Maternal and Child Health Services
Title V Block Grant

State Narrative for Georgia

Application for 2015
Annual Report for 2013

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Georgia's assurances and certifications are available on file in the state's Title V agency, the Department of Public Health's Maternal and Child Health Section located on the 11th floor of 2 Peachtree Street, Atlanta, Georgia 30303. For further information, please contact the MCH Section Director's Office at 404/657-2851.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

The MCH Program has made a significant commitment to ensuring adequate and varied public comment opportunities. As part of Georgia's 2010 Needs Assessment process, efforts were made to ensure a mix of parents/consumers and health care providers in the community. Outreach efforts to the Hispanic population in Georgia communities were deployed, and as a result, several focus groups were conducted in Spanish. Additional focus groups were conducted to ensure involvement of MCH internal stakeholders in District Health Offices through the use of VICS, the two-way video-conferencing system operated by the Georgia Department of Community Health. A total of 182 Georgia citizens were engaged through 15 needs assessment community focus groups. A day-long focus group that included 45 non-governmental maternal and child health providers and advocacy groups from throughout Georgia provided an additional opportunity for public comment. The input received through these focus groups was used to identify a comprehensive list of needs in the MCH community in Georgia.

Following the focus groups, 55 needs were identified from which the top ten priority needs in Georgia were to be selected. Public input was sought in the selection of these needs. A web-based survey sent to all Division of Public Health employees was conducted to ensure that all staff had an opportunity to identify the needs they believed to be of greatest priority among the 55 needs identified previously. There were 311 responses from staff throughout Georgia. A meeting was held that included more than 50 participants representing advocacy groups, academia, local MCH staff, other HRSA grantees, and parents of children with special health care needs to evaluate each need on several dimensions. Participants were divided into several tables where they shared their individual expertise and discussed each need prior to each participant completing an individual assessment.

Following the selection of the top ten priority needs, the completion of the quantitative and qualitative data report, and the activity plan for FY11, these three documents were posted on a

dedicated web page where each document could be downloaded and/or reviewed for public comments submitted. All focus group participants who provided an email address, district health directors, advocacy groups, Georgia's AMCHP CSHCN family delegate, non-governmental agencies, and Division of Public Health program directors received an email from the Title V MCH Director with a link to the public comment web page and a request for their input and for them to forward the link as broadly as possible. The initial email was sent to more than 250 people throughout Georgia. The comment period lasted from June 10, 2010 through June 24, 2010. There were 537 unique page views. Forty-three comments were entered, of which nine were from parents or family members of children with special health care needs. Overall, the comments were supportive and complementary of the FY11 activity plan, top priority needs, the detail and presentation of the assembled data, and the process for engaging partners and developing the documents. The comments also identified some key areas of concerns that, if addressed, could help to improve the health status of the MCH population throughout Georgia. All submitted comments are included in the attachment. Comments have been shared with leadership in the Division of Public Health and MCH Program.

Following the submission and review of the FY11 application, the final document will be posted on the MCH Program website (http://health.state.ga.us/programs/family), and one copy will be distributed to each public health district director, all MCH Program staff, and all Division of Public Health Leadership. The quantitative and qualitative data will be developed into a report on the state of women, infants, and children in Georgia with a formal release to MCH partners, stakeholders, and the media.

/2012/For the 2012 application, a draft of the entire application was posted on the Department of Public Health (DPH), Maternal and Child Health (MCH) webpage (http://health.state.ga.us/programs/family/index.asp) with the following message:

"Statewide MCH Partners,

Title V is initiating its annual comment period. On this page, you will find a draft copy of the FY2012 Title V Block Grant. We ask that you review this document and provide comments through the following link (Click here to take survey). We welcome comments not only on the actual document, but on any changes or comments you may have on the MCH Program and the operation of Title V. Your comments will help us improve our programs and ensure that we are moving in the best direction possible. The comment period will close on Tuesday, July 12, 2011. Thank you in advance for your assistance."

In addition to posting the documents to the webpage, e-mail messages were distributed to partners, advocates, parents, and consumers who have an existing relationship with the MCH Program or are on an existing list serv.

A SurveyMonkey link was created to accept comments. Thirty-six individuals accessed this link. Each respondent was asked to identify themselves. The characteristics of these 36 respondents is below. Note that each individual respondent could select multiple characteristics.

District staff - 2
Advocates - 20
State office staff - 4
Consumers - 12
Provider/Provider association staff - 25
University faculty - 5

Overall, comments were extremely positive. There was broad based support for the direction in which the Georgia MCH Program is progressing. This is the second grant application submitted by the new leadership in the Georgia MCH Program.

The full text of all comments received was included in an attachment.//2012//

/2013/ For the 2013 application, a draft of the application was posted on the DPH MCH webpage with a stakeholder message similar to that used in 2012. In addition to posting the webpage, e-mails were distributed to partner, advocates, parents, and consumers who have an existing relationship with the MCH Program. Input was also received from programs throughout the Department that work collaboratively with MCH. Through a Survey Monkey link created to accept comments, 13 individuals accepted this link. As in 2012, each respondent was asked to identify themselves. The characteristics of the respondents are described below. Note that each individual respondent could select multiple characteristics.

District staff - 7
Advocates - 14
State office staff - 2
Consumers - 6
Provider/provider association staff - 15
Professional association member/leader - 13

The comments received were supportive of the MCH Program and the children and families served. No significant changes to the application were suggested.//2013//

/2014/ For the 2014 application, a draft of the application was posted on the DPH MCH webpage with the following message:

"Dear Georgia Residents and Stakeholders,
Title V is initiating its annual public comment period. On this page, you will find four documents. One is the complete draft copy of the Title V Block Grant. The other three documents are specific sections of the grant as it relates to certain sub populations. All three documents address our current activities and our plan for the upcoming year surrounding 1) children and youth with special health care needs, 2) children age 1-22, 3) pregnant women and infants.

We welcome comments not only on the actual document, but on any changes or comments you may have for the MCH Section and the operation of the Title V Block Grant. Your comments will help us improve our programs and ensure that we are moving in the best direction possible. The comment period will close on Sunday July 14, 2013. Comments should be sent to MCHDO@dhr.state.ga.us with the subject Title V comments.

Thank-you in advance for your comments."

In addition to the posting on the webpage, e-mails were distributed to partners, stakeholders, advocates, parents, and consumers who have an existing relationship with the MCH Program. Input was received from both the public and programs throughout the State that work collaboratively with the MCH Section. Some of the comments were in support of the current work and planned activities of the MCH Section, while others requested additional financial support in the coming years. Additionally, eleven comments were collected from families participating in CSHCN. Below are some of the comments received:

"I want to comment on this block grant. If it was not for available funding for one of my daughters who has CP, is deaf and legally blind, She would not have had a change to be the independent person she is today. Places like the CP center, the apple center and other funds helped her gain this independence. I don't think she would have had the chances she has today if it was not for available programs and funding. This started at age 2 when I moved to Atlanta, GA.

My other daughter was not so lucky. Ten years later there was nothing. She has autism and because of limited funding she had to attend Dekalb County schools which did nothing but fight me her hold education because I wanted them to education my child and I had no where else to turn because of no funding. Now I have to assist her with everything."

"Very good program helpful to families w/special needs children"

"They have been a God send and my granddaughter is doing so much better with medsand treatments. Her body movements are improving with exercises. Doing great so pleased"

"Children Medical is very much needed to help all our children with special needs. I drive over 65 miles to the Dalton Clinic. Everyone is so great."

"I appreciate the fact that they help with funding for medicines or things that parents with special needs can't afford and I would like to participate in groups, just let me know."

In regards to SPM 5-"As part of the RPC core requirements- each center must provide periodic neuro-developmental assessments & confirm the presence of a medical home. It seems that partnering with the RPC/developmental follow-up clinics would help accomplish this performance measure because the clinics are performing a developmental screening on every infant/child that they assess. Also, many times these children are referred to Children's 1st or BCW as a result of their developmental follow-up screening."-- the MCH Section plans to take this comment under consideration for the next reporting cycle.

The Georgia OB/GYN society suggested work for the coming year around NPMs 8, 15, 17, 18 and SPMs 2, 7, and 8. Suggestions included promoting LARC's annual state meeting, continuing promotion of P4HB, continuing to provide education on statewide resources for smoking cessation in pregnancy and preconception, supporting the Best Fed Beginnings Initiative, and continuing the Manpower study to identify gaps in obstetrical care in GA. The MCH Section plans to take all of the suggestions under consideration in planning for the upcoming year.
//2014//

II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

a. Any changes in the population strengths and needs in the State priorities since the last Block Grant application.

b. Any changes in the State MCH program or system capacity in those State priorities since the last Block Grant application.

c. A brief description of any activities undertaken to operationalize the 5-Year Statewide Needs Assessment, such as: 1) ensuring that the State addresses the findings and recommendations resulting from the Needs Assessment, 2) monitoring the timelines of the action plans, 3) reporting by a designated person or group responsible for accountability, and 4) linking the Needs Assessment process back into State program planning.

d. A brief description of ongoing activities to gather information from the community and to evaluate implementation of the 5-Year Statewide Needs Assessment. Examples of these activities include: data collection and analysis, key informant interviews, public forums, establishing an advisory group, and surveys. It is important to gather input from general community members as well as providers and community leaders.

III. State Overview
A. Overview
ADMINISTRATIVE STRUCTURE AND FUNCTIONS

Georgia Title V

The purpose of Georgia Title V is to address the overall intent of the Maternal and Child Health Services Block Grant to improve the health of all mothers, women of childbearing age, infants, children, adolescents and children with special health care needs (CSHCN). The state of Georgia has responsibility to provide and assure access to quality MCH services for mothers and children; provide and promote family-centered, community-based, coordinated systems of care for CSHCN and their families; and facilitate the development of community-based systems of care for the MCH and CSHCN populations. The Georgia Title V Program is located within the MCHP. /2014/ The MCHP underwent a name change in July 2012 to MCH Section. //2014//

Georgia Maternal and Child Health Program

The Director of the MCHP also serves as the Title V MCH Services Block Grant MCH Director. In addition to the Georgia Title V Program, the MCHP includes the Georgia Family Planning Program (Title X and XX); Babies Can't Wait Program (Part C Early Intervention); newborn hearing and metabolic/genetic screening follow-up and referral; the Special Supplemental Program for Women, Infants, and Children; MCH epidemiology; Children 1st Program; Oral Health Program; Children's Medical Services (CMS); and other grant-funded and quality assurance work that includes the State Systems Development Initiative, Early Childhood Comprehensive Systems Grant, and the Health Check Program. Each of these programs is described in detail on the MCHP website (http://health.state.ga.us/programs/family/). Within the context of the MCHP, Georgia Title V is a driver for integration across programs, within and beyond the MCHP, and, with all Title V-associated performance measures either explicitly or implicitly required among all other MCHPs, the Title V application and annual activity plan serves as the cornerstone of MCHP strategic activities. The organizational structure and scope of the MCHP is undergoing review. Organizational and structural changes may be proposed to increase staff accountability, facilitate staff professional growth that supports the engagement of key stakeholders and partners, implement evidence-based programming, and deliver excellent customer service. /2012/The Office of Title V and Integration (OTVI) was established to ensure Georgia's Title V Block Grant activity plan is implemented and operated efficiently and is not duplicative.//2012//

/2012/ The Office of Title V and Integration (OTVI) has been established to ensure Georgia's Title V Block Grant activity plan is implemented throughout the state in accordance with our annual application and that funds, services, and programs are operated efficiently and are not duplicative. Arianne Weldon, M.P.H. serves as the MCH Title V Administrator and Director of the Office. //2012//

/2013/Renamed the Office of MCH Integration (MCHI) in 2012, MCHI works with internal and external MCH partners. The Office provides support through coordination, planning, research, evaluation and sustainability of programs and population-based strategies. //2013//

/2014/ The Office of MCH Integration (formerly the Office of Title V and Integration -- OTVI) was eliminated July 1, 2012. The Special Supplemental Program for Women, Infants, and Children is no longer part of the MCHS as of December 1, 2012. The Health Check Outreach and Monitoring Program was discontinued at the State office as of January 1, 2013.

The Perinatal Health Program and Infant Mortality Strategic Plan were instituted July 1,

2012 //2014//

In March 2010, the MCHP (MCHP) implemented new mission and vision statements.

Mission Statement: To implement measurable and accountable services and programs to improve the health of women, infants, children, fathers, and families throughout Georgia.

Vision Statement: Through the implementation of evidence-based strategies, maximization of resources through integration and collaboration, and the use of program and surveillance data, identify and deliver public health information, population-based interventions, and direct services that have an impact on the health status of women, infants, children, fathers, and families throughout Georgia.

The primary change from previous mission and vision statements and the primary driver for the development of these new statements was to increase the focus on measurement and accountability. Integral to the success of the MCHP is the implementation of a data to action culture founded on strong measurement and accountability principles. The MCHP is committed to creating synergy between research and practice by advancing data-driven decision making and strategic planning through the collection, analysis, and interpretation of state and national data to identify trends and challenges that can be addressed through identified best practices or innovative practice solutions. This data to action approach drives all MCHP including Georgia Title V.

The MCHP mission and vision statements are supported by five programmatic goals.

Goal 1: Ensure compliance and operational excellence for all federally and state funded activities.

Ensuring compliance and operational excellence will be achieved through the timely submission of all required products; development and implementation of a quarterly performance measure process track and react to program developments; conducting a review of current MCHP organizational structure and making necessary changes; and ensuring programmatic accountability. Achieving success for Goal 1 also requires the development of annual activity plans that are integrated across programs that have clear expected outcomes and are monitored routinely for progress.

Goal 2: Increase the evidence-base for decision making through improved data collection at the state, district, and county level.

Increasing the evidence-base is directly related to increasing the surveillance, evaluation, and MCH epidemiology capacity of the MCHP. This coincides with infrastructure building activities in the Title V Services Pyramid. For Goal 2, evidence-base is broadly understood to mean implementing best practices, appropriate and thorough programmatic data collection, expanded surveillance, supported MCH research that can inform program development, and the distribution of research and data findings in a manner that is easily consumable by all stakeholders and partners.

Goal 3: Increase population-based services and infrastructure building.

The MCHP will work to identify training needs that, if addressed, would benefit the entire MCH community. Increased public health media messages are of immediate interest in response to Goal 3.

Goal 4: Ensure improved integration within and between the Maternal and Child Health Program and other Division of Public Health (DPH) Programs.

Ensuring improved collaboration and integration within the MCHP and between programs within the Division of Public Health is necessary to accomplish MCHP objectives, ensure efficient and effective program operation, and maximize the resources and benefits available to Georgia's

women, infants, children, youth, fathers, and families. The MCHP must work with its internal partners to ensure that client contacts are leveraged to achieve the programmatic objectives of all applicable programs. Several activities planned for the national and state performance measures in FY11 support this goal.

Goal 5: Provide statewide leadership in the MCH community.

Providing state leadership in the MCH community as well as engaging family partners in all aspects of decision-making will help provide vision and direction for collaborative projects between MCHP and other programs and the MCH community. The MCHP made significant progress in reaching this goal while developing its response to this application. In preparing for the FY11 application, the MCHP made documents available prior to the completion of the application for comment and edits; conducted sixteen focus groups to gather information from consumers, stakeholders, advocates, and partners; and engaged consumers, stakeholders, advocates, and partners in the selection of the state's priority needs. At all opportunities for public input and participation, enhanced efforts were made to ensure the involvement of families with children with special healthcare needs. While much of this activity was driven by the development of the needs assessment, it is the responsibility of the MCHP to ensure that there are opportunities for public, stakeholder, and advocate comment, input, and involvement in the annual Title V application process and the operation of all MCHPs.

Division of Public Health (DPH)

The DPH includes the MCHP and six other programs.

Health Promotion and Disease Prevention
Epidemiology
State Laboratory
Immunization and Infectious Disease
Environmental Health
Vital Records

Each of these programs works with the MCHP to accomplish joint goals and enhance the health of MCH populations throughout Georgia. A brief description of each program follows.

The mission of the Health Promotion Disease Prevention (HPDP) Program is to encourage Georgians to improve the quality of their lives by achieving healthy lifestyles, creating healthful environments, and preventing chronic disease, disability, and premature death. The HPDP Program includes Asthma Control Program, Adolescent Health and Youth Development Program, Comprehensive Cancer Control Program, Breast and Cervical Cancer Program, Tobacco Use Prevention Program, Rape Prevention and Education Program, the Nutrition and Physical Activity Initiative, and several others. A complete listing of the all programs within the HPDP Program can be found at http://health.state.ga.us/programs/chronic/index.asp. The HPDP Program collaborates with the MCHP to address National Performance Measures 8 and 15 and State Performance Measure 1.

The Epidemiology Program is responsible for acute disease, chronic disease, injury, and environmental epidemiology. The Epidemiology Program is responsible for the administration of the Georgia Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System. The Office of Health Indicators for Planning is located within the Epidemiology Program and provides access to several data sets that include MCH indicators through the Online Analytical Statistical Information System (OASIS). OASIS is used to query data sets and population projections needed to report on measures required as part of the Title V MCH Services Block Grant application.

The mission of the State Laboratory Program is to improve the health status of Georgians by providing accurate, timely and confidential clinical and non-clinical laboratory testing in support of Division of Public Health programs, activities, and initiatives as well as performing tests for Emergency Preparedness. The State Laboratory processes all state mandated newborn metabolic/genetic screening tests. The State Laboratory works closely with the MCHP to complete Form 6 and address National Performance Measure 1.

Through collaboration with public and private providers, advocacy groups, and other stakeholders, the mission of the Infectious Disease and Immunization (IDI) Program is to work to increase immunization rates for all Georgians and decrease the incidence of vaccine-preventable diseases. Vaccine-preventable disease levels are at or near record lows. Even though most infants and toddlers have received all recommended vaccines by age 2, many under-immunized children remain, leaving the potential for outbreaks of disease. Many adolescents and adults are under-immunized as well, missing opportunities to protect themselves against diseases such as Hepatitis B, influenza, and pneumococcal disease. Strong collaboration is needed with IDI Program to address National Performance Measure 7.

The mission of the Environmental Health Program is to provide primary prevention through a combination of surveillance, education, enforcement, and assessment programs designed to identify, prevent and abate the environmental conditions that adversely impact human health.

The mission of the State Office of Vital Records is to provide accurate records and data concerning vital events to Georgians and other stakeholders in an expeditious and friendly manner. Many of the reportable measures required as part of the Title V MCH Services Block Grant application could not be reported without the data provided by the State Office of Vital Records.

Department of Community Health (DCH)

DPH is located in the Department of Community Health (DCH). /2012/On July 1, 2011, Public Health will become an independent agency.//2012// The mission of DCH is:

• Access to affordable, quality health care in our communities
• Responsible health planning and use of health care resources
• Healthy behaviors and improved health outcomes

/2013/ The Georgia Department of Public Health (DPH) was established on July 1, 2011. DPH's mission is to promote and protect the health of people in Georgia wherever they live, work, and play. We unite with individuals, families, and communities to improve their health and enhance their quality of life. The new DPH Commissioner, Brenda Fitzgerald, MD, has ten members on her executive team overseeing the following areas:
* The Office of the Chief of Staff which includes Government Relations and Constituent Services, the Office of Health Indicators for Planning, Special Projects, Performance Improvement, and Training and Workforce Development
* Health Protection, including Emergency Preparedness, Epidemiology, Environmental Health, Infectious Disease and Immunization and EMS.
* District and County Operations overseeing Nursing and Pharmacy at the district level.
* Health Promotion which includes Maternal and Child Health, Health Promotion and Disease Prevention, Volunteer Health Care Program, and the Office of Health Equity.
* The Chief Financial Officer overseeing financial services, grants management and the DPH budget.
* The Office of the Inspector General which leads audits, investigations and contract compliance.
* The General Counsel Office which includes Contract and Programs attorneys, Risk Management and the IRB process.
* The Chief Information Officer overseeing Vital Records, Information Security, Project Management, Applications Development and Support and Enterprise Services.
* Communications which includes health, media, digital, internal and risk communications.
* Chief Operating Officer overseeing Facilities and Support Services, Human Resources, the

Public Health Laboratory, Contracts Administration and Procurement Services.//2013//

The vision of DCH is to be a results-oriented, innovative, and productive state agency that seeks to address the health care needs of all Georgians by serving as a national leader in the areas of health planning, health promotion, and health care quality by the year 2011. The DCH mission and vision statements are consistent with the Georgia Title V Program. In addition to the Division of Public Health, DCH includes nine divisions and six offices. A brief description of each follows.

The Emergency Preparedness and Response Division works to ensure a safe and healthy environment for all Georgians. The Emergency Preparedness and Response Division includes the Injury Prevention Program. The mission of the Injury Prevention Program is to prevent injuries by empowering state and local coalitions through the provision of data, training, and leadership, and the leveraging of resources for prevention programs. The Injury Prevention Program is responsible for the Child Occupant Safety Interventions and Education Program and Residential Fire Prevention Program. Through collaboration with the MCHP, the Injury Prevention Program works to address National Performance Measures 10 and 16 and State Performance Measures 2 and 4./2012/ The Injury Prevention Program is now located in the MCHP.//2012//

The Division of Financial Management represents the financial interests of the Department. It is comprised of the Office of Planning and Fiscal Analyses, Financial and Accounting Services, Reimbursement Services and the Budget Office.

The General Counsel Division provides overall guidance and direction for the operations of the Division; drafts and reviews procurement documents; provides legal services for all aspects of the State Health Benefit Plans; develops policies and procedures for compliance with federal and state privacy and public records requirements; drafts rules, regulations and policies for consideration by the Board of Community Health; and provides staff support for the Health Planning Review Board. Also contains the Certificate of Need Section and Division of Health Planning.

Healthcare Facility Regulation is responsible for protecting the residents of Georgia by ensuring the highest quality of health care and safety through professional standards regulation.

Information Technology is responsible for promoting project management standards throughout DCH. The Medicaid Management Information System (MMIS) unit supports the various systems used for the processing, collecting, analyzing and reporting of information needed to support all Medicaid and PeachCare for Kids claim payment functions

The Office of Inspector General is responsible for DCH's efforts to detect, prevent and investigate fraud and abuse in Medicaid, PeachCare for Kids™ and the State Health Benefit Plan.

The Division of Medical Assistance Plans administers the Medicaid program, which provides health care for children, pregnant women, and people who are aging, blind and disabled.

The Operations Division consists of the Office of Vendor and Grant Management, Human Resources, Support Services, the Office of Health Policy and Strategy, and the Department's five Health Improvement Programs, which are the Office of Minority Health, the Office of Women's Health, the Georgia Commission on Men's Health, the Georgia Volunteers in Health Care program and the State Office of Rural Health.

The State Health Benefit Plan (SHBP) provides health insurance coverage to state employees, school system employees, retirees and their dependents. The Georgia Department of Community Health's Public Employee Health Benefits Division is responsible for day-to-day operations.

SOCIODEMOGRAPHIC FACTORS IN GEORGIA

The success of the state's and the Title V Program's efforts to craft and implement a strategic direction depends on an ability to predict, understand, and develop strategies around factors that impact the health and well-being of women and children in the context of their communities. The following information provides an overview of some of the characteristics of Georgia that potentially may have the most significant impacts on the maternal and child health populations.

Geography and Urbanization

Georgia's landmass (59,425 square miles) makes it the largest state east of the Mississippi River and the 24th largest in the United States (U.S.). Since 1990, Georgia's population has increased over 50%, moving it from the 11th to the 9th largest state in the nation. The state's growth comes from a combination of natural increase (i.e., births versus deaths) and domestic and international migration. The explosive increase experienced by the "Sunbelt" states, including Georgia, through most of this decade, slowed dramatically with the onset of the economic recession beginning in late 2007. Nevertheless, from July 2000 to July 2009, the state's population increased by 1.6 million, reaching a total population of 9,829,211. While the rate of population growth has slowed, Georgia has remained among the fastest growing states in the nation, exceeded only by Texas, California, and North Carolina. Georgia was 4th largest in terms of new residents and 9th largest in terms of percent gain. The result of this fundamental shift in Georgia's population has changed the state from a largely rural area with urban clusters to an urban state with rural areas. /2012/The 2010 U.S. Census showed that Georgia's population has grown 18.3% over the last decade, increasing to 9,687,653 people. The state had the 7th largest percentage of growth among all states and gained one new seat in the U.S. House of Representatives. //2012//
/2014/ The 2012 population estimate for Georgia is 9,919,945, a 3% increase from the 2010 census population. //2014//
The 2013 population estimate for Georgia is 9,992,167, a 3.1% increase from the 2010 census population.

Population

While population is a significant consideration in service and delivery planning, the political framework is also an important factor. With 159 counties, Georgia has the second highest number of any state. Four of these counties, all in the Atlanta MSA, have populations in excess of 700,000 (Fulton, Cobb, DeKalb and Gwinnett) with no other county in the state exceeding a population of 276,000. In addition to these four, there are 18 counties having populations of over 100,000, with 10 of these 18 counties located in the Atlanta MSA. The remaining 137 counties have fewer than 100,000 population with 87 of them having populations of less than 25,000 and 30 counties with a population of fewer than 10,000. /2012/ Approximately 54% of all Georgia residents live in metro Atlanta. The region, which accounted for almost two-thirds of the state's growth over the past decade, has a population of nearly 5.3 million and ranks as the 9th largest metro area in the country.//2012// /2013/ 2010 census data suggest there has been a slowdown in the growth in the state's "exurban" counties on the fringe of big cities, with Georgians moving to core counties and inner cities at an increasing rate. Growth in Fulton and DeKalb Counties outpaced Gwinnett and Cobb in 2011 by 26%, a significant reversal of the prior decade's growth patterns. //2013//

Census data highlight the exceptional growth and increasing diversity of Georgia. An increasing amount of Blacks immigrating to Georgia has added to the already large native population. Georgia ranks 3rd nationally, behind New York and Florida, in the number of Black people (2,864,431) and 3rd in the percentage of Black people (30.1%) in the overall population of the state, trailing Mississippi and Louisiana. /2012/Atlanta has replaced Chicago as the metro area with the 2nd largest number of Blacks in the country.//2012//

Reflecting national trends, the number of Asian people and Hispanic people in Georgia have shown dramatic increases, which are projected to continue. Hispanic people, primarily Mexican people,

are the most rapidly growing minority group (729,604) and now reside throughout Georgia. This growth impacts the provision of government and health, education, and human services in the state. Of individuals five years of age or older living in Georgia in 2006 through 2008, 12% spoke a language other than English at home. /2012/ 2010 census data show that Georgia's Hispanic population has increased 96.1% over the last decade, growing from 435,337 people who identified themselves as Hispanic in 2000 to 865,689 (8.8% of all Georgians) in 2010.//2012//
/2014/ Hispanics make up approximately 9% of Georgia's population, while African-Americans account for 31% of the population. Georgia is now one of 13 states with minority groups accounting for roughly 40% of the population. //2014//

According to the US Census Bureau, Georgia's population continues to be younger compared to the U.S. as a whole, ranking 5th in terms of the percentage with the largest population under 18 years old. In 2008, of the state's population, 740,521 (29.2%) were under the age of five years, with another 2,075,140 million children school-age (five through nineteen years of age). In 2008, women accounted for 50.8% of Georgia's residents. Of all women in Georgia, 42.0% are considered to be of childbearing age (15 to 44 years of age). Annually, there are approximately 150,000 resident births in Georgia. Of all children 17 years of age and younger in Georgia, 352,567 (13.9%) have special health care needs. /2012/ According to U.S. Census 2009 population estimates, children under five years of age account for 7.6% of the state's population compared to 6.9% nationally. Children and youth under 18 years of age make up 26.3% of Georgia population compared to 24.3% for the U.S. //2012// /2013// More than 1.6 million children are educated through Georgia's K-13 public school system. Under a new federally mandated formula, the state's graduation rate was reset from 80% to 67.4%, with nearly a third of Georgia students failing to finish high school in four years.//2013

According to the U.S. Census Bureau, children under five years of age account for 6.8% of the state's population compared to 6.4% nationally. Children and youth under 18 years of age make up 25.1% of Georgia population compared to 23.5% for the U.S.

Poverty

Georgia's per capita income has been lower than the national average since 1997. However, the lower per capita income, a measure of well-being, has been offset until recently by the state's cost of living which has remained relatively low, enabling Georgia residents to do more with the income they do earn. Reflecting the economic downturn, the state's per capita personal income decreased from $34,612 in 2008 to $33,786 in 2009, which ranks 39th among all states. /2012/ Georgia's 2010 per capita personal income was $35,490 (87.4% of the national average of $40,584), ranking 37th among all states.//2012//
/2014/ Approximately 16% of Georgia residents live in poverty. Georgia's 2012 per capita personal income was $36,869 (86.4% of the national average of $42,693), ranking 40th among all states //2014//

According to the National Center for Children in Poverty (NCCP), of Georgia's 1,402,694 families, with 2,484,182 children, 42% of these children lived in low-income (income below twice the FPL) families in 2008. In particular, young children (birth to age five) are likely to live in low-income families. Twenty-six (26%) of Georgia's young children (birth to age five) live in a low-income family with income less than 100% of FPL, 22% live in families with incomes 100-200% of FPL, and 52% live above low income in 2008. Fifty-eight percent (58%) of the young children in low-income families lived with a single parent. Children living in minority families and children of foreign-born parents have a greater chance of living in a low-income family. Thirty percent (30% of young white children lived in a low-income family in 2008 compared to 64% of young black children and 71% of young Hispanic children. /2012/According to NCCP estimates, there were 1,283,185 families in Georgia with 2,535,780 children in 2009. Forty-five percent of these children lived in low-income families.//2012// /2013/In 2010, Georgia's poverty rate was the 3rd highest in the U.S. compared to 5th in 2009. Approximately 1.8 million Georgia residents are poor. The state's high poverty rate is reflected in the number of people requesting food stamps, which has increased every year since 2007. In 2010, more than 590,000 households (1.4 million

people)received food stamps, up from 497,000 in 2009.//2013//

/2014/ According to the National Center for Children in Poverty, in 2011, 1,259,217 Georgia families with 2,410,753 children, lived in poverty. Forty seven percent (47%) of children in Georgia live in low-income families (national average is 45%). Minority children have a greater chance of living in low-income families with 62% of black children and 72% of Hispanic children living in low-income families compared to 32% of white children. Fifty two percent (52%) of children under age 6 live in low-income families. //2014//

Despite noted success in enrolling children into Georgia's Medicaid and PeachCare for Kids (State Child Health Insurance Program) programs, 282,247 (10.9%) children are uninsured in Georgia. The vast majority of these children (86.2%) come from families where at least one parent works and over half (55.4%) live in two-parent households. Almost three-quarters of the uninsured children live in families with low or moderate incomes, less than $40,000 for a family of four, an income within the current Medicaid and PeachCare eligibility range. /2012/ The Commonwealth Fund's 2011 Child Health Scorecard ranked Georgia 42nd in the percent of children age birth to 18 years who are insured and 2nd in the percent of insured children whose health insurance coverage is adequate to meet the child's needs.//2012// /2013/ Georgia ranked 8th in the nation in 2010 in number of uninsured residents (19.4% or about 1.9 million Georgians).//2013//
/2014/ In 2011, 20% of Georgians were uninsured (1.87 million). Of children 0-18, 11% were uninsured. //2014//
Nineteen percent (19%) of Georgians were uninsured between 2011-2012. Of children 0-18, 12% were uninsured.

Georgia continues to experience declining employment. In March 2010, Georgia had 3,807,500 jobs, down 3% (116,000 jobs) from March 2009. The state's March 2010 unemployment rate was a record 10.6%. Reflecting the high unemployment rate, Georgia has the 7th highest foreclosure rate. Despite the continued rise in the state's unemployment rate, there are signs of improvement. The pace of new layoffs is slowing significantly, first-time claims for unemployment insurance decreased 28% from a year earlier; and modest job growth has been seen over two consecutive months (February and March 2010), suggesting that the worst of the recession may be over and the state's fledgling recovery may be gaining traction. /2012/ Georgia's unemployment rate has decreased from 10.6% in March 2010 to 9.9% in April 2011. The state rate remains higher than the national rate (9.0% in April 2011) with some unemployed/underemployed parents no longer able to afford child care, contributing to the loss of 1,395 child care programs in Georgia since March 2010. A 2011 child care survey also found an increased number of children are coming to their child care program hungry. The state's economy is forecasted to show modest improvement in 2011. By 2012, the state should see a boost in employment with new 51,800 jobs.//2012//

/2013/ Georgia continues to experience high foreclosure rates. In January 2012, the state had the 4th highest rate of foreclosure filings in the country. However, in a sign that the state's economy is slowly improving, Georgia collected almost 5% more in taxes and fees in March 2012 and income tax collections were up 8.6% from the same time the previous years. The unemployment rate peaked at 10.5% in October 2009, but has fallen recently to 8.9%, higher than the national rate of 8.1%.//2013//
/2014/ The Georgia unemployment rate is 8.3%, higher than the national rate of 7.6%. //2014//
The Georgia unemployment rate is 7.0%, slightly higher than the national rate of 6.7%.

GEORGIA'S HEALTH CARE SYSTEM

Georgia's health system consists of five interconnected components: private providers, hospitals, community health clinics, regional behavioral health and developmental disabilities services, and the state's public health system which has two separate elements, the Medicaid/PeachCare payment system and county public health services. Service delivery in the state's public health system is carried out by 159 county boards of health. These boards of health are combined into 18 district units, ranging from one to 16 counties in size, and are administratively overseen by a district office that provides management services and programmatic support. The county boards

of health provide direct health care services, environmental health activities, and work with community partners in their county around issues of common concern. /2013/ Twenty-one cents of every dollar spent on programs funded through taxes and fees was allocated to health care in FY 2012. Public Health received $191,626,675, 1.2% of the FY 2012 General Funds Budget. DCH, the state Medicaid agency, received $2,352,643,655 (14.4%).//2013//

Private Providers

The Georgia Department of Labor (DOL) employment projections to 2012 indicate that healthcare and social assistance employment is expected to grow the fastest of all industry sectors in the state, with an annual rate of 3.2% and the addition of more than 125,000 new jobs. Eight of the 20 fastest growing occupations are in the health services industry. DOL projects a growth rate of 5.4% for medical assistants, 5.1% for dental hygienists, 4.9% in dental assistants, 4.8% in physician assistants and in medical records and health information technicians, 4.3% in home health aides, 4.1% respiratory therapists, and 3.6% in surgical technologists. Registered nurses (RN), the largest of all healthcare occupations is the occupation with the second most expected job growth, with a projection of 19,880 newly created RN positions.

Georgia faces challenges in meeting the demand for healthcare occupations. The Georgia Board for Physician Workforce, the state agency responsible for advising the Governor and General Assembly on physician workforce and medical policy and issues concluded in 2006 that growth in medical specialties was minimal or negative; there were substantial problems in geographic distribution of primary care physicians, pediatricians, and obstetricians/gynecologists; and the state will require new physicians just to maintain current capacity.

A 2007 State Senate Study Committee report on the shortage of doctors and nurses in Georgia also concluded that the state is facing a severe shortage of physicians and nurses. Data gathered by the American Medical Association (AMA) supports this conclusion. The AMA found that Georgia ranked 40th in the nation in per capita number of practicing physicians and 42nd in its per capita supply of registered nurses. Georgia ranks 34th in the number of medical students per capita and 37th in medical residents per 100,000 population. /2012/ Georgia ranked 40th (38th in 2009) in the U.S. in the United Healthcare's 2010 American Health Rankings for number of primary care physicians per 100,000.//2012// /2013/Georgia has 207 active physicians per 100,000 citizens, 20% below the national rate of 258.7. The Georgia Board for Physician Workforce groups the state's 159 counties into 96 Primary Care Service Areas (PCSAs). Fifty-two percent of the state's physicians are located in five of the 96 PCSAs, which account for 38.1% of Georgia's population. In 2008, 22 PCSAs did not have a pediatric provider; 3 were deficient in family medicine, 33 in internal medicine, 53 in pediatrics, 40 in OB/GYN and 25 in general surgery. Between 2000 and 2008, the number of dentists per capita in Georgia decreased by
17.9%. The state has one school of dentistry that graduates fewer than 60 dentists a year. //2013//
Georgia has 320 active physicians per 100,000 citizens, 12.5% above the national rate of 280.

The Senate Committee also recommended that medical school enrollment in Georgia be increased. A 2008 medical education study on behalf of the University System of Georgia of the Georgia Board of Regents is serving as a road map for statewide expansion of Georgia's public medical education system. A partnership is being developed between the Medical College of Georgia (MCG), the state's only public university devoted exclusively to health sciences, and the University of Georgia (UGA), the leading public research university. With full implementation of the plan, through its partnership with UGA, MCG School of Medicine could expand from its current level of 745 students to 1,200 by 2020, an increase of approximately 60% in medical students.

As of July 2009, there were 101,762 registered nurses (RNs) licensed in Georgia; however, not all of these RNs were practicing full-time. Some were retired, but maintained their licensure; others were working only part-time as a nurse or were employed in a nearby state. Several federal labor sources suggest that only approximately 65,000 of the nurses licensed in Georgia in
2009 were working full-time. Georgia consistently ranks in the bottom ten states in terms of the

number of RNs per population (670/100,000 in 2008).

Despite the recession, nursing employment rates have remained relatively steady in Georgia and the U.S. as a whole, and there are still more jobs than there are nurses. A shortfall of an estimated 16,400 registered nurses in Georgia in 2010 is expected to grow to 37,700 by 2020. One impact in Georgia's economic downturn has been an increase in the number of former part-time nurses who are returning to the workforce as full-time workers, as well older nurses who are delaying plans to retire. This has expanded the pool of experienced nurses in the workforce. /2012/ Although the state's nursing work force shortage has improved, it is anticipated that with the state's improving economy the shortage of nurses may begin to increase. Currently about 106,000 registered nurses hold licenses in Georgia, but only about 65,000 are estimated to be working in the state. A shortage of 26,300 nurses in Georgia is projected by 2015.//2012//

In response to the Senate Committee recommendation to increase nursing school enrollment, the state University System, Technical College System, and private institutions have been working to address the state's shortage of RNs. In 2008, the University System and Technical College System graduated 2,231 new pre-licensure nurses, approximately 1,000 more graduates than in 2002. This gain reflects an increase in the number of nursing programs operated by the Technical College System. In addition, approximately 300 RNs graduated from private nursing institutions as part of the 2007-2009 academic year.

Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs):

Health Professional Shortage Areas (HPSAs) are designated by the federal Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population. Georgia has 125 Mental Health Professional Shortage Areas (MPHSAs), 136 Primary Health Professional Shortage Areas (HPSAs), and 94 Dental Health Professional Shortage Areas.

Georgia Statewide Area Health Education Center (AHEC) Network: The Georgia Statewide AHEC Network is a partnership between the Medical College of Georgia and Mercer University School of Medicine. The Statewide AHEC Network has represented a growing partnership of health providers, health professions, educators, state agencies, and communities joined together to respond to the problems of health professional supply and distribution in rural and underserved areas of the state.

The state's six AHECs work with secondary youth, college and technical college students, displaced workers, older adults, and second career seekers. Programs include general health careers recruitment presentations, health career fairs, and a wide range of video, manual and classroom resources. In addition, intensive programs include health career camps and clubs, as well as academies designed for middle and high school math and science teachers. In 2009, the AHEC network served 48,562 health careers participants and over 150,662 participated between 2007 and 2009. Only 11 of the state's 159 counties did not have an AHEC sponsored health careers recruitment or education program.

The AHEC Network also provides assistance and support for health professions students completing community-based clinical training, including identification and credentialing of training sites, faculty development of community-based preceptors, providing student orientation to the community, providing student travel, and/or housing support during rotations, and conducting site visits. Over 11,160 health professions completed community-based clinical rotations supported by one of the six regional AHEC centers between 2007 and 2009, including 3,893 in 2009. The 11,160 health professionals included 3,035 physicians, 1,601 physician assistants, 656 nurse practitioners, 1,706 nurses, and 4,169 "other."

The Statewide AHEC Network also works to retain health care providers in the workforce. Professional isolation in rural areas of the state is addressed by connecting community-based providers to academic institutions as well as providing relevant and accessible continuing education opportunities for all levels of providers. Between 2007 and 2009, 32,882 AHEC participants completed AHEC sponsored continuing education courses. Participants came from all 159 Georgia counties with 9,071 completing continuing education courses in 2009. /2012/ In FY 2010, the Georgia Statewide AHEC Network provided health careers, clinical training, continuing education or learning resources to 23,547 minority students, residents, trainees, or practicing health professionals. Over 2,600 health professions students and residents were placed in 3,704 rotations in clinical training sites. The Network provided 36,232 youth with health care opportunities.//2012// /2013/ In 2011, the Statewide AHEC Network made health career presentations to 27,778 students, 60+% of whom were minority students.//2013//

Hospital System

There are approximately 200 hospitals in Georgia, including 149 acute care facilities. There is at least one hospital located in 111 of the state's 159 counties. According to a 2008 American Hospital Association survey, the state's hospitals employed more than 138,000 persons; delivered 142,000 babies yearly; provided 959,000 inpatient admissions, 3.8 million emergency room visits, and 10.3 million other outpatient visits; and had an average daily census totaling almost 17,000.

Trauma Centers: One critical aspect of the hospital-based delivery system is the availability of trauma and emergency care. Georgia, which does not have a statewide trauma system, has 15 Trauma Centers. The state's Trauma Centers are ranked as Levels 1, 2, 3, or 4. A Level 1 Trauma Center is the most comprehensive and has a full spectrum of capacity with surgical subspecialties and a clinical research programs. Most of Georgia's Level 1 Trauma Centers are academic facilities. Like a Level 1, a Level 2 Trauma Center has a full spectrum of capacity with surgical subspecialties, but is not required to have a clinical research program. A Level 3 Trauma Center is a community hospital with general surgical, orthopedic, and anesthetic capacity, but without a full spectrum of surgical subspecialty capacity. A Level 4 Trauma Center is generally a small facility which has the capacity to evaluate, stabilize, and transfer major trauma patients to other facilities for more definite care. All of the state's Trauma Centers function within a complex system that includes pre-hospital care and transport, definitive surgical or critical care, rehabilitation, and injury prevention. In addition, all levels of Trauma Centers participate in the state's trauma data registry.

The trauma facilities are primarily clustered around metro Atlanta, Augusta, Columbus, Macon, and Savannah, leaving huge gaps in the state for persons requiring timely, quality trauma care. Another issue affecting trauma care is the lack of direct dial 911 in 21 counties in south and middle Georgia, areas traversed by I-75, I-20, I-16, and I-95. The lack of facilities and the ability to rapidly get trauma patients to quality definitive care during the initial "golden hour" negatively impacts patient survival and outcomes.

Critical Care Access Hospitals: Sixty-seven rural hospitals are eligible for Critical Care Access designation; 34 hospitals are currently designated. This federal program raises Medicare reimbursement rates for eligible facilities and provides cost-based reimbursement from Medicaid and the Georgia State Health Benefit Plan for outpatient services in return for agreeing not to: 1) operate any more than 25 beds, 2) team with a larger facility to deliver inpatient care, and 3) limit inpatient care provided to an average of no more than 96 hours.

Tertiary Hospitals: Six designated regional tertiary hospitals provide a system of high-risk maternal and infant care services including transportation, prenatal care, delivery, post-partum care, and newborn care. These tertiary hospitals, located in Atlanta, Macon, Augusta, Columbus, Albany, and Savannah, also provide outreach and education to area providers to ensure a seamless community-based system. All women and infants who are high-risk are accepted for services at the six regional tertiary hospitals without regard to income. Women and infants who meet program medical criteria (high-risk) and whose incomes are below 250% of the FPL are eligible to receive services.

Impact of the economic downturn on Georgia's hospitals: In 2009 the Georgia Hospital Association surveyed its membership to help determine the impact of the state's economic downturn on hospitals throughout the state. Sixty-three (63) hospitals and health systems responded to the survey. The data showed, like other Georgia businesses, the state's hospitals have had to make difficult operating decisions while still trying to meet the health care needs of the individuals they serve. Survey respondents indicated that:

-- More than six of 10 Georgia hospitals had to, or were considering, reducing staffing
-- One of three had to, or were considering, reducing services; Nearly three out of out four hospitals had experienced increases in bad debt and charity care since October 2008
-- Six of 10 hospitals reported that the recession had affected their ability to meet day-to-day operating expenses
-- Nearly three of four hospitals were postponing or reconsidering capital expenditures
-- Over half had experienced declines in elective procedures (often the most profitable procedures for hospitals)
-- More than half had seen a decline in charitable contributions/philanthropy
-- More than eight of 10 hospitals reported an increase in physicians who were seeking support from the hospital (i.e., hospital employment, increased payment for services)

With the continued economic downturn and the increasing number of individuals who have lost their jobs and health insurance, hospital emergency rooms, which by law must see all patients regardless of ability to pay, provide a safety net for the state's uninsured and underinsured. As a result, Georgia hospitals are experiencing even greater financial pressure.

The state's Medicaid shortfall has added to the financial pressures Georgia hospitals are facing. To fund Medicaid in FY 2011, the 2010 Georgia General Assembly passed a 1.45% bed tax on hospital beds. The full impact of this tax on Georgia's public and private hospitals has not been determined. Major changes are also anticipated with implementation of federal health care reform signed into law in March 2010. The increase in insured individuals as a result of the legislation could help hospitals, particularly safety net hospitals that currently serve many uninsured patients. It could also mean an increase in the number of Medicaid patients that a hospital serves. Hospitals may lose money if their Medicaid patient population increases significantly because Medicaid does not reimburse hospitals the full cost of a Medicaid patient's care.

Community Health Centers

Georgia's CHCs offer a comprehensive range of primary health care and other services including around the clock care, acute illness treatment, prenatal care, well-child care, physicals, preventive services, health education, nutritional counseling, laboratory, x-ray and pharmacy services. The state's network of 28 Community Health Centers serves over 238,000 Georgians each year in over 70 of the state's 159 counties. /2012/ Georgia's current network of 26 Community Health Centers and 138 delivery sites serves over 300,000 residents in 76 of the state's 159 counties.//2012//
/2014/ The state has 27 Community Health Centers serving over 317,000 Georgians in 152 delivery sites. //2014//

Behavioral Health and Developmental Disabilities

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) provides treatment and support services to Georgia citizens with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD has

nearly 9,000 employees whose work is structured in three divisions by disability area: Mental Health, Addictive Diseases, and Developmental Disabilities.

DBHDD operates seven regional state hospitals and provides and oversees community-based services across the state. Five regional DBHDD offices negotiate contracts, manage resources assigned to the regions for community-based and state hospital services, and ensure service access, protection of client rights, and prevention of client neglect and abuse. Each region is required to have an array of mental health and substance abuse services available through a variety of contracted providers. Determination of service needed is based on individual assessment. /2012/In October 2010, Georgia entered into a five-year settlement agreement to increase services to individuals with mental illness and developmental disabilities in community settings and although the state increased funding for these efforts, the waiting list for community services remains.//2012//

In July 2006, the State of Georgia implemented the Georgia Crisis and Access Line (GCAL), a single toll-free telephone number (1-800-715-4225) that individuals can call 24 hours/seven days a week to be connected to local services for mental health, developmental disabilities, and addictive diseases. Previously, each region of the state had a different access number. Managed by Behavioral Health Link (BHL), GCAL was one of sixteen finalists for the 2009 Innovations in American Government Awards from the Harvard Kennedy School's ASH Institute for Democratic Governance and Innovations Award. BHL Call Center clinicians provide brief clinical screening, triage, and service linkage for 25,000 incoming calls per month. Last year, BHL answered over 300,000 incoming calls.

Target populations include adults with chronic mental illness, adults with severe addiction problems, parents or caregivers of children or adolescents with severe emotional disturbances, and adults and adolescents struggling with suicidal thoughts or a psychiatric crisis. Telephone interpreting services are provided to callers with limited English proficiency. The level of service needed is determined and callers are offered a choice of providers. GCAL is staffed with professional social workers and counselors to assist those with urgent and emergency needs. Those callers who need more routine services are directly connected with the agency of their choice and given a scheduled appointment. In addition, a website, www.mygcal.com, offers users a list of DBHDD providers and services by county as well as contact information for the regional office that services the user's community.

DBHDD's Developmental Disabilities services are focused on people with developmental disabilities with chronic conditions that were developed before age 22 and that limit their ability to function mentally and/or physically. State-supported services are aimed at helping the family continue to care for a relative when possible, serving people who do not live with their families in a home setting, and promoting independence and self-determination. The services a person receives depend on a professional determination of level of need and the services and other community resources available. Services may include family support, supported employment, respite services, inpatient services in one of seven state-operated hospitals that serve people with severe and profound mental retardation (individuals may be admitted only under special circumstances for temporary and immediate care during a crisis), community residential alternative or community living support, and community access services that help meet an individual's needs and preferences for active community participation.

Medicaid

The Department of Community Health (DCH) administers the state's Medicaid and PeachCare for Kids State Child Health Insurance (CHIP) programs. Of DCH's $12.3 billion FY 2010 budget, Aged, Blind and Disabled Medicaid accounts for 42.9% of the DCH budget, Low-Income Medicaid 38.9%), and PeachCare for Kids 4.2%. Medicaid's FY 2010 state appropriation of $1,390,745,935 reflected a cut of $664,946,931 from the FY 2009 base. /2012/ Georgia's Medicaid and PeachCare programs comprise $1.88 billion of state funds appropriated to DCH in FY 2012, an

increase compared to the FY 2011 budget due to expiration of funding from the Recovery Act. The FY 2012 budget allocation for Medicaid and PeachCare could be underfunded as result of potential enrollment growth and may need to be addressed by the Georgia General Assembly.//2012// /2013/ From FY09 to FY12, state funding for Medicaid and PeachCare for Kids programs combined remained essentially flat. However, the Georgia Budget and Policy Institute estimates that at least 100,000 more Georgians will be served in FY 2012 than in FY 2009. In addition to health care inflation and enrollment growth due to a weak economy in the state, Georgia's Medicaid program faces additional financial challenges including funding shortfalls and expiration of hospital fees currently in the Medicaid base budget by 2014. The FY13 Medicaid: Low Income Medicaid State General Fund allocation is $1,107,417,540.

DCH is conducting a process to redesign its Medicaid and CHIP programs. DCH engaged Navigant Consulting to identify redesign options. Three state task forces are providing redesign input. MCH leadership serves on the Children and Families Task Force.//2013//

Georgia's Medicaid program provides health care for 1.4 million children, pregnant women, and people who are aging, blind and disabled. The average monthly Medicaid enrollment in FY 2008 was 1,253,453. The average annual payment per Medicaid recipient was $5,005. /2012/ Georgia's Medicaid and PeachCare programs serve about one in six Georgians or approximately 1.7 million people. The combined programs contribute nearly $8 billion to Georgia's health care sector.//2012//

To be eligible for Low-Income Medicaid, adults and children must meet the standards of the former Aid to Families with Dependent Children (AFDC) program (family of four income limit of $6,000 per year). Pregnant women and their infants with family income at or below 200% of the FPL are eligible for Right from the Start Medicaid for Pregnant Women and Their Infants (RSM Adults and Newborns). Children under the age of one whose family income is at or below 185% of the FPL, children ages one to five whose family income is at or below 133% of FPL, and children ages six to nineteen whose family income is at or below 100% of the FPL are eligible for Right from the Start Medicaid Children (RSM Children).

Pregnant women, children, aged, blind, and disabled individuals whose family income exceeds the established income limit may be eligible under the Medically Needy program. This program allows a person to use incurred/unpaid medical bills to "spend down" the difference between their income and the income limit to become eligible.

For the Katie Beckett program, which covers children up to age 18, income is not considered. Eligibility is based on medical need of institutional care. For individuals who do not meet legal immigration criteria, Georgia's Medicaid program provides coverage for emergency medical services as long as the individual meets all other Medicaid eligibility requirements.

The Children's Intervention Service (CIS) program offers coverage for restorative and rehabilitative services in non-institutional settings (i.e., home, therapist's office, child care, or community setting) for Medicaid-eligible members from birth up to age 21 with physical disabilities or with a developmental delay. CIS services must be determined to be medically necessary, and be recommended and documented as appropriate intervention by a physician. Beginning September 1, 2006, a prior authorization was required for units over eight per member per month for therapy in the same specialty. These units include the evaluation visit. A prior authorization is based on medical necessity and can be approved for up to six months.

In June 2009, 997,488 adults and children were enrolled in Low-Income Medicaid. DCH has projected an increase of 7.7% in enrollment between June 2009 and June 2010 (1,074,482 enrollment) and a 2% increase from June 2010 to June 2011 (1,096,502 enrollment). In Georgia, the State Children's Health Insurance Program (SCHIP) is called PeachCare for Kids. It provides health care for children through the age of 18 years whose families' incomes make them ineligible for Medicaid but who cannot afford their own health insurance. The children must live in a home

where the income is at or below 235% of the FPL. Health benefits include primary, preventive, specialist, dental care and vision care. PeachCare for Kids also covers hospitalization, emergency room services, prescription medications and mental health care. Each child in the program has a Georgia Healthy Families Care Management Organization (CMO) who is responsible for coordinating the child's care. /2012/According to the Georgia Budget and Policy Institute's Budget Primer 2011 report there was a 20% increase in the number of Medicaid recipients served in the Low-Income Medicaid program between June 2008 and July 2010.//2012//

PeachCare for Kids exceeded its two year enrollment goal in its first year of operations. Georgia ranks fourth nationally in numbers of enrolled children. Only California, New York, Florida, and Texas have enrolled more children. In June 2009, 205,370 children received services funded by PeachCare for Kids, down from the 250,000 children enrolled in 2008. Enrollment is projected to increase by 8% by June 10, 2010 (221,972 enrollment) and 8% between June 2010 and June 2011 (239,917 enrollment). The average annual payment per child was $1,399. /2012/ PeachCare enrollees represent nearly 17% of total individuals served by DCH's Division of Medicaid, but are responsible for only 5% of programmatic costs.//2012//

In Federal Fiscal Year (FFY) 2010, the state's enhanced SCHIP Federal Medicaid Assistance Percentage (FMAP) is 75.57 percent, with Georgia eligible to receive $3 in federal funding for every $1 of state funding. The FY10 state appropriation was $87,937,542, a cut of $10,735,387 from the FY09 base. /2013/ The FY13 state appropriation is $79,578,343.//2013//

Effective June 1, 2006, Georgia implemented Georgia Families, a managed care program through which health care services are delivered to members of the state's Medicaid and PeachCare for Kids programs. Georgia Families is a partnership between DCH and private Care Management Organizations (CMOs) to ensure accessible and quality health care services for Medicaid and PeachCare for Kids managed care members. DCH contracts with three CMOS: AMERIGROUP Community Care, Peach State Health Plan, and WellCare of Georgia, Inc.

By providing a choice of health plans, Georgia Families intends to enable members to select a health care plan that fits their needs. DCH's Medicaid Division monitors the CMOs to ensure compliance with contractual requirement standards for contract management, member services, provider services, and quality services.

Georgia Families provides health care services to children enrolled in PeachCare for Kids and certain men, women, children, pregnant women, and women with breast or cervical cancer covered by Medicaid. Excluded populations include children in foster care and the remainder of Georgia's Medicaid population, including aged, blind, and disabled citizens.

Children with disabilities who have not been determined eligible for Supplemental Security Income (and do not therefore receive the previously mentioned Children's Intervention Services under Medicaid Aged, Blind and Disabled program) receive services from the CMOs through the Low Income Medicaid program.

Public Health

Service delivery in the state's public health system is carried out by 159 county boards of health. These boards of health are combined into 18 districts, ranging from one to 16 counties in size. Each district is led by a physician district health officer who reports to the state office of the DCH Division of Public Health. The county boards of health provide direct health care services, environmental health activities, and work with community partners in their county around issues of common concern. Approximately 97% of the county health departments' funding comes from the state in the form of general Grants-in- Aid (GIA). The FY10 general GIA state appropriation was $68,154,008; a decrease of $3,703,320 from the FY09 base. /2012/The FY12 budget separates funding for public health functions from DCH and provides funding for the new cabinet-

level Department of Public Health. The budget appropriates $174 million in General Fund support, plus $12 million in Tobacco Settlement funding, for a total of $186 million. Although a 1.5% increase from FY11, it is 1.4% ($23 million) below the pre-recession FY09 appropriation.//2012// /2013/ DPH's FY13 General Fund appropriation is $218,182,964. Total DPH funding, including federal funds and grants, other grants, state funds, and intra-state government transfers, is $684,337,564. The State General Fund allocation includes $8,903,663 for Adolescent and Adult Health Promotion, $2,505,125 for Immunization, $22,079,771 for Infant and Child Health Essential Health Treatment Services, and $12,203,798 for Infant and Child Health Promotion. Included in the Infant and Child Health Promotion allocation was $2,200,000 to maintain Children 1st.//2013//

B. Agency Capacity

The Maternal and Child Health Program (MCHP), part of the Division of Public Health (DPH), Department of Community Health (DCH), is Georgia's Title V agency. The charge of the MCHP is to improve the health of mothers, children, and their families through education, provision of direct services (family planning, children with special health care needs, early intervention, and Special Supplemental Nutrition Program for Women, Infants, and Children -- known as WIC), population-based interventions (newborn screening and oral health preventive services), and the support of the public health infrastructure through the administration of Title V Block Grant funds.

Core MCH services include:

- Universal Newborn Hearing Screening Initiative (UNHSI)
- Newborn Metabolic and Hemoglobinopathy Screening
- Early intervention
- Coordinated care for children with special health care needs (CSHCN)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Family planning
- Regional Perinatal Centers
- Coordinated care and outreach for children
- Prenatal care
- Health education including breastfeeding support, nutrition, and Sudden Infant Death Syndrome (SIDS)
- Oral health preventive services
- Children and Youth with Special Needs, Children's Medical Services
- Injury Prevention

Funding sources include: WIC = $320 million (federal)

- Title X (family planning) = $8 million (federal) and a 10% state match
- Early intervention = $14.7 million (federal), $15.9 million (American Recovery and Reinvestment Act), and $9.7 million (state)
- Universal Newborn Hearing Screening Initiative = $1.3 million (state) and $0.2 million (federal)
- Newborn Metabolic and Hemoglobinopathy Screening = $3.5 million (state) and $0.6 million (federal)
- Regional Perinatal Centers = $15 million (federal), 35%/65% state/Medicaid match
- Oral health preventive services = $2.3 million (state) and $0.6 million (federal)
- Title V Maternal and Child Health Block Grant = $16 million (federal) and $12 million (state)

STATE STATUTES RELEVANT TO TITLE V PROGRAM: The mission of Public Health in Georgia is to promote and protect the health of Georgians. The Official Code of Georgia (31-2-1 and 31-3-5) supports this mission by empowering DCH and the local county boards of health to employ all legal means to promote the health of the people. County Boards of Health develop and establish community-based systems for preventive and primary care services for pregnant women, mothers and infants, children and adolescents through local planning, direct provision of services and collaboration. Relevant DCH O.C.G.A. Titles include 4, 8, 10-1-393, 12, 15-11, 15-21, 16, 17-18-1,

19, 20, 34, 36, 40, 42, 43, 45, 46, 49, and 50. Other relevant state statutes include: Newborn Metabolic -- O.C.G.A. 31-12-6 and 31-12-7; Well Child -- O.C.G.A. 31-12-6 and 31-12-7; UNHS -- O.C.G.A. 31-1-1-3.2; School Health -- O.C.G.A. 20-2-771.2; Children 1st -- O.C.G.A. 31-12-6, 31-12-7, 31-1.3.2; Newborn Hearing Screening -- O.G.G.A. 31-1-3; Family Planning -- O.C.G.A. 49-7-03; and Perinatal Case Management -- 31-2-2. /2012/The 2011 Georgia General Assembly passed House Bill 214 which creates a stand-alone Department of Public Health with its own commissioner and board that report directly to the governor. The legislation, which had the support of the governor, elevates Public Health to a cabinet-level position and increases visibility for public health care issues in Georgia.//2012// /2013/Effective July 2011, Public Health became a separate department. In October, the Governor appointed a nine-person Board of Health to establish the general policy of DPH. The 2012 legislature passed several bills that impact maternal and child health populations in Georgia. House Bill 861 requires drug testing of individuals seeking welfare assistance. Legislation was also passed that reduced the time for elective abortions from 26 to 20 weeks. An exemption is included for "medically futile" pregnancies that gives physicians the option to perform an abortion when a fetus has congenital or chromosomal defects. HB1166 made Child-Only Health Insurance plans available in Georgia for children who do not qualify for PeachCare or Medicaid and who cannot access health insurance any other way. HB 879 requires designated school personnel, in addition to the school nurse, be trained on how to attend to children with diabetes while they are at school. SB 403 provides funding for school nurses. //2013//

The Georgia Department of Public Health is partnering with the Georgia OBGyn Society to start maternal mortality review. Funding is in place. No budget appropriation is needed. The purpose of the bill, which passed this legislative session, is to: support committee development and ensure the committee does not dissolve as it has twice before in Georgia; provide legal protection for committee members and the review process; ensure confidentiality of the review process; provide the committee with the necessary authority to collect data for case review; provide ongoing state recognition of the committee; and assure legislation interest and support in improving the problem of maternal mortality.

The Autism Insurance Mandate bill did not pass, but there are budget items that did including an increase in funds for early intervention providers for earlier detection and diagnosis of autism in children and an increase in funds for the training of early autism intervention providers to support families receiving early intervention services.

Newborn screening rules and regulations are going out for public comment soon. Proposed changes are scheduled to be adopted by July 1, 2014. The changes include the addition of SCID to the newborn screening panel. It also includes the addition of CCHD (point of care testing). The regulations will require reporting of CCHD results and also will require reporting of all hearing screening results (not just the refers).

Two governing bodies, the Board of Community Health and the 159 county boards of health, have key oversight and regulatory responsibilities. The State Board of Community Health's nine members are appointed by the Governor. The Board of Community Health establishes the general policy to be followed by DCH and makes budget recommendations. At the county level, boards of health, each with seven members, are required by state statute. These boards oversee the activities and budgets of the local public health departments and have regulatory and enforcement powers.

Georgia law permits the establishment of administrative multi-county health districts with the consent of county governments and boards of health in the counties involved. Georgia's 18 public health districts range in size from one to 16 counties. Each district has a health director, appointed by the DCH Commissioner and approved by the boards of health of the concerned counties. Typically, each district health office is staffed by a health director (a physician), administrator, program manager, community epidemiologist, chief of nursing, environmentalist, and program and support staff. District health offices are located in the "lead" county of the district, usually the largest county in population. Local level responsibilities are set forth in county Grant-in-Aid (GIA) contracts which describe programmatic activities and provide financial support to carry them out. Direct services are provided by the county health departments. Funds to support county health departments come from fees, state Grant-in-Aid, county taxes and grants.

CAPACITY TO PROVIDE TITLE V SERVICES: The MCHP's capacity to provide: 1) preventive and primary care services for pregnant women, mothers, and infants; 2) preventive and primary care services for children and adolescents; 3) services for children with special health care needs; 4) rehabilitation services for blind and disabled children under the age of 16 receiving benefits under Title XVI; and 5) family-centered, community-based, coordinated care including care coordination services for children with special health care needs and facilitate development of community-based systems of services for such children and their families is described below.

The Maternal and Child Health Program, led by Brian C. Castrucci, M.A., is organized into five areas: Child Health; Community Health Services; MCH Epidemiology; Nutrition and WIC; and Capacity Building. /2013/ Mr. Castrucci resigned in January 2012 and Seema Csukas, MD, PhD was appointed as Interim Program Director.//2013//
/2014/ Dr. Csukas was made MCH Section Director in July 2012. //2014//

The Child Health Section includes:

- Children and Youth with Specials Needs

* Babies Can't Wait
* Children's Medical Services

- Comprehensive Child Health

* Children 1st
* First Care
* Health Check
* Early Childhood Comprehensive Systems (ECCS Initiative)
* SIDS/Other Infant Death

- Newborn Screening Unit

* Newborn Metabolic and Genetic Screening
* Universal Newborn Hearing Screening and Intervention

/2013/ Under recent MCH reorganization, Child Health is now the Office of Child Health. It includes Children and Youth with Special Needs, Comprehensive Child Health, and Newborn Screen Screening.//2013//

Babies Can't Wait (BCW) is Georgia's statewide interagency service delivery system for infants and toddlers with developmental delays or disabilities and their families. The Georgia Division of Public Health is the lead agency responsible for administering the BCW program in Georgia. Through the MCHP, DPH ensures that services are provided in accordance with federal guidelines; that families have access to the services which are needed to enhance their child's development; and training is available to ensure that professionals who work with children and families have up-to-date information. Core services provided at no cost to families include developmental evaluation/assessment, individualized family service plans (IFSP), procedural safeguards (parent's rights), service coordination, and transition planning. Services subject to a system of payment (i.e., private insurance, Medicaid, family cost participation) include assistive technology, health services, nutrition services, physical therapy, special instruction, audiology, medical diagnostic services, psychology services, speech/language therapy, family training and counseling, nursing services, physical therapy, occupational therapy, social work, and vision services. BCW is administered through the 18 public health district offices throughout the state, and Easter Seals of North Georgia in the Gwinnett District. Parent to Parent of Georgia manages a statewide directory of information about local BCW programs that can be accessed by calling 1-800-229-2038.

Children's Medical Services (CMS) serves children and youth with disabilities age birth to 21 that

have a medical diagnosis on the approved CMS list and meet financial eligibility criteria. CMS provides care coordination, specialty medical evaluations and treatment for eligible children and youth who have complex medical conditions. Core CMS services include care coordination with a comprehensive plan of care, assurance that a child has a medical home with a primary care provider, and transition planning for youth ages 16 to 21 years of age. Services for eligible conditions include comprehensive medical evaluations, specialty medical/surgical care, diagnostic tests, durable medical equipment, inpatient/outpatient hospitalization, and medications.

Children 1st is the "single point of entry" to a statewide collaborative system of public health and other prevention based programs and services. This system allows children at risk for poor health and developmental outcomes to be identified early and gives them a chance to grow up healthy and ready for school. Participation is voluntary and there are no financial requirements for enrollment into the program. Core services include identifying high-risk births in Georgia; screening all births and children up to age five; assessing children and families at risk; referral/linkage of children and families with risk conditions to appropriate services; and monitoring of individual children from birth to age five with risk conditions. The Electronic Birth Certificate assists Children 1st in identifying newborns with or at risk for poor health and development. In addition, many health and community providers refer families to Children 1st. Children 1st refers families to other public health programs as appropriate, including BCW and CMS. Linkages are made to Medicaid and PeachCare for Kids as appropriate. Families may also access services from agencies such as Healthy Families Georgia and Head Start. Children 1st is present in all 18 public health districts with services implemented in all Georgia counties to provide a system of support for families. /2013/Children 1st is coordinating the centralized intake function for the MIECHV initiative in Georgia.//2013//
/2014/ Central Intake identified children and families at-risk and referred to appropriate services, such as evidence based home visiting or public health services, by coordinating services through a community based early childhood system of care network. //2014//

First Care provides services to infants, birth to age one, who are at increased risk for health and developmental problems due to medical conditions at birth /2014/ primarily caused by low birth weight or prematurity //2014//. Services may include voluntary in-home or clinic-based nursing assessment, nursing intervention, and care coordination. Services are designed to provide families education, support, and linkage with a medical home and community resources and programs to improve health and developmental outcomes and enhance parenting skills.
/2014/ In 2013, 1st Care standardized the nursing assessment and conducted a Nursing Head-to-Toe Assessment to all districts implementing the service. Currently, twelve of the eighteen districts are providing 1st Care. //2014//

Health Check is Georgia's well child or preventive health care program for Medicaid-eligible children birth to 21 years of age and PeachCare for Kids-eligible children birth to 19 years of age. Health Check screenings provide children and adolescents access to comprehensive medical care to support early detection and treatment of health conditions and aid in prevention of advanced illness and disability. Health Check screenings are provided by eligible providers according to a schedule based on recommendations of the American Academy of Pediatrics and include the following services: comprehensive health and developmental history, comprehensive physical exam, vision and hearing screening, appropriate immunizations, health education/ anticipatory guidance, laboratory tests, and dental referrals.
Funds provided for outreach were eliminated. The program has been discontinued.

The Early Childhood Comprehensive Systems (ECCS) Initiative is focused on developing a framework that fosters integrated early childhood systems at the state and community levels to support children, ages birth to five, who are healthy and ready to learn. The federally funded ECCS Grant is working to build a comprehensive early childhood system through the collaboration of Georgia service providers, families, communities, and policymakers. ECCS addresses five core elements: access to medical and dental care, social-emotional development and mental health, early care and education, parenting education, and family support. The Initiative has two goals: 1) State partnerships around ECCS principles and elements are strengthened through collaborative projects, including assessing, prioritizing, and addressing early childhood statewide resources, gaps and barriers; and 2) All children birth to five receive

coordinated, ongoing standardized developmental screening at recommended levels as well as when observation yields concerns about delayed or disordered development. ECCS work is guided by the ECCS Collaborative Partners Steering Committee, which includes representatives from numerous partnering agencies, all of whom work with or have an interest in children ages birth to five.
The Office of Child Health's grant application was not selected for funding. The ECCS initiative has been discontinued.

Sudden Infant Death (SIDS)/Other Infant Death provides new parents and infant caretakers with information about sleep safety and how to reduce the risk of SIDS, and links families who experience the death of a baby with community resources to assist them with their grief. The Georgia Crib Matching Program began in late 2007. Participating agencies must complete SIDS Risk Reduction Training and agree to purchase a minimum of five new/unused portable cribs with a bassinet. MCH will match three cribs to the respective agency. Families receiving a crib must meet specific eligibility requirements. /2013/The Crib Matching program has been discontinued.//2013//
SIDS/Other Infant Death program has moved from the Office of Child Health to the Injury Prevention Program.

The goal of Newborn Metabolic and Genetic Screening is to assure that every newborn in Georgia has a specimen collected for newborn screening tests prior to discharge from the hospitals; all infants with results outside the normal limits receive prompt and appropriate follow-up testing; and those diagnosed with a disorder are entered into and maintained on appropriate medical therapy. Core services include population screening for all newborns (approximately 150,000 live births/year); follow up of unsatisfactory or abnormal screening results; and diagnosis and referral to intervention.

Universal Newborn Hearing Screening and Intervention's goal is to screen every newborn (approximately 150,000 live births/year) for hearing loss prior to hospital discharge, and ensure infants not passing the initial and a repeat screening receive appropriate diagnostic evaluation before three months of age and when appropriate, are referred to intervention by six months of age.

The Community Health Services Section includes:

- Oral Health Unit

- Perinatal and Women's Health Unit

* Family Planning
* Regional Perinatal Centers

/2013/ With MCH's reorganization, the Oral Health Unit is now the Office of Oral Health and the Perinatal Women's Health Unit is the Office of Women's Health.//2013//

The mission of the Oral Health Unit is to prevent oral disease among Georgia's children through education, promotion of healthy behaviors, preventive interventions (such as sealants), and early treatment. Eligible populations include children with Medicaid/PeachCare for Kids; low income, uninsured children in need of oral health care; special needs children; pregnant women on Medicaid; and in some district practices, adults on a sliding fee scale. School sealant programs are directed at schools with more than 50% of the children on free or reduced lunch. Core services include school-based oral disease prevention and treatment programs for low income children; clinic-based dental treatment and prevention services for low income children and adults; and monitoring, supervision, and surveillance of public community water fluoridation programs. Approximately 96% of Georgians using community water services receive optimally fluoridated water.
Oral Health has expanded its framework to focus on integrating oral health resources and education targeting pregnant and parenting women.

Family Planning provides comprehensive reproductive health services to women of childbearing age and their partners. Services include physical exams; birth control counseling and supplies; abstinence skills training; immunizations; and screening for cancer, high blood pressure, diabetes, HIV and other sexually transmitted infections. The Georgia Family Planning Program also provides screening, counseling and referral for risk factors affecting women's health such as substance abuse, poor nutrition, cigarette smoking and exposure to violence. Services are provided in accordance with the federal guidelines.

We have launched a Fetal Infant Mortality Review/HIV Initiative that will review HIV exposed infant cases and will interview mothers/caregivers. Community review and action teams will be convened to develop recommendations, policies and actions needed to address gaps in policies and services.

In April 2009, DCH, in collaboration with community and agency partners, embarked on an initiative, known as Planning for Healthy Babies (P4HB), to reduce Georgia's low birth weight rate from 9.5% to 8.6% over a five year time span. Currently, the Georgia Medicaid Program provides prenatal coverage for pregnant women with monthly incomes at or below 200% of federal poverty level (FPL). These women are eligible for family planning services through the end of the month in which the 60th postpartum day falls. After 60 days, women whose income exceeds the categorical limits for participation in the traditional Medicaid program lose eligibility for all benefits, including family planning. Implementation of the P4HB program will extend eligibility for family planning services to women ages 18 to 44 years who are at or below 200% of the most current FPL; and provide inter-pregnancy care to women at or below 200% of FLP who have previously delivered a very low birth weight baby. The waiver will begin in January 2011 and end December 31, 2015. /2012/ The P4HB program was launched in January 2011. It is the country's first 1115 Demonstration waiver to place a particular focus on reducing low birth weight rates.//2012// /2013/The interconception care component of the waiver is informing development of one of HRSA's five strategies to address infant mortality through the Regions IV and VI Infant Mortality Collaborative.//2013//

The Designated Regional Perinatal Centers provide multidisciplinary care to high risk mothers and infants through six designated regional perinatal centers. Core services include high-risk perinatal services including transportation, prenatal care, delivery, post-partum care, newborn care, high-risk developmental follow-up and referrals to community and public health providers including, family planning, WIC, Children's 1st, and BCW. Additional services include physician outreach and education to area providers to ensure a seamless community-based system.

Perinatal/Women's Health is an outreach partner/sponsor of text4baby, a new free mobile information service providing timely health information to pregnant women and new moms from pregnancy through a baby's first year. These messages focus on a variety of topics critical to maternal and child health, including birth defects prevention, immunization, nutrition, seasonal flu, mental health, oral health, and safe sleep. Text4baby messages also connect women to prenatal and infant care services and other resources. /2012/Text4baby has moved under MCH OTVI.//2012// /2013/ Georgia customized various Text4Baby messages and currently 2,502 enrollees (English: 1,949; Spanish: 553) in the program. //2013//

The MCH Epidemiology Section works to increase the access, use, and quality of MCHP relevant data; ensuring that MCHPs and program partners have access to the science necessary to effectively guide program and policy development. /2013/ The Section has been renamed the Office of Epidemiology.//2013//

The goal of Georgia's Nutrition and WIC Section is to provide quality supplemental nutritious foods through a complex network of over 1,600 authorized retailers; nutrition and breastfeeding education, counseling, and support; and applicable referral-related services to assure that its targeted populations are eating healthy; practicing breastfeeding for recommended durations; being adequately physically active; and accessing complementary health services. In addition to providing technical assistance to Georgia's WIC, the Nutrition Services Unit conducts population-based services within the three core Public Health functions (assessment, policy development,

and assurance); increases the demand and provides options for achieving healthy eating lifestyles; enables Georgia citizens to make informed food choices; and creates public/private partnerships to promote nutrition-related policies, practices, and system development statewide. Georgia's WIC, the nation's fifth largest, provides various types of services to over 310,000 participants through Georgia's 18 public health districts, two contract agencies, and its authorized retailers. /2012/ In March 2011, the MCH Director assumed operational authority for the WIC Program.//2012// /2013/ The Nutrition and WIC Section is now known as the Office of Women, Infants, and Children (WIC)/Nutrition.//2013//
/2014/ Effective December 2012 the WIC Program was established as a freestanding section under Health Promotion; WIC no longer falls under MCH leadership //2014//

The Capacity Building Section supports the application of best practices and standards of care in order to enhance programs at the state and local levels by providing continuous quality improvement (CQI) and technical assistance (TA). The office is charged with leveraging resources, eliminating duplication of effort, ensuring accountability, and assuring a competent work force. The CQI Unit is responsible for developing, implementing, and supporting a standardized system of monitoring and compliance for MCHPs and initiatives. The TA Unit is responsible for ensuring that MCH services are delivered to children and families by competent staff and providers through technical assistance and training. /2012/The Office has been renamed the Office of Capacity Building.//2012// /2013/ With recent MCH reorganization, effective July 1, 2012, there is no longer an Office of Capacity Building.//2013//
/2014/ This office has been eliminated. //2014//

/2012/ The Office of Title V and Integration is responsible for ensuring implementation of Georgia's Title V Block Grant activity plan and the efficient use of MCH funds, services and programs. //2012// /2013/ Effective July 1, 2012, there is no longer an Office of Title V and Integration. The Title V Administrator has been relocated to the MCH Office of Epidemiology.//2013//
/2014/ The Office of Title V and Integration was eliminated 7/1/12. //2014//

BUILDING MCH CULTURAL AND LINGUISTIC COMPETENCY: Many of the state's health districts have identified growing immigrant populations and increases in clients with limited English proficiency as emerging trends that are having an impact on service delivery in the districts. Hispanics, primarily those of Mexican descent, are the most rapidly growing minority group in Georgia. DPH is committed to ensuring that limited English proficient (LEP) and sensory impaired (SI) clients have meaningful access to all programs and activities conducted or supported by the department. DPH's strategy for providing meaningful access for LEP and SI customers involves assessing language access needs statewide; recruiting and training "qualified" interpreters and bilingual staff; developing a centralized databank of language resources; translating vital forms and informational documents; forming partnerships with community groups for outreach and education; providing diversity training to DPH employees; and implementing a procedure for monitoring services and resolution of complaints. DPH is also working to reduce and eliminate access barriers that discourage the enrollment of all eligible program participants, including those in immigrant and mixed-status families. State and local public health staff, including MCH staff, are also able to draw on several key cultural competency resources, including the DPH's State Refugee Resettlement and Health Programs and Office of Communications, and DCH's Office of Health Improvement, Minority Health. The Office of Communications has widely disseminated a "Directory of Qualified Interpreters and Translators and Multi-Ethnic Community Resource Guide. Minority Health's Information Center has resource materials that focus on health issues relating to minority populations.

Racial and ethnic minorities make up over one-third of Georgia's population, but their disease burden is significantly higher. The DCH Office of Health Improvement, Minority Health works to eliminate the discrepancy in health status between minority and non-minority populations in Georgia. Major focus areas include:

- Identifying, assessing, and analyzing issues related to the health of minority populations;
- Working with public and private organizations to address specific minority community health needs;

- Monitoring state programs, policies, and procedures to assure that they are inclusive and responsive to minority community health needs; and
- Facilitating the development and implementation of research enterprises and scientific investigations to produce minority-specific findings.

Minority Health's work is supported by the Georgia Minority Health Advisory Council. Twelve members, including representatives from the Centers for Disease Control and Prevention, Georgia Rural Health Association, National Center for Primary Care, Center for Pan Asian Services, Medical Interpreter network of Georgia (MING), Children's HealthCare of Atlanta, Georgia Academy of Family Physicians, Georgia Dental Society, DCH, and medical providers, address health disparities and other health care concerns of Georgia's African American, Hispanic/Latino, Asian/Pacific Islander, and American Indian/Alaska Native populations. The Council has provided leadership in the development of a health care strategic plan to address improvement in the health status of minority populations in Georgia and in the work of the Georgia Health Equity Initiative. The "Georgia Health Equity Initiative -- Health Disparities Report
2008: A County-Level Look at Health Outcomes for Minorities in Georgia" provides data and information to help providers and the public understand health disparities, identify gaps in health status, and target interventions in areas of greatest need. The report is the first of its kind to focus solely on minority health outcomes for each of Georgia's 159 counties.

At the local level, public health districts efforts to meet the needs of non-English speaking clients have included hiring bilingual staff and/or utilizing translators or interpreters, conducting staff cultural diversity training, using language assistance phone lines, special health fairs in collaboration with local churches and other community organizations, and offering forms and patient education materials in Spanish and other languages. Districts have also engaged in social marketing and outreach to inform non English speaking clients of available public health services.

To provide meaningful access to services for LEP and sensory impaired (SI) customers, DPH service sites are required to have: 1) Notice of Free Interpretation Service Wall Posters prominently displayed in all reception and intake areas; 2) Notice/Policy of Nondiscrimination prominently displayed in all reception and intake areas; 3) the "I Speak" DPH card, which accommodates the identification of 38 languages likely to be encountered, accessible for DPH staff use; 4) State LEP/SI Plan and accompanying LEP/SI Policy and Procedures accessible for reference for all staff; 5) LEP/SI Intake and Tracking Form, with instructions, accessible for staff use: 6) "Waiver of Right to No-Cost Interpreter Services" form and Discrimination Complaint Form accessible for DPH staff use; 7) a sign posted identifying the Language Access Coordinator and Language Access Team Member for the Division or Office; 8) current listing of DPH Language Contractors, other contractors providing services, and contact information for a telephone interpretation service; 9) list of translated materials by title, date, form number, and language; 10) method of tracking the number of LEP/SI customers receiving services; 11) LEP/SI central file or appropriate alternative for paperless offices; 12) completed Local Language Access Plan; and 13) LEP/SI Reference Notebook (including items listed above) for use by staff, generally housed at the front desk.

All health districts are provided funding through Grant-in-Aid to cover the cost of language interpreters for families receiving hearing follow-up services.

BUILDING MCH COMPETENCIES: DPH offers state and local staff coordinated training and development activities to improve knowledge and job performance. DPH use of the video interactive conferencing systems (VICS) is increasing local public health staff participation in coordinator meetings and trainings. A range of VICS training is provided including New Employee Orientation (Parts I and II), Civil Rights Training, Policy and Procedures revisions, ARRA Stimulus and Stimulus Money Requirements, Data Overview, Family Planning, WIC Food Package Policy, WICS PARS Time Reporting, CMS training, and Infection Control Updates. Quarterly district Women's Health, CMS, and WIC coordinators meetings are held either via VICS or face-to-face to share information and identify opportunities to collaborate.

All new DPH state and district staff receive employee orientation training. In addition, new state MCH staff receive information on the Health Resources and Services Administration's Maternal and Child Health Bureau and the Maternal and Child Health Block Grant.

BUILDING PUBLIC AWARENESS FOR MCH: The Office of Communications serves as DCH's primary point of contact for all marketing, branding, media relations, and internal and external communications activities. The Communications team focuses its efforts on creating and maintaining a consistent brand and messaging for DCH. Specifically the team creates fact sheets for all of DCH's offices, divisions and programs, writes and distributes press releases and media advisories, designs and implements member and provider educational and promotional campaigns, and works with subject matter experts to create legislative briefs. The Office of Communications is also responsible for Intranet and Internet Web site maintenance, and oversees the Governor's Office of Customer Service program at DCH. The DCH website (http://dch.georgia.gov) includes division and program descriptions, a link to DCH publications, public notices, public meeting schedules, grant announcements, press releases, and general assembly presentations. The DPH web site (http://health.state.ga.us/) provides overviews of all public health programs and services, including MCH. Each program description includes state office contact information. /2013/The new DPH organizational structure includes a Communications team. DPH's web-based Live Healthy Georgia campaign serves as the umbrella for an outreach initiative that aims to raise awareness about the risk factors associated with chronic diseases and to provide Georgians with information about ways to live healthier. Key messages include: Get Checked, Eat Healthy, Be Active, Be Smoke Free, and Be Positive. The web site features a new interactive map of Healthy Community resources in Georgia, including farmer's markets, free medical clinics, local health departments, and smoking cessation programs. In addition, the DPH Commissioner has identified childhood obesity and infant mortality as key focus areas.//2013//
/2014/ The DPH website is currently undergoing changes. The new site should go live summer 2013. //2014//

/2014/ MCH is going through some organizational changes as a result of the transformation of public health in the Georgia Department of Public Health. In the end, these changes will allow us to align our work and priorities not only with the Title V block grant but also with the priorities for the Department of Public Health. As open positions are identified, the recruitment process is sometimes slow in order for us to identify the most qualified candidate for the position. This may result in a slower move in achieving goals and matching resources (time, money and people) to the work at hand. The organizational changes also allow us to identify training opportunities to allow staff to be successful and achieve operational efficiencies. //2014//

C. Organizational Structure

The Department of Community Health (DCH) framework in which MCH functions is depicted in the attached organizational charts. The Georgia General Assembly created DCH in 1999 by combining the four state agencies that were responsible for purchasing and regulating healthcare into a single, new agency. The DCH is now the main state agency in Georgia that provides health care planning and purchasing. In 2009, the DCH took over the duties of the Division of Public Health and Emergency Preparedness, formerly located in the Department of Human Resources, in addition to its normal functions. The DCH is also the sole state agency for Medicaid. /2012/ Effective July 1, 2011, Public Health will become a separate department that includes the MCHP. The new department has a $600 million budget and more than 1,000 employees. //2012//

The DCH Commissioner is appointed by the governor of Georgia and is accountable to the State Board of Community Health. The Board provides general oversight of DCH's activities by establishing policy, approving goals and objectives and other appropriate activities. The Commissioner is in charge of overseeing the ten divisions and six offices that make up the DCH. Clyde L. Reese, III, Esq. serves as the DCH Commissioner. Mr. Reese has previous experience as an Assistant Attorney General for the State of Georgia, General Counsel for the State Health Planning Agency, and Deputy General Counsel and General Counsel of DCH. /2012/ In January 2011, Georgia's new governor, Nathan Deal, appointed David Cook to serve as Commissioner of

the Georgia Department of Community Health. Mr. Cook has previous experience as the executive director and chief executive officer with the Medical Association of Georgia (MAG).//2012// /2013/ In June 2011, Governor Deal appointed Brenda Fitzgerald, M.D. to serve as Commissioner of the new Georgia Department of Public Health (DPH) and State Health Officer. Dr. Fitzgerald, a board-certified Obstetrician-Gynecologist and a Fellow in Anti-Aging Medicine, has practiced medicine for three decades. //2013//

The DCH Management Team includes the Chief Operating Officer; Chief Financial Officer; Director of Communications; Director of Healthcare Facility Regulation; Director of Legislative and External Affairs; Chief of the Medicaid Division; Inspector General and Chief of the Program Integrity Unit, Internal Affairs, and Audit Unit; Director of the Division of Public Health; Director of the State Health Benefit Plan; and Chief of Emergency Preparedness and Response Division. DCH Divisions:

-The Emergency Preparedness and Response Division manages the CDC's Public Health Emergency Preparedness Cooperative Agreement and the Health and Human Services Assistant Secretary for Preparedness and Response Hospital Preparedness Program Cooperative Agreement. Its activities include planning support for pandemic influenza and the distribution of medication during disease outbreaks. Injury Prevention, located in the Division along with the EMS and Trauma Programs, provides technical assistance in program evaluation and coalition building to local community groups; provides injury data to community groups and the public at large; distributes safety equipment such as child safety seats, bike helmets, smoke detectors, and dissemination of knowledge on proper use of safety equipment; and provides general support to local coalitions in helping promote safe and injury free life styles and behaviors.

-The Division of Financial Management deals with the DCH's financial needs, including its accounting and budgeting.

-The Office of General Counsel takes care of several administrative and legal tasks for the DCH. It creates policies to comply with federal and state record requirements, drafts rules and regulations to be considered by the Board of Community health, and supplies services for the legal part of the State Health Benefit Plans.

-Healthcare Facility Regulation Division ensures that healthcare providers are safe and competent and comply with professional standards.

-Information Technology is in charge of maintaining the systems for processing and collecting Medicaid and PeachCare for Kids payments.

-The Office of Inspector General prevents and investigates fraud related to Medicaid, PeachCare for Kids, and the State Health Benefit Plan.

-The Division of Public Health promotes healthy lifestyles for all Georgians and works to reduce preventable deaths.

-The State Health Benefit Plan gives health insurance to state employees and their dependents.

-The Division of Medical Assistance Plans runs the state Medicaid program, which offers medical help to children, pregnant women, and people with disabilities.

-The Operations Division is in charge of human resources for the DCH as well as several other initiatives including the Office of Minority Health, Office of Women's Health, Georgia Commission on Men's health, Georgia Volunteers in Health Care program, and State Office of Rural Health.

DCH Offices:

-The Office of Communications serves as the DCH's liaison with the media and the public and maintains the DCH website.

-The Office of Health Improvement is a part of the Operations Division and is comprised of the

Office of Minority Health, the Office of Women's Health and the Georgia Commission on Men's Health.

-The Office of Health Information Technology and Transparency (HITT) facilitates the exchange of information regarding healthcare between healthcare providers, professionals, and consumers.

-The Office of Legislative Affairs and External Affairs works with the Georgia General Assembly to evaluate and provide input on legislation that relates to public health in the state of Georgia.

-The Office of Procurement Services (OPS) is responsible for procuring the highest quality services possible at the lowest cost possible to fulfill the DCH's need. This office works closely with the Department of Administrative Services.

-The State Office of Rural Health is in charge of providing increased access to healthcare throughout rural Georgia.

Division of Public Health:

At the state level, DPH is divided into numerous branches, sections, programs and offices, and at the local level, DPH functions via 18 health districts and 159 county health departments. The county public health departments offer direct healthcare to low-income people and people in underserved areas of the state, and work with private medical providers to assure these groups receive needed care. /2013/Public Health became a stand-alone department on July 1, 2011. DPH's organizational structure is outlined in the attached organizational charts. State public health programs include Health Promotion and Disease Prevention (HPDP), MCH, Infectious Disease and Immunization, Environmental Health, Epidemiology, Emergency Preparedness and Response, Emergency Medical Services, Pharmacy, Nursing, Volunteer Health Care, the Office of Health Equity, Vital Records and the State Public Health Laboratory. //2013//

M. Rony Francois, M.D. M.A., M.S.P.H. is Director of the Division of Public Health (DPH). Prior to becoming Director in January 2010, Dr. Francois served as Assistant Secretary of Louisiana's Department of Health and Hospitals Office of Public Health, where he was responsible for the direction and management of the state's public health programs. He has also served as the Secretary of the Florida Department of Health. /2012/ On February 8, 2011, Brenda Fitzgerald, M.D., was appointed to serve as the new Director of DCH's Division of Public Health. Dr. Fitzgerald, a board-certified Obstetrician-Gynecologist, oversees Public Health's seven main program areas: Maternal and Child Health, Health Promotion and Disease Prevention, Infectious Disease and Immunization, Environmental Health, Epidemiology, Vital Records, and the State Public Health Laboratory. She also directs the state's 18 health districts and 159 county health departments, including the 222 family planning clinics. In June 2011, Governor Deal appointed Dr. Fitzgerald to serve as Commissioner of the new Department of Public Health.//2012// /2013/ Yvette Daniels, J.D., serves as the Director of Health Promotion for DPH, where she oversees four programs including MCH, HPDP, the Volunteer Health Care Program and Office of Health Equity. She was the Deputy Director of Legislative and External Affairs and was responsible for the development and direction of the legislative goals and agenda for areas impacting Public Health.//2013//
/2014/ Ms. Daniels also oversees the WIC section as Director of Health Promotion. //2014//

Miriam T. Bell, M.P.H., Deputy Director, Public Health Programs and Services, provides administrative supervision of Public Health's programs and services. In addition, she supports the Public Health Director and works closely with the Deputy Director of Administration to manage the day-to-day operations of public health, develops and meets strategic goals and priorities for the Division, and ensures the provision of quality programs and services. Prior to her appointment as Deputy Director, Ms. Bell served for 20 years at H. Lee Moffitt Cancer Center & Research Institute in Tampa, Florida. In her last position she served as their Director of Patient Advocacy and Rehabilitation. /2012/ Ms. Bell left DCH in June 2011.//2012//

The Advisory Council for Public Health is responsible for providing assistance and guidance to DPH and DCH on all matters regarding public health programs. Eight council members,

appointed by the governor, serve one to two year terms.

DPH programs include Health Promotion and Disease Prevention, Maternal and Child Health (see Section B -- Agency Capacity), Infectious Disease and Immunizations, Environmental Health, Epidemiology, the State Laboratory Programs, and Vital Records. Each DPH program and service has responsibilities that inter-relate with MCH activities, requiring strong working relationships.

Health Promotion and Disease Prevention (HPDP) programs implement population-based programs and services aimed at reducing disease risks, promoting healthy youth development, targeting unhealthy behaviors, providing access to early detection and treatment services, and improving management of chronic diseases. Targeted risk behaviors include smoking, physical inactivity, unhealthy eating, lack of preventive healthcare, sexual violence, and reducing risky behaviors in youth. HPDP's Office of Cancer Screening and Treatment includes the Georgia Breast and Cervical Cancer Program, Cancer State AID Program, and breast and cervical cancer treatment for eligible women through the Women's Health Medicaid Program. Office of Chronic Disease Prevention and Wellness programs and services include comprehensive tobacco use prevention activities including tobacco cessation services through the Georgia Tobacco Quit Line; population-based strategies to address chronic disease prevention and management; primary sexual violence prevention; health communication and education; primary prevention strategies to address obesity in children, youth, and adults; adolescent health and youth development; and community capacity building through the provision of technical assistance to community-based organizations to address chronic disease prevention, risk reduction, and positive youth development.

Infectious Disease and Immunization includes the HIV, STD, Tuberculosis (TB), and Immunization Programs. HIV coordinates services through Georgia's HIV Care Ryan White Part B Program and the HIV Prevention Program. The STD Program works to reduce morbidity associated with sexually transmitted disease in Georgia by preventing STDs and their complications in both the public and private sectors through coordinated, comprehensive statewide STD prevention; statewide STD screening; and surveillance of STDs. The TB Program, which has legal responsibility for all TB clients in Georgia regardless of who provides the direct services, identifies and treats persons who have active TB disease; finds, screens, and treats contacts; and screens high-risk populations.

The work of the Immunization Program is carried out through the efforts of trained state staff and through partnership and collaboration with medical organizations, other state agencies, and community coalitions. Vaccine financing is accomplished through the use of state and federal funds to provide vaccines for uninsured and under-insured children in Georgia, and for certain adult populations. The Immunization Program oversees the acquisition, distribution, and management of vaccines through the Vaccines for Children (VFC) Program, as well as vaccines acquired through state and other federal funding.
Georgia Immunization Program staff and activities are federally funded by the CDC's Immunization and Vaccines for Children Program (VFC) grant.

All health care providers are mandated by law to report to the Georgia Registry of Immunization Transactions and Services (GRITS) all immunizations given to persons of any age. They also can access this database to get updated information on their clients' immunization status. In addition to housing immunization records, GRITS allows providers to track their vaccine inventory, print the Georgia Certificate of Immunization and send reminder/recall notices to clients.

Environmental Health provides primary prevention through a combination of surveillance, education, enforcement, and assessment programs designed to identify, prevent and abate environmental conditions that adversely impact human health. Programs include Chemical Hazards, Food Service, Land Use (On-Site Sewage), Swimming Pools, Tourist Accommodations, Well Water, and Other Programs (i.e., Mosquito-borne Viral Diseases, Indoor Air Quality Assistance).

Epidemiology includes Acute Disease Epidemiology; Chronic Disease, Injury and Environmental; the Office of Health Indicators for Planning (OHIP), and the Georgia Epidemiology Report (GER). OHIP leads DPH's health assessment component, providing evidence about the health status of Georgia's population. OHIP's internal operations include information quality; health statistics; epidemiological modeling and information mining; Geographic Information Systems and spatial analysis; and web-based distribution of health statistics and forecasting models. OHIP's Online Analytical Statistical Information System (OASIS), a suite of interactive tools, provides access to DPH's standardized health data repository. The repository is currently populated with Vital Statistics (births, deaths, infant deaths, fetal deaths, induced terminations), Georgia Comprehensive Cancer Registry, Hospital Inpatient and Emergency Room Discharge, Arboviral Surveillance, Risk Behavior Surveys, and Population data.

OHIP is now a stand-alone section in the Dept of Public Health.

The Georgia Public Health Laboratory Program (GPHL) provides screening, diagnostic and reference laboratory services to Georgia citizens through county health departments, public health clinics, physicians, other clinical laboratories, hospitals and state agencies. GPHL's five broad areas of testing and support include: chemistry (Newborn Screening Unit, Lead Screening and Fluoride Testing), Emergency Preparedness (Biological/Chemical Terrorism and Molecular Biology Units), Facilities Support, Microbiology (Bacteriology, Microbial Immunology, Mycobacteriology/ Mycology, Parasitology, and Virology Units), and Operations.

The State Vital Records Office maintains Georgia vital records and events, which are defined as birth, death, fetal deaths (stillbirth), induced termination of pregnancy, marriage and divorce certificates and reports.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Title V funds 155 MCH state and district positions. (See attached table.)

SENIOR MCH STAFF QUALIFICATIONS AND CAPABILITIES:

Brian C. Castrucci, MA, Director of the MCHP in the Division of Public Health and Title V Maternal and Child Health Block Grant Director, provides leadership for the statewide maternal and child health program. Provide oversight for 140 FTEs and a budget of approximately $500M. He provides oversight for programs including Georgia's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), family planning (Title X), Babies Can't Wait (Part C Early Intervention program), Early Childhood Comprehensive Systems grant, the Children First Program (Georgia's single point of entry for health-related early childhood services), Title V Maternal and Child Health Block Grant, newborn screening, services for children with special health care needs, oral health, and the Office of Performance Management and Support Services. Prior to serving as MCHP Director, Mr. Castrucci was the Manager of the Family Health Research and Program Development Unit in the Office of Title V and Family Health at the Texas Department of State Health Services. He has worked with Healthy Start projects in Philadelphia and Texas; has developed case management and other health promotion programs; has implemented surveillance systems to monitor local child death review findings, infant sleep practices, and breastfeeding; and has provided support to the Texas Family Planning Program, the Texas Children with Special Health Care Needs Program, and the Texas Women, Infants, and Children Program. He has published research on topics that include adolescent tobacco use, breastfeeding, HIV/AIDS policy, and pregnancy. Mr. Castrucci also worked at the Philadelphia Department of Public Health, The Robert Wood Johnson Foundation, and the Centers for Disease Control and Prevention. (See attached resume.) /2012/In October 2010, as part of the 75th Anniversary celebration for Title V, Mr. Castrucci was awarded the Young Leadership in MCH Award.//2012 /2013/ With Mr. Castrucci's resignation, Seema Csukas, MD, PhD was appointed as MCH Interim Program Director in January 2012. //2013// /2014/ Dr. Csukas was named MCH Section Director July 15, 2012 //2014//

Debbie Cheatham, RN, DNP, Director for the Children and Youth with Special Needs Unit and Title V CSHCN Director, is a doctorally prepared Registered Nurse with over 26 years of experience. She has over 15 years of experience in public health at the state level. Prior to joining the Georgia MCHP in 2009, she was the Program Administrator for Early Childhood Programs at the Ohio Department of Health where she worked closely with the CSHCN program and instituted a public health nurse consultation visit for all children with a medical diagnosis served in the early intervention program. /2013/ Dr. Cheatham has been promoted to the Director of the Office of Child Health. In this capacity, she oversees Children and Youth with Special Needs, Comprehensive Child Health Services, and Newborn Screening. //2013// /2014/ Dr. Cheatham is the Clinical Director for Child Health. Gayle Jones is the new Director of the Office of Child Health.

Gayle Jones, PhD, MPH, CHES, Director of the Office of Child Health, received a Bachelor's in Biology from the University of South Carolina Aiken, Masters of Public Health in Health Administration from the University of South Carolina Arnold School of Public Health, and a PhD in Public Health from Walden University. Dr. Jones has over 10 years of experience in various areas of public health. //2014//

Drs. Cheatham and Jones resigned from their positions. The new Director of the Office of Child Health is Margie Preston.

Beverly Stanley, BA, MCH Deputy Director, provides administrative leadership and guidance for all programs in MCH. She earned her BA in Human Resource Management at the University of South Carolina. She has over 20 years of experience working in the governmental and private sectors providing management of day to day operations, including financial, human resources, contract, and facility services, maximizing resources for effective and prompt delivery of services to local programs. Most recently, Ms. Stanley served as the Operations Director, providing a comprehensive system for all operational needs, including the Standard Operating Procedures (SOP) in the MCHP, the development of the only Supervisor's Guide for Orienting New Employees, and a systematic contract management process.

Abdul K. Lindsay, MScFT, RD, LD, CPT, is Director of the Georgia Women, Infants, and Children (WIC) Program. Mr. Lindsay earned his Master of Science and Bachelor of Science degrees in Food Technology and Dietetics, Nutrition and Fitness from the University of Georgia and Florida State University, respectively. He is registered nationally and licensed as a Dietitian and within the State of Georgia. Mr. Lindsay has held leadership positions overseeing and providing various dietetic components including food and nutrition services as well as nutrition education/counseling in Georgia, Florida and North Carolina as a School Nutrition Director, School Nutrition Administrator, Clinical Nutrition Manager, Public Health Community Nutritionist, Public Health WIC Nutritionist and Administrative Dietitian. /2012/ With Mr. Lindsay's resignation, the MCH Director assumed responsibility for the WIC Program in March 2011.//2012// /2013/ Dr. Csukas assumed responsibility for the WIC program in January 2012.//2013// WIC is a section in the Division of Health Promotion under the direction of Debra Keyes.

Rhonda Simpson, MS is the Director of the Capacity Building Section. She has served in various roles for the MCHP for the last nine years. Ms. Simpson has a Master of Science degree in Human Resources from East Central Oklahoma State University and over 16 years of health-related administrative and counseling experience. /2012/ The Office of Performance Management and Support Services has been renamed as the Office of Capacity Building. //2012// /2014/ The Office of Capacity Building has been eliminated. Ms. Simpson is now the Perinatal Health Director. This position reports to the Director of the Office Family and Community Health. //2014//

Elizabeth C. Lense, DDS, MSHA, the Georgia Oral Health Program Director, received her dental degree and completed a residency in Oral Maxillofacial Pathology at Emory University School of Dentistry, and went on to teach Oral Pathology at West Virginia University Schools of Medicine and Dentistry. After returning to Georgia, Dr. Lense taught Oral Histology and Embryology at Georgia Perimeter College School of Dental Hygiene, as well as served as a clinical instructor for

oral diagnosis and radiology. While working as a dentist in the dental public health system, she received a Master's degree in Healthcare Administration from Georgia State University, and went on to serve as Director of the Pediatric Dental program for Grady Health System at Hughes Spalding Children's Hospital from 1999-2006. She is an Assistant Clinical Professor in the Department of Pediatrics at Emory School of Medicine, and an adjunct instructor in Pediatrics for Morehouse School of Medicine. She has been on the Board of Directors of the Healthy Mothers, Healthy Babies Coalition since 2000, and served as both Vice-President and President. She is also a member of the Hispanic Health Coalition, Hispanic Dental Association, and the Georgia Dental Society. Dr. Lense completed a Fellowship in Public Health at the CDC Division of Oral Health and now serves as the Georgia's State Oral Health Director. /2013/ Dr. Lense resigned in December 2011.//2013// /2014/ The Oral Health Program under the leadership of Carol Smith (unit director) moved into the structure of the Office of Family and Community Health. //2014//

Sharon C. Quary, MS is the Manager of the Newborn Screening Unit. She received her Master of Science in Medical Genetics/Genetic Counseling in 1997 from Howard University, Washington, D.C. Prior to joining Public Health, she served as the Coordinator of the Newborn Screening Follow-Up Program and piloted a Duchene Muscular Dystrophy Infant Screening Program at Emory University, Department of Human Genetics, Division of Medical Genetics. /2013/ Ms. Quary resigned April 2012. DPH is currently recruiting for this position.//2013// /2014/ This position has been filled by Ms. Kelli Rayford. //2014//

Kelli E. Rayford, RN, MSN, PNP is the Program Director for the Comprehensive Child Health Services Unit. She has worked in various areas of Public Health for over 11 years, including positions as a Nurse Practitioner, Nurse Manager, and Nurse Consultant. In her current position, she has oversight of several Public Health programs and services, including Children 1st, Health Check. /2012/ Ms. Rayford is currently the Children and Youth with Special Needs Nurse Consultant. //2012// /2013/ Ms. Rayford is serving as the Interim Program Director for Comprehensive Child Health.//2013// /2014/ Ms. Rayford is now the Manager of the Newborn Screening Unit. The Program Director for the Comprehensive Child Health Services Unit position is currently vacant. //2014//

/2013/ Audrey M. Blake, MPH, Director for the CYSHCN Unit, holds a BA degree in Psychology and a MPH degree in Health Administration. Her professional career over the past 25 years has centered on the Health and Human Services and Public Health fields, including working a social worker at the Department of Social Services -- Economic Services and a Program Information Coordinator at the University of South Carolina's School of Medicine: Center for Developmental Disabilities. In this capacity she provided counseling, referral and advocacy to parents and professionals nationwide. She has also worked as a Health Planning Administrator at the Ohio Department of Health. //2013//
Ms. Blake resigned from this position. Ms. Kelli Rayford is now the Director for the CYSHCN Unit.

Patricka D. Wood, RN, MPH is the Director of the Perinatal/Women's Health Unit. She received her RN training from the University Hospital of the West Indies School of Nursing in Kingston, Jamaica. In 1983, she completed midwifery training at Foresterhill College, Aberdeen Maternity Hospital in Scotland. She received her M.P.H. from Emory University in 1995. She has been employed in high-risk maternal and infant care since 1983. /2013/ Ms. Wood resigned in December 2011. /2013/Dr. Relda Beckly-Robertson will start as the new Director on June 18, 2012.//2013// /2014/ Dr. Relda Robertson-Beckley was promoted to the Director of the Office of Family and Community Health. Wanda Prince was hired as the Director for the Family Planning Program in April 2013.

Relda Robertson-Beckley, BSN, MPH, PhD is our Family and Community Health Director. She brings to this position 20 years of public health experience working at the local, state and federal levels. She also has years of experience in academia. Most recently, she served as the Director of Public Health Nursing, Policy and Planning for Alameda County Public Health. During her tenure, she developed and launched the Foster Care Initiative, Universal Health Screening targeting OUSD schools and the Pre-eligibility and School- based units. //2014//

/2012/Arianne B. Weldon, MPH, Director of the Office of Title V Integration and Title V Administrator, administers the statewide Title V Maternal and Child Health (MCH) Block Grant, managing the planning and implementation of Title V activities. Prior to joining the Georgia MCHP in 2010, Ms. Weldon was the Director of State Partnership Strategies for Georgia Family Connection Partnership (GaFCP) where she served as a liaison to state-level population-based initiatives across multiple state agencies, private sector organizations, and communities to assure coordination and collaboration in efforts to improve child and family well-being. Ms. Weldon's training includes serving as a guest researcher with CDC conducting active surveillance of bacterial meningitis and conducting research at Grady Memorial Hospital with the Emory University School of Medicine on overcoming barriers to care for African-Americans with Type II diabetes.//2012// /2014/ Ms. Weldon resigned in November 2012. //2014//
Title V administration has been moved under the Office of MCH Epidemiology.

/2012/ Theresa Chapple-McGruder, BA, MPH, PhD, Director of the Office of Maternal and Child Health Epidemiology, received her Bachelor's Degree in Psychology from Clark Atlanta University in 2002, Master of Public Health in Maternal and Child Health from the University of North Carolina at Chapel Hill in 2005, and her Doctor of Philosophy in Epidemiology from the University of Illinois at Chicago in 2009. Prior to joining the Georgia MCHP, she was the Acting of Chief of Epidemiology at the Memphis and Shelby County Health Department. She has also worked as the Lead Epidemiologist for the University of Chicago OB/GYN Department and as a Data Coordinator for the University of Illinois at Chicago Perinatal Center.//2012//

Medical Oversight: To assure that MCHPs and services reflect sound clinical practice and medical research, the MCHP has contracted with medical consultants to work with MCHPs and services. /2012/Seema Csukas, MD, PhD, Maternal and Child Health Medical Director, is a board-certified pediatrician and a fellow of the American Academy of Pediatrics. Dr. Csukas has worked as a primary care physician serving low-income families for over 12 years. She joined Children's Healthcare of Atlanta in 1994 and in her 16 years of tenure there served in a number of leadership roles including Medical Director for Primary Care Services, Director of Child Health Promotion, and Medical Director for Child Wellness. Dr. Csukas earned her bachelor's degree from Emory University in Atlanta She received her medical and doctorate degrees from the Georgia Health Sciences University (formerly the Medical College of Georgia) in Augusta. Prior to coming to Atlanta, Dr. Csukas was on faculty in the Department of Pediatrics at the Medical College of Wisconsin in Milwaukee.//2012// /2013/ Dr. Csukas was named Interim Director of the MCHP and WIC in January 2012. //2013// /2014/ Dr. Csukas was named Director of the Maternal and Child Health Section in July 2012. //2014//

Family and community involvement: There are currently nine parent educators who assist the BCW Program with policy development/review, federal grant review, training and support for family members and providers, and encouragement of local and state parent involvement. Eight of the parent educators serve the Dalton, Cobb/Douglas, Clayton, Gwinnett, DeKalb, Valdosta, Albany, and Athens public health districts. In addition, one of the parent educators, who is Hispanic, serves as a statewide multicultural specialist for Georgia's Hispanic families. Recruitment is underway to hire parent educators in the Columbus, Rome, and Waycross districts. Parents of children in BCW and CMS participate in local Interagency Coordinating Council (ICC) meetings in all 18 Georgia public health districts.

The State CMS Office has developed and is facilitating public health district use of a family support group template to foster the establishment of CMS or CYSN family support groups in each district. Currently, all 18 districts have either a Family Action and Support Team (FAST) or a family support group. Goals of these groups include: providing families with special needs children the opportunity to review and advise on development or revision of current policies and procedures for CMS; providing families with the opportunity to advise CMS of the concerns of children with special health care needs and their families in order to improve and develop programs, using a family-centered approach, that are responsive to the identified needs; providing families an opportunity to come together to network and offer each other support and information; increasing public awareness of programs that are community-based, family-centered, and that provide coordinated, culturally-competent services for children with special health care needs; and establishing a Youth Advisory Council within FAST to guide CMS on the needs and concerns of youth with special health needs.

and to provide FAST with the youth perspective on the execution of FAST goals.

CMS involves parents in the development of their child's plan of care (POC) and the identification and prioritization of the child's needs as well as the needs of the family. CMS district staff also support clients and their families through various methods, including providing funding for attendance at diabetes and asthma camps; coordinating mothers' nights out; supporting grandparents groups; holding parent workshops; offering sickle cell training for local school nurses; and providing support for asthma coalitions, parent advisory committees, and other community advisory committees, and task forces.

At the district level, CMS staff attend and support local ICC activities. District staff also participate in local Family Connection Partnership initiatives and other community advocacy activities. The Family Connection Partnership Collaborative brings together more than 3,000 local and state- level partners committed to strengthening children and families so they can learn from their peers, share resources, and replicate best practices. The collaborative organizations in the Family Connection Partnership network, which branches out into all 159 counties in Georgia, are committed to improving the quality of life in their communities. Local collaborative organization membership includes concerned citizens, civic groups, local businesses, faith communities, elected officials, and representatives and leaders from state agencies.

Families are surveyed yearly to obtain information about how best the healthcare services their child receives can be improved. Survey findings assist the state office in identifying program strengths as well as areas for improvement.

The Universal Newborn Hearing Screening and Intervention (UNHSI) Stakeholder Committee currently has one parent representative. Sherry Richardson, Director of the Georgia Family Voices Program with Parent of Parent of Georgia, is MCH's Association of Maternal and Child Health Programs (AMCHP) parent representative. She is also one of two regional field coordinators for Family Voices. As Director of the Family Voices Project, she supports families as they negotiate the complex levels of health care systems and policies in the state of Georgia. Parent to Parent of Georgia supports families of children and youth with special health care needs. Parent to Parent currently serves as Georgia's Family to Family Health Information
Center. (See Section F -- Other Program Capacity for additional information on Parent to Parent services.) /2013/ Ms. Richardson was recently hired as a Program Consultant to assist CSHCN in increasing parent involvement. //2013// /2014/ BCW utilizes Parent Trainers in all in-person training modules for the Skilled Credentialed Early Interventionists (SCEIS) Credentialing process for new BCW Special Instructors and Service Coordinators. DPH was awarded a federal Integrated Community Systems for CYSHCN Grant, for which families and youth play an integral role in implementing grant activities. CMS recruited Family leaders from each of its 18 districts to participate in its program improvement project. Family leaders were involved in decision-making alongside their CMS district coordinator on workgroups for data, services, and financing. //2014//

Families were recruited to participate in Title V program and policy initiatives involving the Early Intervention/Babies Can't Wait (BCW) Taskforce. The taskforce reviewed and made improvement recommendations on financial, administrative and services policies and processes. Families also participated on Title V's Child Health Taskforce to streamline processes and efficiencies across all child health programs. Babies Can't Wait District Coordinators provided approximately 250 opportunities for families and professionals to participate in trainings, presentations, community events, and health fairs. The total number of participants for these events reached approximately 6,600. Topics for events hosted included: A 5K run, Lunch and Learn's, Literacy, Zumba for Autism, Domestic Violence Training, Resource-A-Palooza, HIV Prevention, Family Fun Day, and Fall and Winter Festivals. They also provided several presentations, and outreach and awareness campaigns to Hospitals, Homeless Populations, University Special Education Students, Grandparents Associations, Public Housing Groups, Schools, Churches, Care Management Organizations, Military Bases, Social Workers and Recreational Centers. In addition to serving on Children Medical Services' Program Improvement Teams, family leaders were offered TA support to start local support groups (6 per year) through a contract with Parent to Parent of Georgia, Georgia's Family to Family Health Information Center. Children Medical Services (CMS) Coordinators provided 266 opportunities for family community involvement, with total participation reaching 4,208.

E. State Agency Coordination

Input from Georgia's broad array of public and private sector organizations is key in assisting with the state's MCH policy, planning, and service delivery efforts.

STATE AGENCIES:

Bright from the Start: The Department of Early Care and Learning (DECAL) is responsible for meeting the child care and early education needs of Georgia's children and their families. DECAL oversees a wide range of programs focused on children ages birth to school age and their families. These programs include: 1) administering Georgia's Pre-K Program; 2) licensing and monitoring the state's center-based and home-based child care facilities (approximately 10,000); 3) overseeing the federal Child and Adult Care Food Program and the Summer Food Service Program; 4) maintaining the Standards of Care Program and Family Homes of Quality to help child care providers enhance their program quality; 5) housing the Head Start State Collaboration Office; 6) administering the federal Even Start dollars to promote family literacy; and 7) providing technical assistance, training, and support to families and child care providers who care for children with special needs. DECAL collaborates with Head Start, Family Connection Partnership, the Department of Human Services Family and Children Services, DPH, and Smart Start Georgia to blend federal, state, and private dollars to enhance early care and education. DECAL and DPH have a memorandum of agreement for enhanced services to support early childhood health and development for children and youth. DECAL is implementing an "Agency Accepted Trainer" pilot program with other state agencies to provide for-credit-training for Georgia child care providers. The MCHP has been identified as the first "Agency Accepted Trainer." MCH Ages and Stages training opportunities have been posted on the DECAL website and local training will be initiated by summer 2010. In addition, DECAL staff serves on MCH's Early Childhood Comprehensive Systems (ECCS) Steering Committee and on ECCS subcommittees. /2012/ The MCHP is developing a partnership with DECAL to support shared goals. //2012// /2013/ DECAL recently developed a Quality Rating Improvement System; MCHP assisted in creating the system's child health and nutrition component. Over 500 child care providers have enrolled in the voluntary system to assess, improve and communication of the level of quality in early care and education programs. DECAL's pre-kindergarten program received its first 10 out of 10 measures of quality for 2010-2011 from the National Institute for Early Education. Only 5 of 39 state programs met all 10 standards. DECAL serves as administrative home for federal funding that supports Georgia's Early Childhood Advisory Council. DECAL has contracted with MCH to conduct work around developmental screening follow up. MCH Healthy Development work includes developing an updated social-emotional resource list, providing training on social-emotional awareness, and developing a Health Screening Plan that includes identified state resources, a gap analysis, recommendations, and a roadmap. //2013//
/2014/ The Health Screening Healthy Development project ended May 31, 2013. The final report with key findings and recommendations has been submitted to DECAL. DECAL is compiling a final report for HHS and will be shared with the Early Childhood Advisory Council (now the Children's Cabinet) for review and determining next steps. //2014//
DECAL is the lead agency for Georgia's Early Learning Challenge grant which will fund a range of projects to support access to high quality early learning opportunities for children and families with high needs.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) provides treatment and support services to people with mental illness and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD has five regions. Regional offices oversee the network of state-supported DBHDD community and hospital services in the region.

Georgia's services for children and youth who are seriously emotionally disturbed (SED) focus on family support and intervention and preventing crises whenever possible. When crises do occur, public mental health services aim to serve the child in the home or close to home if possible, and to avoid hospitalization, which can be traumatic for young children. The services a child and family receives depends on a professional determination of level of need and the services and other community resources available. Services vary by region and may include: crisis, outpatient, and/or community support services; intensive family intervention; and outdoor therapeutic programs.

Current child and adolescent mental health initiatives include Community Based Alternatives for Youth (CBAY) and KidsNet Georgia. The CBAY 1915(c) Waiver Home and Community-Based Services demonstration program uses a systems approach that targets youth served by multiple agencies, striving to coordinate, blend, and braid programs and funding to create a comprehensive behavioral system that ensures youth are placed in and remain in intensive residential treatment only when necessary and that a coordinated system of services at the community level is available.

DBHDD's KidsNet Georgia Project is designed to support the transformation of the state's child behavioral health system by strengthening and enhancing the capacity to develop, expand, and sustain behavioral health services across all child-serving agencies for children and adolescents experiencing SED and/or substance abuse and their families. The project is supported by two federal grants (Child and Adolescent State Infrastructure Grant and State Adolescent Coordination Grant). The First Lady's Children's Cabinet serves as the oversight body for the KidsNet Georgia Project. The DCH Commissioner and DPH Director serve on the Cabinet. The MCHP is represented in the KidsNet Collaborative, the project's operational body which governs the project, and in several of KidsNet workgroups. MCH's ECCS Initiative has been integrated into the project as a subcommittee to help support efforts involving early childhood developmental screening and socio-emotional health. DBHDD staff, including the KidsNet Director, serves on the ECCS Steering Committee. DBHDD also is a member of the Georgia ECCS State Team. As a result of these collaborative activities, the KidsNet Part C Finance Committee has been moved to the ECCS Initiative as an ECCS Partnership Subcommittee work group.

DPH works with DBHDD around a number of state and local level concerns that relate to the MCH population such as youth risk prevention and tobacco use prevention. A DBHDD Mental Health representative serves on the BCW Interagency Coordinating Council. DBHDD's Division of Addictive Diseases Office of Prevention Services provided Substance Abuse Block Grant funding to help support DPH's 2008-2009 Healthy Families Georgia Mental Health Screening Project which was designed to help decrease the risk of suicide in pregnant and parenting women with depression and address associated issues with mother/child attachment and positive parenting in mothers participating in Healthy Families Georgia programs. /2013/ MCH and DBHDD partnered to enhance suicide prevention protocols in Georgia's schools and universities.//2013//
MCH staff partnered with DBHDD to submit Project LAUNCH grant application. Staff also participates on DBHDD's Georgia Interagency Director's Team (IDT), a grant-funded initiative to address Attention Deficit Hyperactivity Disorder (ADHD) in children.

The Department of Education (DOE) oversees public education throughout the state, ensuring that that laws and regulations pertaining to education are followed and that state and federal money appropriated for education is properly allocated to the Georgia's 180 local school systems. DOE is comprised of five offices under the State Superintendent of Schools: Policy and External Affairs; Standards, Instruction, and Assessment; Education Support and Improvement; Finance and Business Operations; and Technology Services. The Divisions for Special Education Services and Supports, located in Standards, Instructions, and Assessment, include programs and services that support local school districts in their efforts to provide special education and related services to students with disabilities. These services focus on enhancing student achievement and post-secondary outcomes through implementation of regional and statewide activities for students, families, educators, administrators, and other stakeholders. Targeted areas for services and supports include accessible instructional materials, assistive technology, curriculum access and alignment, dropout prevention, family engagement, least restrictive environment, positive behavior supports, and transition. Additional services include ensuring compliance with federal and state regulations for special education, collecting and analyzing data on education services and outcomes, providing guidance and oversight for federal and state special education funds, and coordinating resolution requirements as required by state and federal requirements. DOE has a memorandum of agreement with the DCH that endorses and encourages joint health and human services and education planning and programming targeting reductions in teen pregnancy, substance abuse, school failure and delinquency. In many parts of the state, strong relationships have been developed between Public Health and the schools.
/2012/ As part of the first statewide school-based flu vaccination project in Georgia, MCH allocated $1 million to purchase flu vaccine to vaccinate children in school-based settings. In 2010, 15 of Georgia's 18 health districts participated in the project with 74,271 doses of flu vaccine administered between

November 2010 and March 2011 in 733 schools.

Starting with the 2011-2012 school year, the fitness of students grades 1-12 in Georgia public schools who participate in classes taught by certified physical education teachers will be assessed. Physical education teachers in participating schools will receive training on FITNESSGRAM, a comprehensive health-related physical fitness and activity assessment and computerized reporting system developed by The Cooper Institute. Parents will receive a copy of their child's "FITNESSGRAM" report card, which will offer recommendations for fitness improvement. The goal is to motivate kids to score in the "Healthy Fitness Zone." SHAPE partners include the Governor's Office, CHOA, DOE, and the Arthur M. Blank Family Foundation.//2012//
/2014/ One hundred and forty trainings were held between July 2011 and December 2011 for teachers. Georgia DOE, in partnership with HealthMPowers, developed a comprehensive professional learning model and training manual. Trainings were developed to ensure consistency of fitness test administration, data collection, and messaging about fitness testing, as well as to improve knowledge about health and fitness. Trainings were scheduled across Georgia to ensure access and minimal travel for teachers from all Georgia public schools. Over 3,000 physical education teachers, paraprofessionals, and other school staff members were trained in a six month period.

Data were collected on 998,774 students. Out of Georgia's 2,231 schools, 97% completed fitness assessments. Fitness scores were reported for 998,774 physical education students from 2,156 schools, representing 67% of the total population of students in grades 1-12. Of those tested, 37% of students assessed are not in the Healthy Fitness Zone (HFZ) for aerobic capacity, 43% of students assessed are not in the HFZ for BMI, 20% of all students across all grade levels (4-12) did not achieve the HFZ in any of the five assessments (0 of 5), and only 14% of all students across all grade levels (4-12) achieved the HFZ in all five assessments (5 of 5). //2014//
Georgia Shape has successfully completed the second year of Fitnessgram (FG) data collection. The first year of data collection was from the 2011-2012 school year. Georgia Shape received the second year of data from the 2012-2013 school year in August of 2013. Results were both positive and negative. The amount of students tested grew from 998,774 (67%) to 1,139,998 (76%). The number of schools districts that submitted data stayed the same at 182 (100%). The number of schools to submit data grew from 2156 (97%) to 2253 (99%). In terms of Body Mass Index (the measure Georgia Shape currently uses to measure statewide success of the initiative), there was some improvement seen. The measure improved from 43% of students (grades 1-12) falling outside the HFZ, to 41% falling outside the HFZ. Students (grades 4-12) that were not inside the HFZ for any component unfortunately increased from 20% to 25%. Students (grades 4-12) that were inside the HFZ zone for every component grew from 14% to 19%. Lastly, students (grades 4-12) that were outside the HFZ for aerobic capacity grew from 37% to 38%.
The training for physical educators is currently available online via webcasts allowing new teachers to be trained at any time, so the state continues to administer the test in this effective way.

/2013/ The FY 2013 State General Fund allocation for DOE includes $26,399,520 to provide funding for school nurses who provide health procedures for students at school. Included in this allocation is funding for a statewide nursing coordinator. MCHP is working with DOE to update mandated reporter training for all educational personnel and parent volunteers. //2013//

The Department of Human Services (DHS) provides Georgia with customer-focused human services that promote child and adult protection, child welfare, stronger families and self- sufficiency. DHS includes the Division of Family and Children Services (DFCS), the Division of Aging Services (DAS), the Division of Child Support Services (DCSS), the Office of Residential Child Care (RCC), and support offices. DFCS is responsible for investigating child abuse; finding foster homes for abused and neglected children; helping low income, out-of-work parents get back on their feet; assisting with childcare costs for low income parents who are working or in job training; and providing support services and programs to help troubled families./2013/ MCHP staff support DFCS on their federal Child and Family Services Review, Citizen Review Panel and CAPTA PIP. Office of MCH Integration and Injury Prevention staff provide leadership on two of the three CAPTA required Citizen Review Panels. //2013//
/2014/ A representative from DOE serves on the early intervention program (Babies Can't Wait) State Interagency Coordinating Council (SICC). There is a collaborative relationship between the

Part C Coordinator (SPH) and the Part B Coordinator in DOE. The Part C Coordinator and the Director of the CYSCHN (as needed) attends the DOE State Advisory Panel (SAP).

A Memorandum of Understanding between the GA Department of Human Services and the GA Department of Public Health was executed effective January 1, 2013, regarding children under age 3 who will be referred by DFCS to Babies Can't Wait through Children 1st. //2014//

The Department of Juvenile Justice (DJJ) provides supervision, detention, a range of treatment and education services for youths referred to DJJ by the Juvenile Courts, and provides assistance or delinquency prevention services for at-risk youth through collaborative efforts with other public, private, and community entities. Over 52,000 youth are served annually, including youth who are placed on probation, sentenced in short-term incarceration, or committed to DJJ's custody by Juvenile Courts. DJJ, Corrections, Pardons and Parole, and MCH work collaboratively to strengthen relationships and create a continuum of care for youth leaving the state's youth detention centers to address their need for community-based health and mental health services.

The Department of Labor (DOL) operates five integrated and interdependent programs that share a primary goal -- to help people with disabilities become fully productive members of society by achieving independence and meaningful employment. The largest of the programs are the Vocational Rehabilitation (VR) Program, Disability Adjudication Services, and the Roosevelt Warm Springs Institute for Rehabilitation. Two other programs serve consumers with visual impairments, the Business Enterprise Program and Georgia Industries for the Blind.

The Governor's Office for Children and Families (GOCF) mission is to build capacity in communities to improve outcomes for Georgia's children, youth and families. GOCF was created in 2008 to ensure that Georgians are using child welfare resources -- funding, policy, and personnel -- in a way that is targeted, consistent, and most effective. This initiative united the Children's Trust Fund Commission, Children and Youth Coordinating Council, Office of the Child Advocate, and Office of Child Fatality Review in the newly organized GOCF.

GOCF supports and strengthens families and improves outcomes for Georgia's children and youth through a community-based system of prevention and intervention services, known as Caring Communities for Children and Families. The Caring Communities system of care approach integrates care planning and management through partnerships with community organizations, children, youth and families. Organizations work in partnership to develop a network in which children, youth and families can access the programs and services that meet their needs.

GOCF is leading Partnerships for Healthy Communities, an interagency collaborative project supported by the University of North Carolina at Chapel Hill's PREVENT Institute. In addition to GOCF, partner agencies include DFCS and Children's Healthcare of Atlanta. Partnerships for Healthy Communities seeks to decrease the rate of physical abuse and abuse related injuries in Georgia's children from infancy to three years of age. To accomplish this, Partnerships for Healthy Communities is assisting health-care providers -- including pediatricians, family practice physicians, and their staff -- in preventing, recognizing and reporting physical and sexual abuse as well as neglect.

GOCF, in partnership with DECAL, leads Strengthening Families Georgia, an interagency collaborative project that seeks to create a child abuse and neglect prevention initiative that can help program developers, policymakers and advocates embed effective prevention strategies into existing systems. The project uses the Strengthening Families assets-based framework of protective factors in all systems, programs, services and activities supporting families with young children.

/2012/GOCF is the governor-designated Maternal and Infant Early Childhood Home Visiting Project (MIECHV) lead for Georgia. The MCHP conducted the needs assessment and works in partnership with GOCF to implement the MIECHV program.//2012// /2013/ GOCF received a 2011 Competitive MIECHV Grant which support two components, a Call Center and Central Intake function. The statewide Call Center will be coordinated by MCHP. The Central Intake component is being implemented in the counties targeted by MIECHV (six in year 1 and an additional county in

year 2). Beginning January 2012, Central Intake is providing Core Screening using a tool developed with DPH and GOCF that incorporates the Children 1st Screening/Referral form with MIECHV risk factors (i.e., military, tobacco/substance use, etc.). In October 2012,
coordination of Central Intake and the statewide call system will move to Children 1st/Public Health. //2013//
/2014/ In October 2012, Children 1st and the DPH/MCHS assumed primary coordination of Central Intake to support the MIECHV federal grant. DPH/MCHS is providing a centralized record of all referrals via a data system that was launched by DPH and is utilized by all agencies involved with the MIECHV system of care. DPH/MCHS also contracted with a statewide Information and Referral Center/Call Center to process all referrals. In the seven MIECHV-funded counties the Health Districts are also contributing to the community level system of care through partnership with other agencies and by providing Comprehensive Core Screenings for those referred via an EBC. //2014//

The Social Security Administration, Rehabilitation, and Disability Unit contracts with the DOL Office of Rehabilitation Services for state disability adjudication services and determines the eligibility of children birth to age 21 for Supplemental Security Income (SSI).

MATERNAL AND CHILD HEALTH PARTNERS IN GEORGIA:

There are a number of advocacy, service, and professional organizations in Georgia that are working to improve outcomes for the state's women, infants, children, and children with special health care needs. Brian Castrucci, who joined DPH in January 2010 as the new MCH Director/Title V MCH Block Grant Director, and his staff are working to engage the state's MCH stakeholders and identify opportunities for collaboration. (See the Georgia 2010 Title V MCH Block Grant Five Year Needs Assessment for a summary of a focus group held on March 18, 2010 with MCH stakeholders to provide input on the critical health and healthcare needs for Georgia's MCH populations.) Several key maternal, child, and family partnerships in the state are highlighted below. A more in-depth description of partners and stakeholders is provided in the Needs Assessment.

The Family Connection Partnership is a public/private partnership created by the State of Georgia and funders in the private sector to help communities address the serious challenges facing Georgia's children and families. As a nonprofit intermediary organization, the Partnership works closely with community, state, and national partners to provide training and technical assistance to Family Connection county collaboratives; enhances public awareness, understanding, communication, and commitment to improve results for children and families; and uses research and evaluation to promote effective practices and programs. Family Connection serves on the ECCS Steering Committee and on the ECCS Planning Committee.

The Georgia Children's Health Alliance (GCHA) is a statewide collaboration uniting public, private, not-for-profit, business sectors, and pediatric health experts to create healthier futures for Georgia children. Children's Healthcare of Atlanta (CHOA), March of Dimes, and Prevent Child Abuse Georgia serve as the lead agencies for GCHA. /2012/ Prevent Child Abuse Georgia closed in March 2011. The agency's helpline is now out of service. A network of over 40 independent local organizations is still alive and continuing to work to prevent child abuse. //2012// In 2009, GCHA and DPH joined together to lead the development of the 2010 "REFOCUS on Child Health in Georgia" report. The purpose of the report, which was released in April 2010, is to: 1) establish a baseline showing where the health of Georgia's children is today and create a starting point for conversations about child health issues, and 2) highlight what data are missing or need improvement and to bring organizations together to work on filling those data gaps. The report not only highlights health issues facing Georgia, but also looks at obstacles to families, individuals, health professionals, and organizations that are looking to improve health outcomes for Georgia's children. In addition to the report, GCHA is leading implementation of the SHAPE act to track fitness levels in school children and improve those levels as well as supporting curriculum in child care centers promoting healthy eating and physical activity. GCHA also supports reduction in
child abuse and neglect through parent interventions and evaluation of home visitation models. /2012/ The functions of GCHA have been absorbed within CHOA. //2012//

/2013/ The Georgia Campaign for Adolescent Pregnancy Prevention (G-CAPP) is a statewide nonprofit organization that works to eliminate adolescent pregnancy in Georgia through

innovative strategies that address underlying causes such as poverty, school dropout, and fragile families. Through CDC funding, G-CAPP is leading a public-private partnership (P3) to develop a strategic plan to reduce teen pregnancy, targeting the 11 counties with the highest populations and birth rate.//2013//

The Georgia Early Childhood Comprehensive Systems (ECCS) Initiative Steering Committee is composed of key early childhood partners across the state. Funded by a grant from the federal Maternal and Child Health Bureau, Initiative activities include the development of two electronic survey tools to: 1) assess the current and potential contributions of existing ECCS partners and system capacity building potential and 2) identify public and private early childhood developmental screening practices and social emotional program systems capacity at the local level. Partnerships have been developed with the Centers for Disease Control and Prevention (CDC) "Learn the Signs, Act Early" State Team and with KidsNet Georgia. A medical/dental home brochure is in the final stage of development to be used with families and non-medical early childhood case managers. /2012/ 2011 ECCS accomplishments have included branding of the Initiative as the Peach Partners ECCS Initiative, completion of the medical and dental home booklet for families, two statewide early childhood provider surveys, and convening of a joint ECCS Steering Committee meeting with the Georgia Team of the Learn the Signs/Act Early Summit. //2012// /2013/ The medical and dental home booklet has received MCH leadership approval and is expected to be disseminated widely in summer 2012 after Departmental approval. The ECCS clearinghouse is being redesigned to broaden its focus. Peach Partners has continued to meet jointly with the Learn the Signs, Act Early State Team and Peach Partner steering committee members are providing input in the development of the Georgia Autism Plan.//2013// /2014/ Training was provided by Sheltering Arms: Georgia Training Institute to various child care and program leadership on the medical and dental home booklet and how to communicate and share information with parents. The Learn the Signs, Act Early developmental brochure was also distributed to attendees during this training. //2014//

Healthy Mothers, Healthy Babies Coalition of Georgia (HMHB) is a strong, statewide voice for improved access to healthcare and improved maternal and child health outcomes through a statewide network of grassroots advocates. HMHB operates the PowerLine, Georgia's toll-free, bilingual helpline for healthcare referrals funded by the MCHP. The PowerLine maintains a database of Georgia's low-cost and sliding-scale providers, free clinics, public health program such as Babies Can't Wait, and community health services. They also refer callers to appropriate WIC Clinics and record reports of complaints or fraud.

Parent to Parent of Georgia is a statewide agency that serves children and youth with disabilities and their families. Parent to Parent offers an on-line data base of various resources such as child care, respite care or support groups that are available in local areas, provides parent-to-parent matching service, training sessions for parents on a wide variety of topics and assist local areas in organizing parent support groups. Parent to Parent of Georgia is a free service and is funded in part by DPH.

Voices for Georgia's Children is an independent, non-profit organization whose mission is to substantially improve the state's low "Kids Count" child well-being ranking by engaging lawmakers and the public in building a sustained, comprehensive, long-term agenda to impact the lives of Georgia kids in five distinct areas: health, safety, education, connectedness and employability.

/2013/Georgia Title V joined with the Kaiser Foundation to provide coordinated funding to United Way of Metropolitan Atlanta to promote group prenatal care in Georgia and support reinvigoration of Grady Health System's group prenatal care program.//2013// /2014/ Prevent Child Abuse Georgia (PCA-GA) provides statewide direction to promote healthy children and develop strong families in five ways: prevention network, public awareness, prevention programs, research and advocacy activities. PCA-GA recently received a $165K challenge grant to re-establish the 1-800-CHILDREN helpline. Currently, a MCH representative serves on the Advisory Board, and continues to identify opportunities to support the work of PCA-GA. //2014//

RELEVANT COUNCILS:

The Governor's Council on Developmental Disabilities (DD Council) serves as an advisory body

and provides broad policy advice and consultation to state agencies.

The Interagency Coordinating Council (ICC) for Early Intervention, mandated under Part C of IDEA, is appointed by the Governor to advise and assist DCH in planning, coordinating and implementing a statewide system of early intervention services for children with or at risk for developmental delays.

The State Advisory Council on Early Childhood Education and Care was created by executive order by Former Governor Sonny Perdue in 2009. The lead agency for the council is the Department of Early Care and Learning, which has authority over early childhood programs. The council seeks to improve early childhood program quality, empower parents of young children, and unify and coordinate early childhood program data systems. The Department of Public Health participates on this advisory council as lead agency for programs under Part C of IDEA.

Federal Qualified Centers: Georgia's Community Health Centers (CHCs) offer a comprehensive range of primary health care and other services including around the clock care, acute illness treatment, prenatal care, well-child care, physicals, preventive services, health education, nutritional counseling, laboratory, x-ray and pharmacy services. The state's network of 28 CHCs serves over 238,000 Georgians each year in over 70 of the state's 159 counties. A number of these CHCs provide perinatal case management services and newborn follow-up.

Tertiary Care Facilities: Relationships have been established throughout the state with tertiary care facilities with technical resources that have enhanced Georgia's capacity to offer services to women of childbearing age, infants, children and adolescents. The state has two Level II pediatric trauma centers, four children's hospitals, and two burn units. Regional perinatal services are provided statewide through six designated tertiary care hospitals located in Atlanta, Macon, Augusta, Columbus, Albany and Savannah. High-risk perinatal services provided include transportation, prenatal care, delivery, post-partum care, and newborn care. A regional perinatal planning process facilitates planning in each of the six perinatal regions, bringing together in each region representatives from hospitals, district public health, and community organizations.

Technical Resources: The MCHP collaborates with the state's Distance Learning and Telemedicine Program (GSAMS) network to bring specialty health care to areas with limited access. BCW also utilizes telehealth technology. All four of the state's medical schools (Medical College of Georgia, Emory University School of Medicine, Morehouse School of Medicine, and Mercer University School of Medicine) have faculty that participate in the CMS program. The Centers for Disease Control and Prevention (CDC) is a valuable resource in providing technical assistance and resources to the Program. The Rollins School of Public Health at Emory University works with DPH in many areas: internships for students; program and outcome evaluation; and technical assistance and consultation. Several other universities (Georgia State University, University of Georgia, and Clayton State) also work with MCH and DPH, providing technical assistance, research, and training. Georgia State University's Health Policy Center (GHPC) conducts, analyzes and disseminates qualitative and quantitative findings to connect decision makers, including DPH and its MCHP, with the objective research and guidance needed to make informed decisions about health policy and programs. The GHPC is working with DCH
on a low birth weight modeling project which dovetails with work on the Planning for Healthy Babies (P4HB) Medicaid waiver that will extend eligibility for family planning services to low income women.
The use of technology is expanding through the development of DPH telehealth/telemedicine network and through association with Georgia Partnership for Telehealth. Currently we are working to expand genetics and sickle cell disease clinics through use of telemedicine.

Professional Organizations: MCH works on an ongoing basis with the Medical Association of Georgia, Georgia State Medical Association, Georgia Chapter of the American Academy of Pediatrics (GA-AAP), Georgia Academy of Family Physicians (GAFP), Georgia Chapter of the College of Obstetrics and Gynecology, Annie E. Casey Foundation-Atlanta Civic Site, Georgia Pathways, Georgia Hospital Association, Association of Women's Health Obstetrical and Neonatal Nurses (national and state), Georgia Early Education Alliance for Ready Students,

Georgia Perinatal Association, Center for Black Women's Wellness, Healthcare Georgia Foundation, and other professional groups to promote increased private sector involvement in serving women, children, and youth in need.

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	22.7	19.6	18.8	18.9	15.9
Numerator	1575	1345	1285	1275	1137
Denominator	692752	687874	683451	675032	713671
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional

Notes – 2013
Data Source Numerator: Georgia inpatient deduplicated discharge data, 2002-2012. Accessed through OASIS. 2013 data is estimated by linear projection using 2000-2012 data from OASIS. 2012 data was updated.

Data Source Denominator: Population estimates data in 5-year groups are prepared by the U.S. Bureau of the Census. However, single-year estimates were prepared from Census data by the Division of Public Health. Population estimates accessed through OASIS. 2013 data is estimated from 2000-2012 using Excel TREND procedure. 2000-2011 data was updated.

Data are unavailable for 2013. The provisional estimates are developed using a linear projection with data from 2000 through 2012. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2013 are estimated using a linear projection with data from 2000 through 2012.

Notes - 2012
Numerator-Georgia inpatient deduplicated discharges, 2000-2010. Accessed through OASIS. 2011 data is estimated using Excel TREND procedure. 2012 data is estimated using 2000-2010 data from OASIS and 2011 estimate.
Denominator-Population estimates data in 5-year groups are prepared by the U.S. Bureau of the Census. However, single-year estimates were prepared from Census data by the Division of Public Health. Population estimates accessed through OASIS. 2012 data is estimated using Excel TREND procedure.

Notes-Data are unavailable for 2012. The provisional estimates are developed using a linear projection with data from 2000 through 2010. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2012 are estimated using a linear projection with data from 2000 through 2010 and estimate of 2011.

Notes - 2011
Data are unavailable for 2011. The provisional estimates were developed using a linear projection with data from 2000 through 2010. Population data was provided by the Georgia Online Analytic Statistical Information System (OASIS). Population data for 2011 are estimated using a linear projection with data from 2000 through 2010. Data were updated for 2010.

Notes - 2010
Data are unavailable for 2010. The provisional estimates are developed using a linear projection with data from 2000 through 2009. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2010 are estimated using a linear projection with data from 2000 through 2009.

Narrative:

Health Systems Capacity Indicator 05A: Percent of low birth weight (<2,500 grams)

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (<2,500 grams)					

Narrative:

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
State					
Infant deaths per 1,000 live births					

Notes - 2014
Data source: data warehouse (final birth data)
Numerator (Medicaid/Non-Medicaid): number resident births that have been linked to an infant death, where payor status is known
Denominator (Medicaid/Non-Medicaid): number of resident births, where payor status is known
Numerator (All): number resident births that have been linked to an infant death
Denominator (All): number of resident births

Notes-Payor information was missing overall 11.6% and for deaths 13.8% in 2010. All records were included for the 'All' calculation, regardless of payor information.

Narrative:

Health Systems Capacity Indicator 05C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester					

Notes - 2014
Data source: EBC (Provional)
Numerator (Medicaid/non-Medicaid): number of resident births with 1st trimester PNC, where payor status is known
Denominator (Medicaid/non-Medicaid): number of resident births, where payor status is known
Numerator (All): number of resident births with 1st trimester PNC, where month PNC began is known
Denominator (All): number of resident births

Notes-Month PNC began was missing 23.6%, and payor information was missing overall 6.0% and for known PNC 1st trimester 1.4% in 2012. Records with missing data were excluded. Estimates are not likely stable. However, all records were included for the 'All' calculation, regardless of payor information, but where month PNC care began is known.

Narrative:

Health Systems Capacity Indicator 09A: The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes

REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2014

Narrative:
The Office of MCH Epidemiology conducts data linkage, analyzes and interprets the data from these linked files, and uses the data for increasing the effectiveness of MCH programs and/or policies. We do not have access to Medicaid Files, nor do we have a birth defects surveillance system. Both of these data sources are of high importance to the MCH Section and we have begun exploring mechanisms to access both data sources.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This current needs assessment and application occurred at a time of significant transition for the Georgia MCHP. Within the 12 months prior to the submission of the FY 11 Title V MCH Services Block Grant, DPH was reorganized into a different department, a new MCHP Director was selected, and both the Title V MCH and CSHCN Directors changed. These changes coupled with the implementation of the needs assessment and an application at the start of a new five-year cycle presented challenges, but also significant opportunity. The Georgia MCHP leadership capitalized on this opportunity by conducting a thorough analysis of existing quantitative data and collecting needed qualitative data from providers, advocates, and consumers throughout the state. These data provided the foundation for the identification and selection of the state's top priority needs. This process included significant involvement from the public, advocacy groups, statewide service organizations, professional societies, and state agencies. As described in Section B. State Priorities, most priority needs were aligned with national performances measures, others were addressed through the development of state performance measures or through activities linked to state and/or national performance measures. Section B also outlines the available capacity to address each priority measure. The success of this process is demonstrated, in part, by the public comments received pertaining to the needs assessment and selection of priority needs. Selected comments are provided below. All comments are included in the Attachment to I. General Requirements, E. Public Input.

"The data presented was thorough. It is great that the state involved many stakeholders."

"I am pleased to see Decrease Infant Mortality and Injury high on our list. I believe home visiting and parent education (as in Children 1st) to be the key to accomplishing this goal."

"I agree with the top 10 priority needs for Georgia mothers and children."

"I appreciate the very inclusive process used by MCH to help set priorities for Georgia."

"I am truly impressed with the new direction at the state office and am looking forward to making significant changes in the health outcomes of Georgia's maternal and child health population. The collaborations and partnerships that have been made and/or strengthened will be beneficial to Georgia's families."

"It appears that the strategies and approaches that you've come up with will eventually benefit all. There had to have been a lot of effort in orchestrating these processes. Job well done."

"I participated in the meetings held to select the 10 top priority needs for Georgia on June 3-4, 2010. I was impressed with the organization and method in which our groups worked to make these hard choices."

"I participated in the Title V Needs Selection Meeting in June 2010. I was very impressed with the focus group information presented, the 'real' grassroots process to identify the top ten priorities."

The MCH leadership also altered the activity planning and reporting process in FY11. In previous applications, Georgia Title V did not report on specific activities with the link between last year's accomplishments and the activities listed in Table 4a unclear. Beginning with the FY11 application, each year Georgia Title V will initiate a planning process that involves partners and stakeholders to yield a specific activity plan for each national and state performance measure for the upcoming year that includes expected outcomes and a monitoring methodology. Progress on the FY11 annual activity plan will be reported under current activities in the FY12 application. In the FY13 application, the activities included in the FY11 activity plan will be reported under last year's accomplishments and each activity will be reflected in Table 4a. Reporting will be specific to each activity in the plan compared to the current process of listing broad accomplishments that relate to the performance measure. The activity planning process will occur each year to develop an annual activity plan for each upcoming year. It is expected that each annual activity plan will build on the accomplishments of the previous year. By implementing this activity planning and reporting process, Georgia Title V increases accountability for specific activities and increases the probability of impacting national and state performance measures by ensuring incremental improvements through successful completion of each activity. /2013/ Office of MCH Integration Staff met with each DPH program included in the activity plan, and with external partners, to refine activities related to each performance measure. //2013//

/2012/The MCHP added a medical director and Title V grant administration. A new director was hired for the Office of MCH Epidemiology, who will bring strong scientific leadership to the Georgia MCHP. As of July 1, 2011, the Division of Public Health was established as its own Department reporting to the governor. Streamlined processes and more direct access to the governor will present greater opportunities for the MCHP including increased participation on the First Lady's Children's Cabinet. It will be the responsibility of the MCHP to capitalize on the opportunities available due to these changes.

Research and evaluation projects of note include linking the Georgia birth record to education data. The inclusion of several MCH-specific questions to the 2011 Georgia BRFSS further enhances the surveillance capacity. Specifically, questions addressed the MCH priority need of increasing the public's awareness of the need for preconception health care. These questions will provide information that will be used for planning.

The MCHP worked to develop a plan that will lead to implementation in FFY12. Reducing infant mortality is a strategic initiative for the Department of Public Health, but is also an MCH priority need. A report on infant mortality has been prepared and will be published in the Fall of 2011 in partnership with a local healthcare foundation. /2013/ The Georgia Infant Mortality Report was published and distributed. //2013//

During the most recent year, MCH has focused on carrying out components of the strategic plan. Specifically, focus has been on creating and implementing a maternal mortality review and a perinatal quality collaborative (GaPQC). We have also worked in two communities with high rates of infant mortality, conducting home visitation programs. We also re-evaluated our infant mortality cluster data analysis, which originally identified six geographical areas with high infant mortality. However, only four clusters remain after three years of working to address infant mortality in our state.

Obesity prevention and intervention is a focus of both Commissioner of the Georgia Department of Public Health and the governor. Obesity is also a priority need for the MCH population. The Georgia Title V program is the primary funder of the implementation of the Student Health and Physical Education Act, which requires a fitness assessment for all Georgia children enrolled in physical education classes. Through partnership with other agencies, there are significant opportunities for data linkages that will greatly increase the value of these data and the information that they can

provide. The fitness assessment data will provide important data for Georgia to select and evaluate the interventions that will most effectively and efficiently impact the issue in Georgia.//2012// /2013/ The Georgia Student Health and Physical Education (SHAPE) Act, passed in 2009, requires local school districts to conduct an annual fitness assessment program, beginning with the 2011-2012 school year, for all students in grades 1 - 12 enrolled in Georgia public school physical education classes taught by certified physical education teachers. The Department of Education selected FITNESSGRAM, a comprehensive health-related physical fitness and activity assessment and computerized reporting system developed by The Cooper Institute. Title V has funded an epidemiologist to be housed within the
Department of Education to begin the FitnessGram evaluation.//2013// /2014/ An epidemiologist has not been hired. //2014//

B. State Priorities

Georgia's 2010 Needs Assessment submitted with the FY2011 Application identified nine priority needs. All state performance measures are associated with one or more of the nine priority needs. The pyramid levels, population groups, capacity to specific to the need, related national performance measures (NPMs) and state performance measures (SPMs), and the relationship between the need, NPMs, and/or SPMs is addressed for each need below.

Priority Need: Decrease infant mortality and injury

Pyramid Levels: Infrastructure building, Population based services, Enabling services, and Direct health care

Population Groups: Women and Infants

Capacity Specific to Need: There is significant capacity to address infant mortality and injury. To build infrastructure and understanding of infant mortality, capacity exists to perform detailed analyses of infant mortality at the county level including perinatal periods of risk analyses. Strategic coordination with WIC will allow the communication of messages to a high risk population. Through the Children 1st Program, very low birth weight infants receive home visiting follow-up care. By applying an algorithm to the electronic birth file, all infants born in Georgia are screened for socio-economic risk factors that may contribute to developmental delay or infant mortality. Through partnerships with the Georgia Chapter of the American Academy of
Pediatrics, the Georgia Obstetrical and Gynecological Society, and Georgia Association of Family Physicians, strategies can be developed with the provider community that may include tailored messaging to clients. Through WIC and Title V, strong support for breastfeeding promotion also contributes to reducing infant mortality and injury. Developing partnerships with the Georgia Injury Prevention Program, Georgia Safe Infant Sleep Committee, and Georgia Child Death Review will strengthen and guide activity development to address this need.

Related NPMs and SPMs: NPMs 1, 10, 11, 15, 17 and SPMs 2, 7

Relationships between NPMs, SPMs, and Priority Needs: Several state and national performance measures contribute either directly or indirectly to addressing this priority need. SPM 2 is worded in a way that directly addresses this priority need. In response to SPM 2, activities can address such threats to infant health and survival as infant safe sleep, infant falls, and exposure to second hand smoke. SPM 7 and the NPMs listed each contribute indirectly to addressing this priority need. SPM 7 addresses the group at greatest risk for infant death by providing home visits to infants born weighing less than 1,500 grams. By identifying and providing follow-up for children who have failed a genetic screening, NPM 1 helps to ensure these children receive services necessary to prevent possible infant death. Through NPM 10, infant mortality resulting from
motor vehicle crashes can be addressed through greater use of infant safety seats. Breastfeeding through the first six months of life and beyond (NPM 11) is associated with decreased morbidity and increased immunity. Activities focused on reducing cigarette smoking in the third trimester (NPM 15) and throughout the entire pregnancy will help to reduce poor birth outcomes that can contribute to infant death. NPM 17 helps to ensure that high risk deliveries occur in an environment that best supports infants who may have complicating conditions.

Priority Need: Decrease obesity among children and adolescents

Pyramid Levels: Infrastructure building, Population based services, Enabling services

Population Groups: Children, Children with Special Health Care Needs

Capacity Specific to Need: Decreasing obesity among children and adolescents will require significant collaboration. The MCH Program has several opportunities to impact the obesity rate in early childhood through WIC. New legislation requiring all students to receive a fitness assessment has created an opportunity for collaboration between the Division of Public Health, Department of Education, and the Georgia Children's Health Alliance. These partners are working together to ensure that the information collected through the assessment can be used to strengthen existing surveillance and to target and evaluate health promotion interventions.

Related NPMs and SPMs: NPM 14, SPM 1

Relationships between NPMs, SPMs, and Priority Needs: SPM 1 is worded to directly address this priority need. The focus of the state performance measure is to reduce obesity among adolescents. However, interventions will need to be implemented prior to adolescence. The activity plan associated with SPM 1 will need to include activities in early and middle childhood and will need to address physical activity and nutrition. By contributing to reduced rates of obesity in early childhood, NPM 14 also contributes to success in meeting this priority need.

Priority Need: Reduce motor vehicle crash mortality among children ages 15 to 17 years

Pyramid Levels: Infrastructure building, Population based services

Population Groups: Children

Capacity Specific to Need: Capacity to address this need reside in the Division of Emergency Preparedness, Injury Prevention Program. The Injury Prevention Program can identify training and population-based messages to reduce the motor vehicle crash mortality through a variety of interventions.

Related NPMs and SPMs: SPM 4

Relationships between NPMs, SPMs, and Priority Needs: SPM 4 is worded to directly address this priority need.

Priority Need: Reduce repeat adolescent pregnancy Pyramid

Levels: Infrastructure building, Enabling services Population

Groups: Children

Capacity Specific to Need: Capacity exists within the MCH Program to analyze and produce annual reports on the prevalence of repeat adolescent pregnancies. Increased collaboration with delivery hospitals and medical providers could lead to increased referrals for adolescent mothers to family planning services provided through the public health districts or Title X. Protocols can be developed between the WIC and the Family Planning Program to increase referrals and to ensure completion of referrals.

Related NPMs and SPMs: NPM 8

Relationships between NPMs, SPMs, and Priority Needs: This priority need will be addressed as an activity in NPM 8 activity plan.

Priority Need: Increase developmental screening for children in need

Pyramid Levels: Population based services, enabling services, direct health care

Population Groups: Children with special health care needs

Capacity Specific to Need: Through several MCH programs and improved collaboration, there is significant capacity available to address this need. The Part C Early Intervention Program (Babies Can't Wait), Children 1st, and Children's Medical Services all encounter children ages birth to five years of age. Additionally, discussions have occurred to develop plans to include developmental assessments throughout Georgia WIC clinics. Through existing partnerships with medical providers, the MCH Program can work to promote the need for every child in need to have appropriate developmental screening.

Related NPMs and SPMs: SPM 5

Relationships between NPMs, SPMs, and Priority Needs: SPM 5 is worded to directly address this priority need. While the focus of the need is all children, SPM 5 limits the denominator to those children who are encountered through MCH programs.

Priority Need: Improve the maternal and child health surveillance and evaluation infrastructure

Pyramid Levels: Infrastructure building

Population Groups: Women and infants, Children, Children with special health care needs

Capacity Specific to Need: The MCH epidemiology capacity in the MCH Program is increasing. As recommended in Maternal and Child Health Epidemiology in State Health Agencies: Guidelines for Enhanced Functioning, MCH Epidemiology was moved to be administratively located within the MCH Program in April 2010. The administrative change ensures seamless interaction between epidemiology and program staff. The newly created MCH Epidemiology Section includes a section director and nine full-time FTEs. With increased staffing, the MCH Epidemiology Section Director will work with stakeholders to understand their data needs and the existing data gaps.

Related NPMs and SPMs: SPM 3

Relationships between NPMs, SPMs, and Priority Needs: SPM 3 is worded to directly address this priority need.

Priority Need: Improve childhood nutrition

Pyramid Levels: Population based services, Enabling services

Population Groups: Children, Children with Special Health Care Needs

Capacity Specific to Need: Capacity exists to improve nutrition childhood nutrition through the Nutrition Unit in the Nutrition and WIC Section. While the nutrition unit has focused on the WIC population, this focus can be expanded to provide increased population-based messaging. MCH Program staff have contributed to discussion pertaining to farm-to-school initiatives and initial plans have been made to develop an RFP to fund increased nutrition education in schools that also develop school-based gardens. To ensure inclusion for children with special health care needs, Nutrition Unit staff have provided training and nutritionists have been hired to support Georgia's Part C Early Intervention Program -- Babies Can't Wait.

Related NPMs and SPMs: SPM 1

Relationships between NPMs, SPMs, and Priority Needs: While SPM 1 directly addresses obesity, improvements in childhood nutrition will contribute to reductions in obesity. This priority need will be addressed by ensuring that activities to improve childhood nutrition are included in the SPM 1 activity plan.

Priority Need: Increase awareness of the need for preconception health care among women of childbearing age

Pyramid Levels: Population based services, Enabling services, Direct health care

Population Groups: Women and infants

Capacity Specific to Need: There are several opportunities for the dissemination of preconception health messaging through MCH programs. The Family Planning Program in the Women's Health Unit has opportunities to develop standard messages that can be delivered through client contacts. Through improved collaboration with Medicaid and the implementation of Georgia's Women's Health Waiver, there will be opportunities to increase population-based
media messages pertaining to family planning and preconception health. Through coordination with WIC, women who have given birth can receive interconception health messages to increase the likelihood of healthy future pregnancies. The MCH Program will need to work with the Health Promotion and Disease Prevention Program and internal experts in communications to develop strategies to ensure broad dissemination of preconception health messages.

Related NPMs and SPMs: NPMs 15, 18 and SPM 8

Relationships between NPMs, SPMs, and Priority Needs: Several state and national performance measures can contribute to achieving success for this priority need. SPM 8 addresses folic acid consumption prior to conception. NPM 15 addresses cigarette smoking in the third trimester of pregnancy. By incorporating anti-smoking messages among child bearing age, NPM 15 can contribute to improvement in this priority need. NPM 18 addresses early entry into prenatal care. Early entry into prenatal care requires awareness and planning of pregnancy. Improved preconception messages to support NPM 18 will also positively impact this priority need.

Priority Need: Increase the percent of qualified medical providers who accept Medicaid and who serve children with special health care needs

Pyramid Levels: Infrastructure building

Population Groups: Children with special health care needs

Capacity Specific to Need: Current contracts with the Georgia Chapter of the American Academy of Pediatrics and the Georgia Association of Family Physicians provide access to practicing providers. With the assistance of these partners, surveys will be implemented to determine the current attitudes of practicing providers to treating children with special health care needs. MCH Program staff will work to develop recognition programs for providers who have positive attitudes toward treating CSHCN and who ensure family involvement in decision making.
/2014/ The Georgia Department of Public Health holds regular meetings with the Georgia Department of Community Health (Medicaid) to address outstanding issues that present challenges in provider enrollment. Data collection on the specific challenges early intervention providers experience in Medicaid Fee for Service and Medicaid Care Management Organization enrollment are currently being addressed. The early intervention program contract requires all providers to be enrolled in Medicaid Fee for Service. Providers must also be enrolled in at least one of the State's three Medicaid Care Management Organizations. //2014//

Related NPMs and SPMs: SPM 6

Relationships between NPMs, SPMs, and Priority Needs: SPM 6 monitors the percent of pediatricians and family physicians with positive attitudes toward treating CSHCN. Provider willingness to care for CSHCN is central to ensuring adequate supply. Through activity plans associated with SPM 6, it is hypothesized that the percent of providers with positive attitudes can be increased, which may impact the supply of qualified providers serving CSHCN. Activities will equally focusing on the existing provider community and students still matriculating in medical schools throughout Georgia.

/2012/There have been no changes to the state's priority needs. Infant mortality and obesity

prevention have been escalated as each is now a strategic objective for the Department of Public Health.//2012//

/2013/ There have been no changes to the state's priority needs. Infant mortality and obesity prevention continue as strategic objectives for DPH.//2013//
/2014/ There have been no changes to the state's priority needs. Infant mortality and obesity prevention continue as strategic objectives for DPH //2014//
There have been no changes to the state's priority needs.

C. National Performance Measures

Performance Measure 01: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	99.7	99.6	96.4	99
Numerator	327	318	230	268	264
Denominator	327	319	231	278	266
Data Source	Georgia NBS Program	Newborn Screening Program	Newborn Screening Program	Newborn Screening Program	Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

Notes – 2013
Source: Emory Dept of Human Genetics and State Electronic Surveillance System

The numerator was total number of diagnosed cases for infants born in 2013. The date of diagnosis was subtracted by the date of treatment. 10 cases with missing dates of diagnosis were removed from the sample. The numbers of days > 180 were removed from the numerator.

Notes - 2012
2012 provisional data is supplied by Emory University Genetics Follow-up Program, contracted to investigate all positive metabolic newborn screens and provide services to confirmed cases.

Notes - 2010
As per Form 6, the data reported here are lagged by one year. Therefore, the data reported in the 2010 column are data collected in 2009.

a. Last Year's Accomplishments

The Newborn Screening Program applied for and was awarded the CDC Severe Combined Immunodeficiency (SCID) screening cooperative agreement. In December 2012, the Georgia Newborn Screening and Genetics Advisory Committee recommended the addition of SCID to the Georgia NBS Panel. The NBS Program, Children's Medical Services Program and Children's Healthcare of Atlanta Cystic Fibrosis Center partnered to improve follow-up and coordination for infants with CFTR Related Metabolic Syndrome (CRMS).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Making referrals for infants diagnosed with metabolic disease and hemoglobinopathies to appropriate CSHCN programs.			X	
2. Providing funds for special formula through NBS Follow-up.		X		
3. The Georgia Public Health Laboratory and Newborn Screening Program collaborate on policies, procedures and improving the exchange of electronic records.				X
4. Continuing MCH Epidemiology linkage of newborn screening records with electronic birth certificates.				X
5. Providing access to and monitoring hospital performance reports to identify each hospital's unsatisfactory specimens.				X
6. Following up on all abnormal screening test results.			X	
7. Holding regular advisory committee and work group meetings to gain stakeholder insight and advisement.				X
8. Providing NBS education to parents and providers.			X	
9. Providing genetic counseling to parents and legal guardians of newborns who are deemed carriers of a genetic mutation.		X		
10.				

b. Current Activities
Activity 1: Reduce the number of unsatisfactory specimens (unsats) by: identifying hospitals who submit unsats, notifying those submitters of their specimen collection performance and conducting site visits, and offering technical assistance and training to improve specimen collection techniques.

Last year, 31% of all hospitals met the unsatisfactory screening rate goal of less than 1%. There was an overall increase in compliance. Telephone consultations and on-site in-services continue.

Activity 2: Implement a protocol that identifies and tracks newborn screens from unsatisfactory to satisfactory.

The development of a follow-up system for unsatisfactory specimen is currently on hold until the improvements in the database have been completed. The Georgia Public Health Laboratory continues to notify providers when an unsatisfactory specimen has been submitted and the largest birthing hospitals actively request repeats on all unsatisfactory specimens submitted by their facility.

Activity 3: Educate pre- and postnatal families and healthcare professionals about newborn screening and the importance of follow-up of positive results by disseminating information via multiple communication methods including PSAs, the NBS brochure, DPH website, social networking sites, newsletter articles and training/professional development.

Education was provided to primary care providers through the GAAAP, GOGS, and GAFP conferences. Hospital and primary care providers received site visits with training classes.

Activity 4: Improve the electronic database (SendSS) and monitoring capabilities by developing an unsatisfactory specimen tracking module, creating metabolic reports and improving matching algorithms.

SendSS IT staff are receiving and loading Emory follow-up data files daily. SendSS programmers and Emory IT staff are working on dumping historical files into the SendSS database. The NBS kit number has been added to the electronic birth certificate to improve the matching algorithm.

c. Plan for the Coming Year

Activity 1: Implement statewide screening and reporting for severe combined immunodeficiency (SCID), critical congenital heart disease (CCHD) and hearing impairment by incorporating these conditions into the six part newborn screening program and adding them to the Georgia NBS Panel.

Output Measure(s): Additional conditions added to the GA NBS Panel; a reporting system for hospital based screening test; and a system for education, screening, follow-up, diagnosis, treatment and evaluation measures developed and implemented for each new condition.

Monitoring: Regular meetings to revise the rules and regulations; adopted rules and regulations; and meetings to enhance or develop a system for SCID, CCHD and hearing impairment.

Activity 2: Reduce the number of unsatisfactory specimens (unsats) by: identifying hospitals who submit unsats, notifying those submitters of their specimen collection performance and conducting site visits, and offering technical assistance and training to improve specimen collection techniques.

Output Measure(s): Percent of hospitals with unsat rates less than or equal to 1%; percent of unsatisfactory newborn screens; and documentation of site visits, technical assistance and training activities.

Monitoring: Monthly review of site visits, technical assistance, and training activities; percent increase/decrease in unsats; and percent increase/decrease of all hospitals with unsats less than or equal to 1%.

Activity 3: Educate pre- and postnatal families and healthcare professionals about newborn screening and the importance of follow-up of positive results by disseminating information via multiple communication methods including, the NBS brochure, DPH website, social networking sites, newsletter articles and training/professional development.

Output Measure(s): Type and number of materials distributed; number of newsletter articles written; and number of presentations given.

Monitoring: Quarterly review of education activities; bi-monthly monitoring and updates of social networking sites.

Activity 4: Improve the electronic database (SendSS) and monitoring capabilities by creating metabolic reports improving the sickle cell disease patient tracking module, and improving matching algorithms.

Output Measure(s): Percent of newborn screens matched to the birth record; metabolic reports developed; and enhancements in patient tracking module developed.

Monitoring: Notes from bi-weekly IT meeting to review the progress towards the completion of the matching algorithm, enhancements and reports; meeting attendance.

Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	56	55.1	56.2	57.3	69.4
Annual Indicator	67.6	67.6	67.6	67.6	67.6
Numerator	279340	269807	269110	269940	283089
Denominator	413225	399123	398091	399320	418771
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	69.4	69.4	69.4	69.4	

Notes - 2013
Denominator is based on the American Community Survey for years 2007-2012. 2013 was not available. The numerator is based off of the estimated population that was calculated. Query includes by year population under 18 for Georgia.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2011 were projected using data from 2000 to 2010

CSHCN prevalence for 2005/2006 = 13.9%. This estimate was used for calculating the denominator (CSHCN population) for 2007 and 2008.

CSHCN prevalence for 2009/2010 = 16%. This estimate was used for calculating the denominator for the years 2009, 2010, 2011

Wording for outcome 05/06 which was used for the indicator for 2007 and 2008- CSHCN whose families are partners in decision-making at all levels and are satisfied with the services they receive (derived)

Wording for outcome 09/10 which was used for the indicator for 2009, 2010 and 2011 - CSHCN whose families partner in shared decision-making for child's optimal health (Note. This estimate is not comparable to estimates for 2007/2008 which were obtained from the 2005/2006 survey)

The data from the two surveys are not comparable for PM 02

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available.

Numerator and denominator estimates were made. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows. Numerator data were estimated by multiplying the percent by the denominator. The denominator is estimated by multiplying the CSHCN prevalence (13.9%) by the total number of children ages birth to 17 years. The total number of children ages birth to 17 years is from population projections provided by OASIS. Population projections were not available for 2010. The population estimate for 2010 was estimated using a linear projection with data from 2000 through 2009.

Sufficient data are not available to use a projection to forecast the annual performance objective between 2011 through 2015. An anticipated 2% increase will be applied to the annual performance objective in 2010.

a. Last Year's Accomplishments

CMS Coordinators developed a plan of care (POC) for 100% of CYSHCN clients, with families participating in the determination of the priority for their child’s needs. CMS Coordinators review the plan of care with families every 6 months. BCW Coordinators develop an (IFSP) with100% of enrolled families within a 45 day timeframe prior to services being performed. Families help determine the priority for their child’s needs.

Parent to Parent of Georgia (P2PGA) provided online training to 165 families of children with

disabilities or chronic medical conditions. P2PGA also fielded 10,752 family and professional requests for disability specific information and resources from their online database.

The DPH/MCH Parent Consultant developed an online family leadership training module that will be made available on the DPH/MCH/CYSN webpage for families to view.

Families participating in Part C Early Intervention Services/Babies Can't Wait (BCW) reported that early intervention services have helped the family:
A) Know their rights
B) Communicate their children's needs
C) Help their children develop and learn

CMS epidemiologist developed a family satisfaction survey as a result of program improvement efforts, which included parents and grandparents of children receiving CMS services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continuing family participation through development of CMS care coordination plan of care and BCW IFSP development.		X		
2. Conducting CYSHCN family satisfaction surveys statewide as an ongoing part of quality assurance programmatic/ fiscal review.				X
3. Conducting client satisfaction surveys annually in the Genetics and Sickle Cell clinics. Surveys are offered in English and Spanish.				X
4. Continue to involve families in state and local program planning and operations.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Involve families of CSHCN receiving services from CMS in the development of plans of care.

The FY13 unduplicated count of CMS families served was 10,983. Plans of care were reviewed with families every 6 months. The FY13 unduplicated count of families served for BCW was 16,411. BCW collaborated with families to develop individual family service plans IFSP(s).

Activity 2: Plan for the development of an online family leadership training module.

Parent to Parent of Georgia (P2PGA) provided 165 online training opportunities for families of children with disabilities or chronic medical conditions. P2PGA completed a second round of transition to adulthood webinars with youth as presenters or co-presenters alongside professionals. Also, the DPH/MCH Parent Consultant developed an online family leadership training module which was added to the DPH/MCH/CYSN webpage.

Activity 3: Survey CYSN families participating in Part C Early Intervention Services/Babies Can't Wait (BCW), and families receiving genetic services through CMS clinics.

BCW families reported that early intervention services have helped them:
A) Know their rights –
B) Communicate their children's needs –
C) Help their children develop and learn –

Families participating in Genetics and Sickle Cell clinics reported that they either strongly agree or agree to the following:

A) Satisfied with services received at clinic visit
B) Needs were met during clinic visit

These same families reported that they strongly disagreed or disagreed to the following:

C) Satisfied with timeliness of getting an appointment
D) Learned adequate information about their child's condition (most of which were based upon first clinic visit)

Activity 4: Involve families in state and local program planning and operations by including them in activities such as reviewing materials, serving on committees and councils, attending trainings, co-presenting with professionals, providing presentations and trainings to families and professionals, providing support and health information to other families.

Families were chosen to participate as team members in BCW State Interagency Council Subcommittee program planning activities, the Child Health Restructuring Committee, the BCW Taskforce, CMS Program Improvement activities, the Title V Block Grant Review. Also, families and youth were an integral part of the D70 Youth Summit serving as planning committee members, and as panelists, keynote speakers and presenters.

c. Plan for the Coming Year

Activity 1: Involve families of CYSHCN receiving services from CMS and BCW in the development of plans of care (POC) and individual family service plan (IFSP).

Output Measure(s): Number of families with input on plans of care or individual family service plans and BCW IFSP plans.

Monitoring: Quarterly Reports

Activity 2: Increase family knowledge and participation in block grant activities

Output Measure(s): Number of families involved in block grant activities; development of family-friendly materials and resources on block grant process

Monitoring: Informational materials developed; Block grant family participation form

Activity 3: Survey CYSN families for satisfaction in services and support

Output Measure(s): BCW Family Participation Results; Genetics/Sickle Cell Satisfaction Survey Results, CMS Family Satisfaction Survey(s)

Monitoring: Quarterly Reports

Activity 4: Increase opportunities for family participation in DPH/MCH/CYSN activities and trainings

Output Measure(s): Number of participation opportunities provided

Monitoring: Quarterly Reports

Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	51	52	53.1	54.1	53.1
Annual Indicator	67.6	67.6	67.6	67.6	45.7
Numerator	279340	269807	269110	269940	191378
Denominator	413225	399123	398091	399320	418771
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	53.1	53.1	53.1	53.1	

Notes – 2013
Denominator is based on the American Community Survey for years 2007-2012. 2013 was not available. The numerator is based off of the estimated population that was calculated. Query includes by year population under 18 for Georgia.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are

comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2011 were projected using data from 2000 to 2010 prevalence for 2005/2006 = 13.9%. This prevalence was used for calculating the denominator (CSHCN population) for 2007 and 2008. CSHCN prevalence for 2009/2010 = 16%. This prevalence was used for calculating the denominator for the years 2009, 2010, 2011

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

The annual indicator will reflect the data from this survey until a new data source or an updated survey is available.

Numerator and denominator estimates were made. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows. Numerator data were estimated by multiplying the percent by the denominator. The denominator is estimated by multiplying the CSHCN prevalence (13.9%) by the total number of children ages birth to 17 years. The total number of children ages birth to 17 years is from population projections provided by OASIS. Population projections were not available for 2010. The population estimate for 2010 was estimated using a linear projection with data from 2000 through 2009.

Sufficient data are not available to use a projection to forecast the annual performance objective between 2011 through 2015. An anticipated 2% increase will be applied to the annual performance objective in 2010.

a. Last Year's Accomplishments

A medical and dental home training and booklets were developed and presented. Through the new Integrated Community Systems for CSHCN Grant, P2PGA was contracted to extend this training in our health districts. Agencies that attended the training requested a total of 10,471 booklets and brochures to distribute throughout the state to families and professionals. Of that total, 1,650 requests were for a Spanish version of the developmental milestones brochure.

CMS Coordinators and BCW Service Coordinators assess whether or not clients have a primary care provider (PCP) upon enrollment and every 6 months, thereafter. Coordinators make referrals for those clients who do not have a PCP. 76% of CMS clients reported having a PCP.

Meetings with representatives from GA AFP and GA AAP to review contract deliverables and timelines have occurred. Through our Integrated Community Systems for CSHCN contracts with GA AFP and GA AAP, both organizations will require its members to complete an online training on medical home.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Continuing CSHCN participation in the Integrated Community Systems for CSHCN (D70) grant. One component of the grant is the development of a statewide transition plan for youth with special health care needs. This includes partnering with other agencies and community partners to collaborate on transition efforts and increase knowledge of and access to medical home(s).				X
2. Continuing to facilitate CSHCN program enrollees accessing a medical home.		X		
3. Documenting the percentage of CSHCN enrollees who have a documented medical home.		X		
4. Referring CSHCN without a medical home to a primary care provider.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Work with GA-AAP and GA-AFP to increase professional development opportunities to state and district level staff and medical and non-medical providers on the definition and components of a medical home.

Dr. Jeoffrey White, Georgia's first pediatric practice to receive national Medical Home certification, presented on medical home and transition. Dr. White was also recognized as DPH's physician of the year for FY13. GA-AAP created a page on the Chapter's website regarding transition and archived webinars pertaining to transition and medical home. GAFP provided an overview of the Patient Centered Medical Home University to DPH staff. GA-AAP and GA-AFP provided a dedicated "Chapter Champion" to help promote Medical Home and Transition initiatives of the Integrated Community Systems for Georgia's CSHCN.

Georgia has made tremendous progress in increasing the number of certified medical home providers. Within a period of about two years, Georgia saw an increase from approximately 250 certified medical home providers/ practices to over 1,000.

Activity 2: Assess new BCW and CMS clients for a primary care provider and make appropriate referrals for clients without a medical home.

Upon enrollment families in BCW and CMS were assessed to whether or not they had a medical home. 95% of CMS families reported having a primary care provider. Upon enrollment BCW Coordinators assessed families for access to a medical home. Referrals to a primary care provider were made as needed.

We made great strides through our Integrated Community Systems for CSHCN Grant (D70) to increase knowledge and awareness of the medical home concept. We targeted families, providers and community partners. Through a contract with P2PGA, medical and dental home curricula were developed based upon booklets created through our previous Early Childhood and Comprehensive Systems (ECCS) Grant. Curricula presentations were then recorded in English and Spanish by DPH. The presentations will be made available online to families, professionals and district staff. Also, districts that serve clients at clinics will have access to CDs to play for families while they wait for clinic services.

Activity 3: Partner with Parent to Parent of Georgia to provide a training curriculum, materials and outreach activities on Medical and Dental Home.

Contracted with Parent to Parent of Georgia to develop a medical and dental home curriculum using the brochures developed by the ECCS grant. DPH then hosted P2PGA parents to create presentations using the curriculum to distribute as CDs to districts hosting clinics, and to add to the DPH internal and external website for viewing by state and district staff as well as families and professionals. An additional 200 Medical home fact sheets were distributed statewide to families and professionals. P2PGA added certified Medical Home providers to their database for access by families and professionals.

c. Plan for the Coming Year

Activity 1: Work with GA-AAP and GA-AFP to increase professional development opportunities to state and district level staff and medical and non-medical providers on the definition and components of a medical home.

Output Measure(s): Number of trainings; staff trained; positive change in baseline knowledge, and number of brochures distributed

Monitoring: AAP &AFP Quarterly Reports

Activity 2: Assess new BCW and CMS clients for a primary care provider and make appropriate referrals for clients without a medical home.

Output Measure(s): Number of clients who have been assessed for a primary care provider; number of referrals provided to clients who did not have a primary care provider

Monitoring: Quarterly Reports

Activity 3: Partner with Parent to Parent of Georgia to provide a training curriculum, materials and outreach activities on Medical and Dental Home.

Output Measure(s):Number of trainings; number of participants trained; number of medical and dental home brochures and fact sheets distributed

Monitoring: Quarterly program reports from Parent to Parent of Georgia

Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	62	62.4	63.7	63.7	63.7
Annual Indicator	62.2	62.2	62.2	62.2	62.2
Numerator	257026	248255	248160	248377	260476
Denominator	413225	399123	398091	399320	418771
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	63.7	63.7	63.7	63.7	

Notes – 2013
Denominator is based on the American Community Survey for years 2007-2012. 2013 was not available. The numerator is based off of the estimated population that was calculated. Query includes by year population under 18 for Georgia.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2011 was projected using data from 2000 to 2010 CSHCN prevalence for 2005/2006 = 13.9%. This prevalence was used for calculating the denominator (CSHCN population) for 2007 and 2008. CSHCN prevalence for 2009/2010 = 16%. This prevalence was used for calculating the denominator for the years 2009, 2010, and 2011

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

The annual indicator will reflect the data from this survey until a new data source or an updated survey is available.

Numerator and denominator estimates were made. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows. Numerator data were estimated by multiplying the percent by the denominator. The denominator is estimated by multiplying the CSHCN prevalence (13.9%) by the total number of children ages birth to 17 years. The total number of children ages birth to 17

years is from population projections provided by OASIS. Population projections were not available for 2010. The population estimate for 2010 was estimated using a linear projection with data from 2000 through 2009.

Sufficient data are not available to use a projection to forecast the annual performance objective between 2011 through 2015. An anticipated 2% increase will be applied to the annual performance objective in 2010.

a. Last Year's Accomplishments

CMS Coordinators and BCW Service Coordinators assessed 100% of clients for insurance coverage upon enrollment and every six months thereafter. In fourth quarter 2013, 87% of CMS clients were covered by insurance or another health care payment source; 13% were uninsured with CMS as the only payor source. CMS is the payor of last resort.

CMS Coordinators and BCW Service Coordinators refer clients identified as uninsured to Georgia's Department of Family and Children Services to apply for Medicaid, PeachCare for Kids (SCHIP) and other social services resources.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitoring payment sources for services (i.e., types of insurance or payment source) and referring families to potential resources.				X
2. Developing a plan to identify the diverse needs of families not covered by insurance.				X
3. Continuing to work with Medicaid and PeachCare for Kids (State Child Health Insurance Program) to link all eligible children.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Assess insurance status and coverage of new clients in CMS and BCW

CMS clients: 72% Medicaid, 5% PeachCare for Kids (SCHIP), 9% Private, 1% Tricare, 13% CMS only.

Activity 2: Assist CMS and BCW clients to apply for Medicaid and other insurance or health care financing benefits

72% of CMS clients are covered by Medicaid; 5% PeachCare for Kids (SCHIP); 32% of CMS clients receive SSI.

Activity 3: Work in partnership with GA State Medicaid agency and managed care organizations to increase adequacy of coverage for CSHCN

The CMS and BCW Program Managers were invited to participate on the Medicaid Georgia Families 360 Taskforce to migrate children receiving foster care and/or adoptive assistance to Care Managed Organizations (CMOs). As a result of their participation, children and youth with special needs within

this population were allowed to be exempted from coverage through the CMO. It was determined that CYSHCN with more intensive medical needs would receive a higher level of care coordination through fee-for-service Medicaid and Children Medical Services (CMS). Also, BCW providers were added as CMO network providers, thereby reducing delays in services for children receiving early intervention services. Lastly, the Care Management Organization provided training to state and district office staff, as well as, providers.

c. Plan for the Coming Year

Activity 1: Assess insurance status and coverage of new clients in CMS and BCW.

Output Measure(s): Annual report of insurance coverage in CMS and BCW; percent of new clients assessed; percent with insurance coverage by type of coverage.

Monitoring: CMS Quarterly Reports/BCW Data Report (Medicaid / CMOs/Private Insurance
Activity 2: Assist CMS and BCW clients to apply for Medicaid and other insurance benefits.

Output Measure(s): Number of family referrals to Medicaid, insurance and other health care financing options

Monitoring: Quarterly reports

Activity 3: Work in partnership with GA State Medicaid agency and managed care organizations to increase adequacy of coverage for CSHCN

Output Measure(s): Number of partnership activities completed

Monitoring: Create new and engage in existing Medicaid partnership activities

Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	92	92.8	94.7	96.6	98.5
Annual Indicator	62.2	62.2	62.2	62.2	69.5
Numerator	257026	248255	248160	248377	291046
Denominator	413225	399123	398091	399320	418771
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	

Notes – 2013

Denominator is based on the American Community Survey for years 2007-2012. 2013 was not available. The numerator is based off of the estimated population that was calculated. Query includes by year population under 18 for Georgia.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2011 were projected using data from 2000 to 2010 CSHCN prevalence for 2005/2006 = 13.9%. This prevalence was used for calculating the denominator (CSHCN population) for 2007 and 2008. CSHCN prevalence for 2009/2010 = 16%. This prevalence was used for calculating the denominator for the years 2009, 2010, 2011
The data from the two surveys are not comparable for PM 05

Notes – 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

The annual indicator will reflect the data from this survey until a new data source or an updated survey is available.

Numerator and denominator estimates were made. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows. Numerator data were estimated by multiplying the percent by the denominator. The denominator is estimated by multiplying the CSHCN prevalence (13.9%) by the total number of children ages birth to 17 years. The total number of children ages birth to 17 years is from population projections provided by OASIS. Population projections were not available for 2010. The population estimate for 2010 was estimated using a linear projection with data from 2000 through 2009.

Sufficient data are not available to use a projection to forecast the annual performance objective between 2011 through 2015. An anticipated 2% increase will be applied to the annual performance

objective in 2010.

a. Last Year's Accomplishments

CMS served 8806 clients in the first quarter and 8846 clients in the second. CMS Coordinators made a total of 675 referrals to community resources. BCW and CMS families have access to online and one-to-one support to help find resources for families of CYSHCN. The CMS program conducts clinics in 9 of 18 health districts. Clinics located in rural areas of the state provide access to communities with limited specialty services. DPH has initiated the use of telemedicine to supplement face-to-face clinics where appropriate. DPH began distributing 13 telemedicine carts to health districts around the state to expand the network of clinical services offered. DPH has also implemented a telehealth network for public health education in all counties.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Gathering data from other states and MCHB sponsored contracts that have completed previous work in this area.				X
2. Conducting ongoing CMS family satisfaction surveys and data collection as part of CMS quality improvement process.				X
3. Promoting the use of Federally Qualified Health Centers to clients with Sickle Cell Disease (through Sickle Cell Foundation of Georgia).		X		
4. Providing funds to the public health districts to assist patients with the cost of genetic testing.	X			
5. Offering Transcranial Doppler (TCD) ultra-sonograms to pediatric Sickle Cell patients ages 2 to 16 years in 10 pediatric Sickle Cell outreach clinics.	X			
6. Holding telemedicine clinics in Waycross and Valdosta to enable families to see medical specialists at Georgia Health Sciences University in Augusta, Georgia and Shands Hospital in Jacksonville, Florida.	X			
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Assist families served in CMS with accessing available community resources (CMS/BCW/C1st)

At risk children, age birth to five, are referred to community resources through our Children's 1st (C1st - point of entry) program. C1st served 13,376 families, BCW served 16,411 families and CMS served 10,983 families during FY13. BCW and CMS families are regularly referred to community resources. Parent to Parent of Georgia serves as our BCW Central Directory for CSHCN ages birth to three, and they also provide information and referral services to Title V families for CSHCN ages birth to twenty-one. Through our D70 Integrated Community Services for CSHCN, P2P received 1,688 online page view requests for transition-related information. The highest number of requests was for: general information on transition (516), transition planning (286), and independent living skills (199). P2P received 5,739 page view requests for health-related information. The highest number of requests was for: Katie Beckett/Deeming Waiver (1,583), general Medicaid information (1,043), general healthcare information (674), Medicaid residency & citizenship (377), and financial assistance for health (243). Medical home received 151 page view requests. (Data reported over three quarters)

Activity 2: Conduct specialty clinics for CYSHCN in areas with limited specialty providers/services (CMS/BCW/C1st)

The CMS program conducted clinics in 9 of 18 health districts. Clinics located in rural areas of the state provided access to communities with limited specialty services.

Activity 3: Expand telemedicine services in targeted health districts based on data and need (CMS).

We've provided training on telemedicine to all district coordinators and have suggested those with clinics continue researching the feasibility of using telemedicine for their clinics with TA and support provided by the state office.

Georgia Regents University (GRU) sickle cell disease physicians have completed an equipment demonstration, an online telemedicine certification training, and are currently pursuing their credentials. They are also finalizing billing and reimbursement processes as well.

Activity 4: Connect families to existing, or create new support groups or disability community activities for CYSHCN within their districts.

Through a contract with P2P, local family leaders will be trained to start new support groups or connect with existing organized groups to share information and supports for CSHCN (6 per year)

c. Plan for the Coming Year

Activity 1: Assist families served in CMS with accessing available community resources (CMS/C1st)

Output Measure(s): Number of referrals made to community resources).

Monitoring: Quarterly reports.

Activity 2: Conduct specialty clinics for CYSHCN in areas with limited specialty providers/services (C1st/CMS).

Output Measure(s): number of clinics conducted.

Monitoring: Quarterly reports.

Activity 3: Expand telemedicine services in targeted health districts based on data and need (CMS).

Output Measure(s): Number of new telemedicine sites; number of specialties represented; number of clients served at telemedicine sites.

Monitoring: Quarterly reports.

Activity 4: Connect families to existing, or create new support groups or disability community activities for CYSHCN within
their districts

Output Measure(s): Number of CMS families connected to support groups or disability community activities

Monitoring: Quarterly reports.

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	38	37.7	38.5	39.3	37.7
Annual Indicator	33.9	33.9	33.9	33.9	33.9
Numerator	140083	135303	134953	135369	141963
Denominator	413225	399123	398091	399320	418771
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	37.7	37.7	37.7	37.7	

Notes – 2013
Denominator is based on the American Community Survey for years 2007-2012. 2013 was not available. The numerator is based off of the estimated population that was calculated. Query includes by year population under 18 for Georgia.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline

data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2011 were projected using data from 2000 to 2010 CSHCN prevalence for 2005/2006 = 13.9%. This prevalence was used for calculating the denominator (CSHCN population) for 2007 and 2008. CSHCN prevalence for 2009/2010 = 16%. This prevalence was used for calculating the denominator for the years 2009, 2010, 2011

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

The annual indicator will reflect the data from this survey until a new data source or an updated survey is available.

Numerator and denominator estimates were made. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows. Numerator data were estimated by multiplying the percent by the denominator. The denominator is estimated by multiplying the CSHCN prevalence (13.9%) by the total number of children ages birth to 17 years. The total number of children ages birth to 17 years is from population projections provided by OASIS. Population projections were not available for 2010. The population estimate for 2010 was estimated using a linear projection with data from 2000 through 2009.

Sufficient data are not available to use a projection to forecast the annual performance objective between 2011 through 2015. An anticipated 2% increase will be applied to the annual performance objective in 2010.

a. Last Year's Accomplishments

CMS Coordinators are required to develop a transition plan with the client and their family beginning no later than age 16 and review the plan every six months thereafter. Parent to Parent of Georgia was contracted to conduct four focus groups to gather input to update the CMS Transition Manual. Through the D70 State Integrating Systems of Services for CYSHCN Grant, statewide stakeholder meetings were scheduled to develop a statewide plan for Transition to Adulthood to improve transition in six core areas: Education, Health, Employment, Legal Issues, Independent and Community Living, and Recreation and Leisure.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to provide literature and updates on transition services to district coordinators.		X		
2. Continuing to update the CMS transition manual and materials for district coordinators to use with clients and families.				X
3. Collecting data on percent of clients and families with a transitional plan of care.				X

4. Developing webinar series to train families, professionals, and district coordinators on transition of youth with special health care needs to all aspects of adulthood.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Develop transition plans for CMS clients ages 16 to 21 years.

94% of CMS clients aged 16-21 had active transition plans.

Activity 2: Partner with Parent to Parent of Georgia (GA's Family to Family Health Information Center) to revise the CMS Transition Manual

Parent to Parent conducted 4 statewide focus groups, one of which was held in Spanish, and one which was held with youth only. CMS coordinators will have an opportunity to provide their input; then, families will have an opportunity to view the proposed updates prior to the finalization of the updates. Afterwards, CMS districts and families will be trained on the changes.

Activity 3: Partner with GA-AFP, GA-AAP to provide information and training opportunities to physicians to increase their understanding of transition planning.

Dr. David Levine was identified as the GA-AAP Chapter Champion for transition services to assist in facilitating and promoting the Integrated Community Systems for CYSHCN to society membership. Two physician trainings completed at the Pediatric by the Sea conference. Dr. Peter Lane presented on "Sickle Cell Disease in Georgia – from Newborn Screening to Transition." Dr. Jeoffrey White presented on medical home and transition. GA-AAP created a page on the Chapter's website regarding transition and archived webinars pertaining to transition and medical home. DPH in collaboration with GA-AAP and GAFP is developing a "Physicians Guide to Transitioning Youth from Pediatric Primary Care to Adult Primary Care" to assist practitioners in implementing the six core elements of health care transition.
GA-AFP made available free CME program on the chapter's website "Promotion of Transition Care of the Sickle Cell Patient – New Insights to Management" presentation by Dr. James Eckman. GA-AFP published an article in the national Chapter's Practical Playbook titled "Georgia Provides Transition Care Plan for Children with Special Health Care Needs."

Activity 4: Connect families to transition resources to promote transition to adulthood.

GA DPH/MCH/CYSN developed a webpage to host D70 transition and medical home materials and resources for families and professionals. Parent to Parent of Georgia enhanced their website, database, virtual library, and "Roadmap to Services" (pictorial map) with transition related materials. DPH contracted with Parent to Parent to develop and conduct peer leadership and transition to adulthood trainings for youth peer mentors, and to train transition-aged youth to serve as peer mentors for others dealing with transition to adulthood issues such as accessing insurance, being successful in college, etc. This is similar to their Parent to Parent Support Model. Lastly, Parent to Parent developed separate e-communities to connect youth, families and professionals using social media tools and resources. To date the youth community has approximately 75 members and the parent/family community has approximately 150 members.

DPH contracted with Children's Healthcare of Atlanta (CHOA) to enhance and replicate their Sickle Cell Transition to Adult Healthcare Mentorship Program. CHOA volunteered to work with DPH to conduct continuous improvement activities using the PDSA (Plan, Study, Do,

Act) Tool for their mentorship program.

Activity 5: Partner with community partners to host a Youth Transition Summit

Through the D70 Grant, MCH partnered with Georgia State University's Center for Leadership in Disability (GA Lend Program) to host a statewide youth transition summit. Presentations covered the six key areas of transition: Education, Health, Independent and Community Living, Recreation and Leisure, Legal Issues, and Employment. Youth participated as presenters and panelists. There was also a separate track for parents. Statewide Partners for the event included: GA Department of Public Health, GA State University-Center for Leadership in Disability, University of GA-Fanning Institute, GA Council on Developmental Disabilities, disABILITY LINK (Self-Advocates), Special Olympics Georgia, Disability Resource Center, All About Developmental Disabilities, Kennesaw State University, Georgia Vocational Rehabilitation Agency and Parent to Parent of GA. One of Georgia's State Senators was in attendance to support his youth with special needs. Over 100 youth, family members and professionals attended the summit. Organizers would like to replicate the event in Middle and South Georgia.

c. Plan for the Coming Year

Activity 1: Develop transition plans for CMS clients ages 16 to 21 years.

Output Measure(s): Percentage of CMS clients who have a documented transition plan.

Monitoring: Quarterly reports from CMS staff.

Activity 2: Partner with Parent to Parent to revise the CMS Transition Manual.

Output Measure(s): Updated manual; number of focus groups conducted

Monitoring: Parent to Parent monthly programmatic report, statewide training plan.

Activity3: Partner with GA-AAP and GA-AFP to provide information and training opportunities to physicians to increase their understanding of transition planning.

Output Measures: # of trainings conducted; # of factsheets or informational documents distributed

Monitoring: Monthly program reports.

Activity 4: Connect families to transition resources to promote transition to adulthood

Output Measure(s): Number of transition information materials developed and referrals made

Monitoring: Develop informational materials for and referrals made to connect families to transition resources, including P2P e-community resources

Activity 5: Partner with community partners to host a Youth Transition Summit

Output Measure(s): Youth Transition Summit Planned and Completed

Monitoring: Youth Transition Summit contract executed

Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	77	75.1	76.6	79.7
Annual Indicator	69.3	73.9	83.9	77.9	79.3
Numerator	138467	145466	164312	150748	162793
Denominator	199808	196842	195843	193515	205304
Data Source	NIS	NIS	NIS	NIS	NIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	81.3	81.7	81.7	81.9	

Notes-2013
Numerator data were calculated using the annual indicators and the denominator.
Annual indicators were updated based on the annual indicators retrieved from http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/data/tables-2012.html on May 15, 2014. Series 4:3:1:3:3:1 for Georgia. This file can be downloaded from the top of the website in the second box labeled "Coverage with Individual Vaccines and Vaccination Series by State (includes birth dose of HepB and 2+doses Hep A)" (download name: tab03_antigen_state) We have chosen to use this series even though it includes Varicella in order to maintain consistency across years and calculate trends.
Denominator data for 2007-2012 were updated based on reviewing OASIS figures.
Linear projections were used to derive population estimates and the annual indicator for 2013. The numerator for 2013 was derived by multiplying the annual indicator with the denominator.

Notes - 2012
Data retrieved from http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2011.htm on May 28th, 2013. 2011 data were updated with final numbers based on NIS. Linear projections were used to derive population estimates and the annual indicator for 2012.

Notes - 2011
2009 - tables retrieved from http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2009.htm on May 18th, 2012.
2010 - tables retrieved from http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2010.htm on May 18th, 2012.
The 2007 estimate was updated to 79.6 using the table: http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2007.htm retrieved on May 18th, 2012.

2011 indicator estimate is based on a linear projection of data for 2007 - 2010.

The denominator was derived from population estimates provided by OASIS. Linear projections for the population estimates were made for 2011.

The number of 19-35 months old is estimated by taking the number of children age 1 year,

dividing by 12 and multiplying by 5 plus all children age 2 years.

2007 and 2008 data have recalculated as follows:

2007: numerator 165,284; denominator 207,643; and annual indicator 79.6

2008: numerator 149,988; denominator 208,606; and annual indicator 71.9

Notes - 2010
Data reflect the 4:3:1:3:3:1 immunization series. Data retrieved from http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2009.htm on July 2, 2011. Numerator and denominator are estimates based on the percentage reported by the National Immunization Survey. Data are unavailable for 2010. The 2010 estimate is developed using a linear projection with data from 2000 through 2009. The number of children 19 to 35 months is estimated by taking the number of children age 1 year dividing by 12 and multiplying by 5 plus all children age 2 years. Population estimates are provided by the Georgia Online Analytical Statistical Information System.

This indicator is trending in an undesired direction. Annual performance objective is based on a 2% annual increase from the 2010 estimated point estimate.

a. Last Year's Accomplishments

GDPH sent out a press release during National Infant Immunization (April 20-27, 2013) promoting the importance of childhood immunization.

GA childcare facilities are assessed annually by local public health staff to ensure that facilities are in compliance with GA laws pertaining to immunization of children attending daycare.

Sept 2013- Statewide Immunization Conference had over 300 attendees. Topics included CDC's childhood immunization schedule and Dr. Paul Offit spoke on how to communicate with parents who are hesitant to have their children vaccinated.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Utilize WIC enrollment information sent monthly by WIC to assess immunization status by WIC enrollment.			X	
2. Improve compliance with recommended hepatitis b birth dose administration to decrease incidence of hepatitis b infection.			X	
3. Use the best available data to identify coverage disparities among children and promote vaccination through key partnerships.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Utilize WIC enrollment information sent monthly by WIC to assess immunization status by WIC enrollment.

Due to staff turnover and vacant positions immunization status of WIC clients has not been assessed.

Activity 2: Improve compliance with recommended hepatitis b birth dose administration to decrease incidence of hepatitis b infection.

The PHBPP mailed printed copies of the Immunization Action Coalition's e-book, Hepatitis B: What Hospitals Need to Do to Protect Newborns, to all Georgia birthing facilities. The mailing also included lab interpretation guides, triage flow charts and other educational tools.

An article regarding the importance of the hepatitis B birth dose, Hepatitis B Birth Dose Saves Lives, was published in the GA AAP's Winter 2014 newsletter, The Georgia Pediatrician.

Activity 3: Use the best available data to identify coverage disparities among children and promote vaccination through key partnerships.

The Immunization program through collaboration with the GA Chapter of AAP promotes Healthcare Provider Immunization education (www.gaepic.org/Immunization.html).

The AAP Immunization Coordinator attends quarterly PH Immunization Coordinators meeting.

c. Plan for the Coming Year

Activity 1: Promotion of childhood immunization through stakeholders and key partnerships.

Output Measure(s): Number of presentations, seminars, and in-service trainings on immunization related topics for public and private health care professionals.

Monitoring: Education reports submitted by Immunization Program Consultants & District Immunization Coordinators.

Activity 2: Identify and track infants exposed to HBV at birth to ensure completion of the HepB vaccine series and post-vaccination serologic testing

Output Measure(s): Number of HBV-exposed infants enrolled in the PHBPP

Monitoring: SendSS quarterly reports

Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	27	26.3	25.4	24.7	20.4
Annual Indicator	23.7	21.0	18.9	20.6	
Numerator	4816	4297	3814	4356	
Denominator	203359	204871	202149	211241	
Data Source	Vital Records	Vital Records	Vital Records	OASIS (birth data, pop/census data)	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	20	19.6	19.2	18.8	

Notes - 2012
Data Source: OASIS (birth data, population/census data)
Numerator: number of births to residents aged 15-17 years old
Denominator: number of resident females aged 15-17 years old
Notes-Birth record and population data are unavailable for 2011. The provisional estimates are developed using a linear projection with data from 2000 through 2010.

Notes – 2011

Birth record and population data are unavailable for 2011. The provisional estimates have been developed using a linear projection with data from 2000 to 2010.

2007 and 2008 data have been recalculated as follows:

2008: numberator 5,493; denominator 198,403; and annual indicator 27.7.

2007: numerator 5,785; denominator 193,272; and annual indicator 29.4.

Notes - 2010
Birth record data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear projection with data from 2000 through 2008. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 and 2010 are estimated using a linear projection with data from 2000 through 2008.

Annual performance objective estimates are developed by applying the average annual percent change (-3.0%) between 2000 through 20010 to the 2010 point estimate.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continuing training, technical assistance (TA) and monitoring of contract and Grant-in-Aid (GIA), both of which include deliverables that address community and parent education/collaboration, outreach, and youth development activities for adolescents				X
2. Collaborating with the Department of Community Health (DCH) to provide linkage with Medicaid and PeachCare for Kids for case management and receipt of medical services.				X

3. Collaborating with the Department of Juvenile Justice to provide services to youth. Collaborating with DCH to provide linkage with Medicaid and PeachCare for Kids for case management and receipt of medical services upon release.				X
4. Operating family planning clinics for adolescents in health	X			
departments and non-traditional sites (e.g., night clinic, vans, jails, DFCS offices).				
5. Funding Southside Medical Hospital Project, working with adolescent males to encourage them to get involved in health care.		X		
6. Providing abstinence and adolescent pregnancy information and contraceptive services in teen centers.			X	
7. Participating in the development of Regional Comprehensive youth Development Systems throughout Georgia.				X
8.				
9.				
10.				

b. Current Activities

Activity 1:

c. Plan for the Coming Year

Activity 1:

Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	24	39.8	37.6	37.8	37.4
Annual Indicator	39.0	37.4	37.4	37.4	37.4
Numerator	51681	48574	48113	48341	49036
Denominator	132515	129876	128645	129253	131113
Data Source	Basic Screening Survey	Basic Screening Survey	Basic Screening Survey	Basic Screening Survey	Basic Screening Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	37.4	37.4	38.3	38.3	

Notes – 2013
All denominator data are Fall enrollments (October enrollments) for K-12 Public Schools obtained from http://app.doe.k12.ga.us/ows-bin/owa/fte_pack_enrollgrade.entry_form. Denominators and numerators from 2011 and 2012 were updated. The percent of third grade children who have received a protective sealant on at least one permanent molar tooth is determined from the Basic Screening Survey. The Basic Screening Survey is a sample survey that includes an oral examination performed by a trained professional. The most recent Basic Screening Survey is for the 2010/2011 school year. The same indicator was used in the years thereafter.

Notes - 2012
The denominator for 2012 was estimated by linear projection using Fall enrollments for K-12 Public Schools from 2000 to 2010 -obtained from http://gaosa.org/report.aspx (Enrollment by demographics tab), and estimate of 2011 enrollements. Denominators for previous years were updated so that all denominators reflect Fall enrollments for 3rd graders for the respective years.

Notes - 2011
Data Collected in Year: 2011. Children 0 to 17.
Data were updated for 2006, 2007, 2008, 2009, and 2010. New link for the Current Population Survey tables is: http://www.census.gov/cps/data/cpstablecreator.html

Denominator estimates were obtained from OASIS for the 0 to 17 year old population. We could not tell the source of the denominator for the previous years so we used OASIS and updated the denominators for 2006 to 2010. Population estimates for 2011 are not available and so were estimated by linear projection using values for 2000 to 2010. Data have been recalculated for 2007 and 2008 as follows:
2007: numberator 311,656; denominator 2,513,356; and annual indicator 12.4

2008: numerator 286,619; denominator 2,536,452; and annual indicator 11.3

Notes - 2010
The percent of third grade children who have received a protective sealant on at least one permanent molar tooth is determined from the Basic Screening Survey. The Basic Screening Survey is a sample survey that includes an oral examination performed by a trained professional. The most recent Basic Screening Survey is for the 2010/2011 school year.

Denominator data from K-12 Public Schools Annual Report Card (http://reportcard2010.gaosa.org/). Denominator data are from the Fall enrollment. Data are not available for 2010, so a linear projection was estimated using data from 2003 through 2009.

Given the decline from the previous Basic Screening Survey, an annual increase of 0.5% will be projected for the Annual Indicator through 2015.

a. Last Year's Accomplishments

The Oral Health Program was one of 17 states awarded the CDC Oral Health Prevention grant, in September of 2013. This funding will assist the program with infrastructure and resources for the school-based/linked sealant program and community water fluoridation. In addition, Oral Health America and the Renaissance Foundation assisted the program with resources for the school-based/linked sealant program through mini-grants. During one sealant/educational event, in one day, dental hygiene students and faculty, district public health staff, a school nurse, and state oral health staff educated 600 children in three rural inner city elementary schools with some children getting sealants. The Renaissance Foundation supplied book bags, toothbrushes, brushing timers,

floss, stickers and other incentives for the children. The oral health program has built strong partnerships in the state; these partnerships assist the program in reaching more children in rural and low income communities with oral health literacy programs and school based/linked sealant programs.

The OHU Epidemiologist and staff presented a poster presentation on ER non-traumatic oral health visits for children in Georgia at the National Oral Health Conference, April 2013. The Oral Health Director, Carol Smith presented round table discussions at the Special Care Dentistry Meeting and National Oral Health Conference (NOHC). In addition, the staff presented a poster presentation at the NOHC.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continuing to visit schools to conduct screenings on children, place sealants when needed and provide prevention services, including education and fluoride treatments.			X	
2. Sharing best practices through quarterly Oral Health Coordinators' meetings with dental public health providers throughout the state.				X
3. Continuing to provide ongoing consultative support and technical assistance (TA) to the districts, including monitoring and evaluation.				X
4. Continuing to provide TA and monitoring to school-based sealant programs (offered in schools with high student participation in the free and reduced school lunch program).				X
5. Continuing to train school and public health nurses on oral disease prevention methods such as sealants and fluoride varnish. Providing oral screenings and emergency dental care.				X
6. Through the Oral Health Coalition, assessing strategies to improve oral health and develop and implement an oral health plan for Georgia.				X
7. Providing training to the medical and dental professional communities on infant oral health and application of fluoride varnish.				X
8.				
9.				

b. Current Activities

Activity 1: Increase the capacity to provide dental sealants through school-based programs.

In FY 2013, the oral health school based prevention program placed 7,149 dental sealants on 2105 children. Working with a CDC Economist and data from the CDC SEALS database the relationship of caries/ untreated caries for children screened during the random selection process (Third Grade Survey) and the targeted population our school programs serve was evaluated; the results demonstrate the target population our program focuses on is a good representation for high risk factors for oral disease. In addition, later in 2014, information will be available evaluating the cost of public health's preventive services/cost of averted caries or cost of restorations prevented. This information will be important in supporting the economic value of our State's public health program's oral health preventive services.

Activity 2: Increase oral health surveillance capacity: PRAMS, BRFSS, YRBS, utilize data from Head Start Oral Health Survey

A Head Start Oral Health BSS is scheduled for fall of 2014. An Advisory Committee of Head Start staff, the Georgia Dental Association, the Oral Health Epidemiologist and Oral Health staff assisted in planning the survey. The Association of Dental and Territorial Dental Directors Epidemiologist also helped the Advisory Committee in planning the survey. Survey questions have been added to the screening forms and Early Head Start will be screened allowing the state to better identify the timing of early caries development for this population.

Activity 3: Promote increased capacity to provide oral health services in Georgia through partnership with the Oral Health Coalition.

Training materials for school nurses on dental preventive measures were developed and trainings continue for school nurses on screening for oral diseases, referring and educating children on good oral health and home care. Two oral health, tobacco prevention/oral health systemic connection presentations for middle and high schools were developed for school nurses and public health dental hygienists use for educating students in schools. These presentations will be vetted through the chronic disease programs to ensure messaging is consistent with their programs.

The Oral Health Program (OHP) staff continues to expand on reaching external and internal partners by presenting at state meetings: Women, Infants and Children (WIC), Perinatal, Family Planning, Head Start Annual Session, the Oral Health Coalition, Regional Oral Health Coalitions, and Aging Communities, working with these partners for improving the oral health of their clients.

Activity 4: Provide education and training for dental and non-dental health care providers on initiation of infant oral health screening and fluoride varnish application by age one year.

Implementation of fluoride varnish application during routine well baby and toddler visits has been slow although training of medical providers was offered. Georgia Chapter of the Academy of Pediatrics on tracking how many practices have implemented this preventive treatment for high-risk kids. The OHU will continue to request data from the Academy as they survey their members.

Activity 5: Maintain Community Water Fluoridation program

Georgia serves over 96% of the population on community water fluoridation. The Fluoridation Specialist educates water plant operators on the value of water fluoridation supporting their work in ensuring the fluoridation levels are at optimal levels and they understand the value of fluoridation. The continued partnership of the DPH OHU staff with Georgia Rural Water Association, water plant operators, and the Fluoridation Advisory Committee ensures the continued quality of fluoridated water in Georgia. Due to the partnerships and continued education of water plant operators the CDC Quality Awards for water plants for excellent monitoring and reporting of fluoridation has increased every year for five years.

c. Plan for the Coming Year

Activity 1: Increase the capacity to provide dental sealants through school-based programs.

Output Measure(s): Number of sealant events occurring in school-based or community settings per year.

Monitoring: Quarterly review of data collected in the oral health database and CDC sealant-tracking system (SEALS).

Activity 2: Increase oral health surveillance capacity: PRAMS, BRFSS, YRBS, utilize data from

Head Start Oral Health Survey

Output Measure(s): Number of questions asked about oral health on PRAMS; number of questions asked about oral health on YRBS; number of questions asked about oral health on BRFSS; data from 3rd Grade Oral Health and Nutrition/Obesity Survey and Head Start Oral Health Surveys conducted annually; full data review every 2-3 years to determine gaps in oral health services.

Monitoring: Quarterly review of surveillance instruments and survey progress.

Activity 3: Promote increased capacity to provide oral health services in Georgia through partnership with the Oral Health Coalition.

Output Measure(s): Number of publication materials developed for Oral Health Coalition (OHC) website; use of social media to increase public awareness of oral health activities; number of volunteer dentists and hygienists maintained through the OHC; number of presentations given to Public Health and community dental providers; # of people trained.

Monitoring: Quarterly monitoring reports.

Activity 4: Provide education and training for dental and non-dental health care providers on initiation of infant oral health screening and fluoride varnish application by age one year.

Output Measure(s): WIC-Oral Health pilot programs implemented in select county public health departments to provide oral health education and fluoride varnish to pregnant and new mothers, and fluoride varnish to their infant children; number of presentations to dental and non-dental providers on infant oral health care; number of dental and non-dental providers trained.

Monitoring: Yearly review of PH data to determine number of children and prenatal patients receiving at least one dental prevention service; development and implementation of training plans for non-dental providers and quarterly updates.

Activity 5: Maintain Community Water Fluoridation program.

Output Measure(s): Number of water plant operators trained; number of CDC quality awards for fluoridation.

Monitoring: Quarterly monitoring reports.

Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.5	3.2	3	2.9	2.8
Annual Indicator	2.9	4.0	2.9	3.0	2.7
Numerator	59	82	61	62	58
Denominator	2064991	2074416	2076584	2078585	2151774

Data Source	Vital Records	Vital Records	Vital Records	OASIS (death data, pop/census data	OASIS (death data, pop/census data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	2.7	2.7	2.5	2.5	

Notes - 2013

Death record data are unavailable for 2012 and 2013, and population data are unavailable for 2013. The provisional estimates for the number of deaths are developed using a linear projection with data from 2000 through 2011, and for the population using a linear projection with data from 2000 through 2011.

Data source: OASIS (death data, population/census data)

Numerator: number of deaths to children aged 14 years and younger caused by motor vehicle crashes

Denominator: number of children aged 14 years and younger

Notes - 2012

Data source: OASIS (death data, population/census data)
Numerator: number of deaths to children aged 14 years and younger caused by motor vehicle crashes
Denominator: number of children aged 14 years and younger

Notes- Death record data are unavailable for 2011 and 2012, and population data are unavailable for 2012. The provisional estimates for the number of deaths are developed using a linear projection with data from 2000 through 2010, and for the population using a linear projection with data from 2000 through 2011.

Notes - 2011

Death record data is unavailable for 2009, 2010, and 2011 and population data is unavailable for 2011. The provisional estimates for the number of deaths were developed using a linear projection with data from 2000 to 2008 and for the population using a linear projection with data from 2000 through 2010.

Notes - 2010

Death record data are unavailable for 2009 and 2010. The number of deaths are developed using a linear projection with data from 2000 through 2008. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 and 2010 are estimated using a linear projection with data from 2000 through 2008.

Annual performance objective estimates are developed by applying an annual decline of 3% to the 2010 point estimate based on the annual decline between 2000 and 2010.

a. Last Year's Accomplishments

The COSP expanded the CPS Mini-Grant Program to include 154 counties, compared to the 142 participating in FFY 2012. Based on a Centers for Disease Control and Prevention (CDC) best practice, COSP provides local coalitions with child safety seats for distribution to income eligible families in conjunction with education in their use. The COSP distributed 7,737 child safety seats statewide through the CPS Mini-Grant program, special needs appointments, and car bed distribution to hospitals (this included 40 seats for children with special needs and 26 car beds to families, local coalitions, and hospitals). COSP staff collaborated and assisted with CPST Certification courses across the state. In addition, Injury Prevention (IP) staff provided technical assistance or consultation for grantees during 101 onsite visits, innumerable e-mails, video conferencing, and telephone contacts. IP staff provided technical assistance and/or training to 16 hospital groups, including three hospitals new to our program through the Keeping Kids Safe Hospital Training initiative. Staff continued to work with Law Enforcement to educate on the CPS law. The COSP continued to support certification of Georgia State Patrol (GSP) troopers and other law enforcement officers by co-teaching Child Passenger Safety Technician (CPST) certification classes.

The COSP continued to grow support for and collaboration with Georgia Head Start Association (GHSA), and the Department of Early Care and Learning (DECAL) by building CPS capacity in school settings; and providing training on safe transportation of children in vehicles. The COSP conducted 13 trainings, 2 conference, 6 meetings, 18 on-sites and 1 Roadeo for approximately 661 participants.

In order to ensure staff are aware of all the county needs, the COSP released a survey in July to determine how many counties currently have wait lists of families in need of car seats. Sixty counties responded with a collective need for 500 seats across the state. The COSP is seeking out ways to meet the needs of the counties, but was able to ship additional seats for those counties who responded.

The COSP received 33 Teddy Bear Sticker (TBS) fax back forms from health departments and emergency response agencies in 12 counties. The efforts of these agencies helped the COSP document 33 children saved from serious injury or death as a result of our statewide Mini-Grant program.

Specific activities for the TBS program included trainings for the following agencies:
IP staff attended the following meetings for EMS:
Regional EMS-C meeting in Augusta
State-wide EMS Advisory Council in Macon
Region 1 Northwest GA EMS
EMS-C in Augusta
State EMS-C Federal Visit
Athens Clarke County Law Enforcement
Fulton County Law Enforcement
Barrow County Sheriff and other law enforcement program staff
During these meetings the COSP staff presented material on occupant safety work across the state, Teddy Bear Sticker Evaluation program and procedures, overviews of the COSP, and the training “The Power is in Your Pen”. Through the increased collaborative work with EMS this year, the COSP was able to get the TBS form created in pdf fillable format so responders can submit online. Other trainings included IP staff presenting along with Henry County School Transportation and National Bus Sales at the Fire Safety Symposium “Are You Prepared to Evacuate Special Needs Children from a School Bus” followed by a live extrication demonstration of a school bus on July 15. 68 participants attended (33 CPSTs).

During the FFY 2013 grant period, the COSP continued to utilize process evaluation outcomes to

determine the number of people reached and the amount of public information and educational materials distributed. The staff initiated a separate outcome evaluation component to look at the specific Mini Grant project and the way the child passenger safety messaging and instruction is being provided to caregivers. The COSP has strived to initiate this formal evaluation component to determine the overall effectiveness of the process and return on investment. The final result of the evaluation has forced the COSP to meet with Safe Kids Georgia and Emory School of Medicine to identify another mechanism or guidance on achieving higher results with the evaluation plan and # of respondents.

During 2013, the COSP staff utilized funding from the Maternal and Child Health Section to purchase a web based address to house the new web portal. The portal went live on November 1, 2013 and is receiving monthly reports at this time. The portal is located at www.gacarseats.com .The portal eliminates the need for project staff to manually input reports and allows staff to focus more time on program needs, objectives, and efficient documentation. The COSP program manager attended training to create COSP site pages for the new DPH website launch for September. All COSP pages were redesigned. The new website listing for the child occupant safety project is:
http://dph.georgia.gov/injury-prevention-program
http://dph.georgia.gov/child-occupant-safety-project-overview

The COSP was involved with eleven press events/releases. Over 67 stories have run and 2,199,550 people were reached through media. Staff partnered with DECAL and GOHS to host a statewide media event demonstrating heatstroke warnings for parents, caregivers, and childcare providers and for all to be aware of the dangers leaving children in cars during hot months. Despite a cool/windy day, temperatures inside the vehicles that day still rose above 100 degrees inside. This event hit television prime time on Fox 5 and Channel 2 news, as well as being a published media event on Ga PH Health Weekly newsletter with an estimated outreach of 6,000 per GA DPH Communications staff. There were four television stations in attendance including the Weather Channel. The host event brought 30 people onsite to support the initiative which included multiple state agencies including GOHS, DECAL, GA DPH, Injury Prevention, GSP, DFCS, and Ga Building Authority. Several stories can be seen at the following resources listed below. It is very difficult to give an overall outreach number for these types of events.
http://www.myfoxatlanta.com/story/22220107/officials-remind
http://www.mysouthwestga.com/news/story.aspx?id=896498#.Ubd53OeHySq
http://www.wtvm.com/story/22238635/the-dangers-of-leaving-kids-in-hot-cars

COSP staff was asked by Safe Kids Georgia and Walker County Safe Kids to develop a presentation for ISIS Parenting Group on child passenger safety and best practice. Walker county Safety Kids presented this best practice education via a live webinar with this program. The release of this webinar reached at least 6 million people as per ISIS reporting.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Providing child passenger safety training, technical assistance and monitoring.			X	
2. Distributing car safety seats.		X		
3. Providing education child passenger safety.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Distribute conventional seats and seats for children with specialized health care conditions/requirements

During the CPS monthly classes, a total of 4,420 caregivers were trained and counties distributed 2,483 child safety seats in the classes. This number reflects existing inventory in months prior.
In total, 8,966 pieces of PI&E materials were distributed. This includes 1,275 total child safety seats (including the19 Special Needs and 2 car beds) and possibly 191,227 total individuals were reached.

IP staff worked with counties on the 2014 CPS Mini-Grant guidelines and application process. One hundred twenty-eight (128) 2014 CPS Mini-Grant Applications were received. Upon receipt, applications are reviewed and logged by IP staff. IP staff also e-mails the applying organization with a notification of receipt and requests any missing supporting documentation, when needed.

COSP staff worked with sixteen families to arrange for appointments, seat distributions, and Medicaid coverage processing.

Activity 2: Document number of children saved from serious injury or death due to program-funded child safety seats

One TBS form was received from Clayton County Board of Health for a 2 year old child involved in a crash. The county received a replacement combination car seat, 4 bike helmets, and 10 window clings.

Activity 3: Offer child passenger safety training and presentations to internal and external stakeholders.

The COSP will be hiring a bilingual Spanish Program Consultant position to determine what type of minority CPS education and outreach is being offered in Georgia. Staff will be a resource providing up-to-date information as needed for CPS activities/events focusing on work with Bilingual technicians and minority communities in the key areas identified via data evaluation. The position will also work with the healthcare providers involved with minority groups in order to increase outreach and education on child occupant safety.

Some of the trainings and presentations offered by IP staff include:

- Conducted LE training "You have the Power in Your Pen" to multiple LE agencies @ the SCTEN meeting where 79 were in attendance.
- Lead Instructor on a 4 day CPST class October 29th – November 1st. 10 persons were certified as CPST's
- Conducted a CPST recertification class for 17 current CPST's on October 28th.
- Exhibited at the GA AAP conference and offered education on correct CR use for conference attendees October 10th – 12th.
- Met with Walker County Fire and EMS staff as well as local county EMS first responders in order to identify ways to work together and provide information on the TBS program county wide.
- Conducted a CPS and SN training at the annual Do You Care for Kids (DUCK) conference on November 1, 2013. The purpose of the DUCK Conferences is to promote the

education of Neonatal, Peri-Natal, Maternal, and Pediatric care givers. This conference included 112 nurses, physicians, respiratory therapists, and students.

- Provided CPS education classes to two TAPS(Teenage Parents) classes at Appalache and Winder Barrow High Schools on November 21, 2013.

- Staff exhibited at the GA AAP Nurse Manager conference on Friday, November 1, 2013. There were 250 people in participation.

- Presented a lunch/learn to DPH employees to cover an overview of the COSP/GOHS initiatives in occupant safety – collaboration with Older Drivers, CODES, and COSP.

Activity 4: Host "Transporting Children with Special Healthcare needs" training once per year.

The training is scheduled for May 22, 2014.

Activity 5: Review child fatality review team report and deaths across multiple sources of data

The report was reviewed in January 2014. Recommendations were made for CFR team and to GOHS for purposes of minority outreach data collection.

c. Plan for the Coming Year

Activity 1: Distribute child safety seats to children including specialized child safety restraint systems for children with special healthcare needs.

Output Measure(s): # seats distributed and # counties served.

Monitoring: Quarterly monitoring of seats distributed and participating organizations involved.

Activity 2: Document # lives saved from injury and/or death due to program funded child safety seats by applying teddy bear stickers to the seats.

Output Measure(s): # of presentations/updates provided regarding the TBS program, # seats reported involved in crashes, # lives saved reported.

Monitoring: Quarterly report on number of TBS Fax Back forms received; develop and implement strategic plan for encouraging participation in TBS program.

Activity 3: Offer Child passenger safety training to internal and external stakeholders.

Output Measure(s): Audience trained, # of presentations and # people trained, certified.

Monitoring: Quarterly monitoring reports

Activity 4: Special Needs training scheduled for Oct. 9, 2014 in Hall County.

Output Measure(s): Will produce evaluation results including pre/post testing and participant attendance, # attendees.

Monitoring: Planning updates

Activity 5: Review of report in combination with other data sets on child deaths resulting from much and make policy recommendations to reduce deaths.

Output Measure(s): Annual child fatality report, annual report for occupant safety initiatives and state highway safety report.

Monitoring: Quarterly monitoring reports

Performance Measure 11: The percent of mothers who breastfeed their infants at 6 months of age.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	42	40.4	41.6	42.8
Annual Indicator	40.8	31.8	33.9	33	32.2
Numerator	57663	42506	44829	42886	40757
Denominator	141332	133668	132239	129959	126575
Data Source	NIS	NIS	NIS	NIS	NIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Provisional	Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	44.1	45.4	46.6	47.3	

Notes-2013
2004 data is based on the 2004 birth cohort - retrieved from the 2007 Breastfeeding report card
2005 data is based on the 2005 birth cohort - retrieved from the 2008 Breastfeeding report card
2006 data is based on the 2006 birth cohort - retrieved from the 2009 Breastfeeding report card
2007 data is based on the 2007 birth cohort - retrieved from the 2010 Breastfeeding report card
2008 data is based on the 2008 birth cohort - retrieved from the 2011 Breastfeeding report card
2009 data is based on the 2009 birth cohort - retrieved from the 2012 Breastfeeding report card
2010 data is based on the 2010 birth cohort - retrieved from the 2013 Breastfeeding report card
Indicator estimates for 2011 to 2013 are based on projections using 2004-2010 data.
The denominator, number of births for 2004 - 2012 was obtained from OASIS. The number of births for 2013 was obtained from provisional data.
The numerators were obtained by multiplying the indicators and the denominators for each year.

Notes - 2012
Indicator estimates for 2010 to 2012 are based on projections using 2004-2009 data.
The denominator, number of births was obtained from OASIS. The births for 2012 were projected using data for 2000 to 2011.

Notes - 2011
2007 data is based on the 2007 birth cohort - Final (changed from the way it was done before; we need to discuss that)
2008 data is provisional data obtained from the Breastfeeding report card for 2011

Indicator estimates for 2009 to 2011 are based on projections using 2004-2008 data

The denominator, number of births was obtained from OASIS. The births for 2011 were projected using data for 2000 to 2010.

2008 data has been recalculated as follows:

nominator: 53,752
denominator: 146,464
annual indicator: 36.7

Notes - 2010
Data accessed on July 3, 2011 at http://www.cdc.gov/breastfeeding/data/nis_data. Data are based on birth cohorts. Therefore, the data reported for the 2007 reporting year is from the 2006 birth cohort. Data from the 2008 birth cohort (2009 and 2010 reporting years) are not available. Data are estimated using a linear projection with data from reporting years 2001 through 2008. While NIS is a sample survey, the numerator is estimated by multiplying the number of birth reported for the specific birth cohort.

Based on trends in the data, an increase of 3 percent annually is expected in the annual indicator through 2015.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintaining breastfeeding coalitions and collaborative efforts at the state and district level.			X	
2. Assisting districts implement breastfeeding education and support plans.				X
3. Continuing monitoring and surveillance of breastfeeding initiation and duration data.				X
4. Integrating breastfeeding promotion into relevant MCH, public health and community-based programs to prevent obesity.				X
5. Continuing to implement revised data collection systems in the Office of Nutrition and WIC and monitoring new data on duration rates.				X
6. Distributing revised Peer Counselor Program Guidelines to district programs as standard of care and best practices.				X
7. Making site visits to district Peer Counselor Programs to offer technical assistance and conduct program evaluation.				X
8. Expanding outreach to Georgia businesses and corporation via "The Business Care for Breastfeeding" tool kit.			X	
9. Maintaining the lactation room at the state office building.		X		
10. Continuing contract for peer counselor training and supervisor in-service training and education.				X

b. Current Activities
Activity 1: Increase surveillance of breastfeeding rates and community attitudes to breastfeeding.

Activity 2: Standardize and improve breastfeeding messaging statewide.

Activity 3: Develop strategy implementation plan and timeline for establishing breastfeeding-friendly hospitals in Georgia.

Activity 4: Establish Baby Cafés in Georgia to support breastfeeding mothers.

Activity 5: Expand WIC Peer Counseling program to include all 18 public health districts and two contracted WIC sites

c. Plan for the Coming Year
Activity 1: Increase surveillance of breastfeeding rates and community attitudes to breastfeeding.

Output Measure(s): Development of a biennial survey to be implemented in WIC clinics; data from state BRFSS.

Monitoring: Quarterly reports.

Activity 2. Standardize and improve breastfeeding messaging statewide.

Output Measure(s): Development and implementation of a statewide media campaign to promote breastfeeding.

Monitoring: Project plan and implementation timeline; quarterly reports.

Activity 3: Develop strategy implementation plan and timeline for establishing breastfeeding-friendly hospitals in Georgia.

Output Measure(s): Guidelines for new program; hospitals participating in Georgia adaptation of Ten Steps to Successful Breastfeeding; number of hospitals to express interest and commitment in achieving Baby Friendly Certification from Baby Friendly USA.

Monitoring: Quarterly reports.

Activity 4: Expand WIC Peer Counseling program to include all 18 public health districts and two contracted WIC sites.

Output Measure(s): Number of peer counselors; percentage of districts/contracted sites with participating in program; number of clients who receive peer counseling services.

Monitoring: Quarterly reports.

Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99.1	99.5	97.8	97.8	97.8
Annual Indicator	99.3	99.6	99.9	92.2	98.5
Numerator	123021	118851	117588	125975	124308
Denominator	123912	119292	135781	136606	126174
Data Source	Newborn	Newborn	Newborn	Newborn	Newborn

	Hearing Program Data	Hearing Program Data	Hearing Program	Hearing Program Data	Hearing Program Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	99.9	99.9	99.9	99.9	

Notes – 2013
The denominator is the number of live births as reported by hospitals collected in SendSS. The numerator is the number of births screened as reported by hospitals this was collected from SendSS.

Notes - 2012
The denominator is the number of live births as reported by hospitals. The numerator is the number of births screened as reported by hospitals. Source: Hospital quarterly reports SENDSS retrieved 05/01/13

Notes - 2011
The denominator is the number of eligible births reported by the hospital, which equals live births minus newborn deaths, minus refused screening, minus transferred out without screen, plus transferred in without screen. The numerator is the number of births screened. It is common that hospitals report that they screen more births than are eligible and then have a report of screening over 100% of their births. The data reported adjusts for over reporting screening by not allowing any hospital to go over 100%.

The annual performance objectives reflect Georgia's goal and belief that 100% of all newborns should receive a hearing screen prior to hospital discharge and progress toward this goal.

2007 and 2008 data have been recalculated as follows:

2007: numerator is 140,201; denominator 148,403; and annual indicator is 94.5

2008: numerator is 127,191; denominator 128,532; and annual indicator is 99

Notes - 2010
The denominator is the number of eligible births reported by the hospital, which equals live births minus newborn deaths, minus refused screening, minus transferred out without screen, plus transferred in without screen. The numerator is the number of births screened. It is common that hospitals report that they screen more births than are eligible and then have a report of screening over 100% of their births. The data reported adjusts for over reporting screening by not allowing any hospital to go over 100%.

The annual performance objectives reflect Georgia's goal and belief that 100% of all newborns

should receive a hearing screen prior to hospital discharge and progress toward this goal.

The data are not available for 2010. The data presented are an estimate based on data from 2008 and 2009.

a. Last Year's Accomplishments

The revised Surveillance of Hearing Impairment in Infants and Young Children form was implemented October 2012 to be used for reporting diagnostic hearing test results after referral from newborn hearing screening and for initial diagnosis of permanent hearing loss birth to age 5. The new form includes documentation for transient conductive.

UNHSI Program Staff attended the Georgia American Academy of Pediatrics (GA AAP) and Georgia Academy of Family Physicians (GAFP) conferences in November 2012 and the Pediatric Nurses Association Meeting in May 2013 as exhibitors to address questions/concerns from providers and to distribute materials about newborn hearing screening and follow-up including the revised UNHSI Guidelines for Pediatric Medical Home Provider. Presentations were made at the GA AAP conference addressing current issues in early hearing screening and referral; at the GAFP conference about childhood hearing screening – detecting hearing loss from newborn to adolescence; and at the Pediatric Nurses Association meeting to review follow-up for newborns that refer their hearing screening or are at risk for late onset hearing loss.

Georgia participated in the Improving Hearing Screening and Intervention Systems (IHSIS) Learning Collaborative from June 2011 through September 2012 and presented a webinar about the experience to UNHSI District Coordinators, Stakeholders, hospitals, audiologist, and interested partners in December 2012.

UNHSI Program Coordinator presented to Healthy Mothers Healthy Babies (HMHB) Coalition of Georgia in December 2012 about the UNHSI Program's purpose, goals, and the message to be communicated to parents. The "Have You Heard" brochure is included in HMHB folder for expectant mothers. UNHSI Program Staff presented at UNHSI District/Regional Meetings in December 2012 on risk factors for hearing loss and March & May 2013 on mandatory reporting of newborn hearing screening and all follow-up testing. UNHSI Program Coordinator presented to parent advisors who work with families and children with hearing loss at the Georgia Parent Infant Network for Educational Services (Georgia PINES) in June 2013 about the UNHSI Program.

The UNHSI Stakeholders Committee Meetings continue to be held quarterly with work on the Action Team Plan. Presentation on tele-therapy was presented at the January 2013 meeting. The audiology newsletter/memo continues to be distributed at least quarterly to pediatric audiologists on program updates and best practices, reporting and upcoming events and trainings. Parent and physician letters have been revised or created in an effort to improve education on the importance of newborn hearing screening and appropriate follow-up. The parent letters are available in English and Spanish.

Collaborated with the Georgia Obstetrical and Gynecological Society (GOGS) to include information about newborn hearing screening in prenatal packets with mailing to members in February 2013. The survey for pediatricians developed with assistance from GA AAP and Chapter Champion regarding pediatric practices and newborn hearing screening and follow-up has been distributed, completed, and evaluated. Plans are to publish results in the GA AAP quarterly newsletter.

Revisions have been completed on Georgia's Resource Guide for families of children with hearing loss. The intent of the booklet is to assist families of children newly identified with hearing loss as a guide/resource about hearing loss, modes of communication, amplification, and professionals and organizations that are dedicated to helping families and children with hearing loss. The booklet has been reviewed by stakeholders –(parents and audiologists) and approved by leadership. The Resource Guide is with DPH – Communications for formatting.

September is National Newborn Screening Awareness month and multiple newborn hearing screening messages were posted on DPH Facebook and Twitter pages. Also in September 2013 the Georgia DPH revised website went live including the UNHSI section. Enhancements continue with the website.

The UNHSI Policies and Procedures Manual, after review by stakeholders and approval by leadership, was formatted by communications for printing. The manual has separate sections that address relevant issues for hospitals, audiologists, otorhinolaryngologists, and primary care physicians.

UNHSI District Coordinators Process Flow for follow-up from newborn hearing screening to intervention was completed and implemented in August of 2013. Coordinators were educated on the revised process flow at video conference.

State Electronic Notifiable Disease Surveillance System (SendSS) enhancements continue in improving the program's data management system for documenting and tracking hearing screening referrals to better assist UNHSI District Coordinators in follow-up. The loss to follow-up protocol has been built into SendSS ensuring all UNHSI District Coordinators will perform the same actions before closing a case as loss to follow-up. The parent and physician letters are incorporated in the loss to follow-up protocol with the letters accessible in SendSS.

UNHSI District Coordinators and four pilot hospitals entered third quarter aggregate data into the revised quarterly Hospital Report form that was built into SendSS. Issues with the data were addressed with hospitals individually, educating on accurate reporting not only for aggregate data, but also for child-specific data on infants who refer or who were not screened prior to discharge. This process continued from October 2012 through September 2013 with UNHSI District Coordinators contacting hospitals each quarter for direct online entry and follow-up on any issues encountered. Plan is to have all hospitals reporting online by first quarter 2014.

Data entry screen was developed in SendSS. In November 2012 a number of hospitals were contacted regarding manually entering newborn hearing screening results for infants born in their facility. None of the hospitals contacted have been able to assist due to the time and personnel needed to input the information in SendSS.

Newborn hearing screening results are to be added to the state's Electronic Birth Certificate (EBC) which uploads into SendSS. This will eliminate the need for hospitals to manually enter hearing screening results. UNHSI and MCH have been working with Vital Records to add hearing screening results and risk factor information to the new Georgia Vital Events Registration System (GAVERS) birth file, which is under development. All information requested from the UNHSI Program has been provided. Birth certificate worksheet is in final approval with pilot set to begin by first quarter 2014.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continuing analysis of quarterly hearing screening data to identify hospitals with unsatisfactory screening and referral performance.			X	
2. Continuing to promote UNHSI.				X
3. Providing training and technical assistance to hospitals and other health care providers screening newborns.				X
4. Developing data system to link newborn hearing screening information with the electronic birth certificate (EBC).				X

5. Providing technical assistance to Children 1st and UNHSI Follow Up Coordinators in health districts to link with children identified through screening reports from hospitals and other healthcare providers.				X
6. Developing UNHSI module in SendSS and providing access to healthcare providers statewide.				X
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Provide professional development for pre- and postnatal families and healthcare professionals about newborn hearing screening (UNHSI) and the importance of follow-up hearing screening by disseminating information via multiple communication methods, including PSAs, the UNHSI brochure and website, social networking sites, newsletter articles and presentations.

UNHSI Program Coordinator presented at the Georgia Association of Young Children (GAYC) Conference October 2013 about the importance of newborn hearing screening and monitoring developmental milestones for hearing. UNHSI Program Staff attended the Georgia American Academy of Pediatrics (GA AAP) and Georgia Academy of Family Physicians (GAFP) conferences in November 2013 as exhibitors to address questions/concerns from providers and to distribute UNHSI materials. Program Staff continue to attend UNHSI District/Regional Meetings to provide updates on state activities. The UNHSI Stakeholders Committee Meetings continue to be held quarterly with SWOT analysis at the October meeting to determine future program goals/objectives. The audiology newsletter/memo continues to be distributed at least quarterly to pediatric audiologists on program updates and best practices, reporting and upcoming events and trainings. The survey for pediatricians developed with assistance from GA AAP and Chapter Champion regarding pediatric practices and newborn hearing screening and follow-up has been submitted for publication in the GA AAP quarterly newsletter. Georgia's Resource Guide for families of children newly diagnosed with hearing loss is in the process of being submitted for printing and will be posted on the UNHSI website. The Resource Guide will be available in English and Spanish.

Activity 2: Improve the UNHSI system by developing and implementing a policy and procedure manual on early detection and intervention of children with suspected or confirmed hearing loss for hospitals, audiologists, and program staff.

Activity 2 has been completed. The UNHSI Policies and Procedures Manual was released October 2013. It is posted on the UNHSI website as a resource for hospitals, audiologists, otorhinolaryngologists, primary care physicians, health departments/districts, UNHSI District Coordinators, and stakeholders in following best practices for newborn hearing screening and follow-up.

Activity 3: Reduce the percentage of babies who are lost to follow-up.

SendSS enhancements continue in improving the program's data management system for the purpose of documenting and tracking hearing screening referrals to better assist UNHSI District Coordinators in follow-up. Paper version of the Surveillance of Hearing Impairment in Infants and Young Children form will be phased out as audiologists will be able to directly input hearing screening and diagnostic results directly into SendSS. Alerting function was implemented that notifies UNHSI District Coordinators whenever a record is updated allowing paper reporting to be phased out. All hospitals should be inputting quarterly hospital report data in directly into SendSS by first quarter 2014. SendSS genetics module was enhanced to include hearing screening results enabling primary care physicians to access hearing screening results that have been manually entered, when obtaining newborn screening (bloodspot) results.

Activity 4 Develop and pilot data entry screen in SendSS for hospitals to manual enter hearing

screening results.

Activity 4 has been completed. The UNHSI Program is moving towards more efficient ways to document all hearing screening results. Newborn hearing screening results and risk factors for late onset hearing loss are to be added to the state's Electronic Birth Certificate (EBC) which uploads into SendSS. Training has begun on the new birth certificate worksheet which is in final approval with pilot set to begin by first quarter 2014. Newborn hearing screening results are to be added to the Newborn Screening bloodspot card. A draft card has been developed and RFP submitted for a vendor to supply cards. Newborn Screening Rules and Regulations have been revised to include hearing impairment requiring hospitals to conduct newborn hearing screening. Rules and Regulations to be posted for public comment.

c. Plan for the Coming Year

Activity 1: Provide educational materials and targeted, planned outreach for pre-and post-natal families, and healthcare professionals about newborn hearing screening (UNHSI) and the importance of follow-up screening by disseminating information via multiple communication methods, including PSA's, the UNHSI brochure, resource guide and website, social networking sites, articles, and presentations.

Output Measure(s): Type and number of materials distributed; number of articles written; number of presentations given; surveying recipients of educational materials and outreach to assess effectiveness; information distributed on social networking sites.

Monitoring: Quarterly review of educational activities.

Activity 2: Reduce the percentage of babies who are loss to follow-up/documentation.

Output Measure(s): Number of UNHSI District Coordinator Scripts; number of hospitals participating in Loss & Found pilot.

Monitoring: Quarterly review of performance measures and loss to follow-up/documentation rates by hospitals, districts, and state.

Activity 3: Obtain individualized hearing screening results on all newborns that have been screened for hearing before hospital discharge through the electronic birth certificate and Newborn Screening bloodspot card uploading into SendSS.

Output Measure(s): Percent of live births with unduplicated complete and accurate hearing screening results.

Monitoring: Evaluate percent received hearing screening results by hospital, district, and state. Compare percent agreement between results via EBC versus bloodspot card.

Activity 4: Continued development of the UNHSI module in SendSS for accurate documentation of hearing screening results; diagnostic evaluations; intervention; follow-up activities and evaluation reports.

Output Measure(s): Number of enhancements; number of providers documenting accurate and complete follow-up hearing screening results; diagnostic evaluations and intervention enrollment online in SendSS.

Monitoring: Accurate and complete documentation in SendSS and loss to follow-up/documentation rates.

Activity 5: Provide training and technical assistance regarding UNHSI process/best practice to hospitals, and other healthcare providers who provide newborn hearing screening and follow-up.

Output Measure(s): Number of facilities visited or contacted; number of providers who participate in training activities.

Monitoring: Accurate and complete documentation; referral and percentage rates for hospital hearing screening; review of documented hearing screen and diagnostic evaluations for best practices.

Performance Measure 13: Percent of children without health insurance.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11.7	10.8	11.2	11.2	11.2
Annual Indicator	10.2	11.9	10.0	11.2	11.7
Numerator	253822	296887	248531	319408	300290
Denominator	2488452	2494846	2493574	2495375	2567388
Data Source	Current Population Survey	Current Population Survey	Current Population	Current Population Survey/OASIS	Current Population Survey/OASIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	11.2	11.1	11.1	11.1	

Notes – 2013
2013 statistic is unavailable and is estimated using linear projection of 2003 through 2012 data.
Numerator: number of children 0 to 17 years without health insurance (Projected)
Denominator: population estimate of children 0 to 17 years (Projected)

2006 through 2010 population estimates for children 0 to 17 were updated due to the intercensal estimates from the census.
2012 annual indicator was updated using Current Population Survey tables: http://www.census.gov/cps/data/cpstablecreator.html and table HI05. 2012 population estimate was updated using final 0 to 17 year old population data from OASIS.

Notes - 2012
Data Collected in Year: 2012. Children 0 to 17.
Current Population Survey tables: http://www.census.gov/cps/data/cpstablecreator.html
Denominator estimates were obtained from OASIS for the 0 to 17 year old population. 2011 denominator was updated to final number. Population estimates for 2012 are not available and so were estimated by linear projection using values for 2000 to 2011.

Notes - 2011
Data Collected in Year: 2011. Children 0 to 17.
Data were updated for 2006, 2007, 2008, 2009, and 2010. New link for the Current Population Survey tables is: http://www.census.gov/cps/data/cpstablecreator.html

Denominator estimates were obtained from OASIS for the 0 to 17 year old population. We could not tell the source of the denominator for the previous years so we used OASIS and updated the denominators for 2006 to 2010. Population estimates for 2011 are not available and so were estimated by linear projection using values for 2000 to 2010.

2007 and 2008 data have been recalculated as follows:

2007: numerator 311,656; denominator 2,513,356; and annual indicator 12.4

2008: numerator 286,619; denominator 2,536,452; and annual indicator 11.3

Notes - 2010
Between 2003 and 2010, there has been a slight decline on average of 0.2%. This is applied to the 2010 point estimate to project the annual performance objective for 2011 through 2015.

a. Last Year's Accomplishments

The DPH's Children 1st program incorporates the identification of uninsured children birth to five into its screening. This occurs via (1)the Electronic Birth Certificate (EBC) surveillance, when parents are contacted and are queried regarding the insurance status of the newborn; and (2)children referred into Children 1st receive a Maternal Child Health Integrated Assessment which also queries parents on insurance coverage status for the child and family. These data are entered into the Central Intake Data System for tracking and reporting.

In October 2012, the DPH MCH program contracted with an Information and Referral Center to assist with the primary contact with families based on the EBC referrals. Families interested in receiving services are then contacted by the district Children 1st program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to assist families during the Children 1st family assessment in identifying uninsured and assisting with linkage to Medicaid or PeachCare for Kids.		X		
2. Launch of Central Intake Information and Referral Center to provide insurance screening and referral to at-risk families.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Monitor and report percentage of children without healthcare insurance by utilizing various sources of data.

Use of Central Intake Information and Referral Center to provide insurance screening and referral to at-risk families was continued. Data is entered into SendSS-NB data system for tracking.

Activity 2: Screen all children participating in MCH programs for eligibility for public insurance options and make appropriate referrals.

All children receiving the MCH Integrated Health Assessment are screened for insurance coverage and linked/referred to Medicaid or PeachCare for Kids (CHIP), as appropriate. Data is entered into SendSS-NB data system for tracking.

c. Plan for the Coming Year

Activity 1: Monitor and report percentage of children without healthcare insurance by utilizing various sources of data.

Output Measure(s): Child health insurance status report.

Monitoring: Quarterly progress reports.

Activity 2: Screen all children participating in MCH programs for eligibility for public insurance options and make appropriate referrals.

Output Measure(s): Number of children screened; number of children insured; number of children referred.

Monitoring: Quarterly data reports.

Performance Measure 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	28	30.4	28.8	28.3	27.8
Annual Indicator	30.6	29.3	33.2	31.3	30.2
Numerator	23650	39959	36278	44650	39084
Denominator	77286	136379	109303	142560	129626
Data Source	PedNSS	PedNSS	WIC report	WIC Performance Measure Report	WIC Performance Measure Report

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or			Provisional	Provisional	Provisional

Final?					
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	27.4	26.9	26.7	26.2	

Notes-2013
Source: WIC Performance Measure Report: June 2013-Child Weight Rpt 1 Cnty/Clinic Yearly SFY

Notes - 2012
Source: WIC Performance Measure Report: June 2012-Child Weight Rpt 1 Cnty/Clinic Yearly SFY

Notes - 2010
Data from Georgia PedNSS report as provided by Georgia WIC.

The average annual percent change between 2008 and 2009 is an decrease of 3.4%. The annual performance objective is decreased by half of this increase through 2015.

a. Last Year's Accomplishments

The WIC program continued to make changes to its organizational structure to increase the quality, efficiency and effectiveness of services provided. Currently, WIC is more than 90% staffed with the expectation to be fully staffed by 1 July 2014.

In addition, the 2014 WIC State Plan was approved by the United States Department of Agriculture (USDA) Food & Nutrition Services (FNS), and all previous findings from the USDA FNS Management Evaluations (ME) were closed. This accomplishment is noteworthy because for the first time in several years, the Georgia WIC program is completely compliant with federal and state operating standards, policies and procedures.

New WIC leadership has implemented standard operating procedures and internal review processes to consistently perform and regularly monitor progress. These improvements, along with the successful closure of the ME, convinced USDA FNS to lift the moratorium on authorizing new WIC vendors in the State. Lifting the moratorium allows more vendors to apply to provide much needed services to WIC participants.

Clinics are using the WHO and CDC Growth charts for Infants and Children that allow the program to capture obesity data at the local level. Local clinics are now able to capture and report monthly child weight data for the WIC population. These reports have been added to the Georgia WIC Information System (GWIS), and state, district and local staff are able to retrieve the reports to track performance goals.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Providing individual counseling to WIC participants on a variety of nutrition topics addressing healthy weight (i.e., Strong-4-Life, healthy eating, stress-free feeding and physical activity).	X			
2. Providing nutrition education to WIC participants through eating and physical activity programs (i.e., Individual counseling sessions, group nutrition education classes, healthy cooking demonstrations).			X	
3. Providing training to WIC staff on nutrition education best practices that result in improved behaviors, including children who are overweight or obese.				X
4. Providing via contracts Lunch and Learn sessions with private providers and sharing information about services available to children who may be eligible for WIC, Medicaid and/or PeachCare for Kids.		X		

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Monthly, quarterly and annual reports will be available at the clinic, county, district and state levels.

The Georgia WIC Information System (GWIS) has been updated to capture individual participant data at the clinic level and provide monthly, quarterly and annual reports on several indicators (Obesity, Breastfeeding, etc.)

Activity 2: Review monthly and quarterly reports to identify clinics, counties or districts with improved rates in order to identify their best practices.

The Georgia WIC Information System (GWIS) has been updated to capture individual participant data at the clinic level and provide monthly, quarterly and annual reports on several indicators (Obesity, Breastfeeding, etc.). However, we have not identified best practices because the program has not been able to hire and retain a full-time Epidemiologist to perform analysis. Currently, the WIC program has identified a quality candidate for the position, and is in the process of making a job offer. We hope to have the individual in place by 1 June 2015. Once acclimated, the Epidemiologist will work with internal leadership to determine quality performance measures and begin producing reports.

Activity 3: Identify at least two nutrition education best practices.

The Georgia WIC Information System (GWIS) has been updated to capture individual participant data at the clinic level and provide monthly, quarterly and annual reports on several indicators (Obesity, Breastfeeding, etc.). However, we have not identified best practices because the program has not been able to hire and retain a full-time Epidemiologist to perform analysis. Currently, the WIC program has identified a quality candidate for the position and is in the process of making a job offer. We hope to have the individual in place by 1 June 2014. Once acclimated, the Epidemiologist will work with internal leadership to determine quality performance measures and begin producing reports.

Activity 4: Implement internet based nutrition education modules.

We are currently piloting GaWIC online, an internet based educational portal, in three (3) health districts with a plan to have 50% of health districts using the system by 1 August 2014.

Activity 5: Evaluate survey that evaluated the prevention, assessment, and treatment of childhood obesity in pediatric practices statewide.

Due to organizational changes in staffing and priorities, including the loss of the WIC Epidemiologist and a new WIC State Plan, the survey was not developed nor implemented. At this time, this survey has not been identified as a priority by WIC leadership. Once we hire a full-time Epidemiologist, we will work to determine additional data to be collected and the best use of the data to help drive quality decision-making.

Activity 6: Provide Strong 4 Life Obesity Training and related resources to an additional three districts.

Columbus and Macon health districts received Strong 4 Life training and education materials, as well as a follow-up evaluation by Children's Healthcare of Atlanta. Initially, it was determined that Public Health was going to contact medical providers and WIC to continue this project at a later date. However, a budget and resources have not been established to expand this project due to organizational changes including leadership and priorities.

c. Plan for the Coming Year

Activity 1: Promote the WIC program to increase participation of eligible clients through diverse outreach efforts (i.e., print, social, television, etc. media outlets).

Output Measure(s): The number of women, infants, children and other eligible clients annually participating in the program.

Monitoring: Participation data is reported monthly by local clinics, and both local leadership and state office staff monitors changes in caseload. State office staff communicates concerns with local agencies and work collaboratively to address and implement improvements. Once hired, the WIC Epidemiologist will begin analyzing monthly reports to identify trends, issues of concern, etc.

Activity 2: Provide training to local clinics on strategies to increase breastfeeding. Strategies include educating WIC clinic staff, clients, and other stakeholders. WIC will also provide breast pumps to clients that request them.

Output Measure(s): Percent of WIC mothers who initiate breastfeeding; Percent of infants breastfed at least 6 months; Number of clinic staff receiving training; Number of clients informed of breastfeeding; Number of breast pumps issued

Monitoring: Staff training and client information is collected at the local level and reported in monthly reports submitted to the state office. Once hired, the WIC Epidemiologist will begin analyzing monthly reports to identify trends, issues of concerns, etc.

Activity 3: Provide nutrition education to WIC participants through healthy eating and physical activity programs (i.e., Individual counseling sessions, group nutrition education classes, healthy cooking demonstrations, Farmer's Market).

Outcome Measure (s): Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile (obese); Percent of WIC clients redeeming vouchers for fresh fruit and vegetables.

Monitoring: Participant weight data is currently being collected at local clinics. Clinics report the data monthly in GWIS, and local, district and state office staff are able to retrieve reports. Farmer's Market participation is also captured. Once hired, the WIC Epidemiologist will begin analyzing monthly reports to identify trends, issues of concern, etc.

Performance Measure 15: Percentage of women who smoke in the last three months of pregnancy.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9.2	7.4	8.7	8.4	8.1
Annual Indicator	8.5	8.3	6.2	7.0	6.7
Numerator	12013	11094	8212	9097	8481
Denominator	141332	133668	132239	129959	126575
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	7.8	7.5	7.3	7	

Notes-2013

The numerator for 2011 is calculated by multiplying the annual Indicator and the denominator. The denominator 2007-2012 comes from OASIS. The denominator for 2013 comes from the 2013 provisional birth file. The annual indicator for 2011 comes from the 2011 PRAMS survey. The 2012-2013 annual indicators have been estimated based on trend data from 2007-2011.

While PRAMS is a sample survey, the numerator is estimated by multiplying the rate from PRAMS and the total number of pregnancies in the year. The number of births to all mothers who are GA residents (from OASIS) is used as a proxy for the total number of pregnancies for that year. PRAMS data are available through 2011, a linear projection was made for 2012 and 2013 using PRAMS data from 2007 -2011. For the total number of pregnanices (births) the estimate for 2013 was obtained from the provisional birth file.

Notes - 2012

While PRAMS is a sample survey, the numerator is estimated by multiplying the rate from PRAMS and the total number of pregnancies in the year. The number of births to all mothers who are GA residents (from OASIS) is used as a proxy for the total number of pregnancies for that year. PRAMS data are available through 2010, a linear projection was made for 2011 and 2012 using PRAMS data from 2007 -2010. For the total number of pregnancies (births) the estimate for 2012 was made using data from 2000-2011.

Notes – 2011

While PRAMS is a sample survey, the numerator is estimated by multiplying the rate from PRAMS and the total number of pregnancies in the year. The number of births to all mothers who are Georgia residents (from OASIS) is used as a proxy for the total number of pregnancies for that year. PRAMS data are available through 2010. A linear projection was made for 2011 using PRAMS data from 2007-2010. For the total number of pregnancies (births), the estimated for 2011 was made using data from 2000-2010.

2007 and 2008 were recalculated as follows:

2007: numerator - 11,461; denominator - 150,804; annual indicator - 7.6
2008: denominator - 11,864; denominator - 146,464; annual indicator - 8.1

Notes - 2010

Previously, data for 2007 were not available. These data are now available and indicate a point estimate of 7.6 percent in 2007. Therefore, there were increases in this indicator in 2008 and 2009. Therefore, the projection for 2010 is based on data from 2007 through 2009 only. While PRAMS is a sample survey, the numerator is estimated by multiplying the rate from PRAMS and the total number of pregnancies in the year.

Given the trend in this indicator, the projections for the annual performance objective are done so to identify intermediate goals to achieve the same rate in 2015 that was identified in 2007.

a. Last Year's Accomplishments

Three major categories best describes last year's accomplishments. They include *Healthcare Provider Awareness and Engagement, Public Awareness and Tobacco Cessation Medication Suppo*rt as well as *Evaluation Support*.

1. Development of the customized evaluation report with the national quitline vendor entitled Georgia Tobacco Quitline Intensive 10-Call Pregnancy Program Evaluation Report.
2. Georgia Tobacco Use Prevention Program partnered with the Georgia OB/GYN Society to feature Georgia Tobacco Quitline promotional materials, healthcare provider clinical practice guideline resources and tobacco cessation counseling reimbursement information in the Society's statewide newsletter.
3. Press Release posted on state agency website announcing the availability of free nicotine replacement therapies medication support (4-week supply) in the form of patches or gum to all uninsured adult Georgians ages 18 and older statewide including non-breastfeeding postpartum women.
4. Georgia Tobacco Quit Line pregnant and postpartum ads (print and web) placed in the Georgia Nurses Association Quarterly Newsletter reaching over 100,000 Registered Nurses statewide.
5. Georgia cAARds Program (Ask, Advise, Refer with Follow-Up) entails health systems interventions for clinicians who provide services including pregnant, postpartum and women of child bearing age patient population groups who use tobacco products. The Georgia cAARds Program implementation continued in the two original public health districts in Central and South Georgia. The dissemination of the Georgia cAARds Program resources statewide (i.e. reference manual and lobby signage).
6. Development and dissemination of Spanish Georgia Tobacco Quit Line brochures and posters to the Hispanic Health Coalition of Georgia including materials tailored to pregnant and postpartum women who use tobacco products.
7. One hundred fifty thousand Georgia Tobacco Quitline brochures (English version) and 65,000 Georgia Tobacco Quitline posters (English version) were disseminated to healthcare organizations (including OB/GYN practices) and governmental local health departments statewide featuring the customized pregnant/postpartum version.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partnered with Georgia Tobacco Quit Line vendor to develop the first annual evaluation report customized for pregnant and postpartum participants.				X
2. Partnered with the Georgia OB/GYN Society			X	
3. Composed and posted press release on the Georgia Dept of Public Health state agency website regarding the availability of free nicotine replacement therapies medication support to all uninsured adult Georgians (18 and older) including non-breastfeeding postpartum women statewide.			X	

4. Partnered with the Georgia Nurses Association to feature Georgia Tobacco Quit Line ads (print and web) in quarterly newsletter reaching Registered Nurses statewide			X	
5. Georgia cAARds Program implementation continued in the two original public health districts			X	
6. Development and dissemination of Georgia Tobacco Quit Line materials (Spanish version) tailored for Spanish speaking pregnant and postpartum population groups who use tobacco products.			X	
7. Statewide dissemination of Georgia Tobacco Quit Line brochures and posters (English version) including materials tailored pregnant and postpartum women who use tobacco products			X	
8.				
9.				
10.				

b. Current Activities

Activity 1: Scheduled to launch the Georgia Tobacco Cessation and Secondhand Smoke Television Media Campaign in targeted disparate public health districts based on several factors including infant mortality rates and tailored to vulnerable population groups including pregnant and postpartum women.

The Georgia Tobacco Cessation and Secondhand Smoke Television Media Campaign is scheduled to air from April 2014 thru June 30, 2014.

Activity 2: Offer 8 weeks of free nicotine replacement therapies (via the Georgia Tobacco Quitline vendor) to non- breastfeeding postpartum women who utilize the Georgia Tobacco Quitline tobacco cessation counseling services (telephone and web-based) to improve tobacco abstinence.

The Georgia Tobacco Quitline continues to maintain the 10-call module that provides specialized tobacco cessation counseling services to assist pregnancy and postpartum women with quitting tobacco use. Effective March 26, 2014, the Georgia Tobacco Quitline began offering 8 weeks of nicotine replacement therapies (NRTs) in the form patches or gum to adult (18 and older) members of vulnerable population groups including non-breastfeeding postpartum women, uninsured Medicaid beneficiaries as well as adults with lower levels of education.

Activity 3: Develop the “2014 Georgia Smoking During Pregnancy” Data Summary

The PRAMS data (2009 - 2011) pertaining to smoking prevalence and smoking behaviors among women before, during, and after pregnancy have been recently reviewed. Plans include reviewing PRAMS data with epidemiology team for data summary development.

Activity 4: Continuation of healthcare provider engagement via Georgia cAARds Program Webinar Series

A total of six webinars have developed and posted on the Georgia Department of Public Health (DPH) state agency website in the Georgia cAARds Program-Webinars and Training Section. A total of three additional webinars are scheduled.

Activity 5: Partnered with Georgia Tobacco Quit Line vendor to develop the second annual evaluation report customized for pregnant and postpartum participants

The second annual evaluation report customized for pregnant and postpartum participants has been ordered.

Activity 6: Tobacco Cessation Resources – Pregnant and Postpartum section of the Georgia

DPH state agency website

The Tobacco Cessation Resources for Pregnant and Postpartum Women Section was developed and launched on the Georgia DPH state agency website. Additionally, the Section includes links to the Georgia Maternal and Child Health Program website as well as customized Georgia Tobacco Quitline resources.

Activity 7: Georgia Quit Line Healthcare Provider Fax Referral form updated with expanded inclusion of Perinatal Case Management referrals.

The Georgia Quit Line Healthcare Provider Fax Referral form updated to include Perinatal Case Management and Medicaid Provider referrals.

c. Plan for the Coming Year

Activity 1: Expansion of Georgia cAARds into 3-5 public health districts

Output Measure(s): Number of calls to the Georgia Tobacco Quitline, number of local health departments implementing Georgia cAARds Program

Monitoring: Georgia Tobacco Quit Line Reports

Activity 2: Georgia Tobacco Cessation and Secondhand Smoke Television Media Campaign (Phase II)

Output Measure(s): GRPs, number of calls to the Georgia Tobacco Quitline, Georgia DPH Website Activity Data - Tobacco Cessation Resources – Pregnant and Postpartum Section

Monitoring: Georgia Tobacco Quitline Reports, Media Vendor Reports, Georgia DPH Website Activity Report

Activity 3: Partnered with Georgia Tobacco Quit Line vendor to develop the third annual evaluation report customized for pregnant and postpartum participants

Output Measure(s): Quit rates among Georgia Tobacco Quit Line pregnant and postpartum women participants

Monitoring: Annual Evaluation Report

Activity 4: Maintaining the Tobacco Cessation Resources – Pregnant and Postpartum Section of the Georgia DPH state agency website

Output Measure(s): Georgia DPH Website Activity Data - Tobacco Cessation Resources – Pregnant and Postpartum Section

Monitoring: Georgia DPH Website Activity Report

Activity 5: Develop the “2015 Georgia Smoking During Pregnancy” Data Summary

Output Measure(s): “2015 Georgia Smoking During Pregnancy” Data Summary posted on the Georgia DPH state agency website, the number of data summaries shared with multiple major stakeholders, the number of presentations featuring the “2015 Georgia Smoking During Pregnancy” Data Summary

Monitoring: Georgia DPH Website Activity Data – Georgia Tobacco Use Data and Fact Sheets Section

Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.5	4.2	4.6	4.6	5.2
Annual Indicator	6.0	6.1	5.7	5.3	6.5
Numerator	43	43	40	37	48
Denominator	712243	707249	700944	699648	737729
Data Source	Vital Records	Vital Records	Vital Records	OASIS (death data, pop/census data)	OASIS (death data, pop/ census data)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	5.2	4.9	4.8	4.8	

Notes – 2013
Numerator: number of suicide deaths to children aged 15-19 years
Denominator: number of children aged 15-19 years

Population data are unavailable for 2013. The polulation was estimated using a linear projection with data from 2000 through 2012. The number of suicide deaths for 2012 and 2013 was obtained from the provisional death files for those years.

Notes - 2012
Data source: OASIS (death data, population/census data)
Numerator: number of suicide deaths to children aged 15-19 years
Denominator: number of children aged 15-19 years
Notes-Death record data and population data are unavailable for 2012. The provisional estimates for the number of deaths are developed using a linear projection with data from 2000 through 2011, and for the population using a linear projection with data from 2000 through 2011.

Notes - 2011
Death record data are unavailable for 2009, 2010, and 2011 and population are unavailable for 2011. The provisional estimates for the number of deaths were developed using a linear projection with data from 2000 through 2008, and for the population, using a linear projection with data from 2000 through 2010.

Notes - 2010
Data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear projection with data from 2000 through 2008. Population data provided by the Georgia Online

Analytic Statistical Information System. Population data for 2009 and 2010 are estimated using a linear projection with data from 2000 through 2008.

Given the increase in 2008, the last year for which there are final data, the annual performance indictor will use a 0.5% reduction to determine estimates from 2011 through 2015.

a. Last Year's Accomplishments

At the time this report was due, a detailed list of last year's accomplishments was not available to the IPP staff. The annual report is filed within the Georgia Suicide Prevention Information Network with assistance and collaborative work with several Suicide Prevention coalition and networks. The IPP staff continues to obtain annual report accomplishments and will submit as the information becomes available.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing training, technical assistance and monitoring of district activities and progress related to suicide prevention plans and objectives.				X
2. Continuing collaborations with the Department of Behavioral Health and Developmental Disabilities, Office of Injury Prevention and other agency staff to develop a statewide suicide prevention plan that includes staff development.				X
3. Continuing development of MCH referral, intake and assessment processes to identify adolescents "at risk" and to assure timely receipt of appropriate mental health resources.				X
4. Continuing to develop outcome and contract requirements, performance expectations/indicators and policies and procedures for contracts and Grant-in-Aid annexes related to adolescent mental health resources.				X
5. Continuing to fund and implement youth development programs and activities that provide adult-supervised activities, caring adult mentors and peer educators for targeted youth.			X	
6. Providing training and technical assistance to the Georgia Association of School Nurses and other school health professionals related to suicide prevention.				X
7. Providing information to CMS staff on identification and referral of at-risk clients.				X
8.				
9.				
10.				

b. Current Activities

The Georgia Suicide Prevention Information Network recently underwent major website changes. From the gspin.org site: GSPIN is your community web site for suicide prevention, intervention and aftercare information. This website has been created and maintained with a grant from Georgia's Department of Behavioral Health and Developmental Disabilities, Suicide Prevention Program to address the specific problems of lack of centralized information, communication, sharing of resources, and need for support for regional/local coalition building, creating a linked network of resources and activities.

The goal is to create and maintain a network for information flow, creating awareness and education by connecting survivor families and the suicide prevention community to prevention, intervention,

and aftercare services, resources, training and activities that are happening around the state.

The IPP staff also work with the Georgia Suicide Prevention Action Network to ensure local communities have resources needed to find instructors and other partners to provide suicide prevention training to EMS and law enforcement partners. Many activities are ongoing including Suicide Day at the Capitol via coalition activities and trainings statewide. Statewide suicide fact sheet was created for distribution (Website access is: www.span-ga.org).

c. Plan for the Coming Year
Activity 1: Work with the GVDRS to produce an age range (age 8 -- 19) specific fact sheet and map with overlay of high schools for distribution to the school systems every two years.

Output Measure(s): Number of suicide attempts by age group; number of suicide completions by age group; production of fact sheets; distribution of reports to school systems; number of health districts receiving fact sheets.

Monitoring: Quarterly progress reports; draft fact sheets.

Activity 2: Follow up on school-based Post-vention training and survey of protocols in high schools regarding suicide ideation, attempts, and school response.

Output Measure(s): Survey designed; survey distributed; report of survey results;

Monitoring: Survey validation report; plan for survey implementation.

Activity 3: Review report on child deaths resulting from suicide completions through Child Fatality Review, in combination with other data sets, and develop policy recommendations and activities aimed at reducing such deaths.

Output Measure(s): Annual Child Fatality Review Team Report across multiple sources of data on child deaths that includes suicide deaths and policy recommendations.

Monitoring: Quarterly reports.

Activity 4: Track DBHDD policy to utilize the Columbia Suicide Severity Risk Scale for all providers.

Output Measure(s): Policy developed; percent of providers utilizing tool.

Monitoring: Quarterly reports.

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	73.4	73.3	73.6	77.8
Annual Indicator	74.9	73.0	77.8	77.1	
Numerator	1945	1846	1868	1785	

Denominator	2596	2529	2400	2316	
Data Source	Vital	Vital	Vital	Data	

	Records	Records	Records	Warehouse (final data)	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Provisional	Provisional	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	77.8	78.2	78.6	78.8	

Notes - 2012
Data source: data warehouse (final birth data)
Numerator: number of VLBW (<1500g) resident births delivered at level III or IV facilities
Denominator: number of VLBW (<1500g) resident births

Notes-Birth record data are unavailable for 2012. The provisional estimates are developed using a linear projection with data from 2008 through 2011. The facility table that was used to obtain estimates for 2000 to 2007 was recently updated with 6 new level 3 (former level 2) facilities. The exact date these facilities became level 3s is unknown but they were included in the analysis for 2008 to 2011 as level 3s.

Notes - 2011
Birth record and population data are unavailable for 2011. The provisional estimates were developed using a linear projection with data from 2008 through 2010. The facility table that was used to obtain estimates for 2000 to 2007 was recently updated with six new level 3 (formerly level 2) facilities. The exact date these because level 3's is unknown, but they were included in the analysis for 2008 to 2010 as level 3's.

The 2007 data was recalculated as follows:

2007: numerator 1931; denominator 2682; and annual indicator 69.5.

Notes - 2010
Georgia has five perinatal levels. Level 0 has no delivery capacity. Level I is basic care. Level II is specialty care. Level III is subspecialty care. Level IV is the state designated perinatal centers. Level I through III are self-designated at the time of application for Certificate of Need. Facilities for high-risk deliveries and neonates are defined as Level III and IV facilities.

Data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear projection with data from 2000 through 2008.

The average annual percent change for this indicator is declining. With an expectation to improve this indicator, the annual performance objective reflects a 0.5% increase.

a. Last Year's Accomplishments

The Perinatal Health Program collaborated with the Office of Contracts to establish a new 5-year contract for Regional Perinatal Centers (RPC). Site visit audit tools were created and Core

Requirements and Recommended Guidelines for Designated RPCs were completed. A 2-year training plan was developed to conduct trainings for RPCs. Training topics include Infant Mortality (Improving Birth Outcomes), Maternal Risk and Protective Factors, Perinatal Substance Abuse Intervention and Prevention, High Risk Neonatal Infants and High Risk Pregnant Women. Face-to-face and bi-monthly Video Interactive Conferencing System (VICS) meetings were conducted.

Grant-In-Aid Annexes were revised and quarterly conference calls were conducted. GIA programs provide education to increase awareness on preventing preterm babies.

The Perinatal Health Program conducted strategic planning to establish goals and objectives and developed a work plan with a prevention framework.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conducting annual performance audits at each regional perinatal center.				X
2. Continuing to work with the Georgia Obstetrical Gynecological Society (GOGS) on increasing the number of very low birth weight facilities for high risk deliveries and neonates.				X
3. Collaborating with statewide partners to increase awareness on preventing preterm delivery.				X
4. Working with RPCs to focus on primary prevention of preterm delivery.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Collaborating with Epi team to develop a standardized reporting tool for the RPC's

RPC Quarterly reporting tool will be completd by July 2014.

Activity 2: Conducting RPC annual site visits

RPC site visits will start by FY2015.

Activity 3: Revise Standard Operating Procedures for Perinatal Health Program

Standard Operating Procedures have been revised.

Activity 4: Collaborating with the RPC coordinators to conduct a Perinatal Capacity Survey

The Perinatal Capacity Survey is in progress and should be completed by end of FY15.

Activity 5: Implement 2-year training plan

Implementation of trainings will begin by FY15.

c. Plan for the Coming Year

Activity 1: Collaborating with GOGS to conduct a Regional Perinatal Meeting

Output Measure(s): Meeting conducted by August 21, 2014

Monitoring: Planning Meetings

Activity 2: Strengthen and enhance RPC's Capacity

Output Measure(s): Technical assistance and training

Monitoring: Annual site visits and quarterly reports

Activity 3: Implement standardized reporting tool

Output Measure(s): Provide tool to RPC's by July 2014

Monitoring: Quarterly Reports

Activity 4: Implement findings for Perinatal capacity survey to ensure all birthing hospitals are operating at appropriate level of care

Output Measure(s): Review level of care

Monitoring: Annual Reports

Activity 5:Provide technical assistance to hospitals to ensure level of care matches designated levels

Output Measure(s): Hospitals level of care matches designated levels

Monitoring: Annual Reports

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	64.5	70	81.8	82.6	83.5
Annual Indicator	80.8	71.4	70.3	71.0	78.9
Numerator	73160	70188	74810	77745	73537
Denominator	90491	98343	106350	109432	93165
Data Source	Vital Records	Vital Records	Vital Records	OHIP Warehouse	Vital Records

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	84.3	85.1	85.1	85.1	

Notes - 2013

Final 2013 statistic is unavailable so 2013 provisional data were used.

Numerator: number of infants born to pregnant women who received prenatal care beginning in the first trimester (Provisional)

Denominator: number of infants born to women who reported prenatal care information. Does not include missing values. (Provisional)

2012 data is updated using final birth data from OHIP-warehouse. The percent of women with unknown entry into prenatal care was 15.8% in 2012 down from 19.6% in 2011. The denominator does not include the missing values.

Denominator statistic is updated using final birth data from OHIP warehouse.

Notes - 2012

The impact of the adoption of 2003 Revised Birth certificate in the middle of 2007 has been documented in previous notes. The percent of women with unknown entry into prenatal care is 19.6% in 2011 down from 26.4% in 2010. The denominator does not include the missing values. The numerator and denominator for 2012 were calculated by linear projection methods using data from 2008 to 2011.

Notes - 2011

The impact of the adoption of the 2003 Revised Birth Certificate in the middle of 2007 has been documented in previous notes. The percent of women with unknown entry into prenatal care was 26.4% in 2009. The denominator does not include the missing values. The numerator and denominator for 2011 were calculated by linear projection methods using data from 2008 to 2010.

Notes - 2010

In 2007, Georgia adopted the 2003, Revised Birth Certificate part way through the year. This had two impacts on NPM18. First, it changed how the entry into prenatal care question was asked from asking for month of entry into prenatal care to asking for date of entry into prenatal care. Second, the vitals reporting system changed. The impact of the first change is well described by NCHS. The impact of the second change was that the percent of women with unknown entry into prenatal care increased beyond what would be expected to happen from the wording change alone.

Data for 2008 and 2009 are actual final data. 2010 is a projection based on these two data points. The denominator differs here from other measures because we did not include the missing values. In 2008, 45.8 percent of the data were missing. In 2009, 36.0 percent of the data were missing.

The annual performance objective is projected using a 1 percent increase to indicate the desire on the part of the state to increase this rate. There are no data that allow for an accurate projection.

a. Last Year's Accomplishments

The Perinatal Health Program partnered with March of Dimes on Centering Pregnancy. March of Dimes provided education to the RPCs increasing their awareness on the benefits of Centering Pregnancy. The Perinatal Health Program participated in Centering Pregnancy quarterly conference calls.

MCH Staff met with United Way to increase the numbers of Medicaid clients participating in Centering Pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to provide referrals to private OB providers, WIC and Medicaid for all clients enrolled in Perinatal Case Management (PCM).			X	
2. Continuing to provide training and TA to the Regional Perinatal Centers and statewide partners on improving birth outcomes in Georgia.				X
3. Partnering with GOGS to provide opportunities to increase education on early access to prenatal care.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Partner with stakeholders to strategically expand Centering Pregnancy Projects.

The Perinatal Health Program participated in quarterly conference calls with stakeholders regarding building capacity to expand Centering Pregnancy Project.

c. Plan for the Coming Year

Activity 1: Hire a Perinatal Nurse that will partner with March of Dimes to increase the numbers of providers hosting Centering Pregnancy classes.

Output Measure(s): Perinatal Nurse hired

Monitoring: Ongoing recruitment

D. State Performance Measures

State Performance Measure 1: Percent of high school students who are obese (BMI > or = 95th percentile)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			12.3	12.2	12
Annual Indicator	12.4	12.4	15.0	15.0	12.7
Numerator	56528	57026	69186	69043	59462
Denominator	455871	459886	461237	460287	468205
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS

Is the Data Provisional or Final?			Final	Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	11.9	11.8	11.8	11.7	

Notes – 2013
Data are from Georgia YRBS. Actual surveys were conducted in 2007, 2009, 2011 and 2013. For the years when the survey is not conducted, the same estimate was maintained.

The denominator was calculated by adding students enrollments for grades 9-12 found at the folowing link: http://app.doe.k12.ga.us/ows-bin/owa/fte_pack_enrollgrade.entry_form. Per YRBS coordinator, the survey is conducted during Spring semester. Thus, Spring enrollments (March enrollments) were used as denominators. Denominators and numerators for 2011, 2012 were updated.

Notes - 2012
Data are from Georgia YRBS. Actual surveys were conducted in 2007, 2009, 2011. For the intervening years when the survey is not conducted, the same estimate is maintained.

The 2012 population denominator was estimated by linear projection and the numerator was obtained as in other years, by applying the indicator to the denominator.

Notes - 2011
Data are from Georgia YRBS. Actual surveys were conducted in 2007, 2009, 2011. For the intervening years when the survey is not conducted, the same estimate is maintained.

Previous notes state that the denominator and numerator were updated using current population estimates. We have searched census.gov and OASIS and cannot locate the actual source for the denominator. It is not also clear which age range was used for high schoolers (14-18 years OR 14-17 years OR 15-18 years OR 15-17 years) to enable exact calculation of the population.

The 2011 population denominator was estimated by linear projection and the numerator was obtained as in other years, by applying the indicator to the denominator.

Notes - 2010
Data are from the Georgia YRBS. These data are available every other year. In even numbered years, when data are not collected, the indicator from the previous year is repeated. While the YRBS provides a point estimate based on a sample survey, the numerator and denominator are updated using current population estimates. The annual performance objective is based on a 1 percent annual decline.

a. Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Leading development and implementation of Georgia's Childhood Obesity Initiative.				X
2. Serving on Fitness Testing Steering Committee.				X
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Activity 1: Support policy and practice change in childcare centers and public school systems to reduce childhood obesity rates.

Activity 2: Participate in a public/private partnership with the Department of Education to implement statewide fitness assessments in schools with a goal of reaching all school systems in Georgia.

Activity 3: Implement statewide social media campaign to promote childhood nutrition and physical activity.

Activity 4: In collaboration with other organization stakeholders regarding childhood obesity prevention, provide data and technical assistance to support selected communities in designing a nutrition and physical activity strategies tailored to local target population needs; partner to support evaluation design and implementation.

c. Plan for the Coming Year
Activity 1: Support policy and practice change in childcare centers and public school systems to reduce childhood obesity rates.

Output Measure(s): Number of partnerships created; number of mini-grants offered to schools/childcare centers for nutrition and physical activity standards; number of practice changes; number of policy changes.

Monitoring: Quarterly reports.

Activity 2: Participate in a public/private partnership with the Department of Education to implement statewide fitness assessments in schools with a goal of reaching all school systems in Georgia.

Output Measure(s): number of school systems implementing fitness assessments; number of individual data records entered.

Monitoring: Quarterly reports.

Activity 3: Implement statewide social media campaign to promote childhood nutrition and physical activity.

Output Measure(s): Number of public service announcements (PSAs); number of website hits; number of click-throughs on interactive geo-coded on-line resource directory.

Monitoring: Quarterly reports.

Activity 4: In collaboration with other organization stakeholders regarding childhood obesity prevention, provide data and technical assistance to support selected communities in designing a nutrition and physical activity strategies tailored to local target population needs; partner to support evaluation design and implementation.

Output Measure(s): DPH points of contact to support strategy design and provide TA identified; initial review and summary of a variety of public health data sources to inform strategy development completed; number of local strategies developed; evaluation plan developed.

Monitoring: Quarterly reports.

State Performance Measure 2: Infant mortality rate among infants born weighing 1,500 grams or more who survive past the first 27 days of life

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			1.9	1.9	1.9
Annual Indicator	1.9	1.7	1.8	1.8	
Numerator	290	226	257	254	
Denominator	153842	131004	143046	144084	
Data Source	Linked Birth-Death Record	Linked Birth-Death Record	Linked Birth-Death Record	Linked Birth-Deaths	Linked Birth-Deaths
Is the Data Provisional or Final?			Provisional	Provisional	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1.8	1.8	1.8	1.8	

Notes - 2012
Source is the Linked Birth-Death Record. Linked birth and death records are only available through 2010. Data (Numerator and Denominator) for 2011 through 2012 were projected usng linear estimation based on data from 2000 to 2010.

Notes - 2011
Source is the Linked Birth-Death Record. Linked birth and death records are only available through 2007. Data (Numerator and Denominator) for 2008 through 2011 were projected usng linear estimation based on data from 2000 to 2007

Notes - 2010
Linked birth and death records were only available through 2007. Data for 2008, 2009, and 2010 were projected usig a linear estimation based on data from 2000 through 2007. Based on trends in this indicator, a decline of 0.2 percent is expected for 2011 through 2015.

TVIS rounds to the tenths place, but this is a measure more accurately expressed to the hundredths place.

a. Last Year's Accomplishments

An Infant Mortality Reduction Initiative Task Force meeting was held in May 2013. Discussion of

the mission and vision of the task force occurred. Also, updates from the 5 COIIns was provided:
1) Early Elective Deliveries-We have worked with March of Dimes and Georgia Hospital Association to decrease EED in Georgia. The rate has reduced, and numbers have been suggested to be as low as 3%. When looking at the state data, we haven't seen the decrease in our data yet. But Medicaid has elected to end payments for early elective deliveries starting July 1, 2013 which is projected to save Medicaid $7M over the next two years.
2) Safe Sleep--The COIIN strategy to provide a standardized education to providers regarding the updated AAP safe sleep recommendations was discussed.
3) Smoking Cessation-The focus will be on capacity and capability for comprehensive systems. Currently, we are supporting providers by providing free Nicotine replacement patches and gum to all pregnant and postpartum women, developing a marketing strategy and partnerships.
4) Perinatal Regoinization-a survey regarding the level of NICUs in each state is being considered.
5)Interconception Care-Work is being done to educate providers on the 1115 waiver.

Work continues in the Perinatal Quality Collaborative.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participating in HRSA's Regions IV and VI Infant Mortality Collaborative.				X
2. Developing an infant mortality strategic plan.				X
3. Establishing a statewide perinatal quality collaborative.				X
4. Strengthening Georgia's 1115 Family Planning Waiver.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All efforts to reduce infant mortality were led by our Infant Mortality Reduction Initiative Task Force. We continued to be active members of the CoIIN, participating in all five teams. We also hired an Infant Mortality Director who started in May 2014. We are funding and providing technical assistance to two home visitation programs throughout the state to address high-risk women and infants by providing intensive case management. We also created a Perinatal Quality Improvement Initiative named GaPQC that has a pediatric arm that is examining opportunities to improve pediatric care.

c. Plan for the Coming Year
Activity 1: Start working in the Eastern part of the state to create a local infant mortality program.

Output Measure(s): Identify a community to work with in the Eastern part of the State; Identify an evidence based or evidence informed program to replicate; Number of people enrolled in the program; Birth outcomes associated with those enrolled in the program compared to the rest of the county

Monitoring: Once a community is identified and contracted with, quarterly reports will be requested to monitor progress.

Activity 2: Continue working with GaPQC to address quality in areas of pediatric care

Output Measure(s): At least one unique program addressing quality of care for the pediatric population

Monitoring: The group meets monthly and has members of DPH MCH program on it. While no reports are submitted, monitoring occurs by the creation of timelines and the monitoring of progress as it compares to the timelines.

State Performance Measure 3: Number of abstracts submitted, reports prepared, presentations made, and publications submitted for peer review where MCHP staff are authors or coauthors

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			5	7	12
Annual Indicator					
Numerator			8	6	
Denominator			1	1	
Data Source		Office of MCH Epi	Office of MCH Epi	Office of MCH Epi	
Is the Data Provisional or Final?			Provisional	Provisional	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	12	15	15	15	

Notes - 2012
This performance measure provides the number of abstracts and reports completed for the project year. Although an annual objective can be established, an annual indicator cannot be determined because there is no denominator for this measure.

Notes - 2011
This performance measure provides the number of abstracts and reports completed for the project year. Although an annaul objective can be established, an annual indicator cannot be determined because there is no denominator for this measure.

Notes - 2010

Data collection for this measure did not initiate until October 1, 2010. Therefore, for calendar year 2010, there were no events that satisfied this measure. Events have occurred during 2011 and will be reported in subsequent years.

a. Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintaining Perinatal Research Collaborative with Emory University.				X
2. Continuing to identify opportunities to present at the local, state, and national level.				X
3. Continuing to prepare reports and publications.				X
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Activity 1: Develop a collaborative annual research agenda for the MCH Program.

Activity 2: Implement studies and disseminate results to address knowledge gaps and inform policy/program activities.

c. Plan for the Coming Year

Activity 1: Develop a collaborative annual research agenda for the MCH Program.

Output Measure(s): Number of external collaborators; number of studies identified; number of studies initiated; number of studies completed

Monitoring: Quarterly reports.

Activity 2: Implement studies and disseminate results to address knowledge gaps and inform policy/program activities.

Output Measure(s): Number of policy/program changes; number of presentations; number of publications; number of reports issued.

Monitoring: Quarterly reports.

State Performance Measure 4: Deaths to children ages 15 to 17 years caused by motor vehicle crashes per 100,000 children

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			14.5	14.3	8
Annual Indicator	9.2	10.7	10.1	8.4	8
Numerator	39	45	42	35	33
Denominator	423461	420430	416990	416790	436844
Data Source	Vital Records	Vital Records	Vital Records	OASIS	Vital Records/OASIS
Is the Data Provisional or Final?		Final	Provisional	Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	8	7.4	7.2	6.9	

Notes - 2013

Data are from OASIS. The Population denominator for 2013 was estimated by linear projection using data for 2000 to 2012.

The numerators for 2012 and 2013 were estimated using 2001 to 2011 data. The numerator for 2011 was updated with final data.

The Annual indicator -number of deaths to children ages 15 to 17 years by motor vehicle crashes

was calculated using the numerator and denominator and expressed per 100,000 children.

Notes - 2012
Data are from OASIS. The population denominator for 2012 was estimated by linear projection using data for 2002-2011.
The numerators for 2011 and 2012 were estimated using 2001 to 2010 data. The numerators for 2009 and 2010 were updated with final data.
The Annual indicator – number of deaths to children ages 15 to 17 years by motor vehicle crashes was calculated using the numerator and denominator and expressed per 100,000 children.

Notes - 2011
Data are from OASIS. The Population denominator for 2011 was estimated by linear projection using data for 2000 to 2010

The numerator for 2009 to 2011 was estimated by linear projection using data from 2000 to 2008
.

The Annual indicator -number of deaths to children ages 15 to 17 years by motor vehicle crashes was calculated using the numerator and denominator and expressed per 100,000 children.

2008 was recalculated as follows:

Annual indicator: 12.1
Numerator: 289
Denominator: 148,501

Notes - 2010
Data for 2008 are final. Data for 2009 and 2010 are not availabe. Data are projected using a linear estimate derrived from data from 2000 through 2008. The average change in this indcator between 2000 and 2010 is positive. Therefore, a 1 percent decline is applied to estimate the annual performance objective.

a. Last Year's Accomplishments
By the end of the fiscal year there were Community Mobilization groups functioning in 26 counties.

There were a total of 74 activities conducted during the year, including teen traffic safety events, seat belt surveys, and child safety seat classes.

Crash data from the hospital inpatient discharge database on crash injuries to teens for Franklin County, the Gainesville Health District Counties and the state were provided to the NE GA RRI and their enforcement networks. This totaled 6 motor vehicle related data variable charts for September. In January 16 data variable maps were provided to NE GA RRI. These provided age, motor vehicle crash injury and death rate and county. In June 208 data variable maps documenting highway safety risk factors in the relevant counties were provided to NE GA RRI and the enforcement networks.

Crash data from the hospital inpatient database for Camden County was provided with two variables presented to the Camden community mobilization group. Data from Vital Statistics and from the Hospital Inpatient Discharge Data base were analyzed by age and injury status for motor vehicle crash related incidents for Wayne County and provided to the local injury prevention group. This resulted in four charts. Five years of data for Toombs, Montgomery, Tattnall, Wheeler and Montgomery were analyzed and provided to the local Safe Kids group for motor vehicle related injuries and deaths for four age groups resulting in forty injury variable charts. A total of 44 variable charts were provided in December. In January, two data variable maps were provided to Vidalia Safe Kids. The maps compared crash rates to counties by rate.

In February, two data maps were provided to the Regional Trauma Advisory Group. The maps showed motor vehicle crashes by county and region. The Office of Health Information and Planning began work in May on developing risk factor maps for SE GA RRI. In June, 384 data variable maps documenting highway safety risk factors in the relevant counties were developed for the SE GA RRI and were distributed to the enforcement networks as well as appropriate CMGs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establishing/maintaining Community Mobilization Groups.				X
2. Hosting traffic safety events.		X		
3. Providing car seat classes and other injury prevention education.		X		
4. Providing survey and crash data sets.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

There is currently no activity occurring for this performance measure as no renewal grant for highway safety at this time.

c. Plan for the Coming Year

No activities planned for the coming year due to lack of funding at this time.

State Performance Measure 5: Among children five years of age and younger who received services through the MCH Program, the percent who received a developmental screen

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			35	35	35
Annual Indicator			38.6	30.1	86
Numerator			7490	7490	16246
Denominator			19382	19382	18823
Data Source			Children 1st quarterly reports	Children 1st quarterly report	Children 1st quarterly report
Is the Data Provisional or Final?			Provisional	Provisional	Provisional

	2014	2015	2016	2017	2018
Annual Performance Objective	35	35	35	35	

Notes – 2013
The denominator was taken from the C1st Quarterly report, BCW Annual report and the count of CMS children aged 5 years or less that received services in 2013. The percentage increase from 30.1% to 86% reflects the change in a Children 1st program policy that every child receiving services must have a developmental screen. The numerator was taken from the C1st report total number of ASQ:3 developmental screens from the FY13 Q3, FY13 Q4, FY14 Q1 and FY14Q2 reports.

Notes - 2012
This is a new measure. Collection of this item began in the second quarter of Fiscal year 2012. The 2012 numerator data were compiled using the Children 1st Annual Report Column G for fiscal quarters 2 and 3. The 2012 denominator data were compiled using the Children 1st Annual Report Column C for fiscal quarters 2 and 3.

Notes - 2011
This is a new measure. The 2011 data was compiled using the Children 1st Quarterly Report Item I1 for fiscal quarters 2 and 3. Collection of this item began in the second quarter of Fiscal year 2012. It is anticipated that the annual performance objective should be estimated at approximately 35 percent but this will likely change as more data become available.

Notes - 2010
This is a new measure. The MCH Program is currently working to develop measurement processes to adequately capture the data. It is difficult to project the annual performance objective without baseline data. However, through discussions with staff, it is anticipated that this performance objective should be estimated at approximately 35 percent. This will likely change as more data become available.

a. Last Year's Accomplishments

Effective September 2013, the ability to enter ASQ:3 developmental and ASQ:SE social-emotional screening data was added to the MCH Children 1st statewide, web-based data system being utilized by all 18 public health districts. As of the end of the second quarter of state fiscal year 2014, the state DPH had the ability to track and monitor the numbers of ASQ screenings conducted by DPH, the number of referrals being received by DPH with pre viously completed developmental screens, and the outcome of the referrals (e.g. whether they were referred to Early Intervention Part C or Part B special-needs preschool services). This enhancement to the data system has greatly improved the ability of DPH/MCH to monitor the percentage of children entering MCH programs who receive developmental screenings. We are also now monitoring those children enrolled in Children 1st over time as follow-up ASQs are also entered into the system.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementing a reporting and measurement strategy that can be applied throughout all MCH programs.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Activity 1: Implement a reporting and measurement strategy that can be applied throughout all MCH programs.

Enhancement to SendSS-NB web-based data system adding ASQ and ASQ:SE data to system was completed.

c. Plan for the Coming Year

Activity 1: Work with district child health programs to assure all data for ASQs and ASQ:SEs are being included in one centralized data system.

Output Measure(s): Inclusion of the ASQ scores from all child health programs in SendSS Newborn

Monitoring: Quarterly reports, SendSS-NB data

Activity 2: Develop Quality Assurance/Quality Improvement for developmental screening data for all child health programs

Output Measure(s): Inclusion of developmental screening protocols and data monitoring procedures in all child health programs

Monitoring: Child Health program operating procedures/manuals; Quarterly Reports

State Performance Measure 6: Percent of pediatricians and family physicians who have positive attitudes toward treating children with special health care needs

Deactivated

State Performance Measure 7: Percent of very low birth weight infants (<1,500 grams at birth) enrolled in First Care

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			25	25	25
Annual Indicator		14.4	21.5	19.2	10.3
Numerator		364	516	445	282
Denominator		2529	2400	2322	2728
Data Source		Children 1st quarterly reports	Children 1st quarterly reports	Children 1st quarterly reports	Children 1st quarterly reports
Is the Data Provisional or Final?			Final	Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	25	25	25	25	

Notes – 2013

The numerator was taken from the count of infants with birth weight <1500g enrolled in 1st Care in

2013 and the denominator was estimated by the 5 year trend of rate of low birth weights.

Notes - 2012
The 2012 numerator data is from FY2012 enrollment numbers from First Care. Denominator data on the number of very low birthweight births in 2012 was estimated from 2007 to 2011 data from OASIS.

Notes - 2011
The 2011 numerator data is from FY2011 enrollment numbers from First Care. Denominator data on the number of very low birthweight births in 2011 was estimated from 2006 to 2010 data from OASIS.

Notes - 2010
The numberator data are 0 because the MCH Program continues to develop the First Care program for implementation. Implementation is targeted for October 1, 2011.

Denominator data are projected as data for 2010 are not yet available. Actual data from 2000 through 2008 are used to estimate the number of very low birth weight births in 2010.

As there are no data on which to project the annual performance indictor, the goal in year one is to engage at least 25 percent of all very low birth weight infants. This will change as more data become available.

a. Last Year's Accomplishments

In this last year, the twelve out of 18 health districts providing 1st Care services to VLBW infants have continued to provide those services.

The Children 1st and 1st Care Standard Operating Procedures (SOP) manuals were published and distributed to the health districts, standardizing both services and providing districts with a framework for conducting their programs. All forms were standardized and included in the SOP manuals and are also uploaded into a web-based Saba Community for easy access by the district staff.

The requirements for a 1st Care enhancement to the web-based data system utilized by Children 1st have been completed. The IT development team is currently working on incorporating these data elements into the system. At this time, limited data is available for 1st Care, such as number enrolled per quarter, number referred via the Regional Perinatal Centers, number receiving a referral to Part C Early Intervention or Children's Medical Services.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Identifying and implementing evidence-based interventions to support children and families enrolled in 1st Care.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Monitor implementation of districts providing home visiting to infants weighing less than 1500 grams.

State program staff provides review of monthly data in web-based data tracking system.
Staff is working toward improving data system to include all standardized forms.

c. Plan for the Coming Year
Activity 1: Complete enhancements of SendSS-NB data system to include increased data monitoring of district performance in 1st Care service delivery.

Output Measure(s): Inclusion of the 1st Care data in SendSS Newborn

Monitoring: Quarterly reports, SendSS-NB data

Activity 2: Implement Quality Assurance/Quality Improvement protocol for 1st Care services in the district.

Output Measure(s): District Programmatic Audit Results

Monitoring: Quarterly Reports, SendSS-NB data, site visits

E. Health Status Indicators

Health Status Indicators 01A: The percent of live births weighing less than 2,500 grams.

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	9.5	9.8	9.4	9.4	9.3
Numerator	13412	13052	12419	12157	11752
Denominator	141332	133668	132239	129959	126575
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional

Notes – 2013
Final 2013 birth data is not available so Provisional data from Vital Records was used
Numerator: number of LBW (<2500g) resident births
Denominator: number of resident births

Data for 2012 were updated using final Georgia birth data 2012 from OASIS.
Data for the year 2013 are provisional data obtained from Vital Records.

Notes - 2012
Data Source: OASIS (birth data)
Numerator: number of LBW (<2500g) resident births
Denominator: number of resident births

Notes-Data are unavailable for 2012. The provisional estimates are developed using a linear projection with data from 2000 through 2011.

Notes - 2011
Data are unavailable for 2011. The provisional estimates were developed using a linear projection with data from 2000 through 2010. The data was OASIS (birth datat).

Numerator: number of LBW (<2500g) resident births
Denominator: number of resident births

Notes - 2010
Data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear projection with data from 2000 through 2008.

Narrative:

Health Status Indicators 01B: The percent of live singleton births weighing less than 2,500 grams.

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	7.6	8.0	7.6	7.6	7.5
Numerator	10368	10269	9699	9470	9206
Denominator	136388	129056	127701	125079	122286
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional

Notes – 2013
Final 2013 birth data is not available so Provisional data from Vital Records was used
Numerator: number of singleton LBW (<2500g) resident births
Denominator: number of singleton resident births

Data for 2012 were updated using final Georgia birth data from OHIP warehouse. Data for the year 2013 are provisional data obtained from Vital Records .

Notes - 2012
Data source: data warehouse (final birth data)
Numerator: number of singleton LBW (<2500g) resident births
Denominator: number of singleton resident births

Notes-Data are unavailable for 2012. The provisional estimates are developed using a linear projection with data from 2000 through 2011.

Notes - 2011
Data are unavailable for 2011. The provisional estimates were developed using a linear projection with data from 2000 through 2011.

Data source: data warehouse (final birth data)
Numerator: number of singleton LBW (<2500g) resident births

Denominator: number of singleton resident births

2008 data has been recaculated as follows:

Numerator: 11,002
Denominator: 141,386
Annual Indicator: 7.8

Notes - 2010
Data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear projection with data from 2000 through 2008.

Narrative:

Health Status Indicators 02A: The percent of live births weighing less than 1,500 grams.

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.8	1.9	1.8	1.8	1.9
Numerator	2596	2529	2400	2343	2342
Denominator	141332	133668	132239	129959	126575
Check this box if you cannot report the numerator because					
1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional

Notes – 2013
Final 2013 birth data is not available so Provisional data from Vital Records was used
Numerator: number of VLBW (<1500g) resident births
Denominator: number of resident births

Data for 2012 were updated using final Georgia birth data from OASIS. Data for the year 2013 are provisional data obtained from Vital Records.

Notes - 2012
Data Source: OASIS (birth data)
Numerator: number of VLBW (<1500g) resident births
Denominator: number of resident births

Notes-Data are unavailable for 2012. The provisional estimates are developed using a linear projection with data from 2000 through 2011.

Notes - 2011
Data are unavailable for 2011. The provisional estimates were developed using a linear projection with data from 2000 through 2011.

Data source: OASIS (birth data)

Numerator: number of VLBW (<1500g) resident births
Denominator: number of resident births

Notes - 2010
Data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear projection with data from 2000 through 2008.

Narrative:

Health Status Indicators 02B: The percent of live singleton births weighing less than 1,500 grams.

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.5	1.5	1.4	1.5	1.5
Numerator	2015	1995	1830	1815	1774
Denominator	136388	129056	127701	125079	122286
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional

Notes - 2013
Final 2013 birth data is not available so Provisional data from Vital Records was used
Numerator: number of singleton VLBW (<1500g) resident births
Denominator: number of singleton resident births

Data for 2012 were updated using final Georgia birth data from OHIP warehouse. Data for the year 2013 are provisional data obtained from Vital Records.

Notes - 2012
Data source: data warehouse (final birth data)
Numerator: number of singleton VLBW (<1500g) resident births
Denominator: number of singleton resident births

Notes-Data are unavailable for 2012. The provisional estimates are developed using a linear projection with data from 2000 through 2011.

Notes - 2011
Data are unavailable for 2011. The provisional estimates were developed using a linear projection with data from 2000 through 2011.

Data source: data warehouse (final birth data)

Numerator: number of singleton VLBW (<1500g) resident births
Denominator: number of singleton resident births

2008 data has been recalculated:

Numerator: 2051
Denominator: 141,386
Annual Indicator: 1.5

Notes - 2010
Data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear

projection with data from 2000 through 2008.

Narrative:

Health Status Indicators 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	8.5	8.5	7.3	7.4	7.0
Numerator	175	177	152	154	149
Denominator	2064991	2074416	2076584	2078585	2141120
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Provisional	Provisional

Notes – 2013
Data Source: OASIS (death data, population/census data)
Numerator: number of resident deaths due to unintentional injuries among children aged 14 and younger (Motor Vehicle Crashes, Falls, Accidental Shooting, Drowning, Fire and Smoke Exposure, Poisoning, Suffocation, and all other intentional injuries.
Denominator: number of resident children aged 14 and younger

Death data are unavailable for 2009 and 2013. The provisional estimates are developed using a linear projection with data from 2000 through 2008. Population data for 2013 are estimated using a linear projection with data from 2000 through 2012. All the numerator and indicator data for all years were updated because the unintentional injuries on the OASIS query has now been expanded to include injuries due to suffocation and all other unintentional injuries. The ICD-10 codes for suffocation are W75-W84. The ICD-10 codes for all other unintentional injuries are V01,V05-V08, V09.1, V09.3-V11, V15-V18, V19.3, V19.7-V19.9, V80.0-V80.2, V80.6-V80.9, V81.2-V81.9, V82.2-V82.9, V87.9, V88.9, V89.1, V89.3-V99, W20-W31, W35-W64, W85-99, X10-X39, X50-X59, Y85-Y86.

Narrative:

The IPP works with Children's Healthcare of Atlanta and Safe Kids of Georgia to ensure all education programs statewide are consistent and aligned with national and state messaging recommendations. Staff work closely with all local public health departments, law enforcement, and EMS professionals to incorporate consistent prevention messages across community levels to ensure ultimate outreach. Additionally a recent group was assigned through IPP and the Georgia Department of Early Care and Learning to develop a committee to work on injuries occurring in the child care setting. This group is set to begin formal meetings to review the initial data collection in Spring 2014.

Health Status Indicators 03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	2.9	4.0	2.9	3.0	2.8
Numerator	59	82	61	62	60
Denominator	2064991	2074416	2076584	2078585	2141120
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	Provisional

Notes – 2013
Data Source: OASIS (death data, population/census data)
Numerator: number of resident deaths due to motor vehicle crashes among children aged 14 and younger
Denominator: number of resident children aged 14 and younger

Death data are unavailable for 2009 and 2013. The provisional estimates are developed using a linear projection with data from 2000 through 2008. Population data for 2013 are estimated using a linear projection with data from 2000 through 2012.

Notes - 2012
Data Source: OASIS (death data, population/census data)
Numerator: number of resident deaths due to motor vehicle crashes among children aged 14 and younger
Denominator: number of resident children aged 14 and younger

Notes-Death data are unavailable for 2009 and 2011. The provisional estimates are developed using a linear projection with data from 2000 through 2008. Population data for 2011 are estimated using a linear projection with data from 2000 through 2010.

Notes - 2011
Data source: OASIS (death data, population/census data)

Numerator: number of resident deaths due to motor vehicle crashes among children aged 14 and younger

Denominator: number of resident children aged 14 and younger

Death data are unavailable for 2009 and 2011. The provisional estimates were developed using a linear projection with data from 2000 through 2008. Population data for 2011 were estimated using a linear projection with data from 2000 through 2010.

Notes - 2010
Georgia Final Death File, 2000-2008, accessed through OASIS. ICD-10 codes V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V79, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86, V87.0-V87.8, V88.0-V88.8, V89.0, and V89.2 .

Consists of all accidents in which any motorized vehicle (car, truck, motorcycle, etc.) was involved, including ones involving motor vehicles injuring pedestrians or bicyclists.

Data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear

projection with data from 2000 through 2008. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 and 2010 are estimated using a linear projection with data from 2000 through 2008.

Narrative:
The Injury Prevention Program (IPP) seeks diverse funding for support and building capacity in all prevention efforts across the state. The IPP builds capacity by recruiting other professionals to become Child Passenger Safety Technicians and educates/provides services in partnership across the state. Standardizing capacity continues to be an ongoing objective to help achieve these measures. Examples include assurance all Georgia State Patrol Troopers are certified as CPSTS and reaching out to other state agencies for policy coordination in relation to the Child Passenger Safety law. Additionally the IPP strives to maintain the child safety seat distribution mini grant program in at least 140 counties to meet the needs. Capacity to provide these services is entirely contingent on funding.

Health Status Indicators 03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	14.8	15.5	16.1	26.4	19.1
Numerator	206	216	227	377	278
Denominator	1388495	1390834	1408408	1427822	1455830
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	Provisional

Notes – 2013

Data Source: OASIS (death data, population/census data)
Numerator: number of resident deaths due to motor vehicle crashes among 15-24 year olds
Denominator: number of residents aged 15-24 years

Death data are unavailable for 2012 and 2013. The provisional estimates are developed using a linear projection with data from 2012 to 2013. Population data for 2013 are estimated using a linear projection with data from 2000 through 2012.

Notes - 2012
Data Source: OASIS (death data, population/census data)
Numerator: number of resident deaths due to motor vehicle crashes among 15-24 year olds
Denominator: number of residents aged 15-24 years

Notes-Death data are unavailable for 2012. The provisional estimates are developed using a linear projection with data from 2000 through 2011. Population data for 2012 are estimated using a linear projection with data from 2000 through 2011.

Notes - 2011

Data source: OASIS (death data, population/census data)

Numerator: number of resident deaths due to motor vehicle crashes among 15-24 year olds

Denominator: numer of residents aged 15-24 years

Notes: death data are unavailable for 2009 and 2011. The provisional estimates were developed using a linear projection with data from 2000 through 2008. Population data for 2011 are estimated using a linear projection with data from 2000 through 2010.

Notes - 2010
Georgia Final Death File, 2000-2008, accessed through OASIS. ICD-10 codes V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V79, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86, V87.0-V87.8, V88.0-V88.8, V89.0, and V89.2.

Consists of all accidents in which any motorized vehicle (car, truck, motorcycle, etc.) was involved, including ones involving motor vehicles injuring pedestrians or bicyclists.

Data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear projection with data from 2000 through 2008. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 and 2010 are estimated using a linear projection with data from 2000 through 2008.

Narrative:
Previously the IPP collected seat belt usage survey data for teens and also utilized pre and post surveys to portray trends so the desired outcome is an increase from baseline for each school. However, as of October 1, 2013, funding for this program was eliminated from the IPP budget.

Health Status Indicators 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	7649.7	8496.7	8936.3	8895.5	8292.4
Numerator	165548	176021	185570	184901	180753
Denominator	2164112	2071630	2076584	2078585	2179734
Check this box if you cannot report					
the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional

Notes – 2013
Data Source: OASIS (deduplicated inpatient and deduplicated ER hospital discharge data, population/census data)
Numerator: number of deduplicated inpatient and deduplicated ER hospital discharges due to non-fatal injuries among resident children aged 14 and younger (Motor Vehicle Crashes, Falls, Accidental Shooting, Drowning, Fire and Smoke Exposure, Poisoning, suffocation, and all other unintentional injuries)
Denominator: number of resident children aged 14 and younger

Data are unavailable for 2011 and 2012. The provisional estimates are developed using a linear projection with data from 2002 through 2010; ER data are not available prior to 2002. Population data for 2011 are updated. Pop2012 are estimated using a linear projection with data from 2000 through 2010. For nonfatal injuries, deduplicated discharges and ER visits are used because these do not include deaths. The report for all the years have been updated. The categories now included in unintentional and non-fatal injuries are Motor Vehicle Crashes, Falls, Accidental Shooting, Drowning, Fire and Smoke Exposure, Poisoning, Suffocation, and All Other Unintentional injuries. The E-codes for suffocation are E911-E913. The E-codes for all other unintentional injuries are E800-E809, E826-E849, E900-E909, E914-E921, E923-E924.0, E924.2-E929.

Narrative:

IPP staff work with the office of Vital Statistics to accomplish all data collection efforts related to injuries affecting young children. The new website within the OASIS program offers each county to pull their own baseline data summary where they can identify areas to work on and pursue. The child safety seat mini grant programs has the ability to reach all local public health departments to remind them of this effective data use tool and help them identify their top five areas of concern and focus.

Health Status Indicators 04B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	440.1	469.4	451.5	428.8	388
Numerator	9525	9724	9376	8912	8449
Denominator	2164112	2071630	2076584	2078585	2179734
Check this box if you cannot report					
the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Provisional	Provisional	Provisional

Notes-2013
Data Source: OASIS (deduplicated inpatient and deduplicated ER hospital discharge data, population/census data)
Numerator: number of deduplicated inpatient and deduplicated ER hospital discharges due to motor vehicle crashes among resident children aged 14 and younger
Denominator: number of resident children aged 14 and younger

Data are unavailable for 2011 and 2012. The provisional estimates are developed using a linear projection with data from 2002 through 2010; ER data are not available prior to 2002. Population data for 2011 and 2012 are estimated using a linear projection with data from 2000 through 2010. For nonfatal injuries, deduplicated discharges and ER visits are used because these do not include deaths. The report for all the years have been updated.

Notes - 2012
Data Source: OASIS (deduplicated inpatient and deduplicated ER hospital discharge data, population/census data)
Numerator: number of deduplicated inpatient and deduplicated ER hospital discharges due to motor vehicle crashes among resident children aged 14 and younger

Denominator: number of resident children aged 14 and younger

Notes- Data are unavailable for 2011 and 2012. The provisional estimates are developed using a linear projection with data from 2002 through 2010; ER data are not available prior to 2002. Population data for 2011 and 2012 are estimated using a linear projection with data from 2000 through 2010. For nonfatal injuries, deduplicated discharges and ER visits are used because these do not include deaths.

Notes - 2011
"Data Source: OASIS (deduplicated inpatient and deduplicated ER hospital discharge data, population/census data)
Numerator: number of deduplicated inpatient and deduplicated ER hospital discharges due to motor vehicle crashes among resident children aged 14 and younger
Denominator: number of resident children aged 14 and younger"

Notes: Data are unavailable for 2011. The provisional estimates are developed using a linear projection with data from 2002 through 2010; ER data are not available prior to 2002. Population data for 2011 are estimated using a linear projection with data from 2000 through 2010. For nonfatal injuries, deduplicated discharges and ER visits are used because these do not include deaths. The report for all the years have been updated.

2007 and 2008 data have been recalculated as follows:

2007: numerator: 11,581; denominator: 2,109,362; annual indicator: 549

2008: numerator: 10,550; denominator: 2,127,815; annual indicator: 495.8

Notes - 2010
Inpatient and ER discharges with E-codes E810-E825, 2002-2007. Data accessed through OASIS.

Consists of all accidents in which any motorized vehicle (car, truck, motorcycle, etc.) was involved, including ones involving motor vehicles injuring pedestrians or bicyclists.

Data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear projection with data from 2002 through 2008. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 and 2010 are estimated using a linear projection with data from 2000 through 2008.

Narrative:

The IPP requires multiple funding sources to accomplish this objective and serve all populations at risk. In additional to the county mini grant programs, additional populations include children with special healthcare needs, childcare agencies/consultants, and school systems. Distribution of child safety seats requires leveraging multiple funding opportunities and agency partnerships/commitments. The IPP is working with the Maternal Child Health Section to work with the Medicaid office for reimbursement of child safety seats as well as outreach to families in need of assistance.

Health Status Indicators 04C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**

Annual Indicator	2102.5	1959.7	1989.9	1912.6	1827.6
Numerator	29422	27241	28026	27309	26591
Denominator	1399368	1390079	1408408	1427822	1454967
Check this box if you cannot report					

the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Provisional	Provisional	Provisional

Notes – 2013
Data Source: OASIS (deduplicated inpatient and deduplicated ER hospital discharge data, population/census data)
Numerator: number of deduplicated inpatient and deduplicated ER hospital discharges due to motor vehicle crashes among residents aged 15-24 years
Denominator: number of residents aged 15-24 years

Data are unavailable for 2011 and 2012. The provisional estimates are developed using a linear projection with data from 2002 through 2010; ER data are not available prior to 2002. Population data for 2011 and 2012 are estimated using a linear projection with data from 2000 through 2010. For nonfatal injuries, deduplicated discharges and ER visits are used because these do not include deaths. The report for all the years have been updated.

Narrative:

The IPP continues to support staff who work with the Governor's Office of Highway Safety and state EMS office to track data on all injuries related to MVC via hospital discharge information. In October 1, 2013, funding for the rural roads occupant safety program was eliminated, however the IPP continues to work with partners

Health Status Indicators 06A: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	132554	74321	45356	1031	4530	362	6954	0
Children 1 through 4	542478	307134	188195	3571	18417	846	24315	0
Children 5 through 9	700885	407001	236487	4503	25728	997	26169	0
Children 10 through 14	702668	405283	246454	4099	23853	885	22094	0
Children 15 through 19	699648	397311	256596	3910	23030	856	17945	0
Children 20 through 24	728174	421995	259625	4172	25926	1144	15312	0
Children 0 through 24	3506407	2013045	1232713	21286	121484	5090	112789	0

Notes – 2013
Data source: OASIS (population/census data), 2012
In previous (non-census) years, other/unknown is 0; similar to that reflected in 2012

Narrative:
Overall, for 2012, the most populous race among the 0-24 year olds was White (2,013,045), followed by Black (1,232,713). Within each race category, the most populous age group was the 20-24 year olds, except among the American Indians/Alaskan Natives & the multiracial group in which 5-9 year olds were the most populous.
When compared to 2011, the racial groups that experienced population increases in all age groups were the Asian (Range: 0.95% - 8.04%) and the multiracial groups (1.63% - 7.32%).

Health Status Indicators 06B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	109474	23080	0
Children 1 through 4	453698	88780	0
Children 5 through 9	600473	100412	0
Children 10 through 14	620113	82555	0
Children 15 through 19	627469	72179	0
Children 20 through 24	650403	77771	0
Children 0 through 24	3061630	444777	0

Notes – 2013
Data source: OASIS (population/census data), 2012

Narrative:

For 2012, among the non-Hispanics, the most populous group was the 20-24 year olds (650,403) followed by the 15-19 year olds (627,469). Among the Hispanics, the largest age group was the 5-9 year olds (100,412) followed by the 1-4 year olds (88,780).
When compared to 2011, among children 0-24 years old, there has been an overall increase in the population, more among the Hispanics (1.57% increase) than the non-Hispanics (0.48% increase).

Health Status Indicators 07A: Live births to women (of all ages) enumerated by maternal age and race. (Demographics)

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	179	39	106	0	2	1	9	22
Women 15 through 17	3196	1175	1556	2	11	0	121	331
Women 18 through 19	8236	3551	3656	11	40	7	289	682
Women 20 through 34	100316	51308	33005	118	3622	122	2922	9219

Women 35 or older	18032	9292	4887	15	1134	27	580	2097
Women of all ages	129959	65365	43210	146	4809	157	3921	12351

Notes - 2013
Data source: OASIS (birth data), 2012

Notes - 2012
0 represents either 0 or a number less than 5. These numbers were suppressed due to small numbers.

American Indian or Native Alaskan and Asian = 0
Native Hawaiian or Other Pacific Islander = 1

0 represents either 0 or a number less than 5. These numbers were suppressed due to small numbers.

American Indian or Native Alaskan=4
Native Hawaiian or Other Pacifiic Islander=4

Narrative:

In 2012 there were a total of 129,959 births in Georgia. The majority of Georgia births were to women aged 20-34, although underage mothers (< 18 years) accounted for 3,375 births. Black or African American mothers accounted for the majority of births to underage mothers (1,662 births), followed by White mothers (1,214). In general, White mothers accounted for most of the births in Georgia (65,365), followed by births to Black or African mothers (43,210), births to Asian mothers (4,809), births to multiracial mothers (3,921), Native Hawaiian/Pacific Islander (157), and American Indian/Alaskan Natives (146).

Overall the birth rate for 2012 (40.4) fell slightly from 2011 (41.3). This was due to a decrease in births to White, Black or African American, and multiracial mothers.

Health Status Indicators 07B: Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)

HSI #07B - Demographics (Total live births)

CATEGORY	**Total NOT Hispanic or**	**Total Hispanic or**	**Ethnicity Not**
Total live births	**Latino**	**Latino**	**Reported**
Women < 15	134	36	9
Women 15 through 17	2550	526	120
Women 18 through 19	6839	1128	269
Women 20 through 34	84338	12712	3266
Women 35 or older	14815	2628	589
Women of all ages	108676	17030	4253

Notes – 2013

Data source: OASIS (birth data), 2012

Narrative:

In 2012 there were a total of 129,959 births in Georgia. The majority of Georgia births were to women aged 20-34, although underage mothers (<18 years) accounted for 3,375 births. Non-Hispanic mothers accounted for the majority of births to underage mothers (2,684 births). In general, Non-Hispanic mothers accounted for most of the births in Georgia (108,676), followed by births to Hispanic or Latino mothers (17,030). The ethnicity for 4,253 mothers was not reported.

In 2012, the Hispanic birth rate (59.2) fell from the 2011 rate (65.2). For non-Hispanic mothers the decrease in birth rate was smaller, 37.1 in 2012 compared to 37.4 in 2011.

Health Status Indicators 08A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	957	387	476	0	11	7	0	76
Children 1 through 4	282	128	136	0	3	1		14
Children 5 through 9	211	88	104	0	1	2		16
Children 10 through 14	153	69	73	0	2	0		9
Children 15 through 19	308	155	124	1	6	0		22
Children 20 through 24	546	267	242	1	9	1		26
Children 0 through 24	2457	1094	1155	2	32	11		163

Notes – 2013

The 2012 deaths among children 0-24 years of age were calculated using the results of the provisional 2012 Death file titled ProvDeath2012GA. The Asian variable was combined from 7 different variables for the Asian origin (Chinese, Korean, Japanese, Vietnamese, and 3 Asian other variables). The Native American and Pacific Islander also had numerous race variables that had to be combined in order to calculate the count of deaths by age group among children. The multiracial category was not calculated because it could not be determined what variable within the provisional file adequately captured the multiracial race group.

Narrative:

Health Status Indicators 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	867	106	

Children 1 through 4	264	25	

Children 5 through 9	192	20	
Children 10 through 14	139	14	
Children 15 through 19	280	28	
Children 20 through 24	515	32	
Children 0 through 24	2257	225	

Notes – 2013

The count from the provisional file for the Hispanic deaths in 2012 was calculated using the provisional death file from 2012 titled ProvDeath2012GA. There were five different variables that were combined to determine the count of Hispanic deaths among children aged 0-24. The unknown variable was not calculated due to the coding of some of variables. The author could not decipher which code was used for unknown. The counts for the columns were coded as “H” for Hispanic and “N” for non-Hispanic.

Narrative:

Health Status Indicators 10: Geographic living area for all children aged 0 through 19 years.

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	862433
Living in urban areas	2318246
Living in rural areas	459987
Living in frontier areas	0
Total - all children 0 through 19	2778233

Notes – 2013

Georgia population data provided by the Office of Health Information for Planning. Georgia population data accessed through OASIS. http://oasis.state.ga.us/oasis/qryPopulation.aspx

Narrative:

The majority of children 0-19 years of age (83%) live in urban areas, and 31% live in metropolitan areas. The population of children 0-19 years increased 0.03% from 2011 to 2012. However, the population of children living in rural areas decreased by 1.5%, while the population of children living in non-rural areas increased by 0.3%. This slight change in population is not expected to have an immediate impact on the services provided to children.

F. Other Program Activities

Toll-free Hotlines: Georgia's Title V toll-free hotline, PowerLine, is run by Healthy Mothers, Healthy Babies Coalition of Georgia (HMHB) under a MCH contract. PowerLine assists women, pregnant women, parents, health care providers, social service agencies, community organizations, and any other individual or agency experiencing difficulties in obtaining information about health care and/or health care services. The bilingual toll-free number (statewide 1-800-822-2539; Metro Atlanta 770-481-5501) is available Monday-Friday 8:00 A.M. through 6:00 P.M., staffed with Information and Referral Specialists that provide callers with information on local general practitioners and medical specialists; dentists; prenatal healthcare services; low cost healthcare resources for the uninsured;

HIV testing sites; dental, vision, and hearing screening facilities; breastfeeding information resources; plus other healthcare and public health referrals. PowerLine also answers the state WIC customer service toll-free telephone line, referring callers to the appropriate WIC Clinic and recording complaints or fraud reports. PowerLine also provides referrals for DPH's Perinatal HIV Prevention Project, Women's Health, Newborn Screening, Babies Can't Wait, Women's Right to Know, PeachCare for Kids, and Children 1st. PowerLine maintains Georgia's most comprehensive database of physicians and clinics that accept Medicaid and PeachCare, reduced fees, and/or low cost fees. Annually, PowerLine assists over 25,000 individuals experiencing difficulties or delays in accessing healthcare services, providing over 50,000 referrals to services. /2013/ HMHB is enhancing PowerLine's breastfeeding support by obtaining Certified Lactation Counselor certification for all Information and Referral Specialists. Access has also been enhanced with the addition of online referrals.//2013//

Babies Can't Wait (Part C, IDEA) supports a separate toll-free number (1-800-229-2038) for individuals with disabilities, families of children with special needs, and professionals that provides a special needs database/directory of over 5,000 public and private early intervention services, research and demonstration projects, professional groups, parent support groups and advocate associations available in the state for children with or at-risk for developmental delays or disabilities. There are over 150 searchable categories, including advocacy, early intervention, diagnostic, physical therapy, speech therapy, occupational therapy, child care centers, respite care, Medicaid, education, counseling, support groups, camps, vocational services, and many others. A unique hotline feature is that a parent of a child with a disability answers the phone. The BCW central directory is operated by Parent to Parent of Georgia, a statewide parent-run organization. Hotline callers can be matched with supporting parents whose children have similar disabilities. The Parent to Parent of Georgia website allows users to search the special needs database online (http://p2pga.org). Other website content includes a parent designed graphic roadmap to services that walks parents through what they need to know to navigate Georgia's disability, health, and education systems; information on reading materials, health and education training courses, and family leadership and community opportunities; and a parent blog. Users can sign up for an email list, FaceBook updates, and twitter notices and news.

The toll-free Georgia Tobacco Quit Line (1-877-270-7867), funded by the tobacco Master Settlement Agreement and implemented through DPH in collaboration with the Georgia Cancer Coalition, connects callers 13 years of age or older to a trained counselor who can help them develop a personal plan to stop smoking. The Quit Line is also available to the parents of youth who use tobacco products. Trained counselors offer counseling tailored to the caller's needs, self- help materials, and referral to other resources. The Quit Line is available 8:00 A.M. to 12:00 A.M. daily. A line (1-877-266-3863) is dedicated for Spanish-speaking callers. /2013/ Third party counseling in over 140 languages is offered by AT&T Translation Services and services are available for the deaf/hard of hearing. In 2010, there were 9,100 direct calls to the Quit Line; 2,295 tobacco users received services; and 1,362 users registered for web-based services.//2013//

The Georgia Crisis and Access Line (GCAL) serves as the central access point to connect the state's youth and adults to local services for mental health and addictive diseases services. Individuals can call the hotline (1-800-715-4225) 24 hours/seven days a week and be connected to clinical staff that assist callers with information and brief screening and evaluation services. In addition, a website (www.mygcal.com) offers users a list of Behavioral Health and Developmental Disabilities providers and services by county. /2013/ On 12/15/11, Behavioral Health Link, the GCAL contractor, was one of 10 crisis centers to receive funding from the National Suicide Prevention Lifeline (NSPL) to collaborate in the development of IM/Chat based services to increase community access to online crisis services to each center's community.//2013//

Internet Resources: In 2008, DCH launched georgiahealthinfo.gov, a consumer-focused, one-stop resource for information on health education, health care providers, health care facilities, and health care comparison/planning information in Georgia. Website content includes health education materials, wellness and prevention information, local health care provider profiles, quality and cost comparison data, a long-term care decision support tool, and health plan comparison.

Georgiahealthinfo.gov is now available on twitter (gahi.gov) and Facebook.

MCH's Early Childhood Comprehensive Systems (ECCS) initiative is developing an online early childhood clearinghouse for consumers, childcare providers, health care providers, early childhood advocates, and others. Clearinghouse resources are grouped in seven main information categories (child development, children with special needs, community advocacy and policy, early learning and child care, family support, health and dental care, and parenting information). The clearinghouse (www.eccsga.org) is live and currently includes summaries and links to over 400 early childhood web-based resources.

/2102/MCH's Office of Title V and Integration is the state coordinator to expand partners and promote enrollment in the National HMHB text4baby campaign. Title V funds will used to purchase the customized text4baby option. MCH is also exploring ways to track father enrollment in this service.//2012// /2013/ Georgia customized various Text4Baby messages and currently has2,502 enrollees in the program. //2013// /2014/ For the period of July 1, 2012 through June 30, 2013, 3,435 subscribers were active in the text4baby protocol, 495 subscribers completed the new baby protocol, and 2,718 subscribers cancelled. //2014//

/2012/MCH is partnering with the Georgia campaign for grade level reading which aims to increase the percentage of children reading at or above grade level by the end of 3rd grade from 30% to 60% by 2015. Title V funds support this effort in four health districts to increase the number of referrals from primary care providers to child health programs and the number of ASQ trainings by ASQ certified trainers for staff, community partners and parents.//2012//

Other Activities: Outside of Title V funded activities, there are a number of other program activities comprising the MCH system that significantly impact the state's Title V population. These programs include Health Check (EPSDT), Right from the Start Medicaid, Family Planning, and Immunization, as well as activities focused on CSHCN, such as the Governor's Council on Developmental Disabilities and Social Security determination. The relationship between the MCHP and these activities is described in III. State Overview, Sections C (Organizational Structure) and D (Other Capacity) of this application. Family leadership and support activities are discussed in Section D.

G. Technical Assistance

The MCH Services Block Grant and Medicaid, known as Title V and Title XIX respectively, were created by the Social Security Act and are mandated to collaborate by a 1989 amendment to the act. Together these programs ensure that low-income families receive the health services they need. Georgia Title V seeks technical assistance to enhance the current relationship between Title V and Title XIX. Through the development of the FY11 Title V MCH Services Block Grant application, Medicaid was a topic of several public comments. These comments ranged from the selection of a care management organization and coordination of services for children with special health care needs through a medical home to the role that improved collaboration could have in treating obesity or supporting breastfeeding. One of Georgia's top priority needs also addresses the provider supply available through Medicaid to treat children with special health care needs. While the Division of Public Health and the Division of Medical Assistance are confronting significant funding challenges, a possible solution may lie in improved coordination, consolidation, and support of priorities shared by Title V and Title XIX.

The most recent agreement between Title V and Title XIX was effective July 1, 2003. This agreement was developed when Title V and Title XIX were in different state agencies. Following the reorganization of the Division of Public Health, Title V and Title XIX are now co-located in the Department of Community Health. With changes in leadership in the Divisions of Medical Assistance and Public Health and the MCH Program, there is an opportunity to review the previous agreement and develop and implement an updated agreement. To develop and implement an updated agreement, each program must understand the limitations and priorities of the other to reach a consensus of what can be done to ensure optimal service for the Georgia MCH population.

In addition to an updated agreement, improved understanding of the intersection between MCH programs, for example, WIC, Children's Medical Services, and Babies Can't Wait, and Medicaid is needed to ensure that Georgia maximizes each funding source. Another area of needed collaboration between the MCH Program and Medicaid will be the implementation of a planned Medicaid Women's Health Waiver. Given the funding for family planning in Georgia, successful implementation of this waiver will require coordination between Titles V, X, XIX, and XX.

Form 15 reflects the desire of Georgia Title V to work with an outside contractor that can identify education needs about each program and implement necessary training and/or prepare and distribute necessary documents and serve as an intermediary through the development of an updated agreement.

Given the many intersection points between Medicaid and Title V as well as other MCH Programs including WIC, Babies Can't Wait, and the Family Planning program, strengthening the partnership between Titles V and XIX is vital to the health of maternal and child health populations throughout Georgia. While Georgia may have other technical assistance needs, this is the only technical assistance need requested in the FY11 application to ensure that this need will be a priority and focal point for the upcoming year.

/2012/Through a contract with Georgia Family Connection Partnership, Title V is embarking on an opportunity analysis to identify opportunities related to the preferred relationship with Title V and Medicaid. A report is expected by December 2011 at which time a strategic direction will be determined.

For FY12, Georgia seeks technical assistance in the best use of the existing birth certificate data to populate prenatal care measures including calculating the Kotelchuck Index. With the switch to the 2003 Certificate of Live Birth, there has been a significant increase in missing data rendering these variables unreliable and unavailable for use. There are several measures throughout the Title V Block Grant that require the use of prenatal care data derived from the birth certificate. Georgia seeks technical assistance to aid in addressing this challenge.//2012//

/2013/A preliminary report has been completed that identified opportunities related to the preferred relationship with Title V and Medicaid. Additional analysis is currently being conducted and a more comprehensive report will be developed based on analysis findings.

For FY13, Georgia seeks technical assistance to improve performance related to three National Performance Measures:

NPM 3: Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

NPM 4: The percent of children with special health care needs age 0 to 19 whose families have adequate private and/or public insurance to pay for the services they need.

NPM 6: The percentage of youth with special health care needs who receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Technical assistance is requested on how other states, especially in states in Georgia's region, are meeting NPMs 3 and 6. For NPM 4, technical assistance is needed on how other states partner with state Medicaid and private insurance companies.//2013// /2014/ Technical assistance is requested on how to adjust the section's current work in light of the Affordable Care Act. //2014/