitals by providing staff with a step by step guide on implementing a Safe to Sleep Program.</p> <p>Provide in-person trainings to hospitals participating in the program</p>	<p>Brook Cologan, Maternity QI Consultant/Trainer</p>
<p>Encourage birthing hospitals to have policies and education that adhere to the American Academy of Pediatrics (AAP) safe sleep guidelines</p>	<p>Provide participating hospitals with education resources for staff and caregivers on the safe infant sleep recommendations.</p> <p>Collect pre and post crib audits, and policy statements, from participating</p>	<p>Georgia Chapter - American Academy of Pediatrics, Georgia Hospital Association, American Congress of Obstetricians and Gynecologists, individual birthing hospitals</p>

	hospitals.	
	Recognize hospitals for implementing a Safe to Sleep Program and policy	
Increase the percentage of women (ages 15 – 44) served in public health family planning clinics who use long-acting reversible contraception (LARC)	Increase the number of Advanced Practice Registered Nurses (APRN) in public health family planning clinics to improve access to LARCs	Health Districts and Clinics, Hospitals, OB Providers, CMOs and Medicaid, Pharmacy
	Increase the inventory of LARCs in public health family planning clinics	
Increase postpartum long-acting reversible contraception (PPLARC) in high-risk birthing hospitals	Develop and implement an Awareness campaign	
	Collaborate with hospitals to collect data on PPLARC utilization	ASTHO, Emory, PeachState, GaPQC Hospitals (Columbus Regional, DeKalb Medical Center, Grady, Navicent, Northeast Georgia, & Phoebe Putney)
Increase the number of County Health Departments providing Perinatal Case Management (PCM) services		CMOs, Health Clinics, Centering Programs, OB Providers

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SOCIAL DETERMINANTS OF HEALTH

According to RAND Corporation and Harvard School of Public Health researchers Kim and Saada, social determinants of infant mortality include material factors/social resources, social determinants such as individual/area level socio-economic status, race/ethnicity, and social capital. All of

636 which shape individual level determinants, including behavioral factors (e.g., maternal smoking), biological factors, and psychosocial factors (e.g.,
637 social support) for infant mortality. These determinants impact women of reproductive age across the U.S. and Georgia. With non-Hispanic Black
638 infants being born into environments with greater risk to infant mortality due to social determinants, Georgia's infant mortality rate was 7.2 in
639 2013, with the rate of death for non-Hispanic Black infants being twice that of non-Hispanic Whites.

640

641 **POLICY CHANGES NEEDED**

642 Policy changes are not required to accomplish the strategies and activities listed.

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643 **Pediatric Oral Health**

644

OBJECTIVE: INCREASE THE PERCENTAGE OF CHILDREN, AGES 1 THROUGH 17 WHO HAD A PREVENTIVE DENTAL VISIT IN THE LAST YEAR FROM 76.7 TO 79.8 BY 2020.

2016 Baseline	2020 Target
76.7%	79.8%

645

646 **BACKGROUND**

647 In 2011-2012, 18.6% of Georgia’s children had decayed teeth or cavities. In the same time frame, the US average was 19.4%. Surgeon General,
648 Donna E. Shalala, PhD, released the first and only Surgeon General’s Report on Oral Health. This report highlighted the correlation between oral
649 health and overall health, the disparities in oral health among Hispanics and, the populations, including children, at greatest risk for poor oral
650 health. These finding are consistent in Georgia with the highest percentage of tooth decay reported among Non-Hispanic Black children (24.7%)
651 while the lowest was reported among Non-Hispanic White children (13.2%). The percentage among Hispanic children (23.7%) was very similar to
652 non-Hispanic Blacks. More than 20.0% of children over the age of six had oral health problems in 2011-2012, compared to only 9.8% of children
653 ages 1 to 5. Due to changes in survey methodology, trend data for this measure is not available.

654

655 The percentage of children receiving a preventive dental visit in the past year decreased from 80.3% in 2007 to 75.9% in 2011-2012. Georgia
656 exceeded the national average of 78.4% in 2007, but was lower than the average of 75.9% in 2011-2012. There were disparities by race/ethnicity.
657 Parents of Hispanic children in Georgia reported the lowest percentage of preventive dental visits (69.6%) compared to both the national estimate
658 for Hispanic children (73.9%) and peers of other races in Georgia.

659

660 As stated, the Surgeon General’s Report: *Oral Health in America encouraged a call to action to promote oral health.* Within Georgia, the most
661 sizable ethnic disparity for childhood dental visits was in Hispanic children ages 1 to 17 years old in 2011/12. Only 69.6% of Hispanic children
662 had one or more preventive dental care visits (check-ups and cleanings) compared to 73.9% of Hispanic children nationally and 77.5% of non-
663 Hispanic White children in Georgia.

Evidence-Based Strategies	Activities	Partners
Engage active partners to promote perinatal oral health	Partner with districts, private practice, education at dental hygiene programs, the Augusta University, Dental College of Georgia to promote perinatal oral health screenings	American Dental Hygienist Association, Georgia Academy of Family Physicians, Georgia Public Health Districts, Georgia WIC
Develop one oral health resource database for Children with Special Healthcare Needs	<p>Educate and update district oral health staff on special considerations and treatment needs for special needs patients</p> <p>Offer comprehensive educational webinars/presentations</p> <p>Determine data sources and begin collecting data to develop a special needs dental access database with location of practices serving special needs children and adults/special services offered, such as general anesthesia, orthodontics, insurance accepted and other specialties</p>	GA Dental Association, GAPHC (FQHC)
Promote oral health among low-income Hispanic mothers and children in Georgia	The Oral Health Education Initiative program for low-income Hispanic children and adolescents will revise its education to reduce barriers in language and cultural differences among Hispanic populations	GA Department of Education, Georgia Public Health Districts

The revised educational materials will be
used in the program design and tested
with Hispanic populations

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666

667 **SOCIAL DETERMINANTS OF HEALTH**

668 Members of racial and ethnic minority groups also experience a disproportionate level of oral health problems. Individuals who are medically
669 compromised or who have disabilities are at greater risk for oral diseases, and, in turn, oral diseases further jeopardize their health. The reasons for
670 disparities in oral health are complex. In many instances, socioeconomic factors are the explanation. In other cases, disparities are exacerbated by
671 the lack of community programs such as fluoridated water supplies. People may lack transportation to a clinic and flexibility in getting time off
672 from work to attend to health needs. Physical disability or other illness may also limit access to services. Lack of resources to pay for care, either
673 out-of-pocket or through private or public dental insurance, is clearly another barrier. Fewer people have dental insurance than have medical
674 insurance, and it is often lost when individuals retire. Public dental insurance programs are often inadequate. Another major barrier to seeking and
675 obtaining professional oral health care relates to a lack of public understanding and awareness of the importance of oral health.

676

677 **POLICY CHANGES NEEDED**

678 Policy changes are not required to accomplish the strategies and activities listed.

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680

681 **Prevent Maternal Mortality**

682

OBJECTIVE: BY 2020, PARTNER WITH THE DEPARTMENT OF PUBLIC HEALTH CHRONIC DISEASE DIVISION TO DEVELOP AND IMPLEMENT TARGETED EDUCATION AND MARKETING CAMPAIGN TO PROMOTE WELL WOMAN VISITS FROM 62.1% TO 64%

2016 Baseline	2020 Target
62.1%	64%

683

684 **BACKGROUND**

685 The World Health Organization (WHO) definition for maternal death is the death of a woman while pregnant or within 42 days of termination of
686 pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but
687 not from accidental or incidental causes. Most maternal deaths are preventable. However, all women need access to antenatal care in pregnancy,
688 skilled care during childbirth, and care and support in the weeks after childbirth.

689

690 In 2010, Amnesty International released a report entitled “Deadly Delivery: The Maternal Health Care Crisis In The USA”, which listed Georgia
691 as the state with the highest maternal mortality rate in the nation. Based on data from 2001-2006, Georgia’s pregnancy related maternal mortality
692 rate was 20.2 deaths per 100,000 live births and has been rising ever since. In 2009, Georgia had a pregnancy-related maternal mortality rate of
693 24.8 deaths per 100,000 live births, in 2010 the rate was 23.2, and in 2011 the rate increased to 28.7. Between 2009 and 2011, approximately half
694 (48.5%) of the Georgia women entering pregnancy were overweight/obese. The percentage was highest among Non-Hispanic Blacks (58.0%) and
695 lowest among Non-Hispanic Whites and others (42.0% and 37.7%). As maternal age increased, so did the percent of women entering into
696 pregnancy obese. Only 46.1% of women with more than a high school education were obese entering into pregnancy, compared with 52.3% of
697 women with less than a high school diploma.

698

699 The maternal mortality ratio increased from 11.5 (n=16) in 2004 to 43.6 (n=56) in 2013. These deaths were identified by the cause of death on the
700 death certificate, which can underestimate the true prevalence of maternal deaths. Georgia recently implemented a Maternal Mortality Review

701 Committee that thoroughly reviews vital records to identify maternal deaths. The committee identified 25 pregnancy-related and 60 pregnancy-
 702 associated deaths in 2012. Of the deaths that were related to pregnancy, 17 of the women were Black, 6 were White and 1 was Hispanic. The
 703 deaths occurred at a higher percentage among women with a high school diploma or less.

704 **PLAN OF ACTION**
 705

Evidence-Based Strategies	Activities	Partners
Implement the use of the "Every Woman" video in primary care facilities and family planning clinics throughout the state.	<p>Educate District Health Directors and Family Planning Staff on how to effectively implement the use of "Every Woman" video.</p> <p>Partner with community stakeholders to train primary care providers, clinics, and other facilities on the "Every Woman" video.</p>	<p>Chronic Disease Section, District Family Planning Clinics, Georgia OBGyn Society (GOGS), United Way of Greater Atlanta, March of Dimes, Georgia Hospital Association</p>
Conduct statewide focus groups to assess what women know and how they learn about pregnancy-related health during their reproductive years.	<p>Develop a plan to facilitate statewide focus groups for women, including creating an evaluation plan and tools.</p> <p>Collect and analyze qualitative data from focus groups to make strategy recommendations to improve well woman visits.</p> <p>Collaborate with Chronic Disease to develop messaging around women's health visits to different audiences.</p>	<p>Chronic Disease Section, District Family Planning Clinics, Georgia OBGyn Society (GOGS), United Way of Greater Atlanta, March of Dimes, Georgia Hospital Association</p>
Establish an interagency workgroup to develop tiered education and marketing strategies to	<p>Work with Communications Team to create a plan to promote well woman visits</p>	<p>Chronic Disease Section, District Family Planning Clinics, Georgia OBGyn Society</p>

promote well woman visits to women's health stakeholders such as medical providers, health districts, and members of community.	in different media outlets throughout the state.	(GOGS), United Way of Greater Atlanta, March of Dimes, Georgia Hospital Association
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707 **SOCIAL DETERMINANTS OF HEALTH**

708 Georgia's Maternal Mortality Review Committee identified 25 pregnancy related deaths. Of the deaths that were related to pregnancy, 17 of the
709 women were Black, 6 were White, 1 was Hispanic and 1 was unknown. The most common cause of death among pregnancy-related cases was
710 hemorrhage. Hemorrhage and several other causes are impacted by a myriad of social determinants that impact health behavior and access to
711 intervention. Social determinants such as racial/ethnic identity, income, access to insurance and health care, education and, social and physical
712 environment.

713 In 2013, the percentage of women in Georgia who received a preventive medical visit within the last year was nearly 69%. Although the overall
714 percentage is higher than the national average, disparities by race/ethnicity and education were seen, with more women with higher educational
715 attainment and non-Hispanic Black women visiting a provider for a comprehensive medical exam.

716

717 **POLICY CHANGES NEEDED**

718 Policy changes are not required to accomplish the strategies and activities listed.

719 **Children with Special Health Care Needs**

720

OBJECTIVE: INCREASE THE PERCENT OF ADOLESCENTS WITH SPECIAL HEALTH CARE NEEDS WHO RECEIVED SERVICES NECESSARY TO MAKE TRANSITIONS TO ADULT HEALTH CARE FROM 36.9 TO 40 BY 2020.

2016 Baseline	2020 Target
36.9%	40%

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722

723 **BACKGROUND**

724 In 2009-2010, 17.4% of Georgia’s children and youth with special health care needs (CYSHCN) were receiving care in a well-functioning system.
725 A well-functioning system meets all federal requirements for family partnership, medical home, early screening, adequate insurance, easy access
726 to services and preparation for adult transition. The highest percentage of CYSHCN receiving these services were reported among children with
727 household income levels greater than 400% of the federal poverty level. The percentage decreased as income level decreased. Only 12.2% of
728 CYSHCN adolescents received care in a well-functioning system compared to 21.0% of CYSHCN ages 6 to 11. Racial disparities are present as
729 well. White CYSHCN reported receiving care in a well-functioning system more often than Blacks. Due to changes in survey methodology, trend
730 data are not available for this measure.

731

732 During 2009-2010, CYSHCN in Georgia received services necessary to make the transition to adulthood less frequently than in the United States
733 as whole. While 25.3% of Hispanic CYSHCN across the nation reported receiving services, only 14.0% did in Georgia. Among Non-Hispanic
734 Whites, 43.6% indicated receiving transition services. Parents with a higher education reported that their children received transition services more
735 often than parents with lower educational attainment.

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737

738 **PLAN OF ACTION**

Evidence-Based Strategies	Activities	Partners
<p>Increase screening and identification through a coordinated system</p>	<p>Create a connected health record system</p> <p>Use of school-based clinics as screening sites</p> <p>Use telehealth access as screening sites</p> <p>Expand behavioral screening to youth through telemedicine</p> <p>Increase formal screening within physician offices</p> <p>Utilize SENDSS; provide education on SENDSS</p> <p>Expand developmental screening within health departments</p>	<p>A.GA Association of School Nurses (GASN), DJJ, DPH, DCH, ACOG, AAP, OB-GYN, Parent to Parent of GA, DOE, The Children’s Care Network (CIN), Sickle Cell Foundation of Georgia, CHOA</p>
<p>Use technology and telemedicine to increase access to specialty care</p>	<p>Assess the infrastructure needs for telehealth across GA</p> <p>Educate families on telemedicine</p> <p>Provide comprehensive telehealth information to providers</p> <p>Provide a coordinated telehealth system for families and providers</p> <p>Perform community assessment on specialty care gaps and service needs</p> <p>Develop a computer-based</p>	<p>B.DCH, CHOA, AAP, AFP, OB-GYN, DJJ, P2PGA, GASN</p>

<p>Increase transportation for families</p>	<p>resource directory Connect Electronic Medical Record System (EMRS) Encourage peer to peer education on telemedicine DJJ Re-entry Initiative – Include the health component to connect them to providers in their communities Use telehealth to increase access to care coordination, speech therapy and access to hematology services Provide transportation vouchers Perform assessment of transportation services Increase awareness of, and the number of transportation services Cover liability insurance for church vans</p>	<p>C.Marta, Transportation contracts with Uber and Lyft, DCH, Local Church, EMS, DJJ</p>
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740 **SOCIAL DETERMINANTS OF HEALTH**
741 Implementing a systematic change in services is challenging but not impacted by social determinant of health.

742 **POLICY CHANGES NEEDED**
743 Policy changes are not required to accomplish the strategies and activities listed. However, several provider practices and programs that serve
744 CSHCN will need to revise internal protocols to accommodate system changes.

DRAFT

746 **Congenital Syphilis**

747

OBJECTIVE: DECREASE THE RATE OF INFANTS BORN W/CONGENITAL SYPHILIS FROM 13.0 (PER 100,000 LIVE BIRTHS) TO 11.7 BY 2020

2016 Baseline	2020 Target
13.0 per 100,000 live births	11.7 per 100,000 live births

748

749 **BACKGROUND**

750 Congenital syphilis can cause miscarriage, stillbirth, failure to thrive, deformed bones, meningitis, and nerve problems leading to blindness or
751 deafness. Primary and secondary syphilis are the infectious stages of syphilis and are therefore the most important cases to interview and find and
752 treat partners in order to prevent further transmission. After a low point in the 90’s where elimination was discussed, there has been a steady rise in
753 cases. The main forces causing the increase seem to be an increase in the use of internet sites to find anonymous partners and increases seen in the
754 MSM population.

755 Across the country, it appears black, non-Hispanic males are most affected by primary and secondary syphilis and have shown increased case
756 counts over the past several years.

757 There was a low of congenital syphilis cases in Georgia during 2005, but from 2005 through 2013 Georgia has seen a rise in cases. The case
758 definition for congenital syphilis does not necessarily count if the child was born with symptoms of the disease, but instead measures if there was a
759 missed opportunity that kept the mother from being treated correctly before the child’s birth. CDC has estimated only four women have to be
760 diagnosed with syphilis before there is a congenital case, so that is why women of reproductive age are one of the priorities for case follow-up. In
761 2014, Georgia ranked 12 in the U.S. for congenital syphilis rates (13 cases per 100,000 live births). From 2010-2015, Georgia had no less than 11
762 cases in a given year and 20 U.S. states had no cases reported. Congenital syphilis is considered by the Centers for Disease Control and Prevention
763 (CDC) as a winnable battle.

764 **PLAN OF ACTION**

Evidence-Based Strategies	Activities	Partners
Make gonorrhea, chlamydia, syphilis and human immunodeficiency virus a part of routine screening checks for women/men	Supply STD clinics (public/private) and public health department family planning clinics with supplies for screening	Federally Qualified Health Centers, Primary Care Providers, and, Academic Student Health Services
Ensure the pregnancy status of females identified as a new syphilis case is known	<p>Training for professionals (health educators, pediatricians, etc.) on referral resources and STD surveillance requirements</p> <p>Educate community Interns/residents at local public health department STI clinics</p> <p>Educate providers & the general public on the new law regarding 1st and 3rd trimester testing for syphilis and HIV (HB436) Supply STD clinics family planning clinics within public health departments with supplies for treatment</p>	Georgia Obstetric and Gynecological Society, Georgia Department of Juvenile Justice, Community Based Organizations, Federally Qualified Health Centers, and Primary Care Providers
Ensure pregnant females with syphilis are adequately treated at least 30 days prior to delivery	<p>Educate primary care providers, obstetricians and partnering clinics on the methods and importance of timely treatment</p> <p>Revise disease investigation protocols to prioritize syphilis cases</p>	Federally Qualified Health Centers, Primary Care Providers and Georgia Obstetric and Gynecological Society
Ensure disease investigation for female early syphilis cases (of childbearing age)		

765

766

767 **SOCIAL DETERMINANTS OF HEALTH**

768 Congenital syphilis is subject to a blend of social and economic determinants that influence behavior and systems surrounding access to prevention
769 and treatment. Some of those determinants include:

- 770 1. Environment such as; location (housing)++; and social relationships (i.e. substance use of birth mother)
771 2. Racial/ethnic demographics
772 3. Income of birth mother
773 4. Education

774

775

776 **POLICY CHANGES NEEDED**

777 Policy changes are not required to accomplish the strategies and activities listed.

778

DRAFT

779 **Focus Area: Chronic Disease Prevention and Control**

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781

782 1. Pediatric Asthma

783

2. Cancer Prevention and Control

784

3. Diabetes and Hypertension

785

4. Childhood Obesity

786

5. Tobacco Use Prevention

787

788 **Pediatric Asthma**

789

OBJECTIVE: ELIMINATE PEDIATRIC ASTHMA MORTALITY

2014 Baseline	2020 Target
11 deaths per year	0 deaths per year

790

791 **BACKGROUND**

792 During 2013, the prevalence of asthma among Georgia children was 10.8%¹ and that in adults was 8.4%². Among Georgia children, asthma was
793 more common in boys (12.6%) than girls (8.9%); in black children (16.7%) than white children (7.6%); and among those aged 5-9 years (14.1%)
794 than children in other age categories. Among adults, asthma prevalence was higher in females (11.3%) than males (5.3%); blacks (10.8%) than
795 whites (7.9%); those making less than \$25,000 (12.4%) than those making \$50,000 or more (5.7%) per year; those with less than high school
796 diploma (11.4%) than those with college degree (6.5%); and those without health insurance (10.0%) than those with health insurance (7.9%). In
797 Georgia during 2012-2013, the prevalence of current asthma was significantly higher among adults who were obese (10.7%) than adults with
798 normal body weight (7.3%). Current asthma was also more common among adult smokers than non-smokers.

799

800 **PLAN OF ACTION**

Strategies	Activities	Partners
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Implement pilot project in high-burdened health districts to demonstrate the value of a comprehensive approach to control asthma in high-risk children through increased access to guidelines-based care, asthma healthy homes visits, and self-management education.

Reach early care centers and K-12 school environments statewide with opportunities to implement asthma-friendly policies and best practices.

Support health systems and health care providers in providing evidence-based asthma care and self-management education to children with asthma and their caregivers, especially children from families with low socio-economic status.

Implement pilot projects for Asthma Quality Improvement within hospital and health system settings to improve linkages to primary care and integration of NAEPP guideline care as appropriate for the acute care setting.

Maintain GAME-CS asthma education curriculum for school and childcare settings.

Maintain Asthma Friendly School and Childcare recognition programs. Provide technical assistance and consultation on Asthma Quality Improvement projects with health systems and health care organizations.

Support initiatives integrating self-management asthma education in school-based health centers and telehealth scopes of practice.

Support development and implementation of Asthma Practice Improvement course for clinicians and care team as a part of Continued Medical Education (CME) and/or Maintenance of Certification credits (MOC).

Support the integration of Certified Asthma Educators with (AE-C)

Healthcare Systems, ACOs, Georgia CMOs, Georgia Dept. of Community Health

Public and Private School Systems, Childcare Providers and Provider organizations, Community Coalitions and CBOs Georgia Dept. of Education, Region 4 EPA

Healthcare Systems, ACOs, Health Districts

<p>Increase the number of care management organizations and/or health plans providing reimbursement for comprehensive asthma care based in National Asthma Education and Prevention Program (NAEPP) guidelines.</p>	<p>designation on clinical care teams and disease management organizations.</p> <p>Develop ROI and Business Case(s) tailored to specific healthcare systems.</p> <p>Facilitate meetings to educate high-level decision makers about asthma burden and evidence-based strategies.</p>	<p>Federal Agencies (ie. CDC 6 18, HUD, EPA), Georgia CMOs, Georgia Dept. of Community Health</p>
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SOCIAL DETERMINANTS OF HEALTH

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The strategies are aligned to the Coordinated Federal Action Plan to Reduce Racial and Ethnic Asthma Disparities and highlight the needs of populations impacted by adverse social determinants of health, such as income, race/ethnicity, housing, education, and school and local environment (outdoor air quality). Among adults in Georgia, asthma prevalence was higher in: females (11.3%) vs. males (5.3%), blacks (10.8%) vs. whites (7.9%), those making less than \$25,000 (12.4%) vs. those making \$50,000 or more (5.7%) per year, those with less than high school diploma (11.4%) vs. those with college degree (6.5%), and those without health insurance (10.0%) vs. those with health insurance (7.9%).

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POLICY CHANGES NEEDED

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The following policy changes are needed to achieve the asthma related objective listed above.

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1. A State Plan Amendment and/or Medicaid Waiver for reimbursement of comprehensive asthma care according to NAEPP guidelines, including designation and reimbursement for services offered by non-clinical providers for asthma self-management education and in-home environmental assessment. (i.e. certified asthma educators (AE-C) designation) and moderate in-home asthma trigger intervention supplies; and,
2. Adoption of local and state policies that address indoor triggers and air quality in non-owner occupied and multi-family housing environments, including establishing statewide healthy homes standard for adoption by local housing and code enforcement ordinance and legislative support for a bill that would modernize the tenability laws in Georgia to lay standards for landlord and tenant responsibilities to maintain healthy living conditions.

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821 **Cancer Prevention and Control**

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OBJECTIVE: TO REDUCE GEORGIA’S CANCER DEATH RATE AND REDUCE DISPARITIES IN CANCER MORBIDITY AND MORTALITY.

2016 Baseline	2020 Target
17,260 (2013)*	14,260*

* Excludes non-melanoma skin cancer and carcinoma in situ except urinary bladder

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824 **BACKGROUND**

825 Cancer is the leading cause of death in Georgia. In 2013, an estimated 16,630 Georgians died of cancer. The two leading cancer killers in Georgia
826 are lung and colon cancer. And, each day, more than 120 more Georgians are diagnosed with cancer. That is an average of more than 41,000 new
827 cancer cases each year. The Georgia Department of Public Health and other members of the Georgia Cancer Control Consortium, including the
828 Regional Cancer Coalitions of Georgia envision a future for our state that is free from cancer deaths and cancer-related health disparities.
829 However, the causes of cancer and its prevention, diagnosis, treatment, and care are multi-dimensional. A person’s health is not only the product
830 of the health care that she or he receives, but also the result of genetic factors, behavior, and the physical, social, and policy environment in which
831 she or he lives. As a result, there is no single approach or intervention that can reduce the impact of cancer in Georgia. Therefore, multi-faceted
832 and layered approaches to the prevention and control of cancer are needed. Statewide leadership, including leadership from the government,
833 business, academic, and non-profit sectors is also essential to cancer prevention and control. The Georgia Department of Public Health, through
834 and with the Consortium and its membership, will implement this plan and provide the statewide leadership necessary to bring together
835 communities and resources for cancer prevention and control.

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Strategies	Activities	Partners
<p>Cancer risk reduction (preventing or stopping tobacco use, improving diet, and increasing physical activity)</p>	<p>Support physical activity and healthy eating for youth; promote breastfeeding; promote healthy worksites and worksite wellness programs; support the adoption of smoke free environments; reduce youth access to tobacco and alternative tobacco products; increase people served through the Quitline</p>	<p>DPH Georgia Tobacco Use Prevention Program and Georgia SHAPE, Local Public Health Districts, the Public</p>
<p>Vaccination for Human Papilloma Virus</p>	<p>Offer HPV vaccine to boys and girls in conjunction with other vaccinations; engage community based organizations to implement cervical cancer communication programs</p>	<p>DPH, Local Public Health, Healthcare Providers</p>
<p>Screening for breast, cervical, colorectal and lung cancer</p>	<p>Promote and sustain existing community based screening programs; carry out educational campaigns; promote breastfeeding (breast cancer); conduct provider education and trainings (colorectal)</p>	<p>DPH, Academic Partners, Healthcare Providers and Associations; Local Public Health Districts, Regional Cancer Coalitions, National Partners</p>
<p>Quality cancer diagnosis and treatment</p>	<p>Disseminate information regarding CoC accreditation and use of approved guidelines and RQRS; provide technical assistance and resource to increase CoC applications from non-accredited institutions and maintain accreditation at approved centers; engage in statewide public awareness efforts to</p>	<p>Healthcare Providers and Associations, Hospitals, Georgia CORE</p>

	promote cancer care at accredited centers and increase participation in clinical trials	
Access to palliative care and survivorship	Promote integration of national palliative care guidelines into standard oncology services at all CoC cancer centers; promote earlier hospice care transitions for all CoC cancer centers; hold at least one palliative care networking event for registered CoC cancer centers; create a dissemination plan to provide best practices tools; develop a toolkit; develop and deliver education campaigns	Community Leaders, Georgia Hospice and Palliative Care Organization, National Partners
Patient case management and care coordination	Promote patient case management and care coordination; providing continuing education opportunities; educate about the patient navigator's role; engage CPNG participation in all working groups of the Comprehensive Cancer Control Plan	Cancer Patient Navigators of Georgia, Georgia CORE

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SOCIAL DETERMINANTS OF HEALTH

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While the burden of cancer is shared by all Georgians, cancer incidence and mortality is disproportionately greater among men and among minority and medically underserved populations. There are also clear disparities in the burden of cancer between the urban and rural parts of the state. Statewide maps highlight these disparities, showing the highest mortality rates in rural regions of Georgia. Men living in rural areas are more likely to die from lung cancer than men more urban parts of the state, which follows patterns of tobacco use and the absence of protections from secondhand smoke. Every Georgian should have access to appropriate cancer screening to detect the disease early and prevent morbidity and premature mortality.

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POLICY CHANGES NEEDED

849 Policy changes that support physical activity and healthy eating, promote breastfeeding, support the adoption of tobacco-free environments and
850 offer the HPV vaccination in conjunction with other required and recommended childhood and adolescent vaccinations are just a few examples
851 that could help reduce the burden of cancer in Georgia. There is no single approach or single intervention that can reduce the impact of cancer on
852 the State of Georgia; multi-faceted and layered approaches to prevention and control of cancer are needed.

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855 **Diabetes and Hypertension**

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OBJECTIVE: DECREASE THE ANNUAL RATE OF HOSPITALIZATIONS FOR DIABETES BY 25% (FROM 180.2 TO 135) AND FOR HYPERTENSION BY 10% (FROM 73.3 TO 65.7) OVER 2013 RATES

2016 Baseline	2020 Target
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180.2 and 73.3 (2013, Hospital Discharge Data)

135 and 66.7 (2019, Hospital Discharge Data)

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858 **BACKGROUND**

859 Georgia has a significant burden of preventable and controllable chronic disease in the adult population, contributing to the second leading cause
860 of premature death in Georgia—cardiovascular disease. Georgia's adult obesity rate is currently 30.5 percent, up from 20.6 percent in 2000 and
861 from 10.1 percent in 1990 (The State of Obesity, 2015). Across the state, adults age 18 or older represent 74.3% of the state’s population. 37.5
862 percent of Hispanic adults are obese, 37.5 percent of black adults are obese and 27.5 percent of white individuals are obese. Among adults, 31.2
863 percent of 26-44 year olds are obese and 35.7 percent of 46-64 year old individuals are obese (The State of Obesity, 2015). Chronic disease rates
864 corresponding to obesity are high in Georgia. Currently 35.0 percent of Georgian are diagnosed as hypertensive, ranking Georgia the 12th highest
865 state in nation for rates of hypertension. Considering this, hypertension is directly linked to obesity, with more than 75 percent of cases with a
866 demonstrated direct link (Trust for America’s Health, 2015). The health consequences and costs associated with obesity are alarming. In fact,
867 obese adults are at increased risk of developing more than **20** major chronic diseases, including cardiovascular disease and stroke, diabetes,
868 osteoarthritis, gall bladder disease and some cancers (University of Georgia, 2015). Chronic diseases—such as asthma, cancer, diabetes and heart
869 disease—cost Georgia approximately \$40 billion dollars each year, keep kids out of school, cost Georgia employers, and results in more than
870 200,000 thousands of years of life lost (Georgia Department of Public Health). Therefore, access to primary care services is essential to disease
871 prevention.

872

873 Between 2000 and 2013, there were 223,924 diabetes-related hospitalizations, in Georgia, with an age-adjusted rate of 179.1 per 100,000 persons.
874 Among adults ≥ 18 years, the age-adjusted discharge rate was highest among males (182.3 per 100,000 persons) and NH blacks (323.7 per
875 100,000 persons). The age-specific hospital discharge rate was highest among those ≥ 65 years (322.4 per 100,000 persons). From 2012 to 2013,

876 the prevalence of diabetes among Georgia adults was 10.5%. The prevalence was highest among: those aged 65-74 (25.8% vs. 2.3% for those aged
 877 18-24); Females (10.6% vs. 10.3% in males); NH blacks (12.5% vs. 9.7% for NH whites); less than high school graduates (14.3% vs. 7.5% for
 878 college graduates); those with insurance plan (11.5% vs. 6.8% for those without an insurance plan); and those making \$15,000 or less per year
 879 (13.1% vs. 7.8% for those making \$75,000 or more per year). Among Georgia diabetic adults, the prevalence of smoking was 15.9% (vs. 19.9%
 880 for non-diabetics); hypertension was 73.0% (vs. 30.2%); cholesterol was 68.4% (vs. 34.1%); overweight and obesity was 83.0% (vs. 62.7%); at
 881 least once daily fruit intake was 54.9% (vs. 56.5%); at least once daily vegetable intake was 72.9% (vs. 76.3%); and meeting physical activity
 882 recommendations was 40.1% (vs. 50.5%). These poor health outcomes disproportionately impact those without health insurance, who are
 883 unemployed or underemployed, Medicaid participants, or have limited access to primary care. Improved diabetes management is associated with
 884 consistent visits to primary care physicians. High rates of diabetes and complications from poor diabetes management is often times more likely to
 885 occur in sub-groups of the population who lack access to care. In addition, the adult workforce in Georgia are burdened by these conditions,
 886 negatively impacting economic development opportunities, particularly in rural Georgia, and reinforcing the cycle of poverty in some
 887 communities.
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889 **PLAN OF ACTION**

Strategies	Activities	Partners
<p>Develop and test approaches to improve the delivery and use of quality clinical and other health services aimed at preventing and managing high blood pressure and diabetes, reducing tobacco use, and improving nutrition and weight management. Thereby, increasing access to and use of evidence-based preventive services.</p>	<p>CATAPULT: pilot and launch DPH framework for health systems to support Georgia in improving the diagnosis and control of chronic diseases and reducing disparities.</p> <p>Use a Plan-Do-Study-Act approach to test changes in practice, policy, and/or patient management, in an existing panel of patients to improve hypertension control.</p> <p>Implement Hypertension Management Programs in which health systems partner with physician practices to focus on the</p>	<p>Hospital-based Health Systems, Clinics, FQHCs, ACOs, Georgia Association of School Nurses, Department of Behavioral Health and Developmental Disabilities (DBHDD)</p> <p>Hospital-based Health Systems, Clinics, FQHCs, ACOs, Local Public Health Departments,</p>

Increase links between aging, faith based organizations, other community organizations, EMS, public health, and health care systems to provide access to primary care in supporting prevention, self-management and control of diabetes, high blood pressure, and obesity.

Expand access to local public health services that screen for and help to control chronic conditions (primary prevention), including hypertension, diabetes/pre-diabetes/tobacco use as well as improve nutrition and weight management.

control of undiagnosed hypertension using case management and self-management plans in their patient population. (This will insure early detection of warning signs or symptoms)

Work with Pharmacists and Health Systems to provide access to primary care through comprehensive diabetes and medication therapy management to diabetic and hypertensive patients.

Establish DSME via telehealth in underserved health districts. Assist setting up linkages between sending and receiving sites and training staff at both types of sites.

Assist existing or newly accredited DSME sites in establishing satellite sites and increase the number of satellite sites by at least 3 in underserved areas though the state. DSME courses will be provided to local health districts through the telehealth system.

Establish and/or maintain accredited and evidence-based Diabetes Prevention Programs and Diabetes Self-Management Education programs in community settings, such as churches, hospitals, community centers, and senior centers.

Georgia Association of School Nurses

Hospital-based Health Systems, Clinics, FQHCs, ACOs, Local Public Health Departments

Local Public Health Departments, AADE contractor, Community Pharmacies, GPhA, School Based Health Centers, Georgia Association of School Nurses; Department of Behavioral Health and Developmental Disabilities (DBHDD)

Implement the 2016 statewide protocols for hypertension and diabetes in local health departments.

Implement the Ask, Advise, Refer model for tobacco use in all local health departments.

Increase the percentage of patients seen in local health departments with abnormal A1C levels referred to ADA or AADE accredited DSME/T.

Increase access to sustainable (billable) Diabetes Self-Management Education/Training by accrediting new DSME/T sites, particularly in high need areas of the state

Increase access to and distribution of self-monitoring blood pressure monitors for the control and management of hypertension across the state (as a primary prevention activity to improve healthy behaviors and allow for individual level data)

Georgia AAA, Hospital-based Health Systems, Clinics, FQHCs, ACOs

Local Public Health Departments, AADE contractor, Community Pharmacies, GPhA; Department of Behavioral Health and Developmental Disabilities (DBHDD), School Based Health Centers

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891 **SOCIAL DETERMINANTS OF HEALTH**

892 Social determinants of health are “the structural determinants and conditions in which people are born, grow, live, work and age.” They include
893 factors like socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to health care.
894 Social determinants of health can also be incorporated into the health care system. Implementing delivery and payment reform initiatives can
895 address the diverse needs of the populations faced with diabetes and hypertension; and insure everyone has access to care. Activities should focus
896 on linking health care and social needs such as housing, food, and income. Social Determinants of health for Type 2 Diabetes are increased age,
897 family history, culture, lack of physical activity, low socioeconomic status, education level, and access to programs to assist in the management of
898 their disease. Addressing social determinants of health is a key strategy in achieving overall health and well-being. Health care services (including
899 primary care) for chronic disease prevention should consider the social determinants of health and how these factors influence all community
900 members on their journey to optimal health. When access to primary care is unavailable, health inequity is further compounded.

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902 **POLICY CHANGES NEEDED**

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- 904 • A population-based policy and systems change approach to prevent and control hypertension is considered more effective than
905 interventions designed for individuals. According to the Centers for Disease Control and Prevention (CDC), policy and system changes
906 could help individuals with hypertension by ensuring that they receive care consistent with current guidelines and receive effective
907 antihypertensive medication if needed. Home blood pressure monitoring as a part of routine management of hypertensive patients could
include the recommendation that patients be reimbursed for a monitor and that their health care provider be reimbursed for services related

908 to patients using home blood pressure monitoring. Additionally, requiring all local health departments to conduct vital sign readings
909 (respirations, heart rate, blood pressure, weight, and tobacco usage) at all clinical visits is integral to this change process.

910 • Adoption of a uniform electronic health record to be used in each health department and clinic within the 18 public health districts across
911 the state. This will insure health related information is available to primary care providers and all community members; allowing the
912 individual to play an active role in making decisions related to their health.

913 • Adoption and implementation of the Diabetes and Hypertension Nurse Protocol by Health districts.
914 Implement a practice to screen all patients in all patients over the age of 45 for diabetes/abnormal A1C in all local health departments.
915 Screening is a key primary prevention measure in identifying the onset of diabetes and hypertension, in order to prevent the development
916 of these conditions and other associated co-morbidities.

917 • Implement the Diabetes Action Plan recommendations to increase access to screening, self-management and prevention programs.

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919 **Childhood Obesity**

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OBJECTIVE: Increase the percentage of Georgia’s Fitnessgram assessed student population that fall in the HFZ for BMI 1% each year for 10 years (10 year period ends 2022).

2016 Baseline	2020 Target
<p>60.3 % of males and 60.3% of females assessed currently fall in the Healthy Fitness Zone (HFZ) for BMI.</p>	<p>By the year 2020, 64% of males and 64% of females assessed will fall in the Healthy Fitness Zone for BMI.</p>

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922 **BACKGROUND**

923 The prevalence of childhood obesity and overweight is a significant problem in Georgia. In 2007, Georgia’s rate of childhood obesity (37.3%) was
 924 the second highest in the nation for children aged 10-17 years according to the 2007 National Survey of Children’s Health. Created in 2011, the
 925 Shape initiative aims to improve the health of young people in Georgia by offering support and opportunities to achieve a greater level of overall
 926 fitness while decreasing childhood obesity. Multiple strategies for addressing obesity, physical activity, and nutrition in children from birth
 927 through age 18 have been adopted.

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929 **PLAN OF ACTION**

Strategies	Actions	Partners
<p>Utilize effective communication/marketing approaches to promote nutrition, physical activity, and obesity prevention</p>	<p>Keep three social media platforms effectively operating with relevant content for the public</p>	<p>Sharewik, Children’s Healthcare of Atlanta, Royal Foods, The Arthur M. Blank Family Foundation, Healthways, GA Family Connection Partnership, Boys and Girls Club, Voices for</p>
<p>Promotion and dissemination of relevant and innovative research</p>	<p>Continually share partner organization resources, research and content via</p>	<p>Health Children, Harvard Public Health, GSU, Peach State, Emory, reimagineATL, DeKalb PH,</p>

	<p>website and social media</p> <p>Develop toolkits, one-pagers and literature to disseminate to various audiences (schools, healthcare providers, child providers, ECE's, etc).</p>	<p>Georgia Organics, GADOE, Medical College of Georgia, UGA, Zipmilk</p>
<p>Train individuals/organizations on nutrition, physical activity, and obesity prevention best practices and policies</p>	<p>Conduct training events around nutrition, physical activity, and obesity prevention best practices and policies</p> <ul style="list-style-type: none"> • Fitnessgram Teacher Training (K-12, afterschool and refresher courses) • Power Up for 30 Training (K-5, 6-8, afterschool provider) • School Health Summits (K-12) • Growing Fit Training (ECE) • Strong4Life Smarter Lunchroom (K-12) • Power Up for 30 pre-service training for teachers (College) • Strong4Life Provider Training (Physicians, Nurse Practitioners, Physician Assts) • Strong4Life WIC Provider Training (WIC Staff) • Georgia Five Star Hospital Training (Birthing Hospital Staff) 	<p>DOE, HealthMPowers, Alliance for a Healthier Generation, The Cooper Institute, Iowa State University, GSU, UGA, Emory, CHOA, DECAL, DFCS, Arthur M. Blank Family Foundation, Fuel Up to Play 60 (SUDIA), GAHPERD, Playworks, University of West GA, Boys and Girls Clubs, Blaze Sports, GAAAP, Zipmilk</p>
<p>Build capacity for organizations to create healthy nutrition and physical activity</p>	<p>Provide Technical Assistance for Organizations to Build Capacity</p> <ul style="list-style-type: none"> • Power Up for 30 (K-8) 	<p>GADOE, HealthMPowers, Alliance for a Healthier Generation, The Cooper Institute,</p>

<p>environments</p>	<ul style="list-style-type: none"> • Shape Nutrition and PA School Grantee Program • Fund PH Districts to support ECE settings with healthy Nutrition and PA best practices, guidelines, standards, policies and practices. • Promote state employee health and wellness resources (Healthways, Working on Health, State Health Benefit Plan) 	<p>GSU, UGA, CHOA, DECAL, DFCS, Arthur M. Blank Family Foundation, Fuel Up to Play 60 (SUDIA), GAHPERD, Playworks, University of West GA, Boys and Girls Clubs, GAAAP, Organ Wise Guys, Georgia PTA, HealthWays, SNAP Ed</p>
<p>Recognize the adoption of healthy nutrition and physical activity policy and best practices.</p>	<p>Recognize organizations that have adopted healthy nutrition and physical activity environments and policies</p> <ul style="list-style-type: none"> • Governor’s Shape Honor Roll Award • Golden Radish Award • Georgia Shape Quality Rated Award • Georgia Five Star Hospital Award 	<p>Governor’s Office, LT Governor’s Office, GADOE, HealthMPowers, Alliance for a Healthier Generation, The Cooper Institute, Department of Agriculture, DECAL, DFCS, Arthur M. Blank Family Foundation, Fuel Up to Play 60 (SUDIA), GAHPERD, GAAAP, Georgia Breastfeeding Coalition, Reaching Our Sisters Everywhere (ROSE), Zipmilk</p>

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SOCIAL DETERMINANTS OF HEALTH

Energy imbalance results in weight gain and a higher incidence of childhood overweight and obesity. Disparate populations often have higher rates of overweight and obesity due to a number of factors including: calorie dense foods that are often readily available, convenience foods that are often highly processed and high in fat and sugar, lack of access to whole foods including fruits/vegetables/whole grains, poor eating behaviors in the family unit, family history of overweight and obesity, sedentary lifestyles, lack of access to outdoor spaces, and a lack of walkable environments. Socio-economic status (SES) is also a determinant of childhood obesity, as many low SES children lack access to healthy foods and safe environments for physical activity. Tradition and Culture also play an important role, as some cultures identify or define overweight or obesity as being cute in children, or hold positive connotations with overweight.

POLICY CHANGES NEEDED

942 Schools across Georgia are encouraged to adopt wellness policies that support implementation of Georgia’s S.H.A.P.E. Act and the federal
943 Healthy, Hunger-Free Act of 2010. Multiple partners, advocates, technical assistance providers and community members are currently engaged in
944 the promotion and implementation of both Acts.

945 Early care and education (ECE) settings are encouraged to adopt health nutrition and physical activity policies in order to provide healthy
946 environments for children. The Growing Fit training encourages and teachers ECE directors and managers how to effectively create change though
947 the adoptions of these policies. Multiple partners across the state are using this tool to help gain adoption and implantation of healthy ECE
948 policies.

949 Birthing hospitals across the state are encouraged to adopt baby-friendly policies to support mothers in breastfeeding children for at least 6
950 months. The Georgia Five Star breastfeeding program allows each hospital how to create change in small steps and make the Baby Friendly
951 designation more achievable with expert technical assistance. Multiple partners promote this program statewide.

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962 **Youth and Adult Tobacco Use Initiation**

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OBJECTIVE: REDUCE THE CURRENT YOUTH SMOKING RATE FROM 8% MS 19% HS (2013 YRBS) TO 6% MS AND 17% HS AND THE ADULT SMOKING RATE FROM 17.4% (2014 BRFSS) TO 15.4%

2016 Baseline	2020 Target
Youth: 8% MS 19% HS (2013 YRBS) Adult 17.4% (2014 BRFSS)	Youth: 6% MS AND 17% HS Adult: 15.4%

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965 **BACKGROUND**

966 Tobacco use is the leading preventable cause of death in Georgia each year, costing the state more than 11,500 lives per year and nearly \$5 billion
967 in direct healthcare and indirect costs, such as lost wages. Over the last 15 years, adult tobacco use has been declining, with a recent increase in the
968 rate of decline. In 2003, the adult tobacco use rate was above 26 percent. In 2013, adult smoking rates fell from 21.2 percent in 2012 to 18.8
969 percent in 2013, according to the Behavioral Risk Factor Surveillance System (BRFSS). Youth cigarette smoking, as measured by the Youth
970 Behavioral Risk Survey (YRBS) demonstrates a decline in youth cigarette smoking rate from 17 percent in 2011 to 12.8 percent in 2013 (See
971 Table 1). However, alternative tobacco use rates have increased, particularly among youth; low income, white, rural males continue to use tobacco
972 at higher rates than the national average; the Medicaid population continues to be two to three times as likely to use tobacco than the general
973 population.

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975 **PLAN OF ACTION**

Strategies	Activities	Partners
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Increase the number of schools (K-12) with the 100% tobacco free schools policy from 114 to 151	Mass media education campaigns and tobacco-free policy adoption targeting schools	Local Health Districts, Department of Education (DOE), Parent Teacher Association (PTA)
Increase the number of parks with either a smoke free or tobacco free policy from 28 to 43	Mass media education campaigns and tobacco-free policy adoption targeting local parks and recreation	Georgia Parks and Recreation Association, Local Health Districts, Youth serving organizations
Increase the number of colleges/university with the 100% tobacco free college/universities policy from 46 to 60	Mass media education campaigns and tobacco-free policy adoption targeting colleges and universities	University Systems of Georgia and the Technical College Systems of Georgia; Historically Black Colleges and Universities
Increase the number of cities/counties with comprehensive smokefree policy from 5 to 10	Education campaigns and capacity building to promote the adoption of smokefree adoption targeting cities/counties	Local Health Districts, community organizations, Association of City and County Governments
Increase the number of multiunit housing (private and public) with smokefree policy from 65 to 250	Education campaigns and capacity building to promote the adoption of smokefree policy in multiunit housing	Georgia Apartment Association, Public Housing Authority, Emory Prevention Research Center
Increase from number of hospitals with tobacco-free policy from 131 to 174	Education campaigns and capacity building to promote the adoption of smokefree policy in hospital	Georgia Hospital Association

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SOCIAL DETERMINANTS OF HEALTH

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Multiple environmental, psychological, and social factors have been associated with tobacco use, including race and ethnicity, age, SES,

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educational accomplishment, gender, sexuality, and geographic location (zip code). These factors within the social environment have a huge

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influence on motivation to begin and to continue using tobacco products for not just the individual but certain community group within the

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population. Working with schools (k-12), parks, colleges/universities, hospitals, worksites, and municipalities to adopt tobacco free policies and

982 promote cessation services provides an opportunity for all members of the community to be tobacco free. As tobacco use is associated with
983 chronic diseases it's imperative to engage all members of the community in tobacco free living.

984

985 **POLICY CHANGES NEEDED**

986 Policy changes are essential to the norm change necessary to preventing youth and adult initiation. In order to carry out the strategies listed here,
987 the following policy changes are needed at the statewide, local, and institutional levels—

- 988 1. Tobacco-Free Schools
- 989 2. Tobacco-Free Parks and recreation
- 990 3. City wide county ordinances to prohibit all forms of tobacco and ENDS product use in public places
- 991 4. Tobacco-free and Smoke-Free Multi-Unit Housing (including public housing)
- 992 5. Tobacco-free workplaces (including bars, restaurants, and hotels)
- 993 6. Tobacco-free hospitals
- 994 7. Employer and insurance coverage to ensure access to comprehensive, free cessation services

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998 **Moving to Action**

999 **Shared Ownership**

1000 Partners throughout Georgia will continue to participate in workgroups within the three focus areas;
1001 Maternal and Child Health, Chronic Disease Prevention and Control; and Access to Care. Partners within
1002 these workgroups will be engaged in regular meetings and communications to support shared ownership
1003 of all phases of the State Health Improvement Plan including assessment, planning, investment,
1004 implementation and evaluation.

1005 The workgroups will continue to develop strong partnerships and encourage alignment of organizational
1006 mission, goals and initiatives with the SHIP. Work group participants will be asked to volunteer on
1007 subcommittees within these respective phases to provide review and feedback throughout the SHIP
1008 process.

1009 **Timeline**

1010 As the coordinating entity, DPH will assist the SHIP workgroups in monitoring, tracking and reporting on
1011 progress and impact via the DPH performance management (PM) system. The system is set up to provide
1012 quarterly updates on all relevant performance measures within a dashboard reporting format to help
1013 viewers understand status at a glance.

1014
1015 DPH focus group team leads will use their work group’s action plan to obtain regular progress updates
1016 from the partners responsible for leading each activity and enter data into the DPH PM system. DPH is
1017 currently in the process of developing an external facing dashboard to allow partners access to the data
1018 entry component of the PM system. In the meantime, all performance measure updates will be published
1019 on the DPH.

1020 **Progress Tracking**

1021 Progress updates will be provided quarterly in the DPH PM system, with consideration given to the
1022 specified timeframe for each strategy and activity. An annual report of progress made in implementing
1023 SHIP strategies will be completed by December 31st of each year.

1024
1025 Results will also be used to identify opportunities for improvement which DPH’s Office of Performance
1026 Improvement will assist the workgroups in utilizing the appropriate quality improvement methods, tools
1027 and techniques to address.

1028 **Revisions to the Plan**

1029 Over time, as changes to the plan are identified by the stakeholders or are needed based on annual report
1030 results, revisions or updates to the SHIP will be made. DPH will facilitate making updated versions of the
1031 plan or sections of the plan available on an annual basis.

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