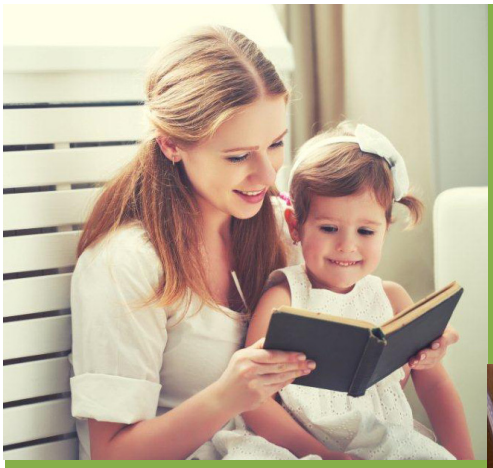
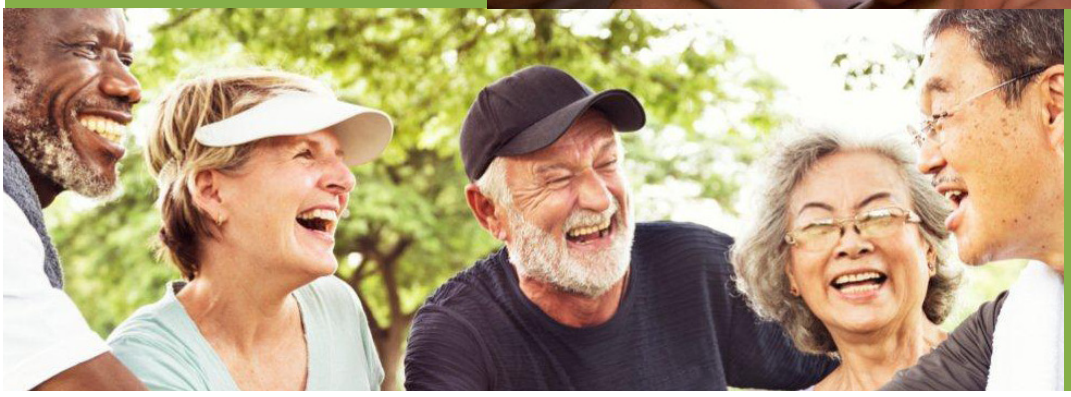
# State Health Improvement Plan





2016–2021 State Health Improvement Plan

Georgia Department of Public Health

## SOCIAL DETERMINANTS OF HEALTH

**Income**

**Education**

**Housing**

**Transportation**

**Race**

**Gender**

**Access to Care**

**Employment**

**Age**

**Language**



# Contents

# Partner Contributions to the Statewide Health Improvement Plan

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**Georgia Chapter American Academy of Pediatrics**
**Georgia Association of Primary Health Care**
**Georgia Academy of Family Physicians**
**Georgia Core**
**Georgia Dental Association**
**Georgia Department of Education**
**Georgia Department of Juvenile Justice**
**Georgia Health Policy Center**
**Georgia Hospital Association**
**Georgia Institute of Technology**
**Georgia Nursing Leadership Coalition**
**Georgia OBGyn Society**
**Georgia Parent Teacher Association**
**Georgia Partnership for Telehealth**
**Georgia Southern University**
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**Georgia State University**
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**Parent to Parent of Georgia**
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# Introduction and Background

The mission of the Georgia Department of Public Health (DPH) is "To prevent disease, injury and disability: promote health and well-being; and, prepare for and respond to disasters." The State Health Improvement Plan (SHIP) is one of the instruments used by DPH to achieve its stated mission and to describe and promote the strategies in place to accomplish statewide health improvement goals. Using innovative strategies, evidence-based and promising practices, DPH is committed to leading efficient and effective initiatives with multidisciplinary partners statewide to improve the health of all Georgians.

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

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

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

# Purpose of the State Health Improvement Plan

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

The SHIP serves as a tool not just for DPH, but also for health providers, government agencies, community-based organizations, advocates, academics, policy makers, and other stakeholders committed to health equity and improvement.

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

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

# Purpose of the State Health Improvement Plan

DPH collaborates with hospitals, public and private health organizations, state and local agencies, and other stakeholders throughout the state to develop and implement programs and strategies. Keeping in alignment with statewide goals, these strategies address local needs to improve the health of our communities. Using the State Health Assessment (SHA) to provide contextual information, DPH solicited community input in establishing the Georgia Department of Public Health Strategic Plan. The overarching goals of the SHIP are tied to DPH's Strategic Plan.

The SHIP aligns with the following DPH Strategic Plan objectives:

- Objective 1.1: Increase the percentage of Georgia's Fitnessgram assessed student populations that are in the Healthy Fitness Zone (HFZ) for Body Mass Index (BMI) by 1 percent each year for four years. By 2019, 64 percent of Georgia's students will be in the HFZ for BMI.
- Objective 1.2: By 2019, eliminate all pediatric asthma deaths in Georgia.
- Objective 1.3: By 2019, reduce the preventable infant mortality rate from 6.3 (2013) to 5.3 per 1,000 births.
- Objective 1.4: By 2019, decrease the annual rate of hospitalizations (2015) for diabetes by 25 percent (from 180.2 to 135) and for hypertension by 10 percent (from 73.3 to 65.7).
- Objective 2.1: By 2019, identify, establish and maintain programs and services to increase health care access and access to primary care.
- Objective 2.2: By 2019, improve technological infrastructure to promote health and well-being by collecting, analyzing and reporting health data, tracking disease and health determinants and applying science and epidemiological principles to support decisions.

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



# State Health Improvement Plan Process

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

DPH conducted four MAPP assessments; each contributed important information for the development of the Georgia SHA.

- The statewide health status assessment was the primary focus of the Georgia SHA.
- A state public health system assessment was distributed to core public health partners to identify strengths and weaknesses and opportunities to improve how public health services are provided.
- Forces of change sessions identified factors that could affect implementation of the SHA.
- Community themes and strengths were gathered from around the state during regional focus groups and work group planning sessions to identify potential resources and partners that could be engaged to execute particular priorities of the plan.

The results of these assessments were released via email to participants and posted on the DPH website for comment. They are included in each of the goal areas of the SHA. The SHA is a "living" document and DPH expects information gathering and sharing will be an ongoing process that will be facilitated by DPH during SHIP implementation.

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

**Public Health System Assessment**
DPH utilized the National Public Health Performance Standards Program (NPHPSP) Local Public Health System Assessment (LPHS) as a guide for conducting a DPH Public Health System Assessment. The survey assessed DPH's activities related to

# State Health Improvement Plan Process *(continued)*

providing the 10 Essential Public Health Services (EPHS). The Public Health System Assessment focuses on how well the 10 EPHS are being provided. The assessment looks at the components, activities, competencies, and capacities of our Georgia public health system. It was distributed to state, district and county health department staff. In addition, it was distributed to county boards of health members. The tool is intended to help DPH gain an understanding of its performance by identifying strengths, weaknesses and opportunities for improvement.

**Forces of Change Assessment**

DPH, in conjunction with the University of Georgia's College of Public Health, held a session on future issues facing public health at the State of Public Health Conference Oct. 6, 2015. This conference was attended by a diverse group of public health professionals. In addition, DPH held a session with state and district health directors and staff in 2015 to assess the forces of change influencing the work of public health in Georgia. Information from these sessions identified factors that could affect implementation of the SHIP.

The most significant external trends that will have the greatest impact on public health can be categorized into four major areas: demographics, economics, policy and health. Since each of these areas is vast and complex, they are being summarized, with those factors having the largest effect in the near and intermediate future being highlighted.

Georgia Demographics

- In just three decades—from 2000 to 2030—Georgia's older adult population (over age 65) will increase by more than 140 percent, one of the fastest rates of increase in the country.
- While the population is aging, the number of working age residents will decline from about 6 persons per elderly resident to around 3.5 in 2030.
- An aging population will place a heavy burden on health care resources, including those provided by the state.
- Georgia's population has been growing at twice the national average.
- More counties are becoming "majority minority;" since 2000, five counties, including four in metro Atlanta, have undergone this change.

Key Economic Issues

- The economy at the state and national levels is showing steady improvement.
- Despite overall improvements in income, between 2008 and 2012, the percentage of Georgia children in poverty increased from 20 percent to 27 percent.
- In addition, while unemployment has dropped from over 10 percent to 6.3 percent, the state still has not regained all the jobs lost in the Great Recession of the late 2000s.
- State revenue collections have been growing steadily in recent years.



National Health Policy Considerations

- The Patient Protection and Affordable Care Act (ACA) provisions around insurance coverage took effect in 2014 and expanded services encompassing prevention, chronic disease management, tobacco cessation, maternal and newborn care, and prescription drugs.
- Before implementation of the ACA, Georgia had the fifth highest number of uninsured in the U.S. with 19 percent of the population (1.67 million individuals) now lacking coverage. According to a Gallup Poll, 20 percent of the state's residents are uninsured, the third highest rate in the country.
- Medicaid eligibility and reimbursement rates influence the numbers and types of providers available throughout the state, which in turn impact some of the health conditions listed in this plan.
- An increase in Medicaid eligible population, coupled with a decrease in the number of providers accepting Medicaid patients could result in a significant increase in demand for local public health services.
- Throughout the state, there are significant health disparities by race, ethnicity, population density, education and county of residence. According to the United Health Foundation, differences in overall mortality rates between Georgia's healthiest and unhealthiest counties are getting worse. Disparities could be prevented or reduced through health in all policies initiatives.
- There are substantial shortages of health professionals in the state, especially in rural areas, and insufficient numbers of federally qualified community health centers to serve the entire population of Georgia.
- In 2013, 69.8 percent of children 19-35 months old were fully immunized, which was a slight decline from previous years.

**Community Themes and Strengths Assessment**

DPH held five regional forums with public health partners across the state. The forums were facilitated by Georgia Southern University's Jiann-Ping Hsu College of Public Health to gain feedback on health data, identify priority health issues, and identify of available assets and resources. DPH subject matter experts presented the Selected Measures of Health Status 2015. Participants were asked to provide feedback on important health issues in their area, what actions should DPH take to address these health issues, and what assets are available to assist DPH in addressing these health issues. In addition, DPH presented the Selected Measures of Health Status 2015 to the Board of Public Health and the district health directors, who serve as executive directors of the county boards of health. Local public health agencies participated in the focus group forums and in work group sessions to provide important perspectives on system capacity from various regions of the state.

# State Health Improvement Plan Framework

Feedback from these forums identified three priority areas for health improvement: 1) Access to Health Care; 2) Maternal and Child Health; and, 3) Chronic Disease. On April 28, 2016, DPH staff and public health partners met to establish key topics within the priorities, identify strategies and resources, and establish performance metrics. This meeting formed the basis for the Georgia SHIP. Along with the three priority areas, stakeholders identified 15 action areas (Figure 1).

| | |
|---|---|
| Priority Area 1: Access to Care | 1.1 Healthcare Workforce |
| | 1.2 School-Based Health Centers |
| | 1.3 Health Care Partnerships |
| | 1.4 Health Care Coverage |
| | 1.5 Telehealth |
| Priority Area 2: Maternal and Child Health | 2.1 Infant Mortality |
| | 2.2 Pediatric Oral Health |
| | 2.3 Maternal Mortality |
| | 2.4 Children with Special Health Care Needs |
| | 2.5 Congenital Syphilis |
| Priority Area 3: Chronic Disease Prevention | 3.1 Pediatric Asthma |
| | 3.2 Cancer Prevention and Control |
| | 3.3 Diabetes and Hypertension |
| | 3.4 Childhood Obesity |
| | 3.5 Tobacco Use Prevention |

Figure 1. Georgia 2017-2021 State Health Improvement Plan Action Areas



At this meeting and in small groups in the summer and fall of 2016, stakeholders in the planning process used existing plans and other current state documents to outline evidence-based strategies and actions needed to make progress on each area. Key partners for each strategy were also identified.

**Cross-Cutting Themes**

In the process of identifying and defining the three priority areas and 15 action areas, stakeholders noted that many of the action areas were interrelated. In addition, several cross-cutting themes or needs were identified that impact the ability of the State of Georgia, DPH, and partners across the state to achieve change on the priorities listed in the plan. These themes were:

- Social Determinants of Health
- Health Disparities and Health Equity
- Cross-Sector Collaborations

### SOCIAL DETERMINANTS OF HEALTH

According to the World Health Organization, the social determinants of health (SDH) are "the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life." For the purposes of this plan, we have defined these as education, level of income, housing, access to health care, access to employment opportunities, transportation, age, language spoken, race and gender. The participants in the planning process noted that Georgia's Health Assessment indicates that persons living in Georgia, especially children, experience higher rates of poverty than in the U.S. as a whole, which influences lifelong health outcomes. This will make it more challenging and also all the more important to achieve the objectives listed in this plan. Because of this critical role, significant social determinants are noted for each objective using associated symbols.

### HEALTH DISPARITIES AND HEALTH EQUITY

Georgia is a diverse state, and according to the Georgia SHA, various populations face significant health disparities across different health outcome areas. For example, African-American women are more likely than White women to be diagnosed with breast cancer at later stages, regardless of insurance status, and more likely to die of breast cancer in Georgia. Low income children are more likely to be overweight or obese. And, White males in rural communities are more likely to use tobacco products than other population groups in Georgia. Health equity is the idea that, in addition to addressing these disparities, Georgia could create the conditions in which all individuals have an equal opportunity to achieve health, regardless of race, ethnicity, income, childhood experiences, education level or geography. Health equity strategies include things such as providing certain populations with worse outcomes greater access to care or services, or targeting interventions toward these groups. Participants felt that health equity was an important consideration in the priority areas selected as well as an important framework for action on many of the priority areas.

# State Health Improvement Plan Framework *(continued)*

### CROSS OR MULTISECTOR COLLABORATIONS

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

**State and Local Policy Considerations**

During the planning process, it became clear that policy changes might be necessary to achieve certain objectives in the plan. The policy changes discussed fell into four groups:1) appropriations and funding; 2) legislative and regulatory changes at the state or local level; 3) community and worksite policy supports; and 4) healthcare organization policies and protocols.

### APPROPRIATIONS AND FUNDING

America's Health Rankings 2015 ranks Georgia 40th among all state for health outcomes. Participants noted that funding was an important consideration and potential barrier for achieving the objectives in the plan. While not all priorities require additional funding in order to make measureable progress, and low-cost policy and environmental changes exist for several priority areas, some areas have no current funding and/or are funded solely by grants and cooperative agreements with the federal government. For example, increased state funding for school-based health services, diabetes self-management and prevention programs, school nursing, the Georgia Tobacco Quitline, Georgia Tobacco Use Prevention Program, and the Family Planning Program could all make a considerable difference in expanding the reach of existing and highly effective programs.

### LEGISLATIVE AND REGULATORY CHANGES AT THE STATE AND LOCAL LEVELS

In order to achieve some of the objectives outlined in this plan in the proposed timeframe, legislative or regulatory changes at the state or county level are needed. Examples of these changes include the creation of new programs, such as a statewide program for the creation of additional school-based health centers. They also include the recognition and expansion of existing legislatively-sponsored initiatives, like the Diabetes Action Plan, to address areas identified as priorities here. Legislative and county commission support for strengthening existing laws, such as tobacco and smoke-free places. These laws could rapidly influence a number of priority areas, including infant mortality, asthma and tobacco. Similarly, legislative support for laws that protect children and youth from tobacco and e-cigarette sales by raising the price of those products and increasing enforcement of existing laws could help reduce premature death associated with tobacco use.



### COMMUNITY AND WORKSITE POLICY SUPPORTS

Not all changes must have the force of law to have impact on community health. Changes in policies and practices in community settings, such as parks, public housing, community centers, schools, faith-based organizations, churches, and worksites have the potential to reach a large number of Georgians where they spend much of their time. Policies adopted at the organizational level that promote environments that are tobacco-free; offer healthy foods and drinking water; promote physical activity; and support breast-feeding have the potential to have significant impact on health.

There are many recent examples of progress in this area in Georgia. When the Board of Regents adopted a tobacco-free policy for all campuses in its system in 2014, this policy reached an estimated 340,000 students and nearly 60,000 staff. In another example, over 880 elementary schools in Georgia have adopted policies and practices to integrate 30 minutes of physical activity into the school day. And, more than 150 early care and education settings have adopted Growing Fit, a model that encourages early care settings to set organizational or site policies for healthy eating and physical activity for children in their care. Birthing hospitals across the state are encouraged to adopt baby-friendly policies. These policies support mothers in breast-feeding their babies for at least the first six months after delivery. These significant indicators of progress suggest additional effort on promoting healthy community and worksite policies could present a significant opportunity to improve the health of all Georgians.

### HEALTHCARE PAYOR POLICIES

As increasing numbers of Georgians have health insurance and health care technology continues to rapidly evolve, stakeholders in the planning process noted that payor policies around reimbursement for evidence-based, high value health services are of growing significance. While federal law continues to play a key role in overall direction of reimbursement policy, state-specific actions remain important. Stakeholders pointed to many examples, grouped into two categories—Medicaid payment, and all other insurance providers. The majority of the discussions and recommendations focused on Medicaid, which covers approximately 1.9 million of the most vulnerable Georgians annually. Stakeholders identified opportunities to further objectives in this plan through changes in Medicaid that would influence outcomes in a number of areas, such as telehealth, school-based health centers, asthma, diabetes, hypertension, cancer, maternal mortality and infant mortality. Stakeholders also recommended the recognition of public health providers as Medicaid providers for a wider variety of services and the reduction of administrative burden for Medicaid providers. Various models for payment reform and innovation were discussed as potential means to arrive at these improvements, understanding that final recommendations on how to arrive at these improvements in Medicaid was outside the scope of this planning process.

## Priority Area 1: Access to Care

**1.1 Healthcare Workforce**

**1.2 School-based Health**

**1.3 Healthcare Partnerships**

**1.4 Health Care Coverage**

**1.5 Telehealth**

# 1.1 Healthcare Workforce

**OBJECTIVE:** BY 2020, DECREASE THE NUMBER OF GEORGIANS LIVING IN A DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREA (HPSA).

| 2016 Baseline | 2020 Target |
|---|---|
| 981,451 | 850,000 |

## SUMMARY

The demand for primary care services continues to grow with the increase in Georgia's population and growing number of older citizens. Georgia must have a healthcare workforce that is well prepared, equally distributed across the state and sufficient in size to meet the needs of the population.

In Georgia, the healthcare workforce was recently referred to as "two Georgias" describing the health care disparity facing rural Georgia. The Healthcare Georgia Foundation report, Georgia Provider and Policy Organizations Give Insight into Rural Health Care, 2015, highlights the following statistics in Georgia:

- 6 counties had no family medicine physician
- 31 counties had no internal medicine physician
- 63 counties had no pediatrician
- 79 counties had no OB/GYN
- 66 counties had no general surgeon

The Georgia Board of Physician Workforce in the Georgia Physician and Physician Assistant Professions Data Book (December. 2013), recommends providing greater loan forgiveness and more residency slots, increasing the scope of practice for midlevel practitioners such as advanced practice registered nurses (APRN) and physician assistants, ensuring more telemedicine and improving collaboration among providers and healthcare professions. Changing scope-of-practice laws is likely to have a more immediate effect on increasing the supply of primary care providers in Georgia. Research has demonstrated that APRNs can provide many elements of primary care services and expanding the utilization of APRNs has the potential to increase access to health care, particularly to underserved populations. Georgia has more than 8,600 APRNs that currently have a restricted scope of practice which limits their ability to prescribe drugs, order diagnostic tests and to practice in accordance with how they are educated and prepared. Rural areas of the state often experience difficulties in the recruitment and retention of primary care physicians and other health professionals. Because of this, it is important to examine the data, be proactive and recruit health care professionals specifically for these areas.

## PLAN OF ACTION

**S / 1.1.1** Increase access to health care by increasing the number of health care providers practicing at full scope of practice.

| Activities | Partners |
|---|---|
| a. Advocate for legislation each legislative session that would allow health care providers to operate within their full scope of practice.<br><br>b. Increase and expand collaboration among key stakeholders. | Georgia Nursing Leadership Coalition; Georgia Board of Nursing; United Advanced Practice Registered Nurses of Georgia; Georgia Coalition of Advanced Practice Registered Nurses; Georgia Composite Medical Board; Georgia Department of Community Health; Healthcare Georgia Foundation; Georgia Hospital Association; Georgia WATCH; Medical Association of Georgia; Georgia Association of Nursing Deans and Directors; Georgia Nurses Association; Georgia Association of Nursing Students; Veterans Affairs; American Association of Retired Persons |

**S / 1.1.2** Increase the opportunities for providers in HPSA who have access to service cancelable loans.

| Activities | Partners |
|---|---|
| a. Enhance partnerships to initiate and advocate for increased availability of service cancelable loans for health care providers practicing in HPSA.<br><br>b. Increase and expand collaboration among key stakeholders. | Georgia Nursing Leadership Coalition; Georgia Board of Nursing; United Advanced Practice Registered Nurses of Georgia; Georgia Coalition of Advanced Practice Registered Nurses; Georgia Composite Medical Board; Georgia Department of Community Health; Healthcare Georgia Foundation; Georgia Hospital Association; Georgia WATCH; Medical Association of Georgia; Georgia Association of Nursing Deans and Directors; Georgia Nurses Association; Georgia Association of Nursing Students; Veterans Affairs; American Association of Retired Persons. |

# 1.2 School Based Health Centers

**OBJECTIVE:** INCREASE THE NUMBER OF COMPREHENSIVE SCHOOL-BASED HEALTH CENTERS.

| 2016 Baseline | 2020 Target |
|---|---|
| 22 | 30 |

## SUMMARY

Students spend more time in school during the school year than they spend anywhere else. This makes the school environment ideal for the provision of acute care, chronic disease management and well child care. This holistic care is best provided through professional school nurse services as well as through school-based health centers (SBHCs). Services provided in SBHCs and by registered professional school nurses are safe, effective, and easily accessible to students in the environment where they are.

It is the position of the National Association of School Nurses (NASN) that daily access to a registered professional school nurse can significantly improve students' health, safety and ability to learn. Healthy People 2020 includes an objective to increase the proportion of elementary, middle, and senior high schools that have a full-time registered school nurse-to-student ratio of at least 1:750. Further, a policy statement by the American Academy of Pediatrics (AAP) calls for a minimum of one full-time registered nurse in every school. Georgia Code § 20-2-186 addresses nurse to student ratio by indicating that each local system shall earn funding for one nurse for every 750 full-time equivalent students at the elementary school level and one nurse for every 1,500 full-time equivalent students at the middle and high school levels.

Despite the recommendations of AAP, NASN, Healthy People 2020 and even Georgia Code, unofficial numbers from the 2015-2016 school year indicate that the nurse to student ratio is closer to 1 to 1,224. Additionally, cost effective, accessible, and safe health care can be provided to Georgia's students through SBHCs. Currently in Georgia, there are 22 comprehensive SBHCs with many other sites offering limited services for behavioral health care and telemedicine services. Although the number of SBHCs is on the rise, the current clinics are insufficient to support the many students and communities with significant barriers to health care. Providing health services in the school setting decreases common barriers,



## PLAN OF ACTION

| S / 1.2.1 | Increase access to acute and chronic healthcare services, as well as well child care, in the school setting. | |
|---|---|---|
| | Activities | Partners |
| | a. Increase the number of comprehensive SBHCs throughout Georgia by 10 percent each year.<br>b. Advocate for school nurse funding and legislative changes to facilitate the placement of one full-time registered professional nurse (RN) in every school.<br>c. Advocate for enhanced dental services for children in the school setting. | Georgia Department of Juvenile Justice; Children's Healthcare of Atlanta; Georgia Department of Education; Georgia Department of Public Health; Georgia Association of School Nurses; Georgia School Based-Health Alliance; Voices for Georgia's Children; State Superintendent Association; Georgia Parent Teacher Association; Georgia Chapter American Academy of Pediatrics |

# 1.3 Healthcare Partnerships

**OBJECTIVE:** INCREASE THE NUMBER OF PARTNERSHIPS BETWEEN PUBLIC HEALTH AND HEALTHCARE PARTNERS.

| 2016 Baseline | 2020 Target |
|---|---|
| N/A | Increase by 10 |

## SUMMARY

Health departments across the country are experiencing stagnant budgets forcing them to reduce clinical services. At the same time, there is an increase in demand for population-based services. (Forces of Change Survey 2015, NACCHO). Out of Georgia's 159 counties, 148 are either medically underserved or have underserved populations. Almost two-thirds of Georgia's counties are below the statewide average in each of the four medical professional categories of nurses, physician assistants, total doctors and primary care physicians per 100,000 residents. While most of the counties with provider ratios below the statewide average are rural, health care provider shortages are a statewide concern (Georgia Budget and Policy Institute).

The National Prevention Strategy recommends reducing barriers to accessing clinical and community preventive services, especially among populations at greatest risk. Sources such as The Practical Playbook: Public Health and Primary Care Together, Centers for Disease Control and Prevention, de Beaumont Foundation and Duke University School of Medicine, and the 2012 IOM report suggest that we achieve this through partnering efforts. In August 2014, the Georgia Department of Public Health disseminated a health care collaboration online survey to each of its districts in an effort to identify trends in collaboration between public health districts and other health care providers. All 18 districts participated in the survey. The survey results revealed that referrals for client services outside the scope of public health, follow-up/additional diagnostic services and primary care related to chronic health issues and participation in health and community coalitions were among the most common forms of collaboration throughout the state. More than 60 percent of the participants indicated that they were collaborating with family/general practitioners, OB/GYNs, dentists, internists, pharmacists, hospitals, nursing homes, schools, FQHCs and social/advocacy groups. However, less than 50 percent of the districts indicated collaborating with allied health, psychologists and insurance companies.



Three Georgia public health districts are Public Health Accreditation Board (PHAB) accredited (Cobb-Douglas, Gwinnett-Newton-Rockdale and DeKalb), all of which identified improving access to care as a health priority and acknowledge the need to work collaboratively with community partners in order to achieve improved health care access.

## PLAN OF ACTION

**S / 1.3.1** Create opportunities for cross-sector partnerships between public health and private/public partners aimed at improving access to care.

| Activities | Partners |
|---|---|
| a. Assess the number and quality of partnerships | Georgia Department of Juvenile Justice; Georgia Dental Association; Georgia Chamber of Commerce; Employers Like Me; Georgia Hospitals; Health Systems; Georgia Hospital Association; Medical Societies; Federally Qualified Community Health Centers; Accountable Care Organizations; American Association of Diabetes Educators; Pharmacies; Georgia Pharmacy Association; School Based Health Centers, Georgia Association of School Nurses; Georgia Department of Behavioral Health and Developmental Disabilities; Area Agencies on Aging; Health Clinics; Local Public Health Departments; Georgia Department of Public Health |
| b. Convene annual meetings to enhance and foster partnerships between nonprofit organizations, government agencies, health care providers, hospitals, schools and school nurses, religious and community organizations, businesses and the Georgia Chamber of Commerce in local communities to promote access to care. | |
| c. Develop recommendations to public health staff and community partners for strengthening an infrastructure of support for partnerships that increase access to care | |
| d. Develop one resource database to include resources for establishing and sustaining partnerships that promote access to care. | |

# 1.4 Health Care Coverage

**OBJECTIVE:** INCREASE THE PERCENTAGE OF GEORGIANS WHO REPORT THEY HAVE HEALTH CARE COVERAGE.

| 2016 Baseline | 2020 Target |
|---|---|
| 86 percent (2015 data) | 100 percent |

## SUMMARY

Ensuring comprehensive health care coverage for all Georgia citizens was selected as a statewide health priority because of the close link between coverage and health care outcomes. Individuals with health care coverage are more likely to receive care and experience positive outcomes, while those who are uninsured or underinsured are less likely to receive needed medical services and subsequently bear higher burdens of disease. According to Healthy People 2020, "uninsured people are less likely to receive medical care, more likely to die early and more likely to have poor health status." Ensuring coverage for all individuals aligns with national efforts outlined in Healthy People 2020 through Objective AHS-1.1, which seeks to increase the proportion of persons with health insurance from 83.2 percent in 2008 to 100 percent in 2020.

The Kaiser Family Foundation estimates that while 9 percent of the U.S. population was uninsured in 2015, 14 percent of Georgians were uninsured. Even individuals that do have access to coverage may not have the ability to enroll in that coverage or fully utilize the coverage that is available. Patient navigators in hospitals or health clinics, including community health workers, can be very beneficial in helping individuals obtain, enroll in and understand coverage. Even when individuals have access to health care coverage, the insurance provider may not cover all services that are needed. Statutory or regulatory changes are needed to ensure that the most appropriate services are being covered by all insurance providers, including Medicaid.

One of the core functions of public health is to provide gap filling services for individuals that are unable to afford healthcare services or geographically lack access to providers. In Georgia, every county has a public health department that provides basic preventive clinical services. However, public health departments are not fully recognized as providers by many insurance companies. The Georgia Department of Public Health is working with insurance providers to increase the number of billable services, so that individuals can utilize their coverage in their county.

## PLAN OF ACTION

**S / 1.4.1** Ensure comprehensive medical coverage for all Georgia citizens through promoting awareness, utilization and increase of coverage options.

| Activities | Partners |
|---|---|
| a. Increase the number of third party insurance billable services either by increasing the number of contracts or number of covered services in existing contracts with the county health departments. | Georgia Department of Public Health; Voices for Georgia's Children, Georgians for a Healthy Future; Grady Health System |
| b. Develop an advocacy agenda for regulatory and statutory changes to increase services covered by health insurance and options to close the coverage gap in Georgia each year for five years. | |
| c. As stated in the Grady Community Health Improvement Plan, increase opportunities for persons served by Grady Health System to access health care coverage by supporting navigator efforts to increase enrollment of uninsured populations in the health insurance exchange and outreach efforts to enroll eligible individuals in Medicaid and PeachCare. | |
| d. Through the Georgia Enrollment Assistance Resource Network (GEAR), provide handouts, interactive tools and other materials to better educate Georgians on health insurance enrollment and how to use their insurance. | |

# 1.5 Telehealth

**OBJECTIVE:** INCREASE THE UTLIZATION OF TELEHEALTH IN SYSTEMS OF CARE IN UNDERSERVED AREAS.

| 2016 Baseline | 2020 Target |
|---|---|
| Grade of B for Georgia Telemedicine Parity (based on 2015 American Telemedicine Association criteria) | Grade of A for Georgia Telemedicine Parity (based on 2015 American Telemedicine Association criteria) |

## SUMMARY

Technology is opening up many new ways for patients to interact with the health care system in the United States. Increasing access to and utilization of telehealth services is a priority for Georgia as one of the major challenges we face is providing quality care to every segment of the population, especially those who do not have access to specialty physicians because of geographic limitations or socioeconomic conditions. The majority of clients served by the Georgia Department of Public Health are on Medicaid, so it is important to know that Medicaid views telemedicine as a cost-effective alternative to the more traditional face-to-face way of providing medical care. Additionally, the federal Medicaid program encourages states to use the flexibility in federal law to create innovative payment methodologies for services that incorporate telemedicine technology. Given that each state Medicaid program is different, we carefully analyze our state's telehealth coverage policies, promote proper telehealth utilization across the state and advocate for increased funding for state agencies, so that we can collectively address these challenges.

Telehealth technology connects patients with health care providers anywhere in the state, eliminating the cost and time of travel not only for patients but for doctors, while increasing the number of patients doctors are able to see. According to the Georgia Board for Physician Workforce, 52 percent of Georgia's physicians are located in five areas that serve just 38 percent of the state's population. Georgia ranks 40 among the 50 states when it comes to adequate distribution of doctors by specialty and geographic location.

Healthy People 2020 includes, as one of its goals, the use of health communication strategies and health information technology to improve population health outcomes, improve health care quality and achieve health equity. It also includes several related objectives that support shared decision-making between patients and providers. The telehealth movement helps this shared decision-making and fundamentally changes the relationship between patients and providers to an interaction that supports an informed, bilateral conversation to improve health. Other Healthy People 2020 objectives that support telehealth include goals to deliver reliable and actionable health information, to connect with culturally diverse and hard-to-reach populations, and provide sound principles in the design of programs and interventions that result in healthier behaviors.

## PLAN OF ACTION

**S / 1.5.1** Increase funding for telehealth capabilities throughout the state.

| Activities | Partners |
|---|---|
| a. Identify funding streams in the state budget that support telehealth initiatives. Integrate into organized telehealth initiatives (e.g., rural hospital stabilization, mental health, etc.) and advocate to General Assembly for state funding to support telehealth infrastructure each legislative session. | Georgia Department of Public Health; Georgia Partnership for Telehealth; PARTNERS for Equity in Child and Adolescent Health; Voices for Georgia's Children; Georgia Department of Behavioral Health and Developmental Disabilities; Georgia Department of Juvenile Justice; Georgia Department of Community Health; Georgia Department of Education; AHEC; and Ambulatory Services. |
| b. Establish a unified approach to advocate for increased access and quality of access through telehealth, including developing joint language talking points,infographics and advocate for a system of care. | |

**S / 1.5.2** Increase the number of school-based health centers utilizing telehealth services by ensuring placement of technology and providers in the centers.

| Activities | Partners |
|---|---|
| a. Develop a comprehensive inventory (map) of schools with telehealth technology:<br>• Comprehensive SBHCs<br>• Telehealth SBHCs<br>• TH/TM technology | Voices for Georgia's Children; Georgia Partnership for Telehealth; PARTNERS for Equity in Child and Adolescent Health; American Telemedicine Association; Georgia Department of Public Health; Southeastern Telehealth Resource Center; American Telemedicine Association; Georgia Partnership for Telehealth; Georgia Department of Public Health; Voices for Georgia's Children |
| b. Develop guidance on how to connect or integrate into a school system of care (provider/presenter). | |
| c. Train presenters on how to utilize telehealth technology and incorporate into daily use. | |
| d. Assist those sites who have TH/TM technology, not in use, with TA and evaluation. | |

## 1.5 Telehealth *(continued)*

PLAN OF ACTION

**S / 1.5.3** Raise community awareness regarding the benefits of telehealth, what services are available, and where services are available.

| Activities | Partners |
|---|---|
| a. Develop one comprehensive awareness campaign for telehealth services provided throughout the state:<br>• How to navigate<br>• Consumer perspective<br>• Provider perspective<br>• Security/HIPAA | Local Interagency Planning Teams; Georgia Department of Public Health; Georgia Department of Community Health |

**S / 1.5.4** Identify barriers and needed access points where specialty services are unavailable.

| Activities | Partners |
|---|---|
| a. Develop heat maps for specialty providers to understand gaps in access | Georgia Department of Public Health; Georgia Department of Community Health |



# Priority Area 2: Maternal and Child Health

# 2.1 Infant Mortality

**OBJECTIVE:** BY 2019, REDUCE THE PREVENTABLE INFANT MORTALITY RATE.

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


**SUMMARY**

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, 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 of social determinants of health such as education and poverty.

Georgia's infant mortality rate declined from 2008 to 2010 by more than 25 percent. From 2010 to 2013, the infant mortality rate increased from 6.3 to 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 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 high compared to non-Hispanic Whites (5.5). Both non-Hispanic Whites and Hispanics exceeded the Healthy People 2020 objective in 2013. Approximately half (53.1 percent) of Georgia infants were placed to sleep on their back in 2011. The Healthy People 2020 objective for this measure is 75.9 percent. 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 or less and mothers of other racial/ethnic groups. Over half of mothers under 20 years old reported placing their infant on its side or stomach to sleep. Only 38.8 percent of White mothers reported placing their infant on their side or stomach while approximately 57.0 percent of Black and Hispanic mothers did.

Infant mortality is caused by a multitude of factors including genetics, congenital anomalies, injury, maternal complications and preterm birth. Preterm and low-birth weight are the No. 1 cause of infant mortality in Georgia. Both preterm birth and low-birth weight are strongly correlated with the individual environment, health status and socio-economic status of the infant's birth mother. Studies have shown that preventing sleep- related deaths and reducing preterm birth are strategies that may result in lower infant mortality rates.




PLAN OF ACTION

**S / 2.1.1** 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 made environmental changes that encourage and support breast-feeding.

| Activities | Partners |
|---|---|
| a. Recruit hospitals through in person presentations on the 5-STAR Hospital Initiative. | Georgia hospitals; Georgia Department of Public Health; Georgia Hospital Association |
| b. Provide in person trainings to hospitals participating in the initiative. | |
| c. Recognize hospitals for participating in the 5-STAR Hospital linitiative. Each hospital recognized will receive a 5-STAR plaque for meeting the Baby Friendly requirements. | |

**S / 2.1.2** Encourage birthing hospitals to have policies and education that adhere to the American Academy of Pediatrics (AAP) safe sleep guidelines.

| Activities | Partners |
|---|---|
| a. Recruit birthing hospitals by providing staff with a step by step guide on implementing a Safe to Sleep Program. | Georgia Chapter American Academy of Pediatrics; Georgia Hospital Association; American Congress of Obstetricians and Gynecologists; Georgia birthing hospitals; Georgia Department of Public Health |
| b. Provide in-person trainings to hospitals participating in the program. | |
| c. Provide participating hospitals with education resources for staff and caregivers on the safe infant sleep recommendations. | |
| d. Collect pre and post crib audits and policy statements from participating hospitals. | |
| e. Recognize hospitals for implementing a Safe to Sleep Program and policy. | |

## 2.1 Infant Mortality *(continued)*

| S / **2.1.3** | Increase the percentage of women (ages 15 – 44) served in public health family planning clinics who use long-acting reversible contraception (LARC). | |
|---|---|---|
| | Activities | Partners |
| | a. Increase the number of advanced practice registered nurses (APRN) in public health family planning clinics to improve access to LARCs. | Local Public Health Departments; Hospitals; OB/GYN Providers; Medicaid; Care Management Organizations; Georgia Department of Public Health |
| | b. Increase the inventory of LARCs in public health family planning clinics. | |
| | c. Develop and implement an awareness campaign. | |

| S / **2.1.4** | Increase the percentage of women (ages 15 – 44) served in hosptials who use long-acting reversible contraception (LARC). | |
|---|---|---|
| | Activities | Partners |
| | a. Collaborate with hospitals to collect data on postpartum LARC utilization. | Association of State and Territorial Health Officials; Emory University; PeachState; Hospitals (i.e., Columbus Regional, DeKalb Medical Center, Grady, Navicent, Northeast Georgia, and Phoebe Putney); Georgia Department of Public Health |

| S / **2.1.5** | Increase the number of county health departments providing Perinatal Case Management (PCM) services. | |
|---|---|---|
| | Activities | Partners |
| | a. Collaborate with hospitals to collect data on postpartum LARC utilization. | Centering Pregnancy Programs; OB/GYN Providers; Hospitals and Health Systems; Georgia Department of Public Health |

### SOCIAL DETERMINANTS OF HEALTH



# 2.2 Pediatric Oral Health

**OBJECTIVE:** INCREASE THE PERCENTAGE OF CHILDREN, AGES 1 THROUGH 17 WHO HAD A PREVENTIVE DENTAL VISIT IN THE LAST YEAR.

| 2016 Baseline | 2020 Target |
|---|---|
| 76.7 percent | 79.8 percent |

### BACKBROUND

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

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

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

# 2.2 Pediatric Oral Health *(continued)*

## PLAN OF ACTION

**S / 2.2.1** Engage active partners to promote perinatal oral health.

| Activities | Partners |
|---|---|
| a. 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; Local Public Health Departments; Georgia WIC; Georgia Department of Public Health |
| b. Educate and update district oral health staff on special considerations and treatment needs for special needs patients. | |
| c. Offer comprehensive educational webinars/presentations. | |

**S / 2.2.2** Develop one oral health resource database for Children with Special Health Care Needs.

| Activities | Partners |
|---|---|
| a. 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. | Georgia Dental Association; Georgia Association for Primary Care; Federally Qualified Community Health Centers; Georgia Department of Public Health |

**S / 2.2.3** Promote oral health among low-income Hispanic mothers and children in Georgia.

| Activities | Partners |
|---|---|
| a. The Oral Health Education Initiative for low-income Hispanic children and adolescents will revise its education to reduce barriers in language and cultural differences among Hispanic populations. | Georgia Department of Education; Georgia Public Health Districts; Georgia Department of Public Health |



**SOCIAL DETERMINANTS OF HEALTH**

# 2.3 Maternal Mortality

**OBJECTIVE:** DEVELOP AND IMPLEMENT TARGETED EDUCATION AND MARKETING CAMPAIGN TO PROMOTE WELL WOMAN VISITS.

| 2016 Baseline | 2020 Target |
|---|---|
| 62.1 percent | 64 percent |

## SUMMARY

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

In 2010, Amnesty International released a report entitled "Deadly Delivery: The Maternal Health Care Crisis in the USA," which listed Georgia as the state with the highest maternal mortality rate in the nation. Based on data from 2001-2006, Georgia's pregnancy-related maternal mortality 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 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 (48.5 percent) of the Georgia women entering pregnancy were overweight/obese. The percentage was highest among non-Hispanic Blacks (58.0 percent) and lowest among non-Hispanic Whites and others (42.0 percent and 37.7 percent). As maternal age increased, so did the percent of obese women entering into pregnancy. Only 46.1 percent of women with more than a high school education were obese entering into pregnancy, compared with 52.3 percent of women with less than a high school diploma.

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 death certificate, which can underestimate the true prevalence of maternal deaths. Georgia recently implemented a Maternal Mortality Review Committee that thoroughly reviews vital records to identify maternal deaths. The committee identified 25 pregnancy-related and 60 pregnancy-associated deaths in 2012. Of the deaths that were related to pregnancy, 17 of the women were Black, 6 were White, 1 was Hispanic and 1 was unknown. The deaths occurred at a higher percentage among women with a high school diploma or less.

## PLAN OF ACTION

### S / 2.3.1

Implement the use of a communications campaign in primary care facilities and family planning clinics throughout the state.

| Activities | Partners |
|---|---|
| a. Educate district health directors and family planning staff on how to effectively implement the use of communications material. | Georgia Department of Public Health; Local Public Health Family Planning Clinics; Georgia Obstetric and Gynecological Society United Way of Greater Atlanta; March of Dimes; Georgia Hospital Association |
| b. Partner with community stakeholders to train primary care providers, clinics and other facilities on the use of communications material. | |

### S / 2.3.2

Conduct statewide focus groups to assess what women know and how they learn about pregnancy-related health during their reproductive years.

| Activities | Partners |
|---|---|
| a. Develop a plan to facilitate statewide focus groups for women, including creating an evaluation plan and tools. | Georgia Department of Public Health; Local Public Health Family Planning Clinics; Georgia Obstetric and Gynecological Society; United Way of Greater Atlanta; March of Dimes; Georgia Hospital Association |
| b. Collect and analyze qualitative data from focus groups to make strategy recommendations to improve well woman visits. | |
| c. Collaborate with Chronic Disease to develop messaging around women's health visits to different audiences. | |

### S / 2.3.3

Establish an interagency workgroup to develop tiered education and marketing strategies to promote well woman visits to women's health stakeholders such as medical providers, health districts and members of the community.

| Activities | Partners |
|---|---|
| a. Work with communications team to create a plan to promote well woman visits in different media outlets throughout the state | Georgia Department of Public Health; Local Public Health Family Planning Clinics; Georgia Obstetric and Gynecological Society; United Way of Greater Atlanta; March of Dimes; Georgia Hospital Association |

## 2.3 Prevent Maternal Mortality *(continued)*

**SOCIAL DETERMINANTS OF HEALTH**

## 2.4 Children with Special Health Care Needs

**OBJECTIVE:** INCREASE THE PERCENT OF ADOLESCENTS WITH SPECIAL HEALTH CARE NEEDS WHO RECEIVED SERVICES NECESSARY TO MAKE TRANSITIONS TO ADULT HEALTH CARE.

| 2016 Baseline | 2020 Target |
|---|---|
| 36.9 percent | 40 percent |


**SUMMARY**

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

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

## S / 2.4.1

Increase screening and identification through a coordinated system.

| Activities | Partners |
|---|---|
| a. Create a connected health record system.<br>b. Use SBHCs and telehealth access as screening sites.<br>c. Expand behavioral screening to youth through telemedicine.<br>d. Increase formal screening within physician offices.<br>e. Utilize SENDSS; provide education on SENDSS.<br>f. Expand developmental screening within health departments. | Georgia Association of School Nurses; Department of Juvenile Justice; Department of Community Health; Georgia Chapter American Academy of Pediatrics; Georgia Obstetric and Gynecological Society; Children's Healthcare of Atlanta; Georgia Department of Education; Sickle Cell Foundation of Georgia; Georgia Department of Public Health |

## S / 2.4.2

Use technology and telemedicine to increase access to specialty care.

| Activities | Partners |
|---|---|
| a. Provide a coordinated telehealth system for families and providers, and use telehealth to increase access to care coordination, speech therapy and access to hematology services.<br>b. Perform community assessment on specialty care gaps and service needs.<br>c. Develop a computer-based resource directory.<br>d. Connect Electronic Medical Record System (EMRS).<br>e. DJJ Re-entry Initiative – Include the health component to connect them to providers in their communities. | Georgia Department of Community Health; Children's Healthcare of Atlanta; Georgia Chapter American Academy of Pediatrics; Georgia Obstetric and Gynecological Society; Georgia Association of School Nurses; Georgia Department of Juvenile Justice; Parent-to-Parent of Georgia; Georgia Department of Public Health |

## S / 2.4.3

Use technology and telemedicine to increase access to specialty care.

| Activities | Partners |
|---|---|
| a. Provide transportation vouchers.<br>b. Perform assessment of transportation services.<br>c. Increase awareness of and the number of transportation services.<br>d. Cover liability insurance for church vans. | MARTA; Georgia Department of Public Health; Local Faith-based Organizations; Emergency Medical Services; Department of Juvenile Justice; Georgia Department of Public Health |





# 2.5 Congenital Syphilis

**OBJECTIVE:** DECREASE THE RATE OF INFANTS BORN WITH CONGENITAL SYPHILIS.

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

## SUMMARY

Congenital syphilis can cause miscarriage, stillbirth, failure to thrive, deformed bones, meningitis, and nerve problems leading to blindness or deafness. Primary and secondary syphilis are the infectious stages of syphilis and are therefore the most important cases to interview and identify and treat partners to prevent further transmission. After a low point in the 90s where the possibility of eliminating congenital syphilis was discussed, there has been a steady rise in the number of syphilis cases. The main causes of the increase seem to be an increase in the use of internet sites to find anonymous partners and increases seen in the MSM population. Across the country, it appears Black, non-Hispanic males are most affected by primary and secondary syphilis and have shown increased case counts over the past several years.

The rate of reported congenital syphilis cases in the United States has increased each year 2012-2015. Georgia reported 21 cases in 2015 and ranked 8th in the country for congenital syphilis case rate. Congenital syphilis can be transmitted to the baby if the mother is not treated at least 30 days prior to delivery. Georgia recently passed a law for all pregnant women to be tested for syphilis in their first and third trimesters in order to help promote prompt treatment and reduce the possibility of it being transmitted to the baby.

## PLAN OF ACTION

**S / 2.5.1** Ensure gonorrhea, chlamydia, syphilis and human immunodeficiency virus are part of routine screening for adults.

| Activities | Partners |
|---|---|
| a. Supply STD clinics (public/private) and public health department family planning clinics with supplies for screening | Federally Qualified Health Centers; Primary Care Providers; Academic Student Health Services; Georgia Department of Public Health |

**S / 2.5.2** Know the pregnancy status of females identified as a new syphilis cases.

| Activities | Partners |
|---|---|
| a. Training for professionals (health educators, pediatricians, etc.) on referral resources and STD surveillance requirements | Georgia Obstetric and Gynecological Society; Georgia Department of Juvenile Justice; Federally Qualified Health Centers; Primary Care Providers; Georgia Department of Public Health |
| b. Educate community interns/residents at local public health department STI clinics | |

**S / 2.5.3** Ensure pregnant females with syphilis are adequately treated at least 30 days prior to delivery.

| Activities | Partners |
|---|---|
| a. Educate providers and the general public on the new law regarding first and third trimester testing for syphilis and HIV (HB436); Supply STD clinics and family planning clinics within public health departments with supplies for treatment | Federally Qualified Health Centers; Primary Care Providers; Georgia Obstetric and Gynecological Society; Georgia Department of Public Health |

**S / 2.5.4** Ensure early disease investigation of early syphilis cases in females.

| Activities | Partners |
|---|---|
| a. Educate primary care providers, obstetricians and partnering clinics on the methods and importance of timely treatment. | Federally Qualified Health Center; Primary Care Providers; Georgia Obstetric and Gynecological Society; Georgia Department of Public Health |
| b. Revise disease investigation protocols to prioritize syphilis cases | |

## SOCIAL DETERMINANTS OF HEALTH

# Priority Area 3: Chronic Disease Prevention and Control

**3.1 Pediatric Asthma**

**3.2 Cancer Prevention and Control**

**3.3 Diabetes and Hypertension**

**3.4 Childhood Obesity**

**3.5 Tobacco Use Prevention**

# 3.1 Pediatric Asthma

**OBJECTIVE:** ELIMINATE PEDIATRIC ASTHMA MORTALITY.

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


## SUMMARY

During 2013, the prevalence of asthma among Georgia children was 10.8 percent and 8.4 percent in adults. Among Georgia children, asthma was more common in boys (12.6 percent) than girls (8.9 percent); in Black children (16.7 percent) than White children (7.6 percent); and among those ages 5-9 years (14.1 percent) than children in other age categories. Among adults, asthma prevalence was higher in females (11.3 percent) than males (5.3 percent); Blacks (10.8 percent) than Whites (7.9 percent); those making less than $25,000 (12.4 percent) than those making $50,000 or more (5.7 percent) per year; those with less than high school diploma (11.4 percent) than those with a college degree (6.5 percent); and those without health insurance (10.0 percent) than those with health insurance (7.9 percent). In Georgia during 2012-2013, the prevalence of current asthma was significantly higher among adults who were obese (10.7 percent) than adults with normal body weight (7.3 percent). Current asthma was also more common among adult smokers than non-smokers.


## PLAN OF ACTION

**S / 3.1.1** 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 home visits, and self-management education.

| Activities | Partners |
|---|---|
| a. 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. | Georgia hospitals; Health Systems; Accountable Care Organizations; Medicaid; Care Management Organizations; Georgia Department of Public Health |

**S / 3.1.2** Reach early care centers and K-12 school environments statewide with opportunities to implement asthma-friendly policies and best practices.

| Activities | Partners |
|---|---|
| a. Maintain Georgia Asthma Management Education (GAME-CS) asthma education curriculum for school and child care settings. | Public and Private School Systems, Child Care Providers; Georgia Department of Education; Environmental Protection Agency; Georgia Department of Public Health |
| b. Maintain Asthma Friendly School and Child Care recognition programs. | |
| c. Support initiatives integrating self-management asthma education in school-based health centers and telehealth scopes of practice. | |

**S / 3.1.1** 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.

| Activities | Partners |
|---|---|
| a. 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). | Georgia Department of Public Health; Medicaid; Care Management Organizations; Health Systems; Hospitals; Healthcare Providers; Accountable Care Organizations; Environmental Protection Agency; Housing and Urban Development; Centers for Disease Control and Prevention; Local Health Departments |
| b. Support the integration of Certified Asthma Educators with (AE-C) designation on clinical care teams and disease management organizations. | |
| c. Develop ROI and Business Case(s) tailored to specific health care systems. | |

**S / 3.1.4** 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.

| Activities | Partners |
|---|---|
| a. Facilitate meetings to educate high-level decision makers about asthma burden and strategy. | Georgia Department of Public Health; Medicaid; Care Management Organizations; Health Systems; Hospitals; Healthcare Providers; Accountable Care Organizations |

## SOCIAL DETERMINANTS OF HEALTH

# 3.2 Cancer Prevention and Control

**OBJECTIVE:** REDUCE GEORGIA'S CANCER DEATH RATE AND REDUCE DISPARITIES IN CANCER MORBIDITY AND MORTALITY.

| 2014 Baseline | 2020 Target |
|---|---|
| 17,260 (2013)* | 14,260* |

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

## SUMMARY

Cancer is the leading cause of death in Georgia. In 2013, an estimated 17,260 Georgians died of cancer. The two leading cancer killers in Georgia are lung and colon cancer. Each day, more than 120 Georgians are diagnosed with cancer. That is an average of more than 41,000 new cancer cases each year. The Georgia Department of Public Health and other members of the Georgia Cancer Control Consortium, including the Regional Cancer Coalitions of Georgia, envision a future for our state that is free from cancer deaths and cancer-related health disparities. However, the causes of cancer and its prevention, diagnosis, treatment and care are multidimensional. A person's health is not only the product 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 she or he lives. As a result, there is no single approach or intervention that can reduce the impact of cancer in Georgia. Therefore, multifaceted and layered approaches to the prevention and control of cancer are needed. Statewide leadership, including leadership from government, business, academic and nonprofit sectors is also essential to cancer prevention and control. The Georgia Department of Public Health, through and with the Consortium and its membership, will implement this plan and provide the statewide leadership necessary to bring together communities and resources for cancer prevention and control.



## PLAN OF ACTION

### S / 3.2.1 Cancer risk reduction (preventing or stopping tobacco use, improving diet and increasing physical activity).

| Activities | Partners |
|---|---|
| a. Support physical activity and healthy eating for youth; promote breast-feeding; 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 Quit Line. | Georgia Tobacco Use Prevention Program, Georgia SHAPE, Local Public Health Departments; Georgia Department of Public Health |

### S / 3.2.2 Vaccination for Human Papillomavirus.

| Activities | Partners |
|---|---|
| a. Offer HPV vaccine to boys and girls in conjunction with other vaccinations; engage community based organizations to implement cervical cancer communication programs. | Local Public Health Departments, Health Care Providers; Georgia Department of Public Health |

### S / 3.2.3 Screening for breast, cervical, colorectal and lung cancer.

| Activities | Partners |
|---|---|
| a. Promote and sustain existing community based screening programs; carry out educational campaigns; promote breast-feeding (breast cancer); conduct provider education and trainings (colorectal). | Academic Partners; Health Care Providers; Local Public Health Departments; Regional Cancer Coalitions; Georgia Department of Public Health |

### S / 3.2.4 Quality cancer diagnosis and treatment.

| Activities | Partners |
|---|---|
| a. Facilitate meetings to educate high-level decision makers about cancer burden and strategy | Georgia hospitals, Health Systems; Georgia CORE; Georgia Department of Public Health |

| S / **3.2.5** | Access to palliative care and survivorship. | |
|---|---|---|
| | Activities | Partners |
| | a. Promote integration of national palliative care guidelines into standard oncology services at all Commission on Cancer (CoC) centers; promote earlier hospice care transitions for all CoC centers; hold at least one palliative care networking event for registered CoC centers; create a dissemination plan to provide best practices tools; develop a toolkit; develop and deliver education campaigns. | Cancer Patient Navigators of Georgia, Georgia CORE; Georgia Department of Public Health |

| S / **3.2.6** | Patient case management and care coordination. | |
|---|---|---|
| | Activities | Partners |
| | a. Promote patient case management and care coordination; provide continuing education opportunities; educate about the patient navigator's role; engage Cancer Patient Navigators of Georgia participation in all working groups of the Comprehensive Cancer Control Plan. | Cancer Patient Navigators of Georgia, Georgia CORE; Georgia Department of Public Health |

**SOCIAL DETERMINANTS OF HEALTH**



# 3.3 Diabetes and Hypertension

**OBJECTIVE:** DECREASE THE ANNUAL RATE OF HOSPITALIZATIONS FOR DIABETES AND HYPERTENSION.

| 2016 Baseline | 2020 Target |
|---|---|
| 180. 2 and 73.3 (2013 Hospital Discharge Data) | 135 and 66.7 (2020 Hospital Discharge Data) |

## SUMMARY

Georgia has a significant burden of preventable and controllable chronic disease in the adult population, contributing to the second leading cause 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 from 10.1 percent in 1990 (The State of Obesity, 2015). Across the state, adults age 18 or older represent 74.3 percent of the state's population. 37.5 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 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 corresponding to obesity are high in Georgia. Currently 35.0 percent of Georgians are diagnosed as hypertensive, ranking Georgia the 12th highest state in nation for rates of hypertension. Considering this, hypertension is directly linked to obesity, with more than 75 percent of cases having  a demonstrated direct link (Trust for America's Health, 2015). The health consequences and costs associated with obesity are alarming. In fact, obese adults are at increased risk of developing more than 20 major chronic diseases, including cardiovascular disease and stroke, diabetes, osteoarthritis, gall bladder disease and some cancers (University of Georgia, 2015). Chronic diseases—such as asthma, cancer, diabetes and heart disease—cost Georgia approximately $40 billion each year, keep children out of school, cost Georgia employers, and result in more than 200,000 years of life lost (Georgia Department of Public Health). Therefore, access to primary care services is essential to disease prevention.

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. Among adults ≥ 18 years, the age-adjusted discharge rate was highest among males (182.3 per 100,000 persons) and non-Hispanic Blacks (323.7 per 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, the prevalence of diabetes among Georgia adults was 10.5 percent. The prevalence was

highest among: those ages 65-74 (25.8 percent versus 2.3 percent for those ages 18-24); females (10.6 percent versus 10.3 percent in males); non-Hispanic Blacks (12.5 percent versus 9.7 percent for non-Hispanic Whites); less than high school graduates (14.3 percent versus 7.5 percent for college graduates); those with an insurance plan (11.5 percent versus 6.8 percent for those without an insurance plan); and those making $15,000 or less per year (13.1 percent versus 7.8 percent for those making $75,000 or more per year). Among Georgia diabetic adults, the prevalence of smoking was 15.9 percent (versus 19.9 percent for non-diabetics); hypertension was 73.0 percent (versus 30.2 percent); cholesterol was 68.4 percent (versus 34.1 percent); overweight and obesity was 83.0 percent (versus 62.7 percent); at least once daily fruit intake was 54.9 percent (versus 56.5 percent); at least once daily vegetable intake was 72.9 percent (versus 76.3 percent); and meeting physical activity recommendations was 40.1 percent (versus 50.5 percent). These poor health outcomes disproportionately impact those without health insurance, who are unemployed or underemployed, Medicaid participants, or have limited access to primary care. Improved diabetes management is associated with consistent visits to primary care physicians. High rates of diabetes and complications from poor diabetes management are more likely to occur among those who lack access to care. In addition, the adult workforce in Georgia is burdened by these conditions, negatively impacting economic development opportunities, particularly in rural Georgia, and reinforcing the cycle of poverty in some communities.

## PLAN OF ACTION

### S / 3.3.1

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.

| Activities | Partners |
|---|---|
| a. Pilot and launch DPH framework for health systems to support Georgia in improving the diagnosis and control of chronic diseases and reducing disparities. | Georgia Hospitals; Health Systems; Federally Qualified Community Health Centers; Accountable Care Organizations; Georgia Association of School Nurses, Georgia Department of Behavioral Health and Developmental Disabilities; Georgia Department of Public Health |
| b. 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. | |
| c. Implement Hypertension Management Programs in which health systems partner with physician practices to focus on the control of undiagnosed hypertension using case management and self-management plans in their patient population. (This will ensure early detection of warning signs or symptoms.) | |
| d. Work with pharmacists and health systems to provide access to primary care through comprehensive diabetes and medication therapy management to diabetic and hypertensive patients. | |



### S / 3.3.2

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.

| Activities | Partners |
|---|---|
| a. Establish Diabetes Self-Management Education via telehealth in underserved health districts. Assist in setting up linkages between sending and receiving sites and training staff at both types of sites. | Georgia Hospitals; Health Systems; Federally Qualified Community Health Centers; Accountable Care Organizations; Georgia Association of School Nurses; Local Public Health; Area Agencies on Aging; Georgia Department of Public Health |

### S / 3.3.3

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

| Activities | Partners |
|---|---|
| a. Assist existing or newly accredited DSME sites in establishing satellite sites and increase the number of satellite sites by at least three in underserved areas though the state. DSME courses will be provided to local health districts through the telehealth system. | Georgia Hospitals; Health Systems; Federally Qualified Community Health Centers; Accountable Care Organizations; American Association of Diabetes Educators; Pharmacies; Georgia Pharmacy Association; School Based Health Centers, Georgia Association of School Nurses; Georgia Department of Behavioral Health and Developmental Disabilities; Area Agencies on Aging; Health Clinics; Local Public Health Departments; Georgia Department of Public Health |
| b. 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. | |
| c. Implement the 2016 statewide protocols for hypertension and diabetes in local health departments. | |
| d. Implement the Ask, Advise, Refer model for tobacco use in all local health departments. | |
| e. Increase the percentage of patients seen in local health departments with abnormal A1C levels referred to American Diabetes Association or American Association of Diabetes Educators accredited Diabetes Self-Management Education/Training (DSME/T). | |
| f. Increase access to sustainable (billable) DSME/T by accrediting new DSME/T sites, particularly in high need areas of the state | |
| g. 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) | |

**SOCIAL DETERMINANTS OF HEALTH**

# 3.4 Childhood Obesity

**OBJECTIVE:** INCREASE THE PERCENTAGE OF GEORGIA'S STUDENT POPULATION THAT FALL IN THE HEALTHY FITNESS ZONE (HFZ) FOR BMI.

| 2016 Baseline | 2020 Target |
|---|---|
| 60.3 percent of males and 60.3 percent of females assessed currently fall in the HFZ for BMI. | By the year 2020, 64 percent of males and 64 percent of females assessed will fall in the HFZ for BMI. |

## SUMMARY

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

## PLAN OF ACTION

### S / 3.4.1

Utilize effective communication/marketing approaches to promote nutrition, physical activity and obesity prevention.

| Activities | Partners |
|---|---|
| a. Keep three social media platforms effectively operating with relevant content for the public. | Sharewik; Children's Health Care of Atlanta; Royal Foods; The Arthur M. Blank Family Foundation; Healthways; Georgia Family Connection Partnership; Boys and Girls Club; Voices for Georgia's Children; Harvard Public Health; Georgia State University; Peach State; Emory University; reimagineATL; Local Public Health Departments; Georgia Organics; Georgia Department of Education; Medical College of Georgia; University of Georgia; Zipmilk; Georgia Department of Public Health |



### S / 3.4.2

Promotion and dissemination of relevant and innovative research.

| Activities | Partners |
|---|---|
| a. Continually share partner organization resources, research and content via website and social media. | University of Georgia; Emory; Georgia State University; Medical College of Georgia; Georgia Department of Public Health |

### S / 3.4.3

Train individuals/organizations on nutrition, physical activity, and obesity prevention best practices and policies.

| Activities | Partners |
|---|---|
| a. Develop toolkits, fact sheets and literature to disseminate to various audiences (schools, health care providers, child care providers, ECE's, etc).<br><br>b. Conduct training events around nutrition, physical activity, and obesity prevention best practices and policies:<br>• Fitnessgram Teacher Training (K-12, afterschool and refresher courses)<br>• Power Up for 30 Training (K-5, 6-8, afterschool providers)<br>• School Health Summits (K-12)<br>• Growing Fit Training (ECE)<br>• Strong4Life Smarter Lunchroom (K-12)<br>• Power Up for 30 pre-service training for teachers (college)<br>• Strong4Life Provider Training (Physicians, Nurse Practitioners, Physician Assts.)<br>• Strong4Life WIC Provider Training (WIC staff)<br>• Georgia Five Star Hospital Training (birthing hospital staff) | Sharewik; Children's Health Care of Atlanta; Royal Foods; The Arthur M. Blank Family Foundation; Healthways; Georgia Family Connection Partnership; Boys and Girls Club; Voices for Georgia's Children; Harvard Public Health; Georgia State University; Peach State; Emory University; reimagineATL; Local Public Health Departments; Georgia Organics; Georgia Department of Education; Medical College of Georgia; University of Georgia; Zipmilk; Georgia Department of Public Health |

### S / 3.4.4

Recognize the adoption of healthy nutrition and physical activity policy and best practices.

| Activities | Partners |
|---|---|
| a. Recognize organizations that have adopted healthy nutrition and physical activity environments and policies:<br>• Governor's Shape Honor Roll Award<br>• Golden Radish Award<br>• Georgia Shape Quality Rated Award<br>• Georgia Five Star Hospital Award | Georgia Department of Education; HealthMPowers; Alliance for a Healthier Generation; The Cooper Institute; Iowa State University; Georgia State University; University of Georgia; Emory University; Children's Healthcare of Atlanta; Department of Early Care and Learning; Division of Family and Children's Services; Arthur M. Blank Family Foundation; Fuel Up to Play 60; Georgia Association for Physical Education, Recreation and Dance; Playworks; University of West GA; Boys and Girls Clubs; Blaze Sports; Georgia Chapter American Academy of Pediatrics; Zipmilk; Georgia Department of Public Health |

| S / **3.4.5** | Build capacity for organizations to create healthy nutrition and physical activity environments. | |
|---|---|---|
| | Activities | Partners |
| | a. Provide technical assistance for organizations to build capacity:<br>• Power Up for 30 (K-8)<br>• Shape Nutrition and PA School Grantee Program<br>• Fund PH districts to support ECE settings with healthy Nutrition and PA best practices, guidelines, standards, policies and practices<br>• Promote state employee health and wellness resources (Healthways, Working on Health, State Health Benefit Plan) | Georgia Department of Education; HealthMPowers; Alliance for a Healthier Generation; The Cooper Institute; Iowa State University; Georgia State University; University of Georgia; Emory University; Children's Healthcare of Atlanta; Department of Early Care and Learning; Division of Family and Children's Services; Arthur M. Blank Family Foundation; Fuel Up to Play 60; Georgia Association for Physical Education, Recreation and Dance; Playworks; University of West GA; Boys and Girls Clubs; Blaze Sports; Georgia Chapter American Academy of Pediatrics; Zipmilk; Georgia Department of Public Health |

**SOCIAL DETERMINANTS OF HEALTH**



# 3.5 Tobacco Use Prevention

**OBJECTIVE:** INCREASE THE NUMBER OF GEORGIANS PROTECTED FROM DANGEROUS SECONDHAND SMOKE IN ALL BARS, RESTAURANTS, AND WORKSITES.

| 2016 Baseline | 2020 Target |
|---|---|
| 2.4 percent protected | 6 percent protected |

## SUMMARY

Tobacco use is the leading preventable cause of death in Georgia. Each year, tobacco use costs the state of Georgia more than 11,500 lives and nearly $5 billion in direct and indirect (lost wages, absenteeism) health care costs. Progress is being made to reduce the burden of tobacco use in Georgia. Over the last 15 years in Georgia, adult cigarette smoking has declined from 26 percent in 2003 to 17.4 percent in 2015 (2015 Behavior Risk Factor Surveillance Survey). Youth cigarette smoking in Georgia has also declined from 17 percent in 2011 to 12.8 percent in 2013 (2013 Youth Risk Behavior Survey). However, chewing tobacco, electronic cigarettes, vaping and hookah use has drastically increased in youth and adult populations presenting additional challenges.

In partnership with various agencies and stakeholders, communities are learning more about the overall dangers of tobacco use. More municipalities and worksites are eliminating exposure to secondhand smoke by adopting or strengthening city or county smoke-free ordinances, tobacco-free workplace policies and smoke-free public and private housing. Public and private schools, colleges/universities, hospitals, park and recreation facilities, and various worksites are making the choice to protect workers and promote tobacco cessation. These policies are having a positive impact on disparate populations where secondhand smoke has the greatest impact.

Cessation support services are an important component of creating smoke-free and tobacco-free environments. The Georgia Tobacco Quit Line provides cessation counseling and Nicotine Replacement Therapy in the form of the patch or gum to thousands of Georgians. As a result, the tobacco quit rate for Georgia is 29 percent (2015), which is consistent with the national trend for tobacco cessation.

## S / 3.5.1

Prevent tobacco use initiation among youth and young adults.

| Activities | Partners |
|---|---|
| a. Provide appropriate and accurate public health data and statistics on tobacco use and tobacco prevention (including e-cigarettes, flavoring and point of sale) best practices and evidenced based strategies. | Local Public Health Departments; Georgia Department of Education; Parent Teacher Association; Georgia Parks and Recreation Association; University System of Georgia and the Technical College System of Georgia; Historically Black Colleges and Universities; Association of City and County Governments |
| b. Develop and conduct education campaigns using mass media in combination with other community interventions. | |
| c. Increase the number of Georgia school districts that adopt, implement and enforce a model 100 percent tobacco-free school policy from 103 to 181. | |
| d. Increase the number of colleges and universities that adopt, implement and enforce a model 100 percent tobacco-free campus policy from 46 to 128. | |
| e. Increase the number of parks with either a smoke free or tobacco-free policy from 28 to 43. | |

## S / 3.5.2

Promote quitting among adults and youth.

| Activities | Partners |
|---|---|
| a. Promote Georgia Tobacco Quit Line services with special emphasis on coping mechanisms to support quitting. Counter market the use of e-cigarettes as a method of quitting. | Georgia Hospitals; Health Systems; Healthcare Providers; Georgia Hospital Association; American Cancer Society, American Lung Association, American Heart Association, Georgia Public Health Association, Georgia Tobacco Statewide Coalition |
| b. Educate youth centered healthcare providers, pediatricians, etc. on the benefits of referring consumers to the Georgia Tobacco Quit Line. | |



## S / 3.5.3

Eliminate exposure to tobacco and secondhand smoke.

| Activities | Partners |
|---|---|
| a. Adopt tobacco-free voluntary workplace policies targeting businesses of various employment sizes. | Georgia Hospitals; Health Systems; Healthcare Providers; Georgia Hospital Association; American Cancer Society, American Lung Association, American Heart Association, Georgia Public Health Association, Georgia Tobacco Statewide Coalition |
| b. Provide technical assistance to public and private multiunit housing authority regarding adopting, implementing and enforcing tobacco-free policies. | |
| c. Develop and conduct training and public education campaigns (using both earned and paid media) on dangers of secondhand smoke exposure in cities and counties pursuing 100 percent smoke-free ordinances. | |

## S / 3.5.4

Identify and eliminate tobacco-related disparities among population groups.

| Activities | Partners |
|---|---|
| a. Identify and direct interventions toward populations disproportionately impacted by tobacco use. As of this publication, the following population groups experience the highest burden of tobacco use in Georgia: 1) adult males (22 percent); 2) adults with an estimated income below federal poverty level (31.7 percent); 3) adults with less than a high school diploma (29 percent); and, 4) adults who are Medicaid recipients (26 percent). | Local Public Health Departments; Georgia Department of Education; Parent Teacher Association; Georgia Parks and Recreation Association; University System of Georgia and the Technical College System of Georgia; Historically Black Colleges and Universities; Association of City and County Governments; American Cancer Society, American Lung Association, American Heart Association, Georgia Public Health Association, Georgia Tobacco Statewide Coalition |
| b. Expand the number of partners from all sectors and racial and ethnic groups, as well as age groups, engaged in tobacco control initiatives. | |

### SOCIAL DETERMINANTS OF HEALTH

# Moving to Action

**Shared Ownership**
Partners throughout Georgia will continue to participate in workgroups within the three focus areas; Maternal and Child Health; Chronic Disease Prevention and Control; and Access to Care. Partners within these work groups will be engaged in regular meetings and communications to support shared ownership of all phases of the SHIP including assessment, planning, investment, implementation and evaluation. The workgroups will continue to develop strong partnerships and encourage alignment of organizational mission, goals and initiatives with the SHIP. Work group participants will be asked to volunteer on subcommittees within these respective phases to provide review and feedback throughout the SHIP process.

**Timeline**
As the coordinating entity, DPH will assist the SHIP work groups in monitoring, tracking and reporting on progress and impact through the DPH performance management (PM) system. The system is set up to provide quarterly updates on all relevant performance measures using a dashboard reporting format to help viewers understand status at a glance.

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

**Progress Tracking**
Progress updates will be provided quarterly in the DPH PM system, with consideration given to the specified timeframe for each strategy and activity. An annual report of progress toward implementation of SHIP strategies will be published each year.

Results will also be used to identify opportunities for improvement which DPH's Office of Performance Improvement will assist the work groups in utilizing the appropriate quality improvement methods, tools and techniques to address.

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

Georgia Department of Public Health