Maternal and Child Health Services Title V Block Grant

Georgia

FY 2017 Application/ FY 2015 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

Georgia Department of Public Health

Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

2 Peachtree Street NW, 15th Floor
Atlanta, Georgia 30303-3142
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July 15, 2016

Deborah Brower, RN
Division of State and Community Health
SNAFC
61 Forsyth St., SW, Suite 3M60
Atlanta, GA 30303-8909

Grantee Name: Georgia Department of Public Health
Grant Name: Maternal and Child Health Services Title V Block Grant
Grant Number: B04MC29313
Reference: Notification of Submittal

Dear Ms. Brower,

This is a letter of transmittal informing you that a grant application requesting funding for the FY 2017 Maternal and Child Health Services Title V Block Grant has been submitted from the Georgia Department of Public Health.

For any questions related to the grant, please contact Michelle Allen, Maternal and Child Health Director. Ms. Allen can be reached at 404-463-2579 or Michelle.Allen@dph.ga.gov.

Sincerely,

Michelle Allen
Maternal and Child Health Director
Georgia Department of Public Health

Kathryn Pfirman, CPA
Chief Financial Officer
Georgia Department of Public Health

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.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 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

The Georgia Department of Public Health Maternal and Child Health Section (MCH) administers the Maternal and Child Health Services Title V Block Grant. The 2017 Application/2015 Annual Report provides an overview of MCH's recent successes and achievements, as well as a summary of the Five-Year Needs Assessment that MCH conducted. The needs assessment resulted in a new set of priority needs and a five-year plan with objectives and strategies designed to meet those needs.

Annual Report Highlights
MCH achieved several successes in the annual reporting year. Although not comprehensive, the following list provides several highlights of work that were accomplished:

- MCH increased the number of hospitals participating in the 5-STAR Breastfeeding Initiative and Safe Sleep Initiative
- The Department of Public Health's STD Program began a program within the MCH section. This organizational change provides for a greater reach to the MCH population and increased access to improve women and adolescents sexual and reproductive health
- The State of Georgia and MCH will provide metabolic foods to all children diagnosed with a metabolic disease regardless of income and insurance type
- MCH developed an Early Care Environment (childcare facility) toolkit that teaches educators how to implement healthy nutrition and physical activity policies
- MCH provided care coordination services to over 8,000 children with special health care needs
  MCH increased workforce capacity

State Action Plan Summary
Ten priority needs were identified: prevent maternal mortality, increase access to family planning services, prevent infant mortality, reduce maternal substance use, promote developmental screenings among children, promote physical activity among children, prevent suicide among adolescents, improve systems of care for children and youth with special health care needs, increase access to specialty care for CSHCN, and promote oral health among all populations. Twelve performance measures, national and state, will address the priority needs identified.

A summary of the state action plan are as follows.

Georgia's MCH action plan includes a variety of strategies, evidence-based and evidence-informed, that address the 10 priority needs. Health promotion/communication is used to gain improvements in all performance measures, national and state. The health promotion/communication strategies are designed to increase awareness or promote behavior change among the MCH population, their families and/or providers working with women and children. Promoting oral health, safe-sleep, well-women visits, bullying prevention and developmental screening will include

marketing positive behavior directly and indirectly with the MCH population.

MCH will use other strategies that include; system building between partners who deliver service to the MCH population and policy development. Partnerships with MCH stakeholders is instrumental in realizing outcome goals and is also incorporated in all action plans for national and state performance measures. In such, MCH will be building new partnerships, identifying new MCH stakeholders and redefining the collective goals of existing partnerships in the upcoming years. For example: the Safe Sleep Coordinator will be working with first respondents and faith based organizations to expand the safe sleep initiative.

Ongoing Needs Assessment

The Title V needs assessment provided an opportunity for MCH to redefine priorities based on the most current data available and strategically plan to address those needs. The needs assessment has resulted in new priorities, new partnerships and an action plan that will move the needle on the eight selected national performance measures and four state performance measures to impact the identified priority needs.

During the reporting year, Georgia further assessed adolescent suicide and bullying in the state. After reviewing the data, MCH identified an increasing suicide rate among females and a geographic location to target bullying strategies. The findings will help guide the revision of the state action plan to prevent bullying among adolescents.

In the upcoming year, MCH will continue to conduct needs assessment activities and engage stakeholders to build consensus around state performance measures and evidence-based or –informed strategy measures. The upcoming year provides the exciting opportunity to build upon and refine the state action plan based on input from stakeholders, including partners and families.

II. Components of the Application/Annual Report

II.A. Overview of the State

The Georgia Department of Public Health (DPH) is the lead state agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective. The Title V Director uses a multifaceted strategic plan to identify and address the challenges and needs of Georgia's MCH population.

Georgia is a diverse state with a growing population, robust political landscape, and slow growing health care environment and economy. The distinct health care environments in rural Georgia and the urban metropolitan are a unique challenge for the Title V Program. The growing population amplifies challenges that arise from the political landscape, health care environment, economy and/or sociocultural context.

Geographic Description

Georgia is located on the southeastern Atlantic coast of the United States. It is bordered on the south by Florida; on the east by the Atlantic Ocean and South Carolina; on the west by Alabama; and on the north by Tennessee and North Carolina. The highest point in Georgia is Brasstown Bald, 4,784 feet; the lowest point is sea level. Georgia is ranked 24th in terms of land size and is the largest state geographically east of the Mississippi River.

Urban and Rural Counties

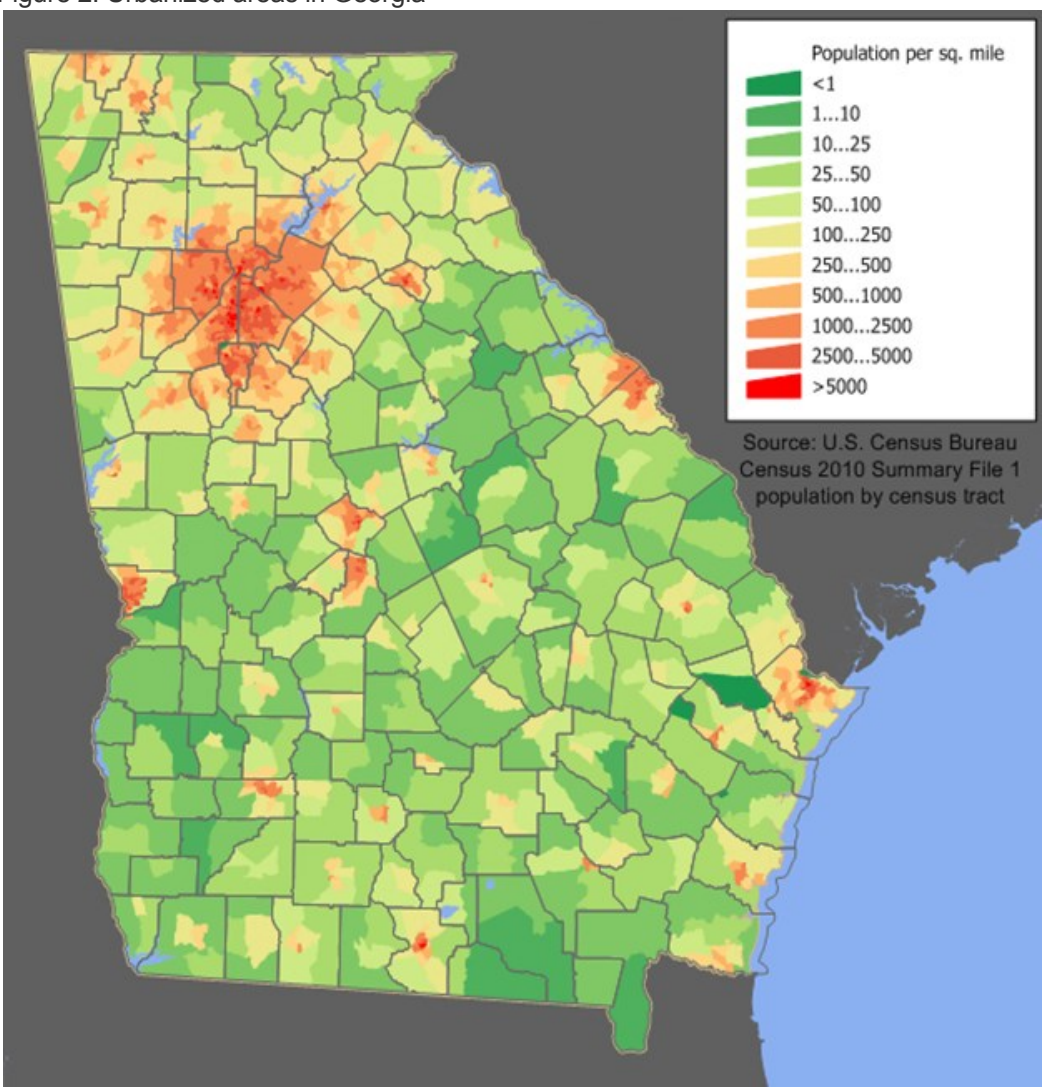
Of Georgia's 159 counties, there are urban and rural ones located throughout the state. The Census Bureau defines two types of urban areas: urbanized areas of 50,000 people or more and urban clusters of at least 2,500 and less than 50,000 people. All other counties are considered rural. In Georgia, 108 counties are designated as rural. There are 20 smaller cities and urban areas with populations above 50,000. The majority of the state's rural counties are located in the southern half of the state.

According to the 2010 census, there are 15 Metropolitan Statistical Areas in Georgia[1]: Albany, Athens-Clarke County, Atlanta-Sandy Springs-Roswell, Augusta-Richmond County (GA-SC), Brunswick, Chattanooga (TN-GA), Columbus (GA-AL), Dalton, Gainesville, Hinesville, Macon, Rome, Savannah, Valdosta and Warner-Robins.

The increasing population and migration trends are resulting in certain rural areas that are experiencing growth in both economics and population while other rural areas are experiencing a decline. The largely rural makeup of the state provides many challenges – and opportunities – to offering adequate health and social services to all Georgia residents.

Due to the large number of counties being designated as rural, access to health care services is challenging, and as such it is essential for DPH to accommodate the needs of the rural population. Telemedicine and other innovative strategies alleviate disparities in access to health care services. The following map generated by the US Census Bureau based on population data for 2010 depicts the urbanized and non-urbanized areas in Georgia.

Figure 2: Urbanized areas in Georgia



Population

As of 2015, Georgia had an estimated population of 10.2 million people[2]. It is ranked the 8th largest state with respect to population based on 2015 estimates[3]. Georgia is the 14th fastest growing state in the nation, with a 4.2% increase from 2010 to 2014[3], and is 4th highest among states with the largest numeric population increase[3]. It is estimated that Georgia's population will increase to 11.3 million by 2020[4]. As with any population growth, there are increasing demands on state and local governments to provide necessary services, including health and social services.

Atlanta, the state capitol, is the economic, cultural and demographic center of Georgia. It is the largest city in the state, with 450,000 people living in the city in 2013 and approximately 5 million living in the Atlanta Metropolitan Statistical Area. The population grew 6.6% from 2010 to 2013, and is expected to continue to do so. Over 6% of residents are under 5, 19.4% are under 18 and 9.8% are over 65. The city also has a high percentage of minorities, with 54% of residents identifying as Black or African American, 38% as White, 5% as Hispanic and 3% as Asian. Hispanics are the largest growing minority, with Asians following as a close second. Poverty is rampant in Atlanta, with 1 in 4 Atlanta residents living below the federal poverty line as of 2009-2013, compared to 18% of the overall Georgia population[2].

Race/Ethnicity

The racial distribution has shifted slightly from 2000 to 2010, although the majority of Georgians are still White or Black. The percentage of Georgians who are White decreased from 65.1% in 2000 to 59.7% in 2010. However, an increase was seen in the percentage who are Black. In 2010, 30.5% of Georgians were Black. The number of Hispanics in Georgia doubled between 2000 and 2010. The number of Asians nearly doubled, with the highest increases seen among Asian Indian, Korean and Vietnamese populations. Such a growth in diversity and population necessitates the availability of culturally-competent health, education and human services.

Table 1. Georgia's Population by Race/Ethnicity, 2000 and 2010

Georgia Population Estimates				
	2000 Census		**2010 Census**	
Population Characteristic	**Number**	**Percent**	**Number**	**Percent**
Total Population	8,186,453	----------	9,687,653	----------
Race/Ethnicity				
White	5,327,281	65.1	5,787,440	59.7
Black or African American	2,349,542	28.7	2,950,435	30.5
American Indian and Alaska Native	21,737	0.3	32,151	0.3
Asian	173,170	2.1	314,467	3.2
Native Hawaiian and Other Pacific Islander	4,246	0.1	6,799	0.1
Some other race	196,289	2.8	388,872	4.0
Two or more races	114,188	1.4	207,489	2.1
Hispanic or Latino (of any race)	435,227	5.3	853,689	8.8

Age and Gender

Georgia is a young state, with 25.7% of the population under 18 years of age, 38.2% between 18 and 44 years, 25.4% between 45 and 64 years and 10.7% over age 65. Georgia is ranked 4th highest for the percentage of the population under age 18. The median age in the state is 35.3[5]. According to 2009-2013 estimates, 6.9% of Georgia's population is under 5 years old[6].

Immigration

In 2010-2014, 9.7% of Georgia residents were born outside of the United States[6]. Majority of foreign born residents (40.5%) identify as White, 16.7% identify as Black or African American and 25.1% as Asian[6]. Of all racial categories 42.8% are Hispanic or of Latin origin[6]. Over 47% are between ages 25 and 44[6]. Nearly 8% of foreign born residents were enrolled in college from 2010-2014[6]. In 2014, 46.3% of foreign born residents fell below 200 percent of the poverty level[6].

From 2000 to 2009, the Department of Homeland Security estimates that the number of unauthorized immigrants in Georgia increased by 115%, ranking Georgia as 6th among states with the largest number of undocumented immigrants. However, data from 2009-2012 show a major decline in the number of undocumented immigrants in Georgia. Georgia was one of 14 states nationwide to have a significant decrease in the number of undocumented immigrants from 425,000 to 400,000. This decrease may be the result of immigration laws Georgia enacted in 2011[7].

Language Proficiency

Over 13% of Georgia residents speak a language other than English[6]. Of the other languages spoken, Spanish or Spanish Creole is the most common. Of those that speak a language other than English, 43.2% speak English less than very well[6]. These factors can have interesting implications on the services that are offered to residents and may necessitate English as a Second Language (ESL) and bilingual teachers and culturally competent approaches to health care delivery.

Family Household Type

Household structures in Georgia are very similar to what is seen across the rest of the United States. In 2010, 47.8% of Georgia households were composed of a husband and wife, with 21.1% of these households having children under the age of 18. Female headed households comprised of 15.8% of the population and 8.9% of these households contained children under the age of 18; 4.9% were male family households, with 2.2% with children under the age of 18. Finally, 25.4% of households were one-person households, with 7.5% being 65 or older. The average number of people per household was 2.6 and 3.2 per family[8].

Educational Attainment

Public schools are the primary source of education in Georgia. In nursery school and preschool, 61.3% are in public school and 38.7% are in private school. From 2009 to 2013, 90.6% of students in Kindergarten to 12th grade were in public school while 9.4% were in private school.

In the 2014 cohort, the high school graduation rate was 72.6 among all students. It was 36.5 for students with a disability, 79.7 among Whites, 64.0 among Hispanics and 65.3 among Blacks[9].

Nearly 85% of Georgia residents over the age of 25 have a high school diploma, and 28% have a bachelor's degree or higher as of 2009 to 2013. More Atlanta residents over 25 have completed high school (88%) when compared to the rest of Georgia and markedly more have at least a Bachelor's degree (46.8%)[2].

Income

Georgia's per capita income was below the national average from 2009 to 2014 with a per capita income of $25,427 relative to the U.S. average of $28,555; at the same time, the state's poverty level was above the national average[2]. In 2014, median household income in Georgia was $49,342 a major decrease from the median income of $55,027 in 2008[6]. However, the trending increase in median household income since 2011 has continued with the largest increase of $1,513 from 2013 to 2014[6].

Table 2. Median Household Income in Georgia and the US, 2008-2014

Year	Georgia	United States
2014	$49,342	$53,482
2013	$47,829	$52,250
2012	$47,895	$52,117
2011	$47,650	$52,306
2010	$49,605	$53,469
2009	$51,684	$54,541
2008	$55,027	$56,290

Poverty

Poverty is more prevalent in Georgia than in many states across the nation. In 2009-2014, 18.3% of Georgians were living below the poverty line, compared with 14.8% for the U.S. overall. Over eight percent were below 50% of the federal poverty level (FPL) and 23.5% were living at less than 125% of the FPL. About 1 in 4 children in Georgia under the age of 18 are in poverty as of 2013. In 2009, only 1 in 5 children under the age of 18 were in poverty. Poverty disproportionately affects ethnic minorities in Georgia, with 26.5% of African-Americans and 32.2% of Hispanics living below the FPL, relative to 13.2% of Whites[6].

Employment

In April 2015, Georgia's unemployment rate was 6.3%, ranking it 41st in the United States. Nebraska, the state with the lowest unemployment rate, only 2.5% of the labor force was unemployed[10]. The high unemployment rate may have serious implications on many of the public and social services offered.

Homelessness

The homelessness rate has decreased in Georgia. In 2009, 12,101 were unsheltered and 8,994 were in transitional or emergency housing, compared to 8,450 unsheltered and 8,497 in transitional or emergency housing in 2013[11]. Of these, 51% were African American and 42% were White. The majority (93%) were living in Georgia when they first became homeless. About 10% of the homeless respondents were veterans, 38% had a disability and 17% were under age 18.

Insurance Status

Eight percent of Georgia's children are uninsured, making it the state with the 8th highest rate of uninsured children. Sixteen percent of the total state's population is uninsured, ranking it 7th highest[12]. Minorities such as Blacks and Hispanics have a significantly higher rate of uninsurance and underinsurance compared to their White counterparts. This is yet another disparity that further contributes to delay in seeking health care, increased visits to the emergency room and poor health outcomes.

Health Reform

The Affordable Care Act, signed in 2010, went into effect in 2014. Although it has been implemented, its effects remain to be seen. It is a state decision to participate in the Medicaid expansion or not, and as of 2016 Georgia will not expand. Although implementation of Affordable Care Act will be complex and challenging, analysts do estimate that 1.17 million Georgia residents that were currently uninsured will obtain coverage by 2019. Approximately 511,826 Georgians acquired health insurance through the marketplace at the end of 2016 open enrollment[13]. It is estimated that half of Georgians eligible through the marketplace have received coverage[14]. HB 943 is in effect in Georgia, which prohibits government agencies from advocating for Medicaid expansion, from operating insurance exchanges and from providing navigator programs[15].

Emerging Issues

Georgia is one of the largest and fastest growing states in the nation, yet residents experience more poverty and unemployment than what is seen nationally. Although economists anticipated that Georgia's economy would catch up with the nation's recovery by mid-year 2011[16], this was not the case. The economic recovery is slow but yielded an increase in state revenue for the 2016 budget.

Although state revenue increased in 2016, the Department of Community Health faced a budget decline. The 2016 budget directs $2.49 billion to the Department of Community Health, not including money for agencies attached for administrative purposes – which is a $30.5 million decline from the 2015 budget. Although the department does allocate funding for nine programs, more than 96% of the general fund spending is for health care services for Medicaid and PeachCare patients[17]. A decreased budget had many implications for the Medicaid and PeachCare

population. The proposed 2017 budget directs an increase to the Department of Community Health.

Education funding has also been significantly cut for the last decade. As a result, 85% of school districts have increased class size, 68% have fewer teachers, 46% have eliminated or reduced art or music, and 36% have reduced programming to help children who are falling behind. The amount the state has reduced from its education budget since 2003 is $8.3 billion, with a $746 million reduction for the 2014-2015 school year[18]. These reductions are concerning as school readiness and adequate education for older children have significant impacts on a person's emotional, social and physical well-being.

Georgia has received an extension of their Planning for Healthy Babies program, which is a Section 1115 Family Planning Demonstration Waiver that extends Medicaid eligibility coverage to women between the ages of 18 and 44 whose incomes are up to 200% of the FPL.

Nearly three-fourths of childhood deaths are due to unintentional injuries, most related to car accidents. Recent efforts have been made to improve awareness of car seat safety. Georgia has increased the age which children must stay in rear facing car seats from one year old to two years old and requires use of a booster seat for children until 8 years old or 80 pounds. While this is making a positive impact on the lives of younger children in Georgia, more work needs to be done to protect the lives of preteens and teens traveling in cars in Georgia.

Title V Priorities

In light of the geographic, demographic and political issues surrounding Georgia, this is a critical time for the Title V program to assess the health status of the MCH population in Georgia and assess priorities. The process used by the Title V Director for determining the needs and priorities of the program is multi-factorial. Primarily, the five-year assessment is used to evaluate priorities. However, efforts are made to align priorities with ongoing needs assessment efforts, priorities of the Governor and Commissioner and Executive Leadership within the agency. Title V priorities are also chosen to the extent that they by address needs that are not otherwise met through other grants, programs and partnering organizations.

DPH developed a new strategic plan to carry the agency through 2019. Although the strategic plan is not comprehensive of all priorities within the agency, it does highlight the areas that will receive specific programmatic emphasis throughout the next three years. The strategic plan includes the following goals and objectives:

GOAL 1: Prevent disease, injury, and disability. Provide population-based programs and preventive services to prevent disease, injury, and disability by advocating for and promoting health, leading change in health policies and systems, and enabling healthy choices.
Objective 1.1: Childhood Obesity
Objective 1.2: Asthma
Objective 1.3: Infant Mortality
Objective 1.4: Cardio Metabolic Syndrome
Objective 1.5: Early Brain Development

GOAL 2. Promote health and well-being. Increase access to care throughout the State of Georgia and educate the public, practitioners, and government to promote health and well-being by collecting, analyzing and reporting health data, tracking disease and health determinants and applying science and epidemiological principles to support decisions.
Objective 2.1: Healthcare Access/Primary Care
Objective 2.2: Infrastructure support and improvement to promote health and wellbeing

GOAL 3: Prepare for and respond to disasters. Insure efficient, effective and quality Public Health infrastructure to prepare for and respond to emergencies to safeguard the health and wellbeing of Georgians by conducting surveillance, inspect for environmental hazards, epidemiological investigations and providing support for district operations.

Objective 3.1: Infrastructure support and improvement to prepare for and respond to disasters

The initiatives outlined in the State Action Plan Chart to prevent infant mortality align with the strategies to meet Objective 1.3 of the DPH Strategic Plan.

II.B. Five Year Needs Assessment Summary

2016 Five-Year Needs Assessment Summary

The 2015 Needs Assessment identified suicide among adolescents 12 to 17as a priority need. In 2013, 25.1% of Georgia's high school students reported either being bullied or bullying others, an increase from 2011. Almost twice as many 9th grade students reported that they were involved in bullying than those in the 12th grade (30.8% and 17.2% respectively). With suicide rates being 1.4 in those ages 10-14, 5.1 in those 15-17 and 8.2 in those 18-19, the MCH Section explored the relationship between suicide and bullying and the landscape of bullying prevention programs in Georgia. An examination of youth suicide and bullying in Georgia was conducted by analyzing the most current information available. Emory University Rollins School of Public Health students researched the evidence-based strategies for bullying prevention in Georgia.

The following reports were used for the Ongoing Needs Assessment:

- Georgia Child Fatality Report
- Evidence for Bullying Prevention in Georgia

Findings from 2015 Needs Assessment

Suicide

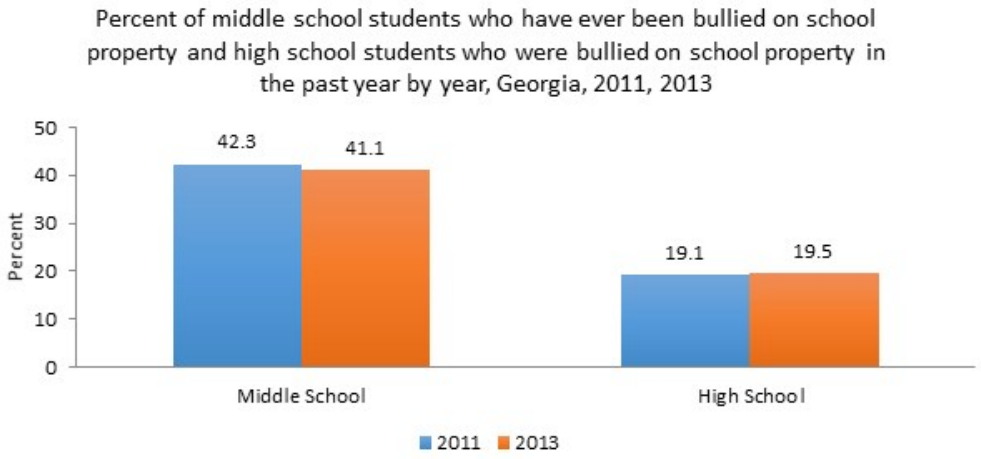
The adolescent suicide death rate increased from 3.2 in 2012 to 5.1 in 2013. From 2009-2013, the rate was 1.4 in those ages 10-14, 5.1 in those 15-17 and 8.2 in those 18-19. The rate was approximately twice as high among Non-Hispanic Whites (5.3) compared to Non-Hispanic Blacks (2.6) and Hispanics (2.7).

Bullying

Just over 40 percent of Georgia's middle school students reported having ever been bullied on school property in 2011 and 2013. Among high school students during the same years, just over 19 percent were bullied on school property during the past year.

The percentage of middle school students who had ever been bullied on school property was similar across all grade levels in 2013. More non-Hispanic White adolescents reported experiencing bullying than non-Hispanic Blacks or Hispanics. Females (46.4 percent) reported being bullied on school property more often than males (36.1 percent).

Bullying on school property during the past year was more prevalent among high school students in 9th and 10th grade (24.7 percent and 23.1 percent) compared to those in 11th and 12th grade (14.8 percent and 12.4 percent). Non-Hispanic Whites and Hispanics were bullied on school property in the past year over 1.5 times more than their non-Hispanic Black counterparts. Slightly more females reported experiencing bullying in the past year compared to males.



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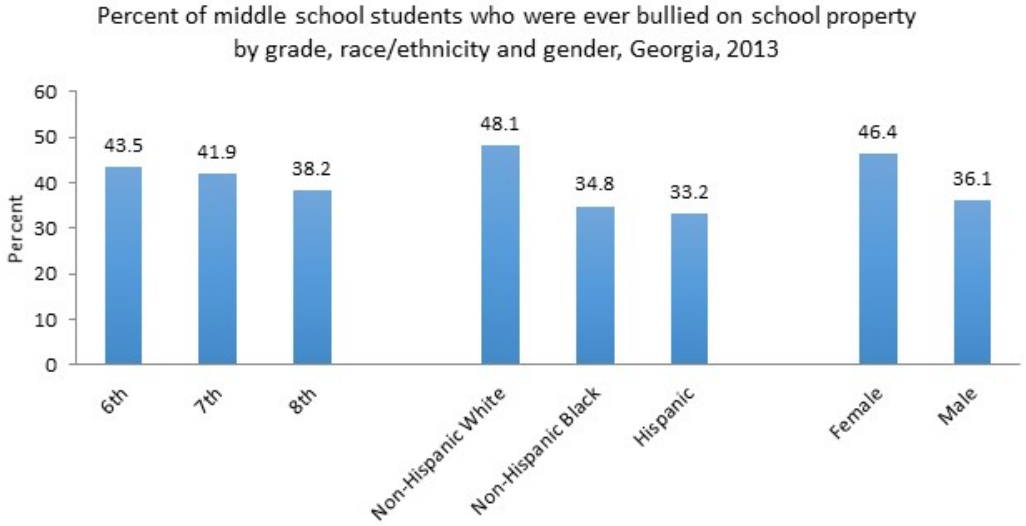

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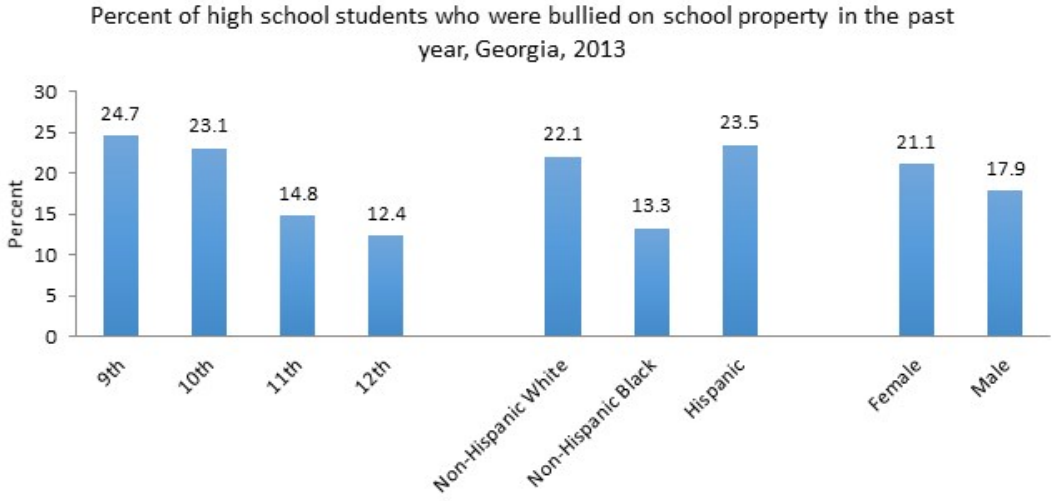


Source: YRBS

Victims and Bullies

In 2013, 25.1 percent of Georgia's high school students reported either being bullied or bullying others. Almost twice as many 9th grade students reported that they were involved in bullying than those in the 12th grade (30.8 percent and 17.2 percent respectively). Racial differences were seen as well. Hispanic and non-Hispanic White students (27.4 percent and 29.0 percent) reported experiencing far more bullying than their non-Hispanic Black (17.3 percent) counterparts. Females experienced bullying more often than did males (27.8 percent compared to 22.2 percent).

Findings from 2016 Ongoing Needs Assessment

Suicide-Georgia Child Fatality Report

Georgia's Child Fatality Review Program (GCFR) was established in 1990 by statute (Section 19-15-1 et seq.). CFR is an independent program currently administered out of the Georgia Bureau of Investigation (GBI). Local CFR committees review all injury, sleep-related, and unexpected/suspicious deaths to children who are less than 18 years old. Local committees submit their reviews using the National CDR Case Reporting System; the state Panel reviews selected case reports that have been completed by the local committees.

GCFR compiles the findings from the review and generates an annual report. The GCFR Annual Report 2014, was used to gather additional information regarding suicides among youth 12 to 17.

In almost half of the youth suicides, local CFR committees reported that the child talked about suicide at some point prior to the death. Suicide warning signs include anxiety, withdrawal from friends and family, uncontrolled anger, severe mood changes, substance use, and feeling like there's no sense of purpose. Additionally, risk factors for youth may include feelings of hopelessness and/or sadness for at least two weeks.
In 2014, 28 suicides were reviewed, marking a decrease from 40 in 2013. Suicide remains the fifth leading cause of death for Georgia's children. Teens ages 15 to 17 are at greatest risk for suicide. Suicide among males reduced from 35 in 2013 to 18 in 2014. However, suicide among females increased from 5 in 2013 to 10 in 2014.
Of the reported risk factors for reviewed suicide deaths (28), five deaths were associated with a bullied victim and three were associated with sexual orientation.
The GCFR Report acknowledges HB 198, to require 3 annual suicide prevention education training for certificated school system personnel, as an opportunity for prevention.

Strengths

The data indicate a reduction in suicides from 2013 to 2014 but an increase in suicides among females. The GCFR Report identified that more than half of the teens that committed suicide talked about suicide before committing the act.

Areas of Opportunity

HB 198 is an opportunity for DPH and the Department of Education (DOE) to partner on suicide/bullying prevention within schools.

Bullying- Evidence for Bullying Prevention in Georgia

Emory University Rollins School of Public Health reviewed Georgia specific data on bullying and suicide to identify high-risk population sub-groups and geographic locations where intervention strategies could be targeted. To identify high-risk groups, Emory students used vital statistics from DPH's Online Analytical Statistical Information System (OASIS), Georgia's Child Fatality Review Report, Youth Risk Behavior Surveillance System (YRBSS) and the National Survey of Children's Health (NSCH).
From 2009-2013 19.3% of youth committing suicide were disabled. Of the population sub-groups youth with disabilities may disproportionately be affected by suicide and bullying related suicide. Although this is a finding to

explore further, authors state the finding cannot describe exact risk. From 2005-2014 one public health district, Cobb-Douglas, had a higher than expected number of suicides.

Strengths

The data indicate a sub-group and geographic location at higher risk for suicide.

Areas of Opportunity

Disabled youth and youth living in the Cobb-Douglas Public Health District were identified as being at greater risk of bullying. MCH will be able to target intervention strategies to reach these population groups.

Five-Year Needs Assessment Summary (Submitted on July 15, 2015)

II.B.1. Process

Goals, Framework and Methodology Guiding Needs Assessment Process

Georgia's Title V Needs Assessment was conducted by the Maternal and Child Health (MCH) Office of Epidemiology within the Georgia Department of Public Health. MCH currently uses the following mission and vision to guide all programmatic efforts, including the Title V Needs Assessment:

MISSION: To implement measurable and accountable services and programs that improve the health of women, infants, children, including children and youth with special health care needs, fathers, and families in Georgia.

VISION: Through the implementation of evidence-based strategies and the use of program and surveillance data, identify and deliver public health information and population-based interventions that have an impact on the health status of women, infants, children, including children and youth with special health care needs, fathers, and families in Georgia.

The focus of MCH Epidemiology is to promote and improve the health and well-being of women, children and families by building data capacity at the state and local levels to effectively use information for public health actions.

The Needs Assessment Workgroup (NAW) was established to complete Georgia's 2015 Title V Needs Assessment. The group, under the leadership of the Title V Director and Manager, consisted of directors and managers from all MCH programs. Monthly meetings were held beginning in April 2014. Although the NAW was charged with primary responsibility for planning and completing Needs Assessment activities, meetings were often held with all program staff by population domain (described below) to incorporate input from all Title V staff. An independent contractor was used to provide consultative services, analyze data, facilitate meetings and produce deliverables for the Needs Assessment.

The Needs Assessment was organized by six population health domains: maternal/women's health, perinatal health, children's health, adolescent health, children and youth with special health care needs (CYSHCN) and cross-cutting/life-course. Key steps for the needs assessment process are outlined in Figure 1.

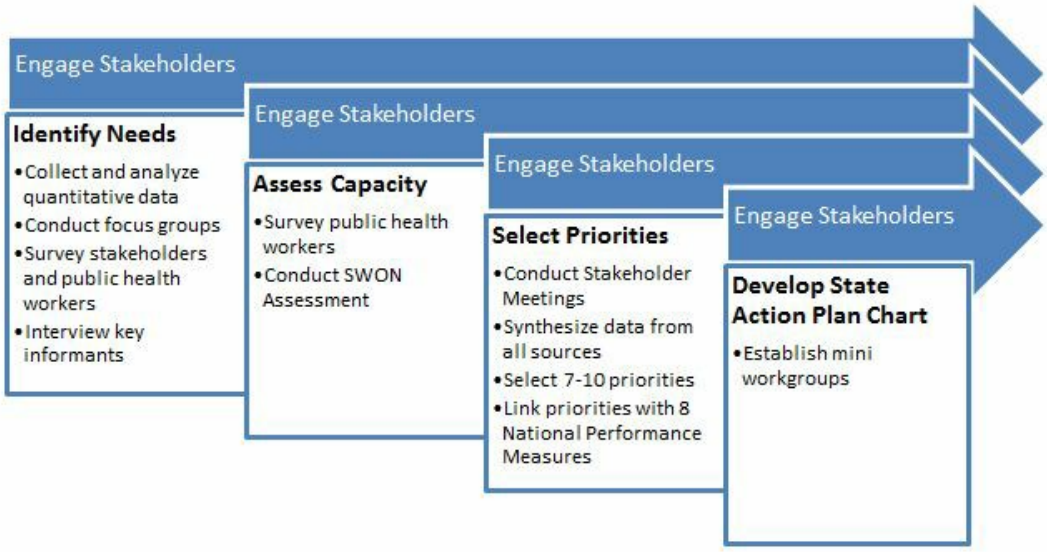


Figure 1. Georgia Title V Needs Assessment Process

Quantitative Methods

A thorough examination of the health status of women and children in Georgia was conducted by analyzing the most current information available by population domain. Trends over time were presented for all data where possible and information was stratified by relevant variables including age, race/ethnicity, education, income, gender, health insurance coverage and CYSHCN status. Comparisons with national averages and Healthy People 2020 objectives were made when possible to provide better context for the data provided. Due to a lack of current data regarding CYSHCN, projection analysis was applied to the 2009/10 National Survey of Children with Special Health Care Needs results. The following data sources were used:

- Behavioral Risk Factor Surveillance System
- Babies Can't Wait Program
- Children's Medical Services Program
- Current Population Survey
- Early Hearing Detection and Intervention Program
- Family Planning Program
- Georgia Comprehensive Cancer Registry
- Hospital Discharge Data
- HIV Surveillance Program
- Metro Atlanta Developmental Disabilities Surveillance Program
- National Immunization Survey
- National Survey of Children's Health
- National Survey of Children with Special Health Care Needs
- National Vital Statistics System
- Online Analytical Statistical Information System
- Pregnancy Risk Assessment Monitoring System
- State Inpatient Databases
- State Vital Records

- STD Surveillance Program
- Youth Risk Behavior Surveillance System
- Youth Tobacco Survey
- Water Fluoridation Reporting System

Focus Groups

Qualitative data were gathered from each of Georgia's 18 public health districts to gain insight into the needs of MCH populations and areas to improve the delivery of public health services. Data were collected through focus groups in 16 districts and through key informant interviews in 2 districts (East Metro and DeKalb). Focus groups were attempted in both East Metro and DeKalb, but due to low participation, key informant interviews were used as a culturally appropriate method of gaining insight into the Hispanic community. The focus groups were on three topics: perinatal health, school readiness and CYSHCN. The topics were chosen to cover the three legislatively-defined MCH populations. School readiness was chosen as the topic for child health due to the lack of quantitative data available.

Table 1. Needs Assessment Focus Groups by Location and Topic

Perinatal Health	School Readiness	CYSHCN
Rome	Waycross	Cobb Douglas
Fulton	Valdosta	Augusta
East Metro	Macon	Columbus
Dublin	Dalton	Gainesville
Albany	LaGrange	Clayton
Athens		Savannah
DeKalb		

Stakeholders and community members were engaged through focus groups, a survey, key informant interviews, priority selection and an ongoing public comment period. Focus groups were not only conducted among community members, they were conducted by community members experienced in focus group facilitation. A survey was conducted to identify needs and 492 responses were received. Snowball sampling, where participants are asked to disseminate the survey, was used to obtain a high number of responses. Key informant interviews were conducted among six leaders in their respective fields. Stakeholders had the opportunity to review the analysis, comment on areas covered and recommend priorities. Although the results from their prioritization were used as a recommendation, their opinions and capacity were given the highest weight when determining priorities. Sections of the Needs Assessment were posted upon completion for public input from March 2015 to July 2015.

Interface Between Needs Assessment Data, Priority Needs and State Action Plan Chart

MCH program and epidemiology staff reviewed all data from the quantitative and qualitative analysis in order to select the potential priority needs for the state for the population domains relevant to their work. Staff individually indicated their top needs based on the data reports and then a consensus was developed across all members. They

were asked to primarily consider whether the data indicated an area of need, whether it was measurable, and whether MCH had the capacity and authority to address the need. A total of 34 priorities were selected and brought to stakeholders for prioritization.

Stakeholder prioritization occurred during two meetings. Meetings were held in Atlanta and Valdosta to encourage the participation of stakeholders in both North and South Georgia. A total of 100 stakeholders representing 38 organizations attended. Following group discussions, each stakeholder individually completed a prioritization tool. The tool was designed to rate each need on a scale of 1 to 5 based on the following criteria: seriousness of the issue, health equity, economic impact, trend, magnitude of the problem and importance. Stakeholders provided key activities and strategies within each area of need to inform the development of the State Action Plan Chart.

The individual rating tools were analyzed across the two meetings to determine the highest rated priority needs in each domain. When determining priorities, the needs with the highest rating in each domain were considered first. The data and results from survey rankings were reviewed to assess consistency and confirm an area of need. Needs were then aligned with a NPM when possible (displayed in Table 2).

Table 2. Linkage between Priority Needs and National Performance Measures

Population Domain	Priority Need	National Performance Measure(s)
Maternal/Women's Health	Prevent maternal mortality	Well-woman visit
	Increase access to family planning services	None
Perinatal Health	Prevent infant mortality	Breastfeeding Perinatal regionalization
Child Health	Promote developmental screenings among children	Developmental screening
	Promote physical activity among children	Physical activity
Adolescent Health	Prevent suicide among adolescents	Bullying
Children and Youth with Special Health Care Needs	Improve systems of care for CYSHCN	Transition
Cross-Cutting	Promote oral health among all populations	Oral health

The State Action Plan Chart was developed by mini-work groups for each domain consisting of staff in MCH Programs, Epidemiology and Strategy. Strategies were identified based on suggestions from the stakeholder meetings, focus group findings and a review of the evidence base for each NPM.

II.B.2. Findings

The following summary provides an overview of the quantitative findings related to the identified priority needs and NPMs and qualitative findings from focus groups and key informant interviews. Each domain includes a summary of strengths and needs relative to the identified priority needs and national priority areas. A more comprehensive discussion of strengths and needs from all findings are provided in the full Needs Assessment report (available at www.dph.ga.gov/titlev). Figures and citations for the data presented below are located in the Supporting Documents.

II.B.2.a. MCH Population Needs

Maternal/Women's Health

Maternal Mortality

The maternal mortality ratio (number of pregnancy-related deaths per 100,000 live births) increased from 11.5 (n=16) in 2004 to 43.6 (n=56) in 2013 (Figure 1). Georgia recently implemented a Maternal Mortality Review Committee to review all maternal deaths. Different inclusion criteria are used for this committee and the data should not be compared to the findings identified from cases identified by ICD codes. The committee identified 25 pregnancy-related and 60 pregnancy-associated cases in 2012 (Figure 2). Of the deaths that were related to pregnancy, 17 of the women were Black, 6 were White, 1 was Hispanic and 1 was unknown (Figure 3). The most common cause of death among pregnancy-related cases was hemorrhage. Hypertension, cardiac conditions and embolism were common causes as well, highlighting the importance of preconception health.

Preventive Visit

Although there was an overall decline in the percentage of women receiving a preventive medical visit between 2009 and 2013 in Georgia (73.9% compared to 68.1%), the percentage remained above the national average in all years examined (Figure 4). Over 78% of non-Hispanic Black women reported having seen a provider, while only 60.7% of Hispanic women attended such a visit. The percentage of women receiving a preventive visit was higher among women with a higher educational attainment (Figure 5).

Family Planning

The percentage of births that were not planned in Georgia increased from 52.6% in 2009 to 54.8% in 2011 (Figure 6). The percentage of unplanned births was 29.4% among mothers over the age of 35 and 82.3% among mothers less than 20 years of age. Non-Hispanic Black women reported a higher percentage of unplanned births (73.4%) than Hispanics (57.9%) and non-Hispanic Whites (42.6%) (Figure 7).

Low-Risk Cesarean Deliveries

The prevalence of low-risk cesarean deliveries in Georgia remained relatively stable from 2009 to 2013, with only a slight increase from 27.8% in 2009 to 28.7% in 2013 (Figure 8). Differences are seen by maternal age and education level. Specifically, 58% more women over 35 years of age had a cesarean section compared to women less than 20 years of age in 2013. More college graduates had low-risk cesarean sections than women with less than a high school diploma (31.6% compared to 23.7%) (Figure 9).

Table 3. Maternal/Women's Health Qualitative Findings

Focus Groups: Perinatal Health	
Individual-Level Factors	• Incorrect/inconsistent use of contraception • Limited or no preparation for a healthy pregnancy • Misunderstanding about birth spacing recommendations • Preference for private vs. public services
Structural-Level Factors	• Long wait times for appointments • Lack of transportation
Key Informant Interviews	
Priority Needs	• Promote preventive medical visits

	• Increase breastfeeding initiation and duration • Prevent maternal mortality • Prevent infant mortality • Reduce primary and repeat teen births • Prevent sexually transmitted infections
Individual-Level Factors	• Little awareness on the importance of preconception health
Structural-Level Factors	• Lack of insurance between pregnancies • Lack of facilities/clinics for prenatal care • Lack of access to mental health care • Reimbursement systems need to be updated • Programs providing birth control for low-income women between pregnancies are not well marketed • Shortages of Maternal and Fetal Medicine and Obstetric providers, especially in rural areas • Labor and Delivery Unit closures

Strengths and Needs

The data indicate areas where sub-groups of Georgia's population are achieving acceptable outcomes. The percentage of women receiving a preventive visit in Georgia is higher than the national average. In Georgia, the percentage is highest among non-Hispanic Blacks and women with higher educational attainment. Younger women in Georgia undergo cesarean deliveries for a low-risk birth less often than older women.

There is a need to reduce the maternal mortality ratio in Georgia. Not only has the statistic been increasing, there are differences among racial/ethnic groups. Additionally, the percentage of women who reported visiting a medical provider in the past year declined from 2009 to 2013. Efforts should be made to ensure that this percentage does not decrease further. Efforts reduce low-risk cesarean sections should be targeted to women over age 30 and with higher educational attainment.

Programmatic Efforts to be Continued

- The Maternal Mortality Review Committee has provided the state with important findings on the prevalence and causes of maternal mortality

Areas of Opportunity

- Continue to refine policies for the Maternal Mortality Review Committee and implement data to action activities
- Promote well-woman visits and pre- or interconception care
- Promote family planning services available through the health department

Perinatal Health

Infant Mortality

The infant mortality rate was 7.2 in 2013 (Figure 10). A significant effort to decrease infant mortality is recognized by DPH Executive leadership and MCH leadership to ensure Georgia achieves the HP 2020 objective of 6.0. Disparities exist by race, with the rate of death for non-Hispanic Black infants being twice that of non-Hispanic Whites (Figure 11).

Perinatal Regionalization

The percentage of very low birth weight infants (VLBW) delivered at a Level III facility has steadily increased in Georgia. In 2008, 74.8% of infants were born in a Level III facility compared to 78.5% in 2012 (Figure 12). Georgia has six perinatal regions. Each region consists of a Regional Perinatal Center, Level III, Level II, and Level I facilities. The Atlanta perinatal region had the highest percentage (80.8%) of very low birth weight infants born at the appropriate level of care. The Augusta (62.3%) and Savannah (66.1%) perinatal regions had the lowest percentages of VLBW infants born in a level III facility (Figure 13).

Breastfeeding Initiation

The percentage of infants ever breastfed in Georgia increased from 64.8% in 2007 to 70.3% in 2011. However, the percentage in Georgia was lower than the national average (79.2%) in 2011 (Figure 14). The HP 2020 objective for the percentage of infants ever breastfed is 81.9%. As of 2011, an increase of over 16% is needed in Georgia to meet the objective by 2020. Mothers 30 years of age or more reported initiating breastfeeding (76.6%) more often than mothers between the ages of 20 and 29 (61.0%). When stratified by race/ethnicity, 61.2% of non-Hispanic Black mothers reported ever breastfeeding their infant compared to 72.6% of non-Hispanic White mothers and 78.4% of Hispanic mothers. The percentage was higher among mothers with higher educational attainment: 87.8% in those with a college degree, 74.4% in those with some college education and 65.8% in those with only a high school degree (Figure 15).

Breastfeeding Exclusivity

There was an overall increase in the percentage of infants exclusively breastfed at six months in Georgia from 2007 to 2011, despite a decrease in 2010. In 2011, 14.5% of infants were exclusively breastfed at six months, less than the national average (18.8%) and HP 2020 target (25.5%) (Figure 16). The percentage of infants exclusively breastfed was higher among mothers with a college education (19.7%) than mothers with less than a high school degree (4.2%). Additionally, a higher percentage of women over 30 years of age were breastfeeding exclusively at six months compared to women less than 30 years of age (14.2% and 8.0% respectively) (Figure 17).

Safe Sleep

Healthy People 2020's safe sleep objective is to increase the percentage of infants sleeping on their backs to 75.9%. In 2011, Georgia was more than twenty percentage points lower than this objective at only 53.1% (Figure 18). During the same year, the national average was 74.3%. Disparities exist regarding maternal age and race/ethnicity. A lower percentage of younger mothers less than 20 years of age put their infants on their back to sleep (37.0%) compared to mothers over 35 years of age (55.7%). Additionally, non-Hispanic White mothers placed their infant to sleep on the back most often, with over 61% compared to non-Hispanic Black (43.0%) mothers. The percentage of infants placed to sleep on their back was 1.7 times higher among mothers who graduated college compared to mothers with less than a high school degree. None of the groups examined meet or exceed the HP 2020 target

(Figure 19).

Table 4. Perinatal Health Qualitative Findings

Focus Groups: Perinatal Health	
Individual-Level	• Familiarity with provider encourages care-seeking behavior • Lack of knowledge on available parenting classes and resources
Structural-Level	• Support systems encourage breastfeeding • Lack of transportation
Key Informant Interviews	
Priority Needs	• Improve the perinatal regionalization system • Promote safe sleep environments • Promote breastfeeding, especially for high-risk infants
Individual-Level	• Lack of awareness on the benefits of breastfeeding
Structural-Level	• Lack of public transportation • Lack of access to specialized care in rural areas • Insurance reimbursement prevents transfer of high-risk neonates to appropriate hospital • Lack of a donor breast milk program in the state

Strengths and Needs

Certain population sub-groups in Georgia are meeting or exceeding national standards. The infant mortality rate among White and Hispanic infants is below the Healthy People 2020 objective. Mothers with high educational attainment are initiating breastfeeding and maintaining breastfeeding exclusivity at acceptable rates.

There is a clear need to improve safe sleep in Georgia. The population as a whole and examined strata are failing to achieve national standards for the percent of infants placed to sleep on their back. Breastfeeding initiation and exclusivity should be promoted among younger mothers and those with lower educational attainment. There is also a need to reduce the disparities in Georgia's perinatal regions, and ensure that all very low birth weight infants throughout the state are receiving care at the most appropriate facility. Addressing all three of these needs will help ensure the infant mortality rate does not increase further.

Programmatic Efforts to be Continued

- The Georgia 5-STAR initiative has been highly successful in motivating hospitals to take steps toward becoming breastfeeding-friendly
- The March of Dimes banner program has been successful in reducing early elective deliveries
- The Safe to Sleep campaign continues to be promoted to change community norms regarding safe sleep environments

Areas of Opportunity

- The Georgia Perinatal Quality Collaborative (GaPQC) has just begun and there is opportunity to implement new quality improvement activities
- There is opportunity to ensure that the defined levels of neonatal care are being implemented in birthing hospitals throughout the state
- The Business Case for Breastfeeding can be promoted to employers throughout the state

Child Health

Developmental Screening

In 2011/12, 30.8% of children in the US were screened for developmental, behavioral and social delays while 40.8% of children were screened in Georgia in 2011/12. In 2007, 22.7% of Georgia's children received a developmental screen. The percentage increased 79.0% from 2007 to 2011/12 (Figure 20). A higher percentage of non-Hispanic Black children (45.4%) receive a developmental screening than non-Hispanic Whites and Hispanics (36.1% and 34.1%). Additionally, more children in Georgia using public insurance receive a developmental screening compared to children using private insurance (44.9% and 38.2% respectively) (Figure 21).

Non-Fatal Injury

The rate of hospitalizations due to non-fatal injury among children was 162.1 in 2008. In 2012, the rate decreased to 134.2 (Figure 22). The rate in 2012 was highest among children under 1 year of age (244.61). It was 162.7 among children 1 to 4 years of age and 91.2 among children 5 to 9 years of age. More non-Hispanic White children experienced hospitalization due to injury (84.5) compared to their Non-Hispanic Black (74.8) and Hispanic (28.3) counterparts. A higher rate was seen among males compared to females (Figure 23).

Physical Activity

There was no notable shift in the overall percentage of children performing physical activity 20 minutes daily between 2007 and 2011/12 both nationally and in Georgia. During 2011/12, more children aged 6 to 11 performed physical activity than those 12 to 17 years of age (35.9% compared to 24.8%). However, the 2011/12 estimate for children in Georgia aged 6 to 11 decreased from 39.2% in 2007 and became very similar to the national estimate of 35.6% for this age group (Figure 24). The most notable disparity is between genders, with 36.3% of males performing physical activity for 20 minutes daily compared to 24.4% of females (Figure 25).

Table 5. Child Health Qualitative Findings

Focus Groups: School Readiness	
Individual-Level	• Lack of cultural competency among teachers

	• Lack of parental knowledge surrounding nutrition • Lack of knowledge about school readiness services • Parental involvement at home is key to success in school
Structural-Level	• Middle class is ineligible for services • Transportation to schools of choice is not available • Long waiting times at the health department • Mandated screenings are difficult to finance • Fruits and vegetables are provided through WIC
Key Informant Interviews	
Priority Needs	• Promote physical activity
Structural-Level	• Lack of pediatricians in rural areas

Strengths and Needs

A major decline has been seen in the rate of hospitalizations due to non-fatal injury among children. Georgia has seen an increase in the percentage of children screened for developmental delays and is exceeding the national standards.

Despite the successes seen around developmental screenings, less than half of Georgia's children receive this screening. Additionally, there are disparities in Georgia related to race and insurance status that are not present at the national level. Obesity levels in Georgia are higher than the national average, and disparities exist due to income levels. Although Georgia's physical activity data are comparable to the US, a concerted effort is needed to ensure that females are performing physical activity and that children ages 6 to 11 continue to perform physical activity into adolescence.

Programmatic Efforts to be Continued

- Georgia SHAPE has successfully promoted physical activity in elementary and middle schools throughout the state
- The Child Occupant Safety Project distributes car seats to prevent injury and death due to motor vehicle crashes

Areas of Opportunity

- Developmental screenings are successfully conducted within public health programs, but there is opportunity to increase this reach and promote screenings for children not using the public health system

Adolescent Health

Suicide

The adolescent suicide death rate increased from 3.2 in 2012 to 5.1 in 2013 (Figure 26). From 2009-2013, the rate was 1.4 in those ages 10-14, 5.1 in those 15-17 and 8.2 in those 18-19. The rate was approximately twice as high among Non-Hispanic Whites (5.3) compared to Non-Hispanic Blacks (2.6) and Hispanics (2.7) (Figure 27).

Bullying

In 2013, 25.1% of Georgia's high school students reported either being bullied or bullying others compared to 24.8% in 2011. Almost twice as many 9th grade students reported that they were involved in bullying than those in the 12th grade (30.8% and 17.2% respectively). Racial disparities exist as well. Hispanic and non-Hispanic White students (27.4% and 29.0%) reported experiencing far more bullying than their non-Hispanic Black (17.3%) counterparts. Females experienced bullying more often than did males (27.8% compared to 22.2%) (Figure 28).

Physical Activity

When it comes to the percentage of high school students who are physically active every day of the week, Georgia is both lower than the national average (27.1%) for 2013 and below the HP 2020 target for adolescents (31.6%). There has been an overall decline in the percentage of high school students who are physically active every day of the week since 2007. In 2013, 24.7% of students performed 60 minutes of physical activity per day (Figure 29). Students in grades 9 through 11 reported more physical activity than 12th grade students. Male students are the only group in Georgia currently achieving the HP 2020 objective and reported two times the physical activity as their female counterparts (34.5% compared to 15.1%) (Figure 30).

Non-Fatal Injury

The rate of hospitalization due to non-fatal injury among adolescents decreased from 2008 to 2012. In 2008, the rate was 260.8, but it decreased to 191.0 in 2012 (Figure 31). As adolescents age, they experience more hospitalizations. Adolescents ages 10 to 14 had a non-fatal injury hospitalization rate of 110.7 in 2012, compared to 271.7 among adolescents 15 to 19 years of age. The disparity due to gender is more pronounced among adolescents than children, with a rate of 240.4 among males and 139.2 among females. The rate was 177.7 among non-Hispanic Whites, 129.7 among non-Hispanic Blacks and 79.5 among Hispanics (Figure 32).

Preventive Visits

In 2007, the percentage of adolescents 12 to 17 years who saw a doctor, nurse or other health care provider for preventive care was 82.9% (Figure 33). This percentage decreased to 77.0% in 2011/12, falling below the national average of 81.7% in 2011/12. Although the national average declined from 2007 to 2012 as well (84.2% to 81.7%), the decline was more pronounced among Georgia's adolescents. Adolescents in rural locations reported far fewer (59.5%) preventive visits than those living in a Metropolitan Statistical Area (MSA) non-central city (83.8%). Of all the groups examined, the only category exceeding the national average for 2011/12 is adolescents living in MSAs that are non-central cities (Figure 34).

Table 6. Adolescent Health Qualitative Findings

Key Informant Interviews	
Priority Needs	• Promote physical activity • Prevent bullying

	• Promote sexual and reproductive health
Structural-Level	• Lack of teen clinics • Providers need to provide teen-friendly services

Strengths and Needs

Georgia has seen success in reducing hospitalizations due to non-fatal injury. The rate has decreased over the previous five years. The prevalence of bullying and the increase in the suicide death rate indicates a need to address suicide, violence and bullying among adolescents. The overall percentages of adolescents performing recommended amounts of physical activity and receiving well-visits remain low.

Programmatic Efforts to be Continued

- Family planning clinics will continue to provide services to adolescents

Areas of Opportunity

- Public health family planning clinics can implement teen-friendly approaches to providing services
- There is an opportunity to initiate bullying prevention initiatives at the state level

Children and Youth with Special Health Care Needs (CYSHCN)

Transition to Adulthood

The percentage of CYSHCN receiving services needed to transition to adulthood in Georgia was less than the national average in 2009/10 (33.9% compared to 40.0%) (Figure 35). Non-Hispanic White children (43.6%) received these services more often than their non-Hispanic Black (21.7%) counterparts. Most notably, half of CYSHCN on private insurance only received these services, while 17.8% on public insurance only did (Figure 36).

Medical Home

In 2009/10, 45.7% of Georgia's CYSHCN received care within a medical home compared to 43.0% nationally (Figure 37). Georgia exceeds the national average for non-Hispanic White and non-Hispanic Black children, as well as those with only private insurance. However, a disparity exists between non-Hispanic Black and non-Hispanic White CYSHCN (38.4% and 53.8% respectively). There is a disparity at the national level due to insurance status, however this gap is more pronounced in Georgia. Of CYSHCN with private insurance only, 59.7% received care within a medical home compared to 31.5% on public insurance only (Figure 38).

Table 7. CYSHCN Qualitative Findings

Focus Groups: CYSHCN	
Individual-Level	• Lack of knowledge about services • Poor communication between parents and providers

	• Lack of knowledge about medical home • Families are responsible for care coordination • Concerns over transition to adulthood
Structural-Level	• Lack of a centralized resource center • Lack of providers/specialists in rural areas • Eligibility restrictions • Lack of safe recreational places • Long wait times for appointments • Transportation • Lack of employment opportunities for CYSHCN and resources to aid with transition
Key Informant Interviews	
Priority Needs	• Increase access to medical homes • Increase access to primary and subspecialty care
Structural-Level	• No pediatric specialists • Lack of centralized body that serves as an information clearinghouse for CSYHCN • Challenges transitioning CYSHCN to comprehensive adult medical homes

Strengths and Needs

Georgia exceeded national averages for CYSHCN receiving services within a medical home in 2009/10. However, the overall percentage is lower than desired and there are racial/ethnic and economic disparities that should be addressed. An effort to ensure that more CYSHCN are receiving the services needed to transition to adulthood is needed. Georgia's CYSHCN fall below the national average and experience larger gaps than what is seen at the national level.

Programmatic Efforts to be Continued

- Parents as Partners has successfully helped parents navigate the health care system for their children

Areas of Opportunity

- There is opportunity to increase services available for CYSHCN within CMS as they transition to adulthood and promote transition clinics throughout the state

Cross-Cutting

Smoking during Pregnancy

From 2009 to 2013, the percentage of mothers who smoked during the last three months of pregnancy decreased from 8.5% in 2009 to 6.2% in 2011 (Figure 39). The percentage of non-Hispanic White mothers (11.9%) who smoked during pregnancy was almost twice as high as the percentage among non-Hispanic Blacks. More mothers with less than a high school diploma reported smoking during the last three months of pregnancy (15.4%) than all other educational levels (Figure 40).

Second Hand Smoke Exposure

In Georgia, 24.9% of children ages 0 to 17 years live in homes where someone smokes. This is similar to the national average of 24.1% in 2011/12. When stratified by race/ethnicity, 14.4% of Hispanic children live in a home where someone smokes compared to 22.2% of non-Hispanic Black and 29.6% of non-Hispanic White children (Figure 41).

Dental Visits during Pregnancy

Although 38.0% of women overall reported having their teeth cleaned during pregnancy, only 29.4% of mothers less than 20 years old saw a dentist or dental hygienist during pregnancy compared to 47.2% of women over 35 years of age. Far more non-Hispanic White women (46.4%) report receiving a dental cleaning than their non-Hispanic Black and Hispanic (33.9% and 19.6%) counterparts (Figure 42).

Childhood Dental Visits

Within Georgia, the most sizable ethnic disparity for childhood dental visits was in Hispanic children ages 1 to 17 years old in 2011/12. Only 69.6% of Hispanic children had one or more preventive dental care visits (check-ups and cleanings) compared to 73.9% of Hispanic children nationally and 77.5% of non-Hispanic White children in Georgia (Figure 43).

Health Insurance

More than 70% of all children are adequately insured in every age category, both in Georgia and in the US. The highest percentage of adequate insurance coverage was among very young children (0 to 5 years old). While Georgia reported adequate coverage higher than the national average in 2007, as of 2011/2012 Georgia's children experienced loss of adequate insurance coverage across each age category and has fallen behind the nation for all age groups with the exception of 12 to 17 year olds. When stratified by income, 80.2% of children 0 to 17 years old in the 0 to 99% FPL category were adequately insured in Georgia compared to only 70.5% of children who lived in households where the income lies between 100 to 199% FPL. Hispanic children had higher adequate insurance coverage (82.9%) compared to non-Hispanic White children (75.7%) (Figure 44).

Table 8. Cross-Cutting Qualitative Findings

Key Informant Interviews	
Priority Needs	• Improve the oral health of adolescents • Promote perinatal oral health • Reduce early childhood caries • Reduce racial disparities in prevalence of gingivitis and periodontal disease • Reduce caries among Hispanics
Individual-Level	• Parents are unaware that children should see a dentist before the age of one • Smoking and poor nutrition are impacting oral health
Structural-Level	• Reimbursement for dental care for special needs population is low • Limited number of Medicaid providers • Limited number of caregivers capable for taking care of oral health for CYSHCN • Dentist shortages • Uninsured clients cannot pay for care

Strengths and Needs

Georgia has shown improvements regarding tobacco use. The percentage of children exposed to second hand smoke has decreased from 29.8% in 2003 to 24.9% in 2011/12. Additionally, the percentage of women smoking during pregnancy in Georgia remained below the national average of 8.4% in 2013.

Several needs should be noted. From 2007 to 2011/12, the percentage of children receiving a preventive dental visit declined. There are disparities among the women who received a dental visit during pregnancy in terms of age, race/ethnicity and education that should be addressed. Most notably, 46.4% of non-Hispanic White women received a teeth cleaning during pregnancy, while only 19.6% of Hispanic women did. Adequate health insurance coverage is another area of need. Between 2007 and 2011/12, Georgia saw a decrease in the number of children adequately insured and fell below the national average. Economic and racial disparities exist and need to be addressed.

Programmatic Efforts to be Continued

- The Oral Health program has achieved high rates of community water fluoridation

Areas of Opportunity

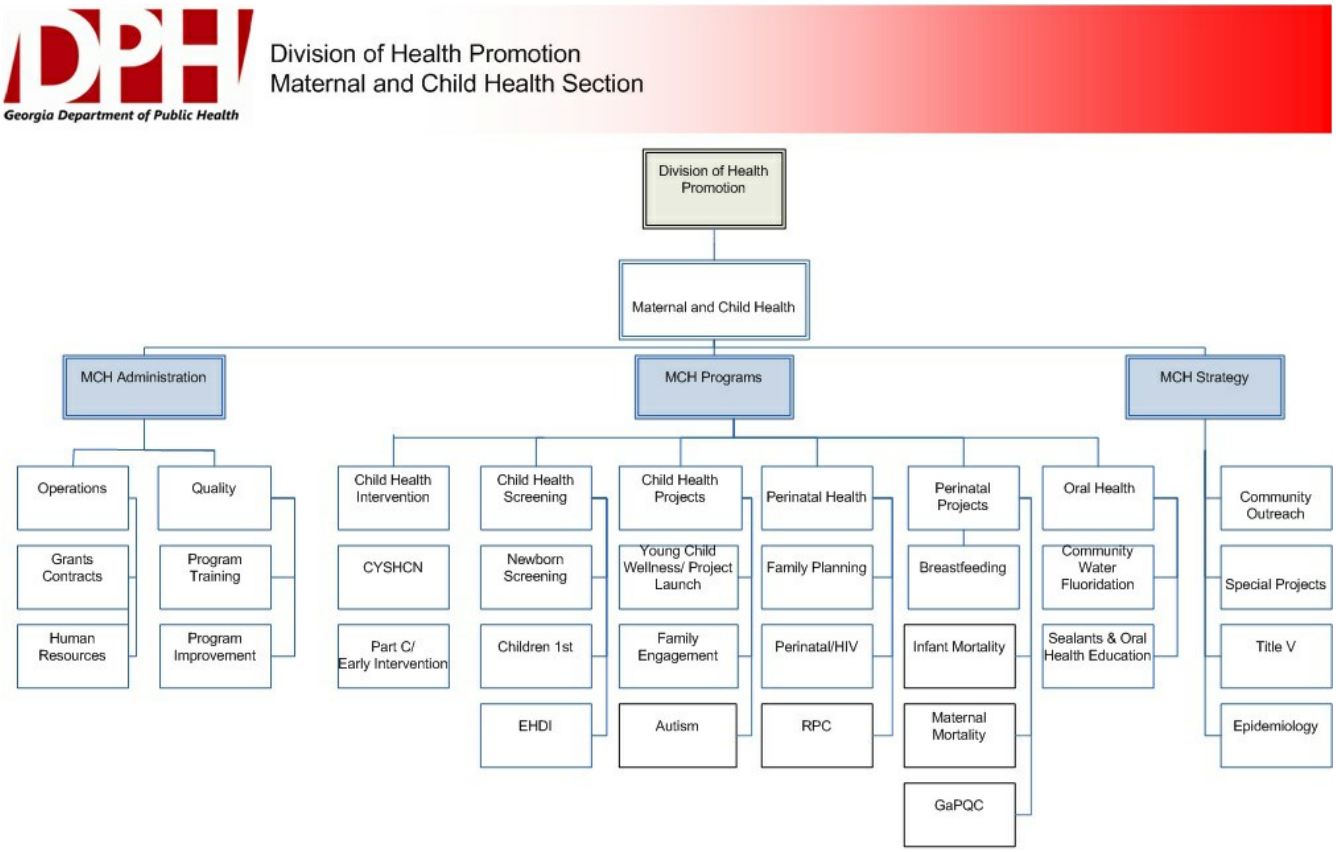
- There is opportunity to develop an oral health resource database for CYSHCN to increase preventive visits in this population

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

The Department of Public Health is the lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a public health perspective. The agency's Commissioner reports directly to the Governor.

The Maternal and Child Health Section (MCH), located within the Division of Health Promotion, has primary responsibility for administration of the Title V Block Grant. The MCH Director serves as the Title V Director. In 2014, MCH began a restructure to provide better coordination across programs. The restructure is expected to be completed by December 2015. There are three Offices within MCH: Office of Programs, Office of Strategy and Office of Administration. The Office of Programs includes the Perinatal Health Program, Perinatal Health Projects, Child Health Screening, Child Health Intervention (CYSHCN programs), Child Health Projects and Oral Health. The CYSHCN programs, Children's Medical Services and Babies Can't Wait, are both under the administration of the CYSHCN Director and Title V Director. The Office of Strategy is responsible for MCH Epidemiology, Community Outreach, Special Projects and activities to support the Title V application. The Office of Administration is responsible for Operations and Quality.



Title V provides funding to Injury Prevention, located in Health Protection, and Georgia SHAPE, located in the Chronic Disease Prevention Section. The following list provides a description of all Title V funded programs.

Title V Funded Programs

Babies Can't Wait (BCW) provides a coordinated, comprehensive and integrated system of early intervention services for infants and toddlers birth to 3 as outlined by IDEA Part C.

Children First serves as the "Single Point of Entry" to a statewide collaborative system of public health prevention based programs and services for children with poor health or developmental delays.

Children's Medical Services (CMS) ensures a community-based, coordinated, family focused, culturally appropriate, comprehensive system of quality specialty health care services available for Georgia's children with chronic medical conditions from birth to 21 years of age who live in low income households.

Early Hearing Detection and Intervention (EHDI) screens infants for hearing loss in the birthing hospital and links them to appropriate interventions.

Family Planning improves the health of women and infants by enabling families to plan and space pregnancies and preventing unplanned pregnancy.

Georgia SHAPE improves the health of children and adolescents by providing opportunity and assistance around physical activity and nutrition.

Injury Prevention provides general support to local coalitions in helping promote safe and injury free life styles and behaviors.

MCH Epidemiology (MCH EPI) supports data collection and analysis for all MCH programs and administers State Systems Development Initiative (SSDI), Early Hearing and Detection Intervention (EHDI) and Pregnancy Risk Assessment Monitoring System (PRAMS).

Newborn Screening (NBS) ensures that every newborn in Georgia has a specimen collected to screen for 28 inherited disorders that would otherwise cause significant morbidity or death.

Oral Health provides community water fluoridation, school-linked fluoride supplement programs for high-risk children, dental sealants and dental health education.

Perinatal Health assures pregnant women in Georgia have every opportunity access comprehensive perinatal health care services appropriate to meet their individual needs and supports outreach efforts at six Regional Perinatal Centers. Perinatal health also addresses infant mortality, maternal mortality and breastfeeding.

II.B.2.b.ii. Agency Capacity

MCH currently has the capacity (structural resources, data systems, partnerships and competencies) to promote the health of all MCH populations. In each domain, MCH initiates partnerships with external organizations to ensure a statewide system of services that are comprehensive, community-based, coordinated and family centered.

Maternal/Women's Health

MCH uses Title V funds to provide services for women of reproductive age. Family planning clinics supported by Title V provide contraceptive counseling and preventive services. Cancer screenings and HPV vaccines are provided in the family planning clinics through a partnership with the Chronic Disease Prevention Section. MCH actively supports the Maternal Mortality Review Committee (MMRC) and will engage in various initiatives to promote maternal health, including the March of Dimes (MoD) Banner program to prevent early elective deliveries. MCH has epidemiology staff to support programmatic efforts. Data sources used are PRAMS, Vital Records, BRFSS and Family Planning program data. MCH also houses the data for the MMRC and identifies cases for review.

MCH has active partnerships with hospitals, private practice physicians, academic institutions, cancer and HIV screening agencies, the Chronic Disease Prevention Section, Healthy Mothers, Healthy Babies (HMHB), Georgia Obstetrical and Gynecological Society (GOGS) and March of Dimes (MoD) to ensure a comprehensive system of services for women of reproductive age in Georgia.

Perinatal Health

Title V staff supports newborn screening, breastfeeding initiatives, preterm birth initiatives, perinatal regionalization and the Safe to Sleep campaign to promote perinatal health. MCH also participates in the Georgia Perinatal Quality Collaborative (GaPQC) to implement quality improvement projects in participating hospitals. MCH also provides financial support towards the Baby LUV program and other pilot projects that target high-risk pregnancies. Title V supports epidemiology staff to collect and analyze data on perinatal health. The primary data sources used are Vital Records and PRAMS.

MCH has active partnerships with the Regional Perinatal Centers, birthing facilities, private practice physicians, MoD, Association of State and Territorial Health Officials (ASTHO), GOGS, WIC, Worksite Wellness and (HMHB).

Child Health

MCH promotes child health through promoting developmental screenings among children, preventing injury and promoting physical activity. MCH state, district and local level staff are well-versed in developmental screening and

the various tools used to assess developmental screening. The Child Occupant Safety Project aims to prevent motor vehicle accident deaths among children. MCH works with the Chronic Disease Prevention Section to promote physical activity and nutrition in early care settings and schools through Georgia SHAPE. Title V supports the work of COSP and Georgia SHAPE, however they rely on additional funding sources as well. DPH also supports an Asthma Control Program in the Chronic Disease Prevention Section that addresses four areas of focusing which include: Environment, Family Support, Health Care Delivery System and Schools and Childcare Settings. MCH has a Child Health Epidemiologist to support data collection efforts. MCH utilizes the State Electronic Notifiable Disease Surveillance System (SendSS) and Babies Information and Billing System (BIBS) to assess developmental screening data.

To ensure a comprehensive system of services among children, MCH has active partnerships with the Chronic Disease Prevention Section, Department of Early Care and Learning (DECAL), Department of Education (DOE), academic institutions, GA Chapter of the American Academy of Pediatrics (GA-AAP), GA Academy of Family Physicians (GA-AFP), Marcus Autism and Emory Autism Center.

Adolescent Health

DPH's Adolescent and School Health (ASH) unit sits within the Chronic Disease Prevention Section. ASH promotes adolescent health through programs targeting youth tobacco prevention, sexual violence prevention, teen pregnancy prevention and positive youth development. Data support for adolescent health is led by the Epidemiology Section.

There is currently no program dedicated to adolescent health within MCH, which provides a new opportunity for partnerships with other sections of DPH. MCH will partner with the Injury Prevention Program, Chronic Disease Prevention Section, the Office of Nursing, the Epidemiology Section and the Department of Education to collectively address adolescent health.

CYSHCN

MCH supports several programs to provide services to Georgia's CYSHCN. Children First acts as the point of entry for children with an identified special need. BCW provides services for children from birth to three. CMS is established and continues to provide on-going, comprehensive medical care for CYSHCN that are not eligible for state funded Medicaid and SCHIP programs. CMS promotes access to specialty care, care coordination, transition to adulthood and medical homes for CYSHCN. Epidemiologists support data collections for CMS. MCH has a data system that only captures youth enrolled in the CMS program at the public health district-level and does not have the data system to capture individual-level data. DPH is currently in the process to improve DPH data systems; however, this is a department initiative and will take approximately 5 years to complete.

To ensure a comprehensive system of services among CYSHCN, MCH has active partnerships with hospitals, private practice physicians, academic institutions, GA-AAP, GA-AFP, medical community members, Children's Healthcare of Atlanta (CHOA) and Parent to Parent.

Oral Health

MCH has Title V, CDC, state and private-donated funds to support oral health initiatives. MCH has access to oral health data through PRAMS, NSCH, CMS and 3rd Grade and Head Start Basic Screening Surveys. The Oral Health program does not have an Oral Health Epidemiologist; however, recruitment efforts are in progress to identify a qualified candidate.

To ensure a comprehensive oral health system of services, MCH has active partnerships with WIC, private practices, dental hygiene programs, academic institutions, middle schools, Oral Health Coalition and CDC.

II.B.2.b.iii. MCH Workforce Development and Capacity
MCH Leadership Staff

There are approximately 45 FTEs working on behalf of the Title V program in Georgia. The MCH leadership staff is comprised of the following individuals:

Seema Csukas, MD, PhD is the Maternal and Child Health Director. Dr. Csukas received her medical and doctorate degrees from Medical College of Georgia at Georgia Regents University. She is responsible for overseeing the Maternal and Child Health Section.

Tiffany Fowles, DrPH, MSPH is the Deputy Director of MCH Strategy and Epidemiology. Dr. Fowles received her doctorate degree from University of Georgia and MSPH degree from Tulane University School of Public Health and Tropical Medicine. She oversees MCH Epidemiology, Community Outreach, Title V Block grant, Special Projects and Operations.

Valeria Newton-Lamb, MHSA is the Deputy Director of Administration. She has over 20 years of experience in health care administration and managing large scale, complex operations for private and publicly funded organizations. Ms. Newton-Lamb is responsible for overseeing quality assurance and operations.

Donna Johnson is the Director of Child Health Intervention. She has over 12 years of experience working with children with special health care needs. Ms. Johnson is responsible for overseeing all child health intervention related programs and initiatives, including Babies Can't Wait and Children Medical Services.

Jeannine Galloway, MPH is the Director of Child Health Projects. She received her MPH from Mercer University School of Medicine and a Bachelor of Science from Spelman College. She has over eight years of experience implementing evidence-based programs. Ms. Galloway oversees Project LAUNCH and the Georgia Autism Initiative.

Johanna Pringle, MPH is the Director of Child Health Screening. Ms. Pringle received her MPH from the University of Florida and has 5 years of experience working in the Newborn Screening program. She oversees Newborn

Screening, Children First and EHDI.

Patricia McAfee, DNPc, MSN, RN is the Director of Perinatal Health Programs. Ms. McAfee has 19 years of experience in direct patient care and 12 years of nursing practice management, including time as the Director of Women's and Infants Services. She oversees all activities related to perinatal health and family planning.

Renee Johnson, MPA is the Director of Perinatal Health Projects. Ms. Johnson has a bachelor's degree in Human Services and a master's degree in Public Administration from Kennesaw State University. She has over 10 years of leadership and administrative experience in project development, management and implementation with organizations in the public, private and nonprofit sectors.

Carol Smith, RDH, MSHA is the Director of the Oral Health. Ms. Smith received her MSHA from Georgia State University and is a registered dental hygienist. She has been in her current role for 5 years with previous experience in clinical practice. Ms. Smith oversees Oral Health program initiatives, including community water fluoridation and school sealant programs.

Two parents of CYSHCN, Sherry Richardson and Donna Johnson, are employed by the Title V program.

Strengths and Needs of Workforce

The majority of the state Title V staff has been in MCH for fewer than 5 years. Over 15.0% have served for 10 years, 20.5% for 5-9 years and 64.0% for less than 5 years.

A survey was disseminated to state, district and local DPH employees providing MCH services to assess the strengths and needs of the workforce. Results indicate that training efforts should be targeted toward the following public health competencies: leadership and systems thinking, public health sciences, financial planning and management skills and community dimensions of practice.

Cultural Competency

Several methods are used to ensure culturally competent approaches are used in service delivery across all programs. MCH EPI routinely collects and analyzes data by race/ethnicity and income to assess health equity and inform program activities. A bilingual interviewer is on PRAMS staff to ensure sufficient response rates from the Hispanic population. Focus groups and key informant interviews were conducted among Spanish speaking families for Title V and CMS.

MCH works closely with community leaders to plan service delivery programs, collaborate on grants and implement culturally competent services that meet the unique needs of populations. Specifically, NBS works with community groups to address strategies specific to needs of the sickle cell community. Injury Prevention goes to where the members of the minority groups are, such as temples, churches or local businesses in an effort to establish community ties.

In all MCH programs, services and/or educational materials are provided in English and Spanish. The Oral Health program has bilingual staff that will provide outreach education targeted to Hispanic children. Oral Health also participates in the Georgia Alliance for Health Literacy to offer health literacy resources. Georgia SHAPE travels to diverse populations to educate on various physical activity and nutrition efforts. BCW and NBS hire bilingual service coordinators to assist in coordinating services in their native language. The CMS program will arrange for the provision of oral language assistance, from language interpreter and translation services, in response to the needs of Limited English Proficiency (LEP) and Sensory Impaired (SI) individuals in both face-to-face and telephone encounters with CMS. Injury Prevention addresses cultural competency through partnering with the state Refugee Health Program and its case managers to address cultures and languages, such as Nepalese, Somali, Congolese, and Iraqi.

II.B.2.c. Partnerships, Collaboration, and Coordination

Georgia maintains partnerships to build the capacity of MCH services in the state.

MCHB investments: Georgia receives MCHB investments through Maternal, Infant and Early Childhood Home Visiting, Healthy Start, and Leadership Education in Neurodevelopmental and Related Disorders Training Program. The Title V program partners with all these programs. State Systems Development Initiative and D70 are MCHB investments provided directly to MCH.

Other federal investments: MCH receives other federal investments through Oral Disease Prevention, PRAMS and Early Hearing Detection and Intervention. MCH partners with Substance Abuse and Mental Health Services Administration grants, Personal Responsibility Education Program, Women, Infants and Children, and Head Start.

Other HRSA programs: District coordinators partner with Federally Qualified Health Centers.

State and local MCH programs: The state Title V program coordinates regularly with district and local health departments to implement activities within all programs.

Other programs within the State Department of Health: MCH partners with several other sections in DPH. MCH partners with Adolescent and School Health, Chronic Disease Prevention, Immunizations, Vital Records and Office of Health Indicators and Planning, Injury Prevention, Tobacco Cessation, HIV and STD Prevention, Environmental Health and Epidemiology. Partnerships with Adolescent and School Health and Injury Prevention are critical to addressing identified priority needs.

Other governmental agencies: MCH has strong relationships with the Department of Community Health, Department of Behavioral Health and Developmental Disabilities, the Division of Family and Children Services and the Department of Education.

Public health and health professional educational programs and universities: MCH frequently partners with Emory University, Rollins School of Public Health, Georgia State, University of Georgia, Valdosta State University and Georgia Regents University.

Others: MCH has a contractual relationship with six regional perinatal centers (RPC) to meet the needs of the perinatal regionalization system. The Georgia Obstetrical and Gynecological Society (GOGS) is contracted to administer the Maternal Mortality Review Committee. Relationships with Children's Health Care of Atlanta and Georgia Regents University will be critical to addressing transition, as these sites have transition clinics that DPH has assisted in establishing and promoting. Parent to Parent and GA-AAP are contracted to support services for CYSHCN. Emory University conducts follow-ups for the Newborn Screening program. MCH participates in three Collaborative Improvement and Innovation Networks (CoIIN): Safe Sleep, Social Determinants of Health and Perinatal Regionalization.

Family/Consumer Partnerships

Nature and Substance

MCH programs primarily engage families and consumers through parent organizations. BCW has contracted with Parent to Parent of Georgia to provide a central directory of resources for families and as a support mechanism for the program. BCW also has State and Local Interagency Coordinating Councils (SICCs and LICCs) in which 20% of members are required to be families. The Newborn Screening and Genetics Advisory Committee is composed of parent representative organizations, Parent to Parent of Georgia and Save Babies through Screening Foundation. Hands and Voices and the Sickle Cell Foundation of Georgia will be included. Other parent groups such as PKU Alliance and Kids Heart have participated in the development of policy or programs. Hands and Voices also currently serves on the EHDI stakeholder group. They assist with developing materials and advocacy for children with hearing impairment. Georgia Family Connection Partnership is Georgia SHAPE's main partner that speaks from the familial perspective. The Oral Health program has invited parents to attend the Georgia Oral Health Summit and they also partner with Voices for Georgia's Children. CMS supports the Family Engagement Specialist position within MCH. Family representatives served on three CMS Program Improvement workgroups. CMS partners with Easter Seals of West Georgia and Parent to Parent of Georgia.

Diversity

A diverse group of families were engaged in Block Grant activities. Parents of CYSHCN and several community members attended the stakeholder meetings. These participants primarily had formal knowledge of MCH issues. The focus groups conducted for the needs assessment included parents from every public health district and various racial groups. Focus groups were conducted in Spanish for Hispanic families.

Number engaged, degree of engagement, compensation, and training on core competencies

We estimate the following numbers of parents have been engaged within the past year at the state level: 20 in BCW, 40 in Georgia SHAPE, 5 in Newborn Screening, 10 in EHDI and 6 in CMS. BCW and CMS district coordinators provide an annual average of 500 opportunities for families to engage in local community activities such as health fairs, disability specific training, etc. Average yearly participation of both families and professionals for these events reaches approximately 10,000.

Only family/consumer partnerships in CYSHCN receive compensation, although other programs are looking to expand this service. Families that participate in the SICC are compensated for their travel expenses to attend meetings including child care if requested. Families are compensated if they provide clerical support for their LICC. The CMS Family Engagement Specialist receives salary and benefits. Parent Partners are paid hourly.

MCH is currently planning curriculum for families. Family Leadership Training, Public Health 101 and MCH 101 will be the first trainings conducted. Trainings on Title V and cultural competency will also be included.

Evidence and range of issues being addressed through the family/consumer partnership

Family/consumer partners primarily provide insight into the types of needs they are facing, and how they can best be addressed by the programs. Through participation in advisory councils, they impact all activities. In the CMS Parents as Partners project, parents are providing emotional support, linkages to community resources, transition to adult health care education and assistance with navigating the health care and special education systems. Families have been engaged with Child Health Screening in the last year on the addition of Critical Congenital Heart Disease Screening and Severe Combined Immunodeficiency, and expanding coverage for medical foods.

Impact of family/consumer partnership on programs and policies

Family/consumer partnerships have impacted programs and policies in several ways. They directly participate in planning through advisory councils. However, there are indirect impacts as well. A survey of program managers and directors showed that established family/consumer partnerships have enabled them to better understand what is relevant to the populations they are serving and the types of family issues involved. The CMS Family Engagement Specialist supports all child health programming with policy development, trainings and quality improvement.

Description of the state's efforts to build and strengthen family consumer partnerships for all MCH populations

Families are recruited through a variety of methods, including those who use the services, pediatricians, schools, workshops, health fairs, word of mouth, non-profit agencies and committees. Georgia SHAPE will work with afterschool programs to recruit families this year. It is intended that several of the families that were engaged for the needs assessment will continue to be engaged throughout the reporting cycle.

Trainings are currently being developed for families of CYSHCN to empower them to provide input on policies and program activities, as well as Block Grant activities.

Program managers were surveyed to determine their perceptions pertaining to the importance of family/consumer partnerships and the barriers they face. Although all respondents expressed the input they receive is crucial to effective program planning, they identified several barriers to engaging families and consumers, including the additional pressure to deliver more than is feasible, lack of father participation, keeping families involved, constraints of time and meeting location and having an ongoing funding source. These results will be used to engage with programs on how to best engage families and consumers throughout all programs.

II.C. State Selected Priorities

No.	Priority Need
1	Prevent maternal mortality
2	Improve access to family planning services
3	Prevent infant mortality
4	Promote developmental screenings among children
5	Promote physical activity among children
6	Reduce suicide among adolescents
7	Improve systems of care for children and youth with special health care needs
8	Promote oral health among all populations
9	Decrease maternal substance use
10	Improve access to specialty care for CSHCN

Top of Form

Selection Process

Georgia defined a priority need as a gap between the observed and desired health status of the population that can reasonably be addressed by the Title V program in which stakeholders have demonstrated strong interest in or support for. In order to select priorities out of all needs identified through the assessment, stakeholders were asked to rate the top needs identified by MCH staff at the stakeholder meetings. Results from the meetings were treated as a recommendation and the ultimate selection of priority needs was determined by MCH leadership to ensure the selected needs were best addressed by the Title V program. In determining final priorities, primary weight was given to the stakeholder meeting results but findings from the quantitative analysis, focus groups, key informant interviews, surveys, public comment period and the capacity assessment were considered to ensure that the topic was identified as a need through multiple sources. Most NPMs were considered as priority needs at the stakeholder meetings. In most instances, the NPMs further informed the selection of the priority need they impact. When appropriate, the NPM became priority needs.

Needs Strongly Considered

Table 1 presents the results from the stakeholder meetings. Participants rated each need from 1-5 based on six criteria: seriousness of the issue, health equity, economic impact, trend, magnitude of the problem and importance. Weights were applied to the criteria as follows: 3 for seriousness of the issue, 3 for health equity, 2 for economic impact, 1 for trend, 2 for magnitude and 1 for importance. The criteria and the weights applied were chosen by the Needs Assessment Workgroup. Ratings for each criterion were averaged, multiplied by their weight, and added together to determine the final rating score for each priority need.

Table 1. Priority Need Rating

	Potential Need Rated		

Rank	by Stakeholders	Rating	Status
1	Reduce the number of infants born with a low or very low birth weight	63.4	Addressed by preventing maternal mortality, infant mortality and increasing access to family planning services
2	Decrease the maternal mortality ratio	62.6	Selected as a priority need
3	Increase physical activity among children	60.9	Selected as a priority need and NPM
4	Increase access to specialty care for CYSHCN	60.4	Selected as a priority need and SPM
5	Reduce the number of infants born preterm	59.8	Addressed by preventing maternal mortality, infant mortality and increasing access to family planning services
6	Decrease deaths related to motor vehicle accidents for children 0-19	59.3	Not selected: Programmatic efforts to prevent childhood deaths are in place in DPH and MCH has a low capacity to address the need
7	Reduce substance abuse during pregnancy	59.2	Selected as priority need and SPM
8	Increase the percentage of VLBW infants born in a Level III facility	59.0	Selected as an NPM
9	Reduce suicidal ideation, planning and attempts	58.7	Selected as a priority need
10	Decrease adverse childhood experiences among children	58.1	Not selected: MCH has low program capacity to properly address the need
11	Decrease the percent of mothers smoking during pregnancy	58.0	Not selected: Although strongly considered as a priority need, percentages have been declining and there is a program outside of MCH to address this need. Tobacco cessation messages will be incorporated into oral health promotion
12	Decrease the percent of children, including those with special health care needs, exposed to second hand smoke at home	57.4	Not selected: Although strongly considered as a priority need, percentages have been declining and there is a program outside of MCH to address this need. Tobacco cessation messages will be incorporated into oral health promotion
13	Increase physical activity among adolescents	57.2	Not selected: There is low program capacity to address this need and resources were targeted to focus on physical activity among children in order to develop healthy behaviors at a young age
			Not selected: Although strongly considered as a priority need, there is a program outside of MCH to address this need. Tobacco

14	Decrease tobacco use among adolescents	56.7	cessation messages will be incorporated into oral health promotion
15	Reduce unplanned teen pregnancies	55.6	Addressed through increasing access to family planning services overall
16	Increase the number of women receiving well-woman visits	55.1	Selected as an NPM
17	Reduce the percent of adolescents who are bullied or who bully others	55.0	Selected as an NPM
18	Increase the percent of CYSHCN who received services necessary to make transitions to adult health care	54.6	Selected as an NPM
19	Increase the number of pregnancies that are planned	54.6	Selected as a priority need and SPM
20	Increase the percent of children and youth, including those with special health care needs, receiving a preventive dental visit	54.3	Selected as a priority need
21	Increase the proportion of women receiving prenatal care in the first trimester	54.2	Not selected: Community support for this need was lower than well-woman visits, which promote health before women enter pregnancy.
22	Increase the percent of CYSHCN having a medical home	54.1	Addressed by improving systems of care for CYSHCN
23	Decrease non-fatal injury among children	54.0	Not selected due to higher community support for other needs
24	Increase the number of CYSHCN that receive care coordination services	53.6	Addressed by improving systems of care for CYSHCN
25	Increase the percent of women receiving a dental visit during pregnancy	52.7	Selected as an NPM
26	Increase the percentage of children receiving a developmental screening	51.8	Selected as a priority need and NPM
27	Increase the number of infants placed to sleep on their back	51.6	Addressed through prevent infant mortality
	Increase the percent of		

28	adolescents receiving a well-visit	50.7	Not selected due to higher community support for other needs
29	Increase the proportion of women receiving postpartum care	50.0	Not selected due to higher community support for other needs
30	Decrease cesarean sections among low-risk first births	49.3	Not selected due to higher community support for other needs
31	Increase the percent of families and emergency responders that feel prepared to assist CYSHCN during an emergency	49.0	Not selected due to higher community support for other needs
32	Reduce non-fatal injury among adolescents	48.1	Not selected due to higher community support for other needs
33	Increase the number of infants who are breastfed	46.1	Selected as an NPM
34	Increase the number of people drinking fluoridated water	41.4	Addressed through improving oral health among all populations

The following priorities (not listed in order of importance) were selected:

Prevent maternal mortality

Preventing maternal mortality is essential to improving the health of women in the state. Both quantitative and qualitative data examined in the needs assessment indicated the need to prevent maternal mortality in Georgia. Georgia's maternal mortality ratio increased from 11.5 (n=16) in 2004 to 43.6 (n=56) in 2013. Additionally, Georgia has been identified as among states with the highest maternal mortality ratio. Interviews with leaders in the field recommended this priority. Preventing maternal mortality was also a clear priority of stakeholders involved in the needs assessment. Maternal mortality was rated highest in the maternal/women's health domain at the stakeholder meetings and second overall. Promoting well-woman visits, a related NPM, was the highest rated NPM in this domain at both the stakeholder meetings and through a survey completed by stakeholders.

Increase access to specialty care for CSHCN

With majority of Georgia being rural and most pediatric specialty providers located in Atlanta's metropolitan and Augusta, access to specialty care for CSHCN is a systemic issue that can be addressed by Title V. Access to specialty care for CSHSCN was ranked 4among the list of 34 needs. This priority is unique to Georgia's health care environment and directly impacts the health and educational outcomes for CSHCN. Thus will be addressed as a state performance measure.

Increase access to family planning services

Unplanned pregnancies, lack of knowledge around birth spacing, and lack of preparation for healthy pregnancies were major themes identified during the perinatal health focus groups. Data showing 54.8% of births in 2011 were unplanned corroborate these findings. Key informants recommended family planning efforts to reduce adverse birth outcomes. Family planning was rated second highest within the maternal/women's health domain in the stakeholder meetings.

Prevent infant mortality

Preventing infant mortality is a clear need that came out of the needs assessment. Quantitative analysis showed that Georgia's infant mortality rate was 7.2 in 2013. Strong racial disparities are present and should be addressed to achieve health equity. Although preventing infant mortality was not independently rated at the stakeholder meetings, factors impacting infant mortality were considered. Low birth weight and preterm deliveries were among the highest ranked needs, displaying strong community support to address the overarching issue of infant mortality. Although breastfeeding, perinatal regionalization and safe sleep received lower ratings, quantitative analysis revealed that Georgia needs to make significant improvements to be comparable to national averages and achieve Healthy People 2020 goals. Strong community support to address breastfeeding was displayed throughout the public input period.

Promote developmental screenings among children

Despite the percentage of children receiving developmental screens being higher among Georgia's children than nationwide, racial and insurance disparities are present in Georgia that do not exist at the national level. Less than half of Georgia's children are screened for developmental and social delays. Due to the benefits of early detection, there is room for improvement. This priority was rated fairly low by stakeholders, however through surveys and public input, a high level of community support was shown to support this need.

Reduce substance abuse during pregnancies

Due to the rise in prescriptive opioid use, Georgia, like many other states, has seen an increase in neonatal abstinence syndrome (NAS). The increase of NAS and heroin use has garnered the attention of DPH's stakeholders and Georgia's politicians. This priority was rated 7th among the list of 34 needs and will be addressed through a state performance measure.

Promote physical activity among children

Given the prevalence of obesity and low percentages of children performing recommended amounts of physical activity, promoting physical activity was selected as a state priority. Physical activity was the highest ranked priority in the child health domain.

Prevent suicide among adolescents

Preventing suicide was identified as the priority need through quantitative data and by stakeholders. The suicide death rate among adolescents was 1.5 times higher in 2013 compared to 2012. Reducing suicide was chosen because it was rated highest in the adolescent health domain and in the top 10 overall. Strong support for reducing bullying, an associated NPM, was also displayed at the stakeholder meetings.

Improve systems of care for CYSHCN

Data examined during the needs assessment identified several areas where the system of care for CYSHCN should be improved. Therefore, this priority need was phrased to reflect the need to improve the overarching system that families engage with. Themes from qualitative data revealed that families are not aware of existing services, provide their own care coordination and medical home, lack access to specialty providers and do not feel prepared to transition to adulthood.

Improve oral health among all populations

Both quantitative and qualitative data examined support the selection for improving health as a priority need. Disparities were noted in women receiving dental care during pregnancy and an overall decline in the percentage of

children receiving a dental visit. A particular lack of access to oral health services for CYSHCN was identified through key informant interviews. Throughout the needs assessment, strong community support for this need was demonstrated through the public input period.

Priority Comparison

The current priority needs were identified through a new vision and framework and are therefore not a direct continuation of priority needs from the previous reporting cycle. However, several similarities between the two sets of priority needs should be noted. Table 2 presents a comparison of these similarities and differences between priority needs for 2011-2015 and 2016-2020.

Table 2. Priority Need Comparison, 2011-2015 and 2016-2020

2016-2020	2011-2015
Prevent maternal mortality	No similar need
Increase access to family planning services	Reduce repeat adolescent pregnancy
Prevent infant mortality	Decrease infant mortality and injury
Promote physical activity	Decrease obesity among children and adolescents
Promote developmental screening	Increase developmental screening for children in need
Prevent suicide among adolescents	No similar need
Improve systems of care for CYSHCN	Increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs
Promote oral health among all populations	No similar need
Increase access to specialty care for CSHCN	No similar need
Reduce substance abuse during pregnancies	No similar need
No similar need	Reduce motor vehicle crash mortality among children ages 15-17 years
No similar need	Improve maternal and child health surveillance and evaluation infrastructure
No similar need	Improve childhood nutrition
No similar need	Increase awareness of the need for preconception health care among women of childbearing age

Promoting planned pregnancies was identified as a key priority in both assessments, although it was expanded to promote family planning across all ages in 2016-2020. Given the overall infant mortality rate for the state and the racial, income, and geographic disparities, preventing infant mortality was identified as a priority in both

assessments. Decreasing obesity among children (2011-2015) is related to increasing physical activity (2016-2020), which promotes overall health and wellness while reducing obesity. An increase in developmental screening has remained a priority for the state. Although there have been some improvements, efforts from 2016-2020 will target all children, not just those in need. Preventing maternal mortality, preventing suicide among adolescents, preventing substance abuse during pregnancy, increasing access to specialty care for CSHCN and promoting oral health among all populations are priority needs for 2016-2020 that are not related to needs identified for the 2011-2015 reporting cycle.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Eight national performance measures were selected based on their ability to impact priority needs and related outcome measures. The selected NPMs and their corresponding priority are displayed in Table 3. Increasing access to family planning services does not have an associated NPM and will be addressed by an SPM.

Table 3. Linkage between Priority Needs and National Performance Measures

Domain	Priority Need	National Performance Measure
Maternal/Women's Health	Prevent maternal mortality	Well-woman visit
Maternal/Women's Health	Increase access to family planning services	None
Perinatal Health	Prevent infant mortality	Perinatal regionalization Breastfeeding
Child Health	Promote developmental screenings among children	Developmental screening
Child Health	Promote physical activity among children	Physical activity
Adolescent Health	Prevent suicide among adolescents	Bullying
CYSHCN	Improve systems of care for CYSHCN	Transition
Cross-Cutting	Promote oral health among all populations	Oral health

NPM 01: Well-woman visit (Percent of women with a past year preventive medical visit)

Priority Need: Prevent maternal mortality

Promoting well-woman visits was chosen to prevent maternal mortality. Findings from the Maternal Mortality Review Committee revealed that poor health status and the presence of chronic conditions prior to entering pregnancy were the primary contributors to maternal death in Georgia. Additionally, 48.5% of women are obese entering pregnancy. It is essential that Georgia ensure women are healthy prior to entering pregnancy through promoting well-woman visits among women of reproductive age. In 2013, the percentage of women in Georgia who received a preventive medical visit within the last year was nearly 69%. Although the overall percentage is higher than the national average, disparities by race/ethnicity and education were seen, with more women with higher educational attainment and non-Hispanic Black women visiting a provider for a comprehensive medical exam. Counseling and screening services provided at well-woman visits are essential to promoting pre- and interconception care for women. Not only do well-woman visits promote the overall health of women through the life-course, perinatal health is impacted by preventing low birth weight and preterm births. Although these outcomes do not directly relate to the priority need, these are important measure to address in Georgia and it should be noted that by promoting well-woman visits these outcomes are expected to improve as well.

NPM 03: Perinatal regionalization (Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU))

Priority Need: Prevent infant mortality

Perinatal regionalization was selected to address infant mortality. VLBW is a common cause of infant mortality. Although these births should be prevented, it is essential to put systems in place to ensure that appropriate care is given to these infants when VLBW births do occur. Due to the high percentages of infants born preterm and at low birth weight in the state, it is imperative to identify these infants early and ensure that they receive care to prevent mortality among these infants. Infants born in a facility with a NICU and with staffing that can accommodate their needs gives them a higher likelihood of survival and reduces infant mortality. There is room to improve the perinatal regionalization system in Georgia and promote the delivery of infants in a facility that provides the most appropriate level of care for their level of risk. Racial and regional disparities indicate that there is room to improve the system.

NPM 04: Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)

Priority Need: Prevent infant mortality

Breastfeeding was selected due to its protective factor against sleep related deaths and ability to prevent morbidity among infants, particularly those who are born preterm or with low birth weight. While there is currently a high percentage of infants born preterm and with low birth weight in Georgia, promoting breastfeeding will improve outcomes among these infants. Georgia is clearly lower than the national averages in terms of initiation and duration. Promoting breastfeeding will provide benefits across the life-course including preventing infant mortality and morbidity, preventing childhood obesity and promoting school readiness.

NPM 06: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)

Priority Need: Promote developmental screenings among children

The NPM for developmental screening directly relates to Georgia's priority need to promote developmental screenings among children. Georgia has had clear success in exceeding national standards for children that are screened for developmental, social and emotional delays. Despite the success, fewer than half of Georgia's children are screened. Georgia will continue to focus on this measure to reduce disparities and promote it among all children, not just those receiving services from DPH. Increasing developmental screenings is intended to promote early identification of children that have social and emotional delays and linkage to services during critical periods of the child's development.

NPM 08: Physical activity (Percent of children ages 6 through 11 who are physically active at least 60 minutes per day)

Priority Need: Promote physical activity among children

The national performance measure for physical activity is identical to the identified priority need for promoting physical activity among children. A low percentage of children in Georgia are performing recommended amounts of physical activity. Disparities are present by income, race/ethnicity and gender. It is essential to address this performance measure in order to impact overweight and obesity among children. It is intended that by promoting positive behaviors early in life, they will continue into adolescence and adulthood to prevent obesity and the prevalence of chronic disease in the population. Promoting physical activity promotes the overall health of children, even in the absence of chronic diseases.

NPM 09: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)

Priority Need: Prevent suicide among adolescents

Bullying was chosen as the national performance measure that most directly impacts the priority need to prevent suicide among adolescents. Bullying can lead to depression and suicide ideation and possibly suicide attempts. Victims of bullying often become bullies themselves engaged in a negative cycle. Approximately 1 in 4 adolescents in the state either experience bullying or bully others. The prevalence of bullying is higher among middle school students than high school students, and particularly seen in the Hispanic population. Not only does addressing bullying prevent suicide, it also promotes overall health by preventing feelings of depression and associated behavior, including violence. Electronic bullying is an area that should be examined throughout the five year reporting cycle as well, as social media usage continues to increase among adolescents. Data examined in the needs assessment showed that Georgia's adolescents frequently engage in violent behavior and weapon-carrying.

NPM 12: Transition (Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care)

Priority Need: Improve systems of care for CYSHCN

Improving transitions to adulthood is intended to address the priority need of improving the overall system of care for CYSHCN by linking them from their source of pediatric care to an adult medical home. It is essential that families receive services to assist as they transition out of state CYSHCN programs. The issue is of increasing significance as children with special health care needs are increasingly living into adulthood. It is also intended to promote their lifestyles by teaching them needed self-help skills as they transition, and teaching them to engage in independence and employment when possible. Fewer youth in Georgia are receiving the services needed to successfully transition

compared to the nation as a whole. Addressing both health and health care will impact the overall health status of Georgians.

NPM 13: Oral health (A. Percent of women who had a dental visit during pregnancy and B. Percent of children, ages 1 through 17, who had a preventive dental visit in the past year)

Priority Need: Promote oral health among all populations

The oral health NPM was selected to promote oral health among all populations. The oral health measure not only promotes access to oral health services among pregnant women, but ensures that infants and children are more likely to receive oral health care. The NPM addresses access to oral health care for all children, including those with special health care needs. Ensuring access to oral health services for children not only prevents decayed teeth and cavities, but promotes positive attitudes toward oral health and teaches children important oral hygiene behaviors to practice into adolescence and adulthood. It is essential to ensure that oral health remains a topic of focus in Georgia, as it is vital to ensuring that Georgians achieve an excellent health status overall.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Improve access to family planning services
- SPM 2 - Improve access to specialty care for CSHCN
- SPM 3 - Decrease congenital syphilis
- SPM 4 - Decrease Neonatal Abstinence Syndrome (NAS)

FFour state performance measures were selected based on their ability to impact priority needs and related outcome measures. The selected SPMs and their corresponding priority are displayed in Table 4.

Table 4. Linkage between Priority Needs and State Performance Measures

Domain	Priority Need	State **Performance Measure**
Women's/Maternal Health	Increase access to family planning	Increase access to family planning
Perinatal Health	Prevent infant mortality	Decrease neonatal abstinence syndrome
Perinatal Health	Prevent infant mortality	Decrease congenital syphilis
CSHCN	Improve systems of care for CSHCN	Improve access to specialty care for CSHCN

SPM 01: Improve access to family planning

Priority Need: Improve access to family planning

Improve access to family planning was selected as a priority need and state performance measure. Unplanned pregnancies (54.8% in 2011), lack of knowledge around birth spacing, and lack of preparation for healthy pregnancies were major themes identified during the perinatal health focus groups. Also, family planning was rated second highest within the maternal/women health domain in the stakeholder meetings. Data shows that the percentage of mothers who had recently given birth and reported using contraception at the time of conception was approximately 50 percent from 2009-2011. The percent of Georgia women ages 25 to 34 and teens who reported using contraception at conception were 60 percent and 47.6 percent, respectively. Thus, the need to improve access to family planning services, particularly long acting reversible contraceptives (LARCS) to impact maternal health as well as perinatal outcomes.

SPM 02: Improve access to specialty care for CSHCN

Priority Need: Improve access to specialty care for CSHCN

Improve access to specialty care was selected as a priority need and state performance measure. CSHCN population lack access to needed health care services. In 2001, 19.0 percent of Georgia's families of CSHCN reported having an unmet need for one of the 14 services, including specialty care. In 2009-2010, the percentage increased to 25.3 percent. During that time period, Georgia's percentage remained slightly higher than the national average. The projected prevalence in 2011-2012 is 20.0 percent. Additionally, the projected prevalence of unmet needs among CSHCN who are uninsured is more than twice that of CSHCN with either public or private health insurance. With majority of Georgia being rural and most pediatric specialty providers located in Atlanta's metropolitan and Augusta, access to specialty care for CSHCN is a systemic issue that can be addressed by Title V. Access to specialty care for CSHCN was ranked 4 among the list of 34 needs. This priority is unique to Georgia's

health care environment and directly impacts the health and educational outcomes for CSHCN.

SPM 03: Decrease congenital syphilis

Priority Need: Infant mortality

Decreasing congenital syphilis was selected as a state performance measure to address priority need infant mortality. Congenital syphilis can cause miscarriage, stillbirth, failure to thrive, deformed bones, meningitis, and nerve problems leading to blindness or deafness. In 2014, Georgia ranked 12th in the U.S. for congenital syphilis rates (13 cases per 100,000 live births). From 2010-2015, Georgia had no less than 11 cases in a given year and 20 U.S. states had no cases reported. Congenital syphilis is considered by the Centers for Disease Control and Prevention (CDC) as a winnable battle.

SPM 04: Decrease neonatal abstinence syndrome

Priority Need: Maternal substance use

Decrease neonatal abstinence syndrome was selected as a state performance measure to address priority need maternal substance use. Due to the rise in prescriptive opioid use, Georgia, like many other states, has seen an increase in neonatal abstinence syndrome (NAS). Maternal substance use was ranked 7th among the list of 34 needs by MCH stakeholders. The rate of infants born with neonatal abstinence syndrome increased in Georgia and the US from 2008 to 2012. However, the rate was consistently two to three times higher in the US than Georgia throughout the same time period. In Georgia, the rate of infants born with neonatal abstinence syndrome was 5.2 among non-Hispanic Whites in 2012. The rate was far lower among non-Hispanic Blacks (1.1) and Hispanics (1.6). Differences were seen by insurance status in 2012 as well. The rate was only 1.1 among those with private insurance, but was 4.8 among those insured by Medicaid.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

The following narrative provides activities, accomplishments, challenges and revisions over the past year for the previously national and state performance measures as well as plans for the future based on newly identified priority needs and selected national performance measures. The narrative is organized by the six federally-recognized population domains with corresponding NPMs and SPMs. The following areas are reported:

- Accomplishments: October 1, 2014 to September 30, 2015
- Current Activities: October 1, 2015 to September 30, 2016
- Plans for Upcoming Year: October 1, 2016 to September 30, 2017

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

Prevent maternal mortality

NPM

Percent of women with a past year preventive medical visit

Objectives

1.1. Partner with the Chronic Disease Section to develop and implement targeted education and marketing campaign to promote well woman visits.

1.2. Increase the number of patients receiving preconception health appraisals to promote wellness

Strategies

1.1.a. Implement the use of the "Every Woman" video in primary care facilities and family planning clinics throughout the state

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

1.1.c. Establish an inter-agency work group to develop tiered education and marketing strategies to promote well woman visits to women's health stakeholders such as medical providers, health districts, and members of community.

1.2.a. Increase awareness about preconception health appraisals in the 18 health districts

1.2.b. Provide training to family planning staff specific to preconception health appraisals and documentation requirements

ESMs

ESM 1.1 - 1.1.1. Promote well-woman visits through marketing and media

ESM 1.2 - 1.2.1. Train staff on preconception health appraisals

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

State Action Plan Table - Women/Maternal Health - Entry 2

Priority Need

Improve access to family planning services

SPM

Improve access to family planning services

Objectives

2.1. By 2020, increase the number of unduplicated patients in family planning clinics by 5%

2.2. By 2020, increase the percentage of teens (under age 19) served in GFPP who use long-acting reversible contraceptive (LARC)

2.3. By 2020 increase the percentage of women (ages 15-44) served in family planning clinics who use long-acting reversible contraception (LARC) from 11% to 15%

Strategies

2.1.a. Increase partnerships with internal and external stakeholders to create awareness about family planning services

2.1.b. Provide professional development training to GFPP health district staff on marketing and developing awareness campaigns for public health programs

2.2.a. Provide counseling to 75% of teens served with GFPP

2.2.b. Provide a minimum of two (2) trainings to family planning providers on the provision of appropriate care to teens; training will include a component addressing cultural competence.

2.3.a. Guide 85% of GFPP clients through creating a Reproductive Life Plan, guidance will include LARC education

2.3.b. Increase inventory of LARCs in GFPP clinics

2.3.c. Increase the number of Advanced Practice Registered Nurses (APRN) in GFPP clinics to improve access to LARCs

Measures

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	62.1	62.1	63	63.5	64	65

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	68.1 %	1.8 %	1,252,401	1,839,932
2013	68.1 %	1.5 %	1,261,902	1,852,487
2012	67.1 %	1.9 %	1,239,926	1,849,086
2011	69.4 %	1.5 %	1,247,498	1,797,224
2010	75.8 %	1.7 %	1,412,726	1,863,237
2009	73.9 %	1.8 %	1,373,616	1,859,677

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 1.1 - 1.1.1. Promote well-woman visits through marketing and media

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	5.0	10.0	15.0	18.0

ESM 1.2 - 1.2.1. Train staff on preconception health appraisals

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	25.0	50.0	75.0	100.0

Women/Maternal Health - Plan for the Application Year

Priority Need: Prevent maternal mortality

Maternal mortality was identified as a priority need in Georgia that will be addressed through promoting well-women visits (State Action Plan Table objectives 1.1-1.2), continuing work with the Maternal Mortality Review Committee (MMRC) and continuing local public health district programs that promote healthy pregnancies.

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Promoting Well-Women Visits

Promoting well-woman visits among women of reproductive age will be an important component of preventing maternal mortality. In order to utilize the capacity of family planning clinics, MCH will spend the upcoming year working with the Chronic Disease Section to develop promotional campaigns and the family planning clinics to air the “Every Woman" video.

MMRC

MCH and the MMRC recently completed the first Maternal Mortality Report with cases from 2012. The MMRC is currently reviewing 2013 cases and will continue in the upcoming year. In the upcoming year, the MMRC will develop a 2013 report after reviewing the 2013 cases.

MCH will also work to increase passive surveillance efforts. Maternal death is a notifiable condition in Georgia that must be reported within 7 days of occurrence. However, reports are rarely submitted. Improving this reporting mechanism can greatly increase the data capacity of the MMRC. Based on the 2012 MMRC Report recommendation to improve the efficiency of identifying possible cases, and the abstraction and review of cases. In the upcoming year, MCH Epidemiology will be 1 in 4 states participating in the pilot pregnancy checkbox quality assurance project which will improve the data for case identification.

Other Efforts

Public health districts will continue to provide services to women during inter-conception and pregnancy to promote healthy pregnancies. Services and programs offered through local communities include; healthy start, family planning, perinatal case management and the Baby Luv Program.

Priority Need: Improve access to family planning services

Increasing access to family planning services was identified as a priority need that will be addressed through marketing, health promotion and education on long-acting reversible contraception (LARC).

The number of clients receiving services through family planning clinics has been decreasing. As a result, MCH plans to implement promotional campaigns in the districts to raise awareness about the services offered. In the upcoming year, MCH will plan potential marketing strategies with district offices.

MCH will also focus on increasing the use of LARC among women receiving family planning services in the public health clinics. One strategy to increase LARC utilization will be to develop educational packets for providers and clients. Providing accurate information on LARCs is intended to make providers feel more confident in recommending LARCs and make clients more likely to choose a LARC as their method of contraception. MCH will also work to increase the inventory of LARCs in public health family planning clinics.

Women/Maternal Health - Annual Report

Annual Report 2015-2016

2015-2016 NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Last Year’s Accomplishments

Perinatal Case Management (PCM) is intended to improve perinatal outcomes by linking high-risk women who test positive for pregnancy with the appropriate prenatal care. MCH continued to provide PCM through DPH's 18 public health districts. Clients who received PCM were referred to OB providers, WIC and Medicaid to receive services to assist with their pregnancy.

Current Activities

MCH is working with the Centering Georgia Workgroup, Emory Rollins School of Public Health and Georgia State Health Policy Center to collect and analyze data from established Centering sites throughout the state. Moreover, MCH is participating in the Social Determinants of Health (SDOH) CoIIN and using the Centering model of prenatal care to reduce health disparities for pregnant women throughout the state.

During the reporting year MCH and the Centering Georgia workgroup (co-led by March of Dimes and United Way of Greater Atlanta) bridged discussions between Medicaid and the managed care organizations to explore funding for the Centering model.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

Prevent infant mortality

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

3.1. Increase the number of birthing hospitals participating in the Georgia 5-STAR Hospital Initiative to 40 by 2020

3.2. Partner with WIC to conduct 1 training per year for public health workers on breastfeeding for five years

3.3. Educate 20 employers on the Business Case for Breastfeeding by 2020

3.4. By 2020, 25% of birthing hospitals will have policies and education that adhere to the American Academy of Pediatrics (AAP) safe sleep guidelines

Strategies

3.1.a. Recruit hospitals through in-person presentations on the Georgia 5-STAR Hospital Initiative

3.1.b. Provide in-person trainings to hospitals participating in the initiative

3.1.c. Recognize hospitals for participating in the Georgia 5-STAR Hospital initiative

3.2.a. Using evaluation forms from previous trainings, identify topics to educate public health workers on

3.2.b. Conduct VICS trainings for public health workers

3.4.a. Recruit birthing hospitals by providing staff with a step by step guide on implementing a Safe to Sleep Program

3.4.b. Provide in-person trainings to hospitals participating in the program

3.4.c. Provide participating hospitals with education resources for staff and caregivers on the safe infant sleep recommendations

3.4.d. Collect pre and post crib audits and policy statements from participating hospitals

3.4.e. Recognize hospitals for implementing a Safe to Sleep Program and policy

3.3.a. Educate employers on the Business Case for Breastfeeding

ESMs

ESM 4.1 - 3.1.1 Promote breastfeeding through the 5-STAR Hospital Initiative

NOMs

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table - Perinatal/Infant Health - Entry 2

Priority Need

Prevent infant mortality

NPM

Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objectives

3.5. Ensure all birthing hospitals have been educated on the requirements for neonatal level of care by 2020

Strategies

3.5.a. Assess neonatal level of care requirement compliance

3.5.b. Develop strategic plan for the Regional Perinatal Centers

3.5.c. Collaborate with the Department of Community Health to promote neonatal level of care requirements

ESMs

ESM 3.1 - 3.5.1. Promote compliance with neonatal level of care requirements

NOMs

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

State Action Plan Table - Perinatal/Infant Health - Entry 3

Priority Need

Decrease maternal substance use

SPM

Decrease Neonatal Abstinence Syndrome (NAS)

Objectives

4.1. Decrease the discharge rate of resident live births diagnosed as having neonatal abstinence syndrome (NAS) from 3.2 to 2.0 by 2021

Strategies

4.1.a. Educate health care providers (physicians, nurses) about NAS; includes educational classes for nurses, presentations to physicians & other health care providers who may come in contact with neonates

4.1.b. Educate pregnant women on the effects of unhealthy substance use

4.1.c. Establish a media campaign to increase community awareness of NAS

State Action Plan Table - Perinatal/Infant Health - Entry 4

Priority Need

Prevent infant mortality

SPM

Decrease congenital syphilis

Objectives

5.1. Decrease the rate of infants born w/congenital syphilis from 13.0 (per 100,000 live births) to 11.7 by 2020

Strategies

5.1.a. Ensure GC/CT/Syphilis/HIV are a part of routine screenings for women and men at targeted locations

5.1.b. Identify pregnancy status of all females identified as a new syphilis case

5.1.c. Ensure pregnant females with syphilis are adequately treated at least 30 days prior to delivery

5.1.d. Ensure disease investigation is conducted on all females ages 15-44 diagnosed with early syphilis

5.1.e. Education providers and the general public on the new law regarding 1st and 3rd trimester testing for syphilis and HIV (HB436)

Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	81.8	82.8	83.9	84.9	85.1	85.3

FAD not available for this measure.

ESM 3.1 - 3.5.1. Promote compliance with neonatal level of care requirements

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	0.0	15.0	40.0	60.0	75.0

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	79.3	80.9	82.5	84.1	85.5	85.9

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2012	73.7 %	4.1 %	93,023	126,212
2011	70.3 %	5.0 %		
2010	72.3 %	3.6 %		
2009	66.1 %	3.3 %		
2008	67.4 %	3.0 %		
2007	61.2 %	3.1 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives						
	2016	**2017**	**2018**	**2019**	**2020**	**2021**
Annual Objective	20.2	21.6	23.2	24.8	25.5	25.9

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2012	18.9 %	3.5 %	23,213	122,970
2011	14.5 %	3.6 %		
2010	6.9 %	1.6 %		
2009	11.7 %	1.9 %		
2008	9.9 %	1.7 %		
2007	9.5 %	1.5 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 4.1 - 3.1.1 Promote breastfeeding through the 5-STAR Hospital Initiative

Annual Objectives					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	0.0	10.0	20.0	30.0	40.0

Perinatal/Infant Health - Plan for the Application Year

Plan for Application Year

Priority Need: Prevent infant mortality

In order to reduce the high infant mortality rate in Georgia, work is being done to promote breastfeeding, safe sleep, expand and provide quality newborn screening, improve perinatal regionalization, reduce neonatal abstinence syndrome and reduce congenital syphilis.

Breastfeeding

The Georgia 5-STAR initiative was implemented to encourage hospitals to take steps toward becoming breastfeeding-friendly and achieving Baby-Friendly designation if desired. Hospitals are recognized with one star for every two breastfeeding-friendly steps they take. In the upcoming year (per the state action plan table 3.1-3.4), MCH will educate hospitals and expand the 5-STAR program to new hospitals. MCH will also continue to provide support to those hospitals that are participating by providing training on the Georgia 5-STAR process and recognizing hospitals for all steps taken.

Safe Sleep

The Safe to Sleep Campaign has been promoted throughout Georgia, and will continue to be so in the upcoming year. The purpose of the campaign is to educate the community on how to ensure that their child's sleep environment is as safe as possible. The Safe Sleep Coordinator leads the initiative at DPH, and will continue to make contact with as many partners as possible throughout the state. Education will be provided to the providers and other educators to help them understand barriers that parents face regarding following safe to sleep recommendations. In addition to educating providers, the Safe Sleep Coordinator will seek to educate nontraditional partners in order to reach as many families as possible in Georgia. The Safe Sleep Coordinator plans to bridge a partnership with a faith-based organization and a first responder organization. The Safe Sleep Coordinator will additionally plan for work to be done with birthing hospitals in Georgia to initiate the development of Safe to Sleep policies within their facility.

Newborn Screening

The Newborn Screening (NBS) Program is a population based heritable and congenital screening program. Georgia's NBS Programs screens children for 31 severe heritable and congenital conditions. This year Newborn Screening will launch two new initiatives. As of June 2016, NBS plans to pilot testing for Pompe Disease and Mucopolysaccharidosis I (MPS I). We will also launch a long term follow-up program for metabolic disorders, as well as, continue to monitor long term outcomes for children with hearing loss. A program to provide medical foods for children diagnosed with metabolic disorders will be implemented in the coming fiscal year.

Perinatal Services

The perinatal regional system is designed to ensure that infants are born in hospitals with the appropriate level of care for their level of risk, or if necessary, transferred to an appropriate facility postpartum. High-risk infants, typically defined as those that are born with a very low birth weight, should be born in facilities with a Neonatal Intensive Care Unit (NICU). These facilities are designed as Level III. In the upcoming year, efforts will also be made to educate hospitals on the neonatal level of care requirements.

Throughout the reporting cycle, MCH will continue to participate in the Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN) Learning Network, a voluntary national effort designed to accelerate improvements in infant mortality that are replicable, scalable, and measurable. MCH is currently participating in three of the CoIIN Learning Networks: 1) Safe Sleep, 2) Perinatal Regionalization, and 3) Social Determinants of Health (SDOH). MCH will also develop plans to implement the March of Dimes Preterm Labor Assessment Tool (PLAT) as well as educate hospitals on the perinatal level requirements.

Neonatal Abstinence Syndrome

DPH has made neonatal abstinence syndrome (NAS) a reportable condition, requiring reporting within 7 days of diagnosis. Passive surveillance of NAS will continue throughout the upcoming year. In addition to surveillance of NAS, MCH will implement an education campaign to reduce maternal substance use by educating providers, women and the general public about the negative effects of unhealthy substance use during pregnancy.

Congenital Syphilis

Congenital syphilis rates are rising in Georgia putting 13 per 100,000 babies at risk for infant death. The MCH Section now includes the Sexually Transmitted Disease (STD) Program who will implement strategies to reduce the rising rates of congenital syphilis. In the upcoming year, MCH will encourage routine screenings for men, women and pregnant women (during the first and third trimester). The STD Program will also identify the pregnancy status of all

women, and ensure appropriate treatment for pregnant women infected with syphilis as soon as possible.

Perinatal/Infant Health - Annual Report

Annual Report

2015-2016 NPM 01: The percent of positive newborns who receive timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs

Last Year's Accomplishments

The Georgia Public Health Lab (GPHL) and the Newborn Screening (NBS) Program collaborate routinely on the development of policies, procedures, budget, data exchange, quality assurance/evaluation and education. Last year, the NBS Program provided hospitals with web-based access to a revised report on their screening practices. The reports also included performance on hearing and pulse oximetry screening procedures. The reports display a list of performance measures important to specimen quality, timeliness, accuracy of screening and interpretation of point-of-care results.

Emory University, Georgia Regents University, and Children's Healthcare of Atlanta are contracted to conduct follow-up of abnormal results. Each contractor utilizes a database to track newborns through diagnosis. The follow-up process utilizes protocols and have at least 12 steps to locating families and providers. The NBS Follow-up Coordinators completed Children First referrals on all diagnosed cases. These referrals are made to assess the newborn's eligibility for IDEA Part C Babies Can't Wait or Children's Medical Services.

The program continues to provide NBS information to each parent in hospitals, doctor's offices and health departments prior to having a metabolic, critical congenital heart disease (CCHD) and hearing screen completed. NBS also trained and educated health care providers on NBS, specimen collection and NBS policies.

The Georgia Newborn Screening and Genetics Advisory Committee meets twice a year to discuss progress and issues relevant to the newborn screening community.

Current Activities

The GPHL began routine testing for severe combined immunodeficiency (SCID) of all NBS specimens. Since the expansion to include mandated hearing screening, CCHD and SCID, the NBS Program has been working on improving the quality of data, improving unsatisfactory specimens and designing a long-term follow-up program. The NBS program is currently working to 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 to offer technical assistance and training to improve specimen collection techniques.

The NBS Program worked in conjunction with family advocates, Emory University and the state legislature to identify appropriations to provide metabolic foods to all children diagnosed with metabolic disease, regardless of insurance coverage. Prior to a designated appropriation for metabolic foods, NBS provided metabolic foods through public health pharmacy and a contract with Emory for newborns awaiting diagnosis, uninsured children and other types of temporary gap coverage. The funding only allowed for the purchase of a limited supply and families often had to wait for WIC coverage or Medicaid coverage to begin.

2015-2016 NPM 11: Percent of mothers who breastfed their infants at 6 months of age

Last Year's Accomplishments

In July 2014, MCH hired a new Project Director for Perinatal Health who began to oversee the 5-STAR program.

As of September 2015, there were 17 hospitals enrolled in the Georgia 5-STAR Initiative and 5 of them have attained both 5-STAR and Baby Friendly statuses. Two 5-STAR workshops were held (May & August 2015) with 45

participants, representing over 15 newly engaged hospitals throughout the state. The workshops provided information on the Georgia 5-STAR initiative, including in-depth information on the 10 Steps to Successful Breastfeeding.

MCH and WIC also held two statewide trainings for all DPH employees via the Video Interactive Conferencing Systems (VICS). Titles of the trainings were: 1) Breastfeeding is a Public Health Issue and 2) Challenges to Breastfeeding Success.

Current Activities

In October 2015, MCH hired an experienced Breastfeeding Coordinator whose main focus would be to provide organization and administration for the 5-STAR initiative. As of March 2016 there are 33 hospitals participating in the Georgia 5-STAR program. The new Project Director and Breastfeeding Coordinator have created an infrastructure for the program, including developing an readiness tool for interested hospitals, an application and enrollment process, and an advisory board to provide guidance and expertise to participating hospitals.

MCH also participated in the ASTHO Breastfeeding Learning Community, including virtual learning sessions to learn about the success and challenges of what other states are doing to achieve their goals centered on breastfeeding success.

WIC and MCH hired new staff to support breastfeeding efforts statewide, including training for public health workers. Since October 2015, two additional VICS trainings have been held for public health staff statewide. Topics covered were: 1) Encouraging Exclusivity and 2) Creating a Breastfeeding Friendly Environment.

Four more VICS trainings have been scheduled to be completed by Sept. 30, 2016 (April, June, August and Sept.). Currently, MCH is working with WIC and Worksite Wellness to improve the breastfeeding support for public health employees and will use the progress made as an example to other employers of the Business Case for Breastfeeding. Activities completed to date include: 1) updating the brochure for the DPH lactation room, 2) conducting a survey of moms currently using DPH's lactation services and 3) working with DPH human resources (HR) to incorporate lactation information in HR orientation.

2015-2016 NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

Last Year's Accomplishments

MCH held 3 meetings to develop a strategic plan for the six regional perinatal centers (RPC) using information from the Perinatal Capacity Survey. Follow up meetings are scheduled to occur every quarter. The RPC membership established three priority committees during their first meeting in July 2015: Quality, Data, and Education. Each committee is represented by nurse educators and physicians, with a physician taking the lead for the committee.

Reviews of quarterly reports have provided opportunities to explore areas of potential improvement for future contract deliverables, such as expanding the topics of education provided by the nursing educators to include topics such as Preterm Labor Assessment (PLAT), Chronic Condition Management, Oral Health, Safe Sleep and Neonatal Abstinence Syndrome.

Marketing tools were provided to the RPC educators to promote themselves and perinatal regionalization. These tools will be helpful in drawing attention to their presence at meetings and conferences.

Current Activities

MCH collaborated with the Georgia Obstetric and Gynecological Society (GOGS) to host an RPC meeting at Sea Island on August 25, 2016. The meeting is for the 65th Annual GOGS Conference and the RPCs will have a meeting, on location, prior to the beginning of the conference. MCH is also working on developing a new geospatial map to display the locations and perinatal levels of birthing hospitals. MCH has also conducted three of six site visits of the RPCs.

2015-2016 SPM 02: Infant mortality rate among infants born weighing 1,500 grams or more who survive past the first 27 days of life

Last Year's Accomplishments

The Georgia Perinatal Quality Collaborative (GaPQC) had two active quality improvement projects during this period one focused on immediate postpartum LARC insertion and the other on improving the CCHD screening process at hospitals. MCH engaged a continuous quality improvement (CQI) consultant to conduct monthly conference calls and engage project teams in CQI activities such as developing team action plans and conducting Plan, Do, Study, Act (PDSA) cycles. The neonatal team focused on improving the CCHD screening process was able to identify and remove an unnecessary steps in the current screening process, reducing the laboratory process for screening by two weeks and make recommendations to hire additional laboratory staff at the state to meet the demands for processing CCHD cards.

The Safe Sleep Coordinator developed an "educational flipchart" as a teaching tool for educators who work one on one with new or expecting parents. The flipchart provides a visual demonstration of a safe sleep environment. During the reporting year, the Safe Sleep Coordinator also partnered with the Division of Family and Children Services to develop a campaign/training initiative for all of their employees and contractors (7,000+ individuals) to ensure consistent messaging for children in foster placement. DPH provided 20 "safe sleep display" kits to local groups and organizations. These kits consist of a pack n play with bassinet, doll with infant sleep sack and, teaching literature. They are designed to "show" what a safe sleep environment looks like and to help answer common questions around safe sleep in different locations within a local community. The Safe Sleep Coordinator has also developed the consistent messaging in all of the educational products and began distribution, Of the 77 birthing hospitals, 75 are participating in the Safe to Sleep Initiative.

Current Activities

MCH continues to support the GaPQC who meets regularly to review collected data and share experiences regarding their quality improvement projects. An annual meeting was held in October 2016, which included a leadership team meeting.

The Safe Sleep Coordinator is currently distributing the consistent safe to sleep materials to a variety of audiences including hospitals, licensed childcare centers, and social media. Tools and materials are being translated into Spanish for distribution and greater reach. Raise awareness about the ABCs (Alone, Back, Crib) of safe to sleep and safe sleep environments among health care providers, public health practitioners, parents or caregivers.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

Promote developmental screenings among children

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

6.1. Increase the number of partner agencies who are trained on developmental screening tools in the 18 public health districts from 0 to 20

6.2. Disseminate educational resources to families and early childhood providers to support developmental screening activities

Strategies

6.1.a. Convene a work group to recommend new, innovative, and effective screening methods (ie. phone, web-based, telephonic)

6.1.b. Identify two new partners per district who are able to administer developmental screens

6.1.c. Use a Train the Trainer model to train newly identified partners in each district on developmental screening tools

6.2.a. Partner with the Georgia American Academy of Pediatricians to disseminate educational resources to pediatric providers

6.2.b. Train public health district staff on developmental milestones and counseling skills to encourage parents to receive a formal developmental screen

6.2.c. Collaborate with early childhood stakeholders to disseminate Learn The Signs. Act Early, information to parents, to increase awareness of developmental milestones

6.2.d. Implement an evidence-informed child health information and referral system, to promote population developmental screening and referral for at-risk children

6.2.e. Collaborate with the Department of Family and Children Services, Women's Infants and Toddler, and Part C to disseminate information and provide training on monitoring developmental milestones.

ESMs

ESM 6.1 - 6.1.1. Identify new methods to administer developmental screens

ESM 6.2 - 6.1.2. Partner attitudes and beliefs toward developmental screening

ESM 6.3 - 6.2.1. Promote developmental screening among local communities

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Child Health - Entry 2

Priority Need

Promote physical activity among children

NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Objectives

7.1. Improve Aerobic Capacity (AC) HFZ measure for students in grandes 4-12 by 1% each year for 4 years. By 2019, 63% of males and 49% of females will be inside the HFZ for AC

7.2. Increase the number of Quality Rated Early Care and Learning Centers that are Shape awarded by 100% over 4 years

7.3. Increase Georgia's student population assessed via Fitnessgram assessment

Strategies

7.1.a. Implement and build sustainability for the Power Up for 30 program that trains educators how to incorporate an extra 30 minutes of physical activity into the day

7.2.a. Collaborate with Department of Early Care and Learning (DECAL) to identify up to 20 learning centers eligible for SHAPE awards

7.3.a. Collaborate with Department of Education to increase the number of students that receive the fitnessgram assessment

ESMs

ESM 8.1 - 7.1.1. Improve aerobic capacity of students in grades 4-12

NOMs

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	42.8	45	47.2	49.6	51	52

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	40.8 %	3.2 %	257,898	632,599
2007	22.7 %	2.8 %	158,483	697,543

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 6.1 - 6.1.1. Identify new methods to administer developmental screens

Annual Objectives					
2017	2018	2019	2020	2021	
Annual Objective	0.0	1.0	2.0	3.0	4.0

ESM 6.2 - 6.1.2. Partner attitudes and beliefs toward developmental screening

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	30.0	50.0	60.0	75.0

ESM 6.3 - 6.2.1. Promote developmental screening among local communities

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	16.0	22.0	30.0	36.0

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	36.6	37.3	38.1	38.8	39.5	39.8

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	35.9 %	2.8 %	309,751	863,401
2007	39.2 %	3.3 %	320,877	819,218
2003	39.4 %	2.5 %	299,200	759,189

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - 7.1.1. Improve aerobic capacity of students in grades 4-12

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	61.0	62.0	63.0	64.0	65.0

Child Health - Plan for the Application Year

Priority Need: Promote developmental screenings among children

Developmental screening was identified as a priority need that will be addressed through promoting developmental screenings, increasing opportunities for developmental screening (state action plan 6.1-6.2) and other MCH programs.

Developmental Screening

The primary activities related to increasing opportunities for developmental screening in the upcoming year, will be to expand the number of trained personnel providing developmental screenings and document the screens occurring in the public health districts. Efforts to standardize the process for documenting developmental screens, and the referral system for children with positive screens will continue. MCH will also continue efforts to provide training opportunities to district staff, providers and families on developmental training tools such as ASQ, and ASQ-SE.

In the upcoming year, MCH will also provide education to primary care providers and other partner agencies on the importance of developmental screening and information on the screening tools with the highest positive predictive values.

Other MCH Programs

Maternal, Infant, and Early Childhood Home Visiting (MIECHV)

In the upcoming year, MCH will lead the MIECHV initiative in Georgia. MIECHV supports pregnant women and families; and helps at-risk parents of children from birth to kindergarten entry to tap the resources and learn the skills they need to raise children who are physically, socially and emotionally healthy and ready to learn.

MCH will continue to identify infants, children and at-risk families through central intake and referral and in the upcoming year identify pregnant women. MCH will also implement strategies and activities that address: maternal and newborn health, child abuse, neglect, and maltreatment and emergency room visits, school readiness and achievement, crime or domestic violence, family economic self-sufficiency, and, coordination of referrals to other community resources and support.

Project LAUNCH

MCH will continue to administer Project LAUNCH from the Substance Abuse and Mental Health Administration (SAMSHA). The purpose of Project LAUNCH Georgia, *Linking Actions for Unmet Needs in Children's Health,* is to ensure the social, emotional and behavioral health among children, birth to age eight, and to promote safe, supportive and nurturing families residing in Muscogee County. Project LAUNCH allows for collaborative efforts among child serving agencies at the state and local level. Through this work, MCH expects to observe changes in child and family outcome trajectories. Project LAUNCH addresses three main goals: (1) expand early identification and linkage of children at-risk for social-emotional and of Muscogee County who serve young children and to provide integrated comprehensive behavioral health services and (3) build common infrastructure between child serving agencies at the state and local levels. As a public Health Initiative Project LAUNCH Georgia seeks to ensure that all children are equipped with the skills they need to achieve developmental milestones. Prevention and promotion activities are key aspects of a public health approach.

Babies Can't Wait IDEA Part C

MCH will continue to administer the Individuals with Disabilities Education Act (IDEA) Amendments of 1997 Part C. Babies Can't Wait (BCW) builds upon and provides supports and resources to assist family members and caregivers to enhance children's learning and development through everyday learning opportunities. BCW aims to meet three goals; (1) provide a coordinated, comprehensive and integrated system of services for infants and toddlers with special needs, birth to 3 and their families, (2) provide early identification and screening of children with developmental delays and chronic health conditions, and (3) improve the developmental potential of infants and toddlers birth to age 3, with developmental or chronic health conditions.

Priority Need: Promote physical activity among children

Physical activity among children was identified as a priority need that will be addressed through a multi-agency initiative to prevent obesity call Georgia SHAPE. The initiative is funded by the Preventive Health Block Grant, 1305, WIC and Title V (state action plan 7.1-7.3). Georgia data suggest that PA and healthy BMI levels plummet at adolescence. Our plan is to continue to collect fitness data over the next several years. Our 10 year goal is to decrease childhood BMI levels by 1% each year, and to improve aerobic capacity measures by 1% as well.

In the upcoming year, Georgia SHAPE will use Power Up for 30 evaluation data to support policy and practice change in childcare centers and public school systems to reduce childhood obesity rates. Georgia SHAPE's strategy is to continue to work with partners and diverse populations to create programming and education opportunities that appeal to child providers of all kinds. Georgia SHAPE plans to continue the 0-5 wellness policy for early care environments toolkit work, as well as our 1-8 physical activity (PA) programs that encourage schools to create PA policy in a way that fits their needs and wants.

Child Health - Annual Report

Annual Report

2015-2016 NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children

Last Year's Accomplishments

DPH's Injury Prevention Program (IPP) provided training and distributed car seats across Georgia. IPP provides monthly classes with early childhood caregivers. Car seats are distributed in the classes, including car seats for children with special health care needs. This is an ongoing effort and we continue to offer training classes and distribute car seats (both traditional and for children with special health care needs).

IPP staff worked with counties on the 2015 CPS Mini-Grant guidelines. One hundred forty-seven (147) counties participated. The Mini-Grant provided 2,567 classes, training 7,951 parents/guardians, and provided 4,519 seats – both traditional and for children with special health care needs. Teddy Bear Stickers are placed on all car seats distributed to document the number of lives saved from injury/and or death due to program funded child safety seats. If a grant provided seat is involved in a crash, the caregiver may receive a replacement seat from the original issuing agency. That agency submits a report, along with the crash report, to IPP staff. In 2015, IPP staff received 32 Teddy Bear Sticker forms and replaced 29 seats.

Special Needs training was conducted in Hall and Henry Counties in 2015 and slated for DeKalb and Whitfield Counties in 2016. Some of the trainings and presentations offered by IPP staff in 2015 included:

"You have the Power in Your Pen" – 4 classes, training 184 law enforcement officers
CPST Class – 4 classes, training 47 people
CPST recertification class for current CPSTs – 3 classes with 98 attendees
"Transporting Children with Special Health Care Needs Training" – 2 classes with 39 attendees
Keeping Kids Safe – 12 hospital group trainings with 175 nurses trained

Building on our minority outreach efforts, the mini-grant training presentation and all training materials were translated with narration in Spanish. IPP continued to work with Refugee Health to provide training to translators and caseworkers. Additionally, Spanish-language training was offered to Georgia Parents for Infant and Toddler Care (GAPTIC) as well as Georgia Migrant and Seasonal Head Start programs.

Current Activities

Injury Prevention continues to distribute child safety seats to children, including specialized child safety restraint systems for children with special health care needs. Child passenger safety trainings to internal and external stakeholders continue. The number of lives saved continues to be documented through Teddy Bear Stickers (TBS) placed on the child safety seats that are distributed. Outreach continues to be conducted to raise awareness about submitting the TBS Fax Back forms to report documentation back to program staff. Data is continually reviewed from the Child Fatality Report, the
Annual Report for Occupant Safety Initiatives and State Highway Safety Report to determine policy recommendations.

2015-2016 NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85 percentile

Last Year's Accomplishments

In an effort to increase the number of participants enrolled in Georgia WIC, the program developed and launched a comprehensive campaign implementing traditional and nontraditional advertising tactics. Utilizing the Metropolitan Atlanta Rapid Transit Authority (MARTA), ads were placed in every train station with a domination at the Five Points MARTA Station. Advertisements were placed inside MARTA trains, inside and outside of MARTA buses, and at bus stops in the areas serving the transit system's patrons. Additionally, ads were placed at gas stations across the state and inside laundromats, salons (both hair and nail), and daycare centers. Spots also ran on the Gas Station Radio Network where available and in movie theaters outside of the metropolitan area. Georgia WIC participated in two major radio station sponsored events aimed at promoting the program on air (via commercials), online (via banner ads), social media (through the station's Twitter account) and face-to-face to WIC –eligible ads participants.
Both events attracted thirty thousand attendees each.

The Georgia WIC Program partnered with Public Health to provide a series of breastfeeding seminars intended to increase knowledge and support of breastfeeding in public health. The education sessions were made available to all public health staff. Evaluation of trainings provided was used to create additional learning opportunities to support breastfeeding. Statewide Videoconference Breastfeeding Training was made available to all Public Health staff including WIC staff on the following dates:

March 2015: Breast Pump Training (WIC Only Training)
March 25, 2015: Breastfeeding is a Public Health Issue
April 29, 2015: Breastfeeding Facts, Myths, and Stigma
September 30, 2015: Challenges to Breastfeeding Success
September 2015: Loving Support Through Peer Counseling Training for New WIC Peer Counselor's

The Georgia WIC program secured a statewide contract to purchase breast pumps. The Georgia WIC program plans to use WIC Food Dollar to purchase breast pumps and expand availability to WIC participants. The Georgia WIC program has implemented a web based breast pump tracking system for hospital grade multi-user pumps. The system allows the WIC program to monitor availability of hospital grade pumps for all districts.

In FY 2015, the Georgia Farmers Market Program authorized 80 farmers, of whom 35 underwent farm visits. Over 70 Farmers Market Program Farmers were authorized to accept EBT. There were 15 Public Health Districts that participated, with a total of 67 Farmers Market Sites. 99.7% of WIC food dollars were expended. 27, 040 WIC participants were served.

Current Activities

DPH continues to build on the advertising campaign that was launched during the summer of 2015 and establish partnerships with various media outlets. In addition to participating in radio sponsored events, the agency has partnered with Univision television station to target WIC eligible participants. This partnership includes WIC TV ads

and social media engagement. This summer, Georgia WIC will play an active role in the National WIC Association's national outreach campaign. Statewide Videoconference (VICS) Breastfeeding Training continues to be made available to all Public Health staff including WIC staff.

Trainings that support Breastfeeding:

October 14, 2015: Encouraging Exclusivity (VICS)
October 28, 2015: Creating a Breastfeeding Friendly Environment (VICS)
February 2, 2016: Baby Behavior Training
August 17, 2016: Community Outreach: Breastfeeding Friendly Business Initiative (VICS)
June 29, 2016: Baby Behavior Training
June 30, 2016: Baby Behavior Training

The Georgia WIC program continues to significantly expand access to breast pumps across the state. The Georgia WIC program has provided an estimated 1,500 additional hospital grade breast pumps to districts statewide. (Year to date FY 2016 Symphony Hospital Grade Multi-User Pumps).

Peer Counselor Data Base (PCDB) initiation: The Georgia WIC program secured a peer counseling data base that allows for improved data collection that saves time and allows documentation of PC activities to be uniform across the state. Peer Counselors managers now have a mechanism to more easily monitor peer counselor activities as well as manage caseload. The PCDB system replaces a number of manual systems that varied across the state.

The state monitors the provision of nutrition education to WIC participants at WIC certifications (Primary Education) and between certifications (Secondary Education) during regularly scheduled program reviews. All districts are monitored at least every two years. Data collected is summarized on two year cycles. The state's year to date overall success as of March 2016 for providing *Primary Education* for FFY 2016 / 2017 was 99.0%. The state's year to date overall success as of March 2016 for providing *Secondary Education* for FFY 2016 / 2017 was 91.5%.

Georgia SHAPE funded Strong4Life and the Georgia WIC Strong4Life initiative intended to improve the Effectiveness of Childhood Obesity Counseling and Goal Setting continues to receive good support from public health and Georgia WIC. State WIC policies have been revised to require monthly WIC Champion Observations in all public health districts. Children's Healthcare of Georgia is on target with development of a web based Strong4Life entry level training for new public health WIC employees. The web based training is scheduled for release August 2016.

2015-2016 SPM 01: Percent of high school students who are obese (BMI > or = 95 percentile)

Last Year's Accomplishments

In fall of 2015, the first Georgia SHAPE Public Health Reports special supplement was completed.
During the early stages of the project, DPH invited the Department of Early Care and Learning (DECAL) and subject matter leaders to analyze current state and national standards and best practices.

In 2015, Georgia SHAPE trained just over 50 early childhood education (ECE) providers to improve their wellness policies and practices. By creating a toolkit with partners across the state, various groups are using the Georgia SHAPE tool, including, the University of Georgia, DECAL, HealthMPowers, and DPH. Using the same tool and language has helped align best practices, health and wellness ECE policy, and create an action plan tool that allows ECEs to create change in their settings that adhere to the state standards and best practice assessment/program (DECAL Quality Rated Program). The Growing Fit Toolkit training has now reached over 110 ECE providers. To view the toolkit, visit dph.georgia.gov search words Growing Fit Kit.

In addition to this toolkit, Georgia SHAPE also created a framework for elementary schools that allows every school in the state to learn how to incorporate an extra 30 minutes of physical activity (PA) into the school day without taking away from academic time. Through private funding, DPH, Department of Education (DOE) and HealthMPowers have partnered to train an administrator, PE teacher and classroom teacher how to create an action plan that adheres to this policy of an extra 30 minutes each day. Due to the partnership with DOE, DPH received a 70% response rate. As of December 2015, Georgia SHAPE has trained 600 schools and over 750 have pledged to the program (Power Up for 30).
This work is aligned with the Center for Disease Control's (CDC) Coordinated School Physical Activity Program (CSPAP).

In 2009 legislation was passed that requires Georgia to assess Child fitness levels in public school physical education classes from 1 -12 grades. A pilot in 2011 informed this work, and in 2012 data were collected statewide for the first time. Since this policy was put in place, Georgia DPH and Georgia DOE have worked together to collect, analyze and report child fitness levels in our state. In 2014-2015 over 1.14 million students were assessed. Aerobic capacity and Body Mass Index measures have improved over the last few years, and recently began to level.

This positive movement may be in part due to the many school interventions that have been implemented at the population level over the last few years. Physical Educators have been trained how to implement testing best practices by having students stand backwards on the scale and recording BMI data without sharing numbers with students. This alleviates any teasing about weight or BMI. Reports are then sent to parents with report cards, or electronically.

Current Activities

Power Up for 30 funding (for elementary schools) ends in August 2015. DPH's goal is to reach 1,000 elementary schools by that time. To date we currently have 833 schools pledged, and 700 trained. To create sustainability and reach some of the more remote schools, DPH has partnered with HealthMPowers and DOE to create an electronic training of the program, comprised of 4 modules (all with live interaction).

Georgia SHAPE began to pilot a middle school version of the Power Up for 30 Program. Three middle schools will be trained with the program in late spring (2016) and three more in early fall (2016). DPH has also partnered with the Department of Family and Child Services (DFCS) to create an afterschool Power Up for 30 Program. All afterschool providers that received funding from DFCS in the fall of 2015 were asked to participate in the training and incorporate extra PA in their afterschool programs. To date, over 250 people were trained, serving over 150 different afterschool centers statewide. Lastly, to create long-lasting sustainability, DPH has been working with the University of West Georgia to create a preservice teacher certificate. This will enable pre-service teachers (PE and regular education majors) how to implement extra bouts of physical activity into the school day, as well as teach peers how to do so with free resources and by creating interdisciplinary lessons that use PA as a teaching method.

2015-2016 SPM 05: Among children five years of age and younger who received service through the MCH Program, the percent who received a developmental screen

Last Year's Accomplishments

The local public health department continues to be a location where parents and children are a captive audience for developmental screening. In many public health districts, public health nurses or Children 1st staff administer developmental screens following a family's WIC appointment. These screens are either entered into the database by county staff or sent to the district Children 1st office to be entered. Public health district staff report roughly 8,000 children receiving a developmental screen through local public health departments.

Public health district staff have also actively educated the community on the importance of developmental screening,

typically focusing on early learning centers, primary care physicians and other community partners who work directly with the birth to 5 population. These education efforts also included information on the public health system and the appropriate methods to refer a child for services.
Some public health districts, have accomplished training the early childcare workforce to administer developmental screens.

Current Activities

MCH continues to administer developmental screens in environments parents and children routinely frequent in local public health departments. This continues to provide opportunities to identify children with developmental delay and simultaneously reduces barriers that may prevent parents from receiving a developmental screen. Developmental screens that are administered over the phone eliminate travel time to family homes and create an opportunity to increase the number of children who are screened in a given time period. Children who have had a developmental screen at time of referral can more rapidly be assessed by public health professionals and, as a result, more rapidly be linked to early intervention services or other appropriate care.

MCH continues to work in partnership with Georgia American Academy of Pediatrics to facilitate messaging to pediatricians about the importance of developmental screening according to the Bright Futures schedule. Through this partnership, providers are also educated on how to refer a child to resources and services through DPH.

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

Reduce suicide among adolescents

NPM

Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Objectives

8.1. Increase the number of media impressions related to youth bullying awareness and bullying prevention

8.2. Increase the number of Georgia schools engaged in "whole school" bullying prevention initiatives or campaigns

Strategies

8.1.a. Develop a statewide communications plan to increase awareness of bullying and bullying prevention to youth and adult leaders of youth (e.g. teachers, youth group leaders, and after school personnel) using a variety of media, including web, social media, and traditional media.

8.1.b. Plan and develop a website with the link www.dph.ga.gov\bullying to share evidence-based best practices for bullying prevention with local public health personnel and other health professionals

8.1.c. Identify partners working in high-risk communities or with high-risk groups such as; lesbian, gay, bisexual and transgender youth, to disseminate bullying prevention education and resources

8.2.a. Fund additional schools to participate in Georgia's Step Up, Step In Sexual Bullying Prevention initiative

8.2.b. Conduct program planning activities to assess the feasibility and costs of directly training youth through groups like "Youth Empowered Solutions (YES)" to promote school district policy changes around bullying, including sexual bullying and cyber bullying

8.2.c. Engage youth groups, such as Vox, a youth-drive communications enterprise, in bullying prevention to promote youth leadership on the topic

ESMs

ESM 9.1 - 8.1.1. Promote bullying prevention among youth

ESM 9.2 - 8.2.1. Increase the number of schools participating in whole school bullying prevention initiatives

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Measures

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	25.3	25	25	24.5	24.5	24

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	16.4 %	2.3 %	129,553	790,591
2007	17.0 %	2.7 %	144,095	846,092

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	25.1 %	1.6 %	110,846	442,284
2011	24.9 %	1.9 %	112,919	454,357

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 9.1 - 8.1.1. Promote bullying prevention among youth

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	No	No	Yes	Yes	Yes

ESM 9.2 - 8.2.1. Increase the number of schools participating in whole school bullying prevention initiatives

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	2.0	4.0	6.0	8.0

Adolescent Health - Plan for the Application Year

Priority Need: Prevent suicide among adolescents

To address suicide and bullying, MCH will partner with DPH's Adolescent and School Health Program (ASHP), Injury Prevention Program, the Georgia Department of Education, DPH's Epidemiologists (YRBSS and GVDRS) and MCH's STI Program to implement strategies for the prevention and monitoring of bullying activity in Georgia. Our MCH STI partnership will allow us to collaborate with organizations that support Georgia's Lesbian, Gay, Bisexual, Transgender and Queer (LBGTQ) community.
The DPH partnership described above will be leveraging existing councils and coalitions, such as *The Georgia Safe Schools Coalition,* to develop a bullying specific council for DPH.

MCH will also develop a bullying website for which a resource database for bullying prevention and mental health promotion will be made available to students, schools, families, providers and community partners. The resource database will compile data from all available sources, and include fact sheets. Information on evidence-based programs will be included, as well as, descriptions and web links to efforts throughout the state to reduce bullying, prevent suicide and promote mental health.

MCH will also work with ASHP to expand a Georgia specific school-based sexual bullying prevention program called Step Up Step In (http://stepupstepin.org/).

Adolescent Health - Annual Report

Annual Report

2015-2016 NPM 08: The rate of birth (per 100,000) for teenagers aged 15 through 17 years

Last Year's Accomplishments

Adolescent Health and Youth Development (AHYD) district level staff receive monthly technical assistance via conference calls and video conferencing. As needed, individual technical assistance site visits are scheduled. Also, webinars and a yearly AHYD staff meeting were provided by state staff. A total of 41 professional trainings/technical assistance activities were provided. AHYD program staff attended and provided in-service training events such as Working with Youth in Foster Care, Master Facilitator Training, Evaluating Evidence-Based Programs, Linking Parents and Educators, Using What Works: Adapting Evidence-Based Programs to Fit Your Needs and Coalition building.

MCH and the Chronic Disease Prevention section continue to participate as a member of Public/Private Partnership to Reduce Teen Pregnancy (P3). MCH worked with Medicaid and GOGS to promote P4HB family planning waiver program aimed at maintaining family planning coverage for low income women.

Youth in areas with high rates of teen pregnancy, HIV/STDs and school dropout were strategically targeted to receive evidence-based teen pregnancy prevention programs. These programs are recognized by the Office of Adolescent Health. The programs included: "Reducing the Risk," "Making A Difference," and "Making Proud Choices." The programs were delivered by certified facilitators in various settings including: faith-based institutions, schools, and afterschool programs in funded health districts where 833 youth were served.

In partnership with the Department of Human Services, District AHYD Programs delivered evidence-based curricula to youth identified as increased risk for teen pregnancy, HIV and/or STDs. Youth received educational and life skills instruction on abstinence and prevention education and healthy relationships. Youth were recruited from funded health districts where 789 youth graduated from program.

Current Activities

Continued progress has been made with our partnership with DHS to provide PREP and additional evidence-based risk reduction curriculum. Currently the program is on track to service more graduating participates than in the past years. AHYD has taken a holistic approach to teen pregnancy prevention by providing life skills and youth development opportunities in addition to sexuality education. Parenting workshops for teens of parents are provided as well.

Programming with WIC on the local level has been provided to teen moms with the intent to reduce second/multiple pregnancies.

2015-2016 NPM 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19

Last Year's Accomplishments

A thorough review of child deaths resulting from suicide completions was conducted through the Child Fatality Review. The Department of Behavioral Health and Developmental Disabilities has a policy to utilize the Columbia Suicide Severity Risk Scale for all providers.

Current Activities

The fact sheets continue to be distributed to the school system. Suicide deaths are reviewed through Child Fatality Reviews. The Columbia Suicide Severity Risk Scale continues to be used. The 2014 Child Fatality Review Report was completed and released.

Adolescent and School Health administers the Step Up. Step In campaign. This campaign addresses sexual bullying prevention.

2015-2016 SPM 04: Deaths to children ages 15 to 17 years caused by motor vehicle crashes per 100,000 children

There are no activities to report as a renewal grant for highway safety was not awarded.

Children with Special Health Care Needs

State Action Plan Table

State Action Plan Table - Children with Special Health Care Needs - Entry 1

Priority Need

Improve systems of care for children and youth with special health care needs

NPM

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Objectives

9.1. Increase outreach and awareness activities on health care transition to community stakeholders, youth and families

9.2. Increase the number of training and educational opportunities for health professionals on health care transition

9.3. Improve the standards of care for youth and young adults by implementing health care transition protocols within public and private practice settings

Strategies

9.1.a. Develop health care transition materials for stakeholders, youth and families

9.1.b. Develop a Health Care Transition Resource Portal

9.1.c. Provide health care transition presentations to community stakeholders

9.1.d. Establish and maintain community partnerships to facilitate the distribution of health care transition resources and materials

9.2.a. Provide an online continuing education module on the six core elements of health care transition targeting a minimum of 10% of public health nurse workforce

9.2.b. Provide continuing education opportunities on the six core elements of health care transition for medical and nursing students, pediatric and adult providers

9.2.c. Provide 20 health care transition planning workshops for families and youth

9.2.d. Provide an annual stakeholder meeting with continuing medical education credit for pediatric and adult providers to discuss evidence based practices, medical home and transition and coordination of care across pediatric and adult systems

9.3.a. Establish an advisory group to include youth, families, and providers to support practice improvement efforts for health care transition

9.3.b. Incorporate the use of transition readiness assessments and planning tools within the 18 district Children's Medical Services (CMS) programs

9.3.c. Assess family and youth satisfaction of the health care transition services and supports upon transitioning out of the program

9.3.d. Partner with pediatric and adult medical providers to provide guidance and support in the development and implementation of a health care transition policy within their practice

ESMs

ESM 12.1 - 12.1.1 Promote health care transition through education and training

ESM 12.2 - 12.2.1 Promote health care transition through marketing and media

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Children with Special Health Care Needs - Entry 2

Priority Need

Improve access to specialty care for CSHCN

SPM

Improve access to specialty care for CSHCN

Objectives

10.1. Increase outreach and awareness activities on telehealth with medical partners, community stakeholders and families

10.2. Improve the telehealth infrastructure required to support children and youth with special health care needs access to medical care

10.3. Improve the standards of care for children and youth with special health care using telehealth technology

Strategies

10.1.a. Provide comprehensive telehealth information to providers

10.1.b. Facilitate efforts to educate families about telehealth as an option for care

10.2.a. Assess the infrastructure needs of the Children's Medical Services (CMS) Program telehealth clinics

10.2.b. Collaborate with the Department's Telehealth team and Waycross Health District to expand telemedicine sites

10.2.c. Expand the telemedicine provider network

10.2.d. Establish a telehealth stakeholder workgroup for CSHCN

10.2.e. Collaborate with the Department's EPI team to conduct a needs assessment and to develop a program evaluation plan

10.3.a. Utilize telehealth to improve care coordination efforts for CSHCN

10.3.b Utilize telehealth to improve access to audiological and speech therapy services for CSHCN

10.3.c Utilize telehealth to improve access to services for children and youth with sickle cell disease

Measures

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	34.2	34.6	34.9	35.3	35.6	36

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	33.9 %	3.4 %	48,646	143,452
2005_2006	37.0 %	3.2 %	43,123	116,600

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 12.1 - 12.1.1 Promote health care transition through education and training

Annual Objectives					
2017	2018	2019	2020	2021	
Annual Objective	5.0	10.0	15.0	20.0	25.0

ESM 12.2 - 12.2.1 Promote health care transition through marketing and media

Annual Objectives					
2017	2018	2019	2020	2021	
Annual Objective	25.0	35.0	50.0	75.0	100.0

Children with Special Health Care Needs - Plan for the Application Year

Priority Need: Improve systems of care for CSHCN

Improve systems of care for CSHCN was identified as a priority need in Georgia that will be addressed through outreach and awareness activities to include training and educational activities, increasing access to specialty care

through telehealth, and developing health care transition protocols within public and private practice settings (state action plan 9.1-9.3).

Outreach and Awareness

In the upcoming year, MCH will develop health care transition materials, a resource portal, provide presentations to community stakeholders, and partner with communities to facilitate the distribution of resources and materials. Workbooks and training curriculum adapted from the Waisman Center (Wisconsin) will be used in education and awareness activities to promote successful health care transition for youth and young adults with and without disabilities. In order to increase awareness of the services available to CSHCN in Georgia, DPH's Child Health website was updated. The website provides a more user-friendly approach to obtaining information about medical homes, transition and local resources.

In the coming year, MCH will also expand partnerships with academic institutions with medical schools, nursing programs and physician assistant programs to plan and define curriculum for CSHCN in clinical programs.

MCH plans to provide an online continuing education module on the Six Core Elements of Health Care Transition to the public health workforce, medical and nursing students, and pediatric and adult providers. MCH host health care transition workshops for families and youth.

In the upcoming year, MCH plans to establish a CSHCN advisory council to support practice improvement efforts, incorporate transition readiness assessments and planning tools, develop a feedback form to measure family satisfaction with transition services, and provide guidance and support to pediatric and adult providers in establishing transition policies.

Priority Need: Improve access to specialty care for CSHCN

Improve access to specialty care for CSHCN was identified as a priority need in Georgia that will be addressed through telehealth (state action plan 10.1-10.3). MCH will 1) increase outreach and awareness activities to medical partners, community stakeholders and families 2) improve our telehealth infrastructure, and 3) improve CSHCN standards of care through telehealth technology.

Outreach and Awareness

In the coming year, MCH will provide comprehensive telehealth information to providers. MCH will also facilitate efforts to educate families about telehealth as an option of care.

Telehealth Infrastructure

MCH will comprise a telehealth stakeholder workgroup for CSHCN, collaborate with DPH's telehealth team to expand telehealth sites, work to expand the telehealth provider network, and collaborate with DPH's epidemiology team to evaluate the current telehealth clinics.

Telehealth Technology

MCH will utilize telehealth to improve care coordination efforts in MCH child health programs, to improve access to audiological and speech therapy services, and to improve access to children and youth with sickle cell disease.

Children with Special Health Care Needs - Annual Report

Annual Report

2015-2016 NPM 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 care they receive.

Last Year's Accomplishments

All Children's Medical Services (CMS) patients received Care Coordination services, which includes the development of a Care Plan. During FY15, 8,696 families received services from CMS. The Care Plan is developed during the initial visit with a CMS Care Coordinator and updated at a minimum every 6 months. Families are involved in the development of their child's Care Plan which incorporates monitoring and assessment, eliciting feedback regarding satisfaction, and discussing met and unmet needs.

In addition to the CMS Care Plan, all Babies Can't Wait (BCW) families receive Service Coordination, which includes the development of the Individualized Family Service Plan (IFSP). A multidisciplinary team, which includes the service coordinator, family and providers from two disciplines work together to develop an IFSP for the child.

Parents with children with special health care needs were recruited to assist with providing feedback on the Health Care Transition materials for youth and their parents/caregivers. Workbooks and training curriculum adapted from the Waisman Center (Wisconsin) used in education and awareness activities were evaluated by parents. Six parents participated in a half day focus group activity to review materials as well as provide their feedback on updates to the Maternal and Child Health webpage.

During the reporting year, MCH hired another Parent Engagement Specialist to specifically support child health services programmatic activities and quality improvement projects. In addition to MCH's staffed parents of CSHCN,

MCH continued collaboration with Parent to Parent of Georgia to support CMS and BCW programmatic activities.

There are three CMS public health districts that are participate in the Parents as Partners Pilot, a family support initiative that places parents in specialty clinics to enhance support services for CSHCN families. Currently there are two parent partners in private pediatric specialty clinics with Augusta University's Sickle Cell Clinic and Children Health Care of Atlanta's Autism clinic. During the first 12 months 1,100 families of CSHCN were served.

Finally, there will be three Transition to Adult Care Youth Summits. Marketing materials created to promote youth summit participation were distributed to CMS Coordinators and with their families.

Current Activities

MCH continues to provide care and service coordination to CSHCN families through developing Care Plans and IFSPs. Families of children with hearing loss are surveyed through our partner agency, Georgia Pines, to provide satisfaction results, which are used to assist our Early Hearing Detection and Intervention program improvement. Families in our BCW early intervention program are also surveyed prior to exiting the program to if they 1) know their rights 2) can communicate their children's needs and 3) help their children develop and learn. Out of 3,489 completed surveys, 97.1% reported early intervention helped them know their rights, 97.2% reported early intervention has helped them communicate their child's needs, and 96.6% reported early intervention have helped their child develop and learn.

MCH has approximately ten parent leaders that are involved in the EHDI program and family organizations such as Hands and Voices. Six family leaders attended the 2016 National EDHI Conference held in San Diego, CA, one of which was sponsored by MCH. One of the parent leaders was a co-presenter at the EHDI conference alongside MCH's EHDI Coordinator. In the reporting year, four new family leaders were appointed to the Newborn Screening and Genetics Advisory Committee (NBSAC). They represent CSHCN with metabolic disorders, deaf and hard of hearing, sickle cell disease, and cystic fibrosis. These family leaders will work alongside doctors, scientists, and public health professionals to influence the strategic direction of newborn screening and promote policy improvements for the families represented by these specialty areas. Two family leaders were appointed by our Governor to the State Interagency Coordinating Council (SICC) for Early Intervention.

2015-2016 NPM 03: Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home

Last Year's Accomplishments

Families in BCW and CMS are assessed for participation in a medical home upon enrollment. Through the Integrated Community Systems for CSHCN Grant (D70), knowledge and awareness of the medical home concept was increased.

Staff receives ongoing professional development opportunities via The National Center for Medical Home Implementation webpage and listserv.

All CMS clients are assessed for a medical home, and referrals are made accordingly. 97% of CMS families reported having a primary health care provider.

Through a contract with Parent to Parent of GA, medical and dental home curricula were developed based upon booklets created through our previous Early Childhood and Comprehensive Systems (ECCS) Grant.

Parent to Parent of Georgia partnered with the CMS Program to launch the Parent Partners Project within three public health districts. Medical and Dental Home training was provided to all newly recruited parents to serve as partners in CMS clinics.

Current Activities

The Georgia Department of Public Health has eighteen public health districts, and each district has a child health program. Each child health program consists of Children's 1st (Single Point of Entry for child health referrals), Children's Medical Services (Title V CYSHCN) and Babies Can't Wait (Early Intervention) services.

Within all child health programs, a comprehensive health assessment is completed on families referred to and/or enrolled for services. The Maternal and Child Health Integrated Assessment is the tool used across all child health staff. In FY15, more than 10,000 families were served in the Children's Medical Services program. All of those families in Children's Medical Services received care coordination services, a comprehensive health assessment and care plan was developed with the family's involvement. The care plan is routinely evaluated and updated in partnership with the family as needed but no less frequently than every six (6) months. Families in Babies Can't Wait received early intervention services, evaluations and assessment completed and an Individualized Family Service Plan was developed with the family's involvement. Approximately 15,678 infants and toddlers were enrolled in Babies Can't Wait in SFY14.

The child health program promotes an integrated, team based model of care coordination by conducting weekly Birth to Five meetings to discuss new referrals and status of referrals. Birth to five meetings included staff from Children 1st, Babies Can't Wait and Children's Medical Services. Based on information from the screening and referral form, referrals are either referred to early intervention, chronic illness management or further monitoring services.

The project continues to operate in Public Health and private medical clinic settings. There are four Parent Partners supporting the Parents as Partners project. These four individuals are located in Albany, Atlanta, Gainesville and Augusta. On a monthly basis, these Parents as Partners provide one on one assistance to about 80 families, while the Parent as Partner Manager works individually with each Parent Partner on their continued knowledge and skill development through face-to-face, telephone and email contacts.

The Parents as Partners project will expand to include seven (7) parents at seven (7) different sites in SFY17.

2015-2016 NPM 04: 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

Last Year's Accomplishments

Assessing insurance status and coverage for newly enrolled patients is completed during the Children's Medical Services (CMS) and Babies Can't Wait (BCW) program enrollment process. All CMS Care Coordinators utilize the CYSHCN Financial Analysis form to collect family income as well as as insurance and coverage information. CMS Care Coordinators have access to the State Medicaid web portal to complete queries on insurance information for members. For families without insurance during the time of enrollment, CMS Care Coordinators assess eligibility for the State's Medicaid and SCHIP programs and assist with the applications. For families that do not qualify for the

State's Medicaid and SCHIP programs, CMS will serve as the payor of last resort for all healthcare and medical expenses.

For families without insurance during the time of enrollment, CMS Care Coordinators assess eligibility for the State's Medicaid and SCHIP programs and assist with the applications. Care Coordinators continuously check status updates of applications on the State's Medicaid web portal and assist families with completing the requirements of the verification documents. For special cases, CMS Care Coordinators requests additional assistance from the CMS State Office. Regional Directors with the Department of Family and Children Services, entity responsible for Medicaid and SCHIP program enrollment, are contacted to provide guidance and resolution.

The CMS Family Engagement Specialist coordinated a quality improvement project to improve access to incontinence supplies for children and youth with special needs. Medicaid representatives were contacted for clarification on EPSDT coverage and requirements. Medicaid vendors for incontinence supplies were identified and shared with all public health district CMS Coordinators. Sample letters of medical necessity were developed, and also shared with CMS coordinators to assist families in meeting fee-for-service Medicaid requirements. The CMS State Office provided technical assistance for CMS Coordinators having issues with adjusting to the new procedures for authorizing payments for incontinence supplies.

Current Activities

CMS and BCW programs assess insurance status and coverage during the initial enrollment process and annually thereafter.

For families that do not qualify the State's Medicaid and SCHIP programs, CMS and BCW will serve as the payor of last resort for healthcare and medical expenses. Dual enrollment in the CMS and BCW child health programs is permissible.

For families without insurance during the time of enrollment, CMS Care Coordinators assess eligibility for the State's Medicaid and SCHIP programs and assist with the applications. Care Coordinators continuously check status updates of applications on the State's Medicaid web portal and assist families with completing the requirements of the verification documents. For special cases, CMS Care Coordinators requests additional assistance from the CMS State Office. Regional Directors with the Department of Family and Children Services, entity responsible for Medicaid and SCHIP program enrollment, are contacted to provide guidance and resolution.

A Memorandum of Agreement with the Division of Family and Children Services (DFCS) and the Maternal and Child Health (MCH) Section of the Georgia Department of Public Health is under development to improve child health referrals and early intervention services for infants and toddlers birth to three across the State of Georgia.

An initial meeting was held between MCH and DFCS in February 2016 to reestablish the partnership, provide an overview of services available to families and decide on next steps to improving the collaboration. Outlined in the MOA, are quarterly meetings to discuss challenges and opportunities as well as quarterly reports to ensure referrals are processed timely and completely. This opportunity will be used to also address Medicaid enrollment processes and procedures.

The Department of Public Health and the Department of Community Health will sign an agreement to establish a 50 percent Federal Medicaid Funds match on allowable Medicaid-related costs associated with the provision of Babies Can't Wait Special Instruction services to support Medicaid beneficiaries receiving Babies Can't Wait Special Instruction Services.

Children's Medical Services is collaborating with the Amerigroup Georgia Families 360 program to ensure better coordination of services for children and youth in foster care, adoption assistance and juvenile justice. Communication materials were developed for care coordinators supporting the Children's Medical Services program and case managers supporting the Georgia Families 360 program to build awareness of services and eligibility requirements.

2015-2016 NPM 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

Last Year's Accomplishments

There are three CMS district programs that are participants in the Parent as Partners Pilot. The Pilot project enhances support services to CMS families and is provided by a parent with a child with special needs. Parent Partners are trained and knowledgeable on the resources available in their communities. If they are not familiar with a resource they are able to request assistance from Parent to Parent of Georgia and the Department of Public Health.

CMS program administrators received training on coordinating nutrition services for patients with Inborn Errors of Metabolism. The CMS State Office and Newborn Screening programs collaborated with Georgia WIC and Emory Genetics Clinic to host the training offered to all 18 public health districts.

There are two CMS district programs that are participants in the Georgia Asthma Control initiative. The Initiative promotes a multi-trigger, multi-component evidence based asthma intervention. The CMS program will screen and enroll eligible participants, provide care coordination and self- management education, and refer families to a healthy home specialist from Environmental Health.

There are nine public health district CMS programs that partner with local providers to conduct specialty clinics for CYSHCN. Clinics vary from orthopedic to neurology and are most often provided on a monthly basis.

Newborn Screening and CMS are working together to expand telemedicine services in Valdosta, Macon, Waycross and Dublin.

CMS Program coordinators continuously connect families to existing support groups. CMS Care Coordinators connect families with existing support groups facilitated by Parent to Parent of Georgia.

Current Activities

The Georgia Department of Public Health has eighteen public health districts, and each district has a child health program. Each child health program consists of Children's 1st (Single Point of Entry for child health referrals), Children's Medical Services (Title V CYSHCN) and Babies Can't Wait (Early Intervention) services.

All of our child health coordinators routinely participate in community health fairs, school events and marketing campaigns that serve both to inform clients of community resources and to also network and update their community referral resource list, which is disseminated to the families served by child health programs.

Most child health programs have also developed partnerships with local community organizations and national organizations, such as United Way, to ensure consistent service delivery.

There are nine public health districts that partner with local and out of state pediatric subspecialists to conduct specialty clinics for CSHCN. Clinics vary from orthopedic to neurology and are most often provided on a monthly basis. Clinic services are available to families enrolled in the CMS program and reside in the public health district offering the services.

Between July 1, 2015 and March 31, 2016, there were 278 specialty clinics held within nine (9) public health districts, and approximately 3,202 CSHCN were served. Telehealth clinics were held in the Waycross and Valdosta public

health districts and accounted for 67 of those specialty clinics.

Newborn Screening (NBS) and Children's Medical Services (CMS) partners with Augusta University's Sickle Cell Center to provide sickle cell services via on-site and telehealth in three public health districts (Waycross, Dublin and Valdosta). Discussions for the expansion of services to the Albany public health district is in process for sickle cell services.

NBS and CMS is also partnering with a specialist in the areas of pediatrics and genetics to improve access to genetic services via telehealth. A contract between the Department of Public Health and the provider is signed and equipment purchased and installed for services to begin within the next couple of months. The Athens public health district will receive training in the month of April to work with this provider for genetic services.

The Georgia Department of Public Health is committed to establishing a sophisticated telehealth network to underserved areas of Georgia. According to the Georgia Board of Physician Workforce, 52 percent of Georgia's physicians are located in five areas that serve just 38 percent of the state's population. There is adequate partnerships, resources and staff expertise within the Department to allow for continued success within the areas of telehealth.

A Memorandum of Agreement with the Division of Family and Children Services (DFCS) and the Maternal and Child Health (MCH) Section of the Georgia Department of Public Health is under development to improve child health referrals and early intervention services for infants and toddlers birth to three across the State of Georgia. Outlined in the MOA, are quarterly meetings to discuss challenges and opportunities as well as quarterly reports to ensure referrals are processed timely and completely.

The Child Health program is also developing training materials for foster parents and DFCS case managers on child health services offered to families and practical skills in identifying developmental delay with the children they serve.

The Maternal and Child Health contract with Parent to Parent of Georgia, the Family to Family Health Information Center (F2F) and Parent Training Information Center (PTI) was revamped to better align their services with the needs of CYSHCN and their families.

A major shift in the responsibilities for Parent to Parent of Georgia include the Parents as Partners project. The project continues to operate in Public Health and private medical clinic settings to support families of children and youth impacted by special healthcare needs. The project enhances care coordination and support services to Children's Medical Services and Babies Can't Wait families. There are four Parent Partners funded through this contract. These four individuals are located in Albany, Atlanta, Gainesville and Augusta. On a monthly basis, these Parents as Partners provide one on one assistance to about 80 families, while the Parent as Partner Manager works individually with each Parent Partner on their continued knowledge and skill development through face-to-face, telephone and email contacts. The Parents as Partners project will expand to include seven (7) parents at seven (7) different sites in SFY17.

Parent to Parent of Georgia will also continue to provide and maintain a Statewide Central Directory database which allows users to search using various criteria. The database will be used to provide information and referral services for families of children ages birth to twenty-one (21) with developmental delays, disabilities and chronic health care conditions. To improve family support services, parents will be able to access parent training videos as well as the Supporting Parents Program which connects families to other parents with a child with special needs for emotional support. Through the Supporting Parents Program, there are on average thirty-five (35) families that are connected on a monthly basis.

The Maternal and Child Health contract with Easter Seals of West Georgia was revamped to ensure that assistive technology services for preschool kids was utilized by more families and therapists across the State. Marketing and

public awareness activities were included in the contract to ensure that families with preschool aged children and a referral from their therapist were aware of these services. There was also a cap/per family implemented to ensure more families were served compared to prior years.

Easter Seals of West Georgia was able to expand their reach to families in the Cobb, Columbia, DeKalb, Effingham, Harris, Jefferson, Lowndes and Tattnall counties. During the months of July 2015 and March 2016, seventy-five (75) families received assistive technology services. The average number of devices provided per family decreased from 8 to 3 devices with the implementation of the cap/family.

2015-2016 NPM 06: Percent of youth with special health care needs who received the services necessary to make transition to all aspects of adult life

Last Year's Accomplishments

85% of CMS patients ages 16 to 21 have a transition plan. The CMS Transition Manual is under development. Discussions with public health district CMS Coordinators were conducted to gather current transition planning activities, information on local community barriers to transition services and supports and the feasibility of incorporating enhanced transition protocols.

GA-AAP will provide two CMS Grand Rounds events with two Georgia Hospital Pediatric Departments on "Transitioning Youth with Special Health Care Needs to Adult Health Care."

GA-AFP, in partnership with GA-AAP and Parent to Parent of GA, will host and facilitate a "Conversation about Challenges and Strategies in Transitioning Youth with Special Health Care Needs from Pediatric to Adult Care." At minimum fifty family physicians and internists who treat or have an interest in treating patients with diabetes, autism and sickle cell disease will participate in the meeting.
GA-AAP and GAFP will continue to promote the "Physicians Guide to Transitioning Youth with Special Health Care Needs" produced in collaboration with the Department.

CMS designed web content for the newly created Transitioning Youth to Adult Care webpage hosted on the Department's website.

Three youth summits funded by the Department and hosted by Georgia State Center for Leadership Disability will be held during the months of May and June 2015. More than 300 youth, young adults, parents, and caregivers are expected to participate in the all-day event.

Current Activities

The Children's Medical Services Health Care Transition Training curriculum and materials package will include a host of resources for youth, parents and care coordinators. The Children's Medical Services (CMS) program partnered with Parent to Parent of Georgia to develop Health Care Transition curriculum and workbooks for parents and youth to assist with transition planning. "Transition to Adult Health Care, a workshop for Youth and Parents/Caregivers" will be used to provide several training workshops to CMS families across the State.

The CMS program also produced and distributed Health Care Transition booklets to all eighteen local CMS programs to assist with informing youth on the importance of taking charge of their health and starting the health care transition process early. This booklet is used as a tool to begin the conversation of health care transition with youth and young adults enrolled in the CMS program.

Work will be completed in the next few months in developing materials to support the care coordinators role with Health Care Transition.

The Georgia Chapter American Academy of Pediatrics hosted a Transition from Pediatric to Adult Care stakeholder meeting for pediatricians, family physicians and internists to discuss the state of transition in Georgia and to share

resources and tools.

The Georgia Chapter American Academy of Pediatrics and Georgia Academy of Family Physicians spring conferences held health care transition training sessions with continuing medical education credits. .

Health Care Transition training opportunities were made accessible to all eighteen local CMS programs. The 16th Annual Chronic Illness and Disability Conference Transition from Pediatric to Adult-based Care was provided via live stream and 34 care coordinators participated and received continuing education credits.

The Children's Medical Services program will partner with Parent to Parent of Georgia to provide training to all eighteen local CMS programs on the Health Care Transition curriculum and workbooks for parents and youth at the next Child Health Meeting.

Work will be completed in the next few months to update the Health Care Transition Manual and assessment tools for the CMS program.

The Children's Medical Services program partnered with Parent to Parent of Georgia to implement the Parents as Partners project. The Parents as Partners project enhances care coordination efforts across all child health programs by connecting families with a supporting parent that has a child with a special need. The Parent Partner assists families with locating resources and services within their community. The Parents as Partners project began more than 12 months ago with four sites and will expand to seven sites within the next few months. Health Care Transition Planning training will be provided to Parent Partners to assist them with supporting families with successful transition from pediatric to adult care.

The Parents as Partners project will be a component of the enhanced transition planning intervention. Those identified sites with a Parent Partner will be considered a pilot project site.

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - Cross-Cutting/Life Course - Entry 1

Priority Need

Promote oral health among all populations

NPM

A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Objectives

11.1. Collaborate partners working with MCH to promote perinatal oral health

11.2. Develop an oral health resource database for CSHCN

11.3. Promote oral health among low-income Hispanic mothers and children

Strategies

11.1.a. Partner with public health districts, private practices, dental hygiene programs (the Augusta University, Dental College of Georgia) to promote perinatal oral health screenings

11.1.b. Offer comprehensive educational webinars/presentations

11.2.a Educate public health district oral health staff on special considerations and treatment needs for special needs patients

11.2.b. Determine data sources and begin collecting data to develop a special needs dental access database with location of practices serving special needs children and adults/special services offered, such as general anesthesia, orthodontics, insurance accepted and other specialties

11.3.a. Improve the Oral Health Education Initiative program to include culturally competent messages for low-income Hispanic children and adolescents

ESMs

ESM 13.1 - 11.1.1. Promote oral health for pregnant women among health care professionals

ESM 13.2 - 11.1.2. Promote oral health for pregnant women among health care professionals

NOMs

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

NOM 19 - Percent of children in excellent or very good health

Measures

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	39.5	41.1	42.7	43.0	43.5	44.5

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	29.3 %	2.7 %	18,443	63,060
2012	38.0 %	2.0 %	47,208	124,225

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	76.7	77.4	78.2	79.0	79.8	79.9

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	75.9 %	1.5 %	1,773,709	2,337,183
2007	80.3 %	1.5 %	1,892,253	2,357,427

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 13.1 - 11.1.1. Promote oral health for pregnant women among health care professionals

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	4.0	8.0	12.0	16.0	20.0

ESM 13.2 - 11.1.2. Promote oral health for pregnant women among health care professionals

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	4.0	8.0	12.0	16.0	20.0

Cross-Cutting/Life Course - Plan for the Application Year

Plan for Application Year

Priority Need: Promote oral health among all populations

The Oral Health program within MCH has expanded its focus beyond school-age children and water fluoridation to include CSHCN, women and pregnant women. MCH will continue to promote oral health among all populations, with a special emphasis on teledentistry, promoting oral health care services among pregnant women and preventive visits for children, in the upcoming reporting cycle (state action plan 11.1-11.3).

Teledentistry

The Teledentistry Project is a partnership of two rural Georgia public health districts (Southeast and South Central Health Districts), Georgia Regents University School of Dentistry and a private practice dentist in rural Georgia. Partners developed a strategic plan for teledentistry. In the upcoming year, the Oral Health Program will work towards accessing coverage for teledentistry, and developing a teledentistry protocol for providers and public health districts.

Public Health District Oral Health Services

The Oral Health Annex (contract with public health districts) provides for local oral health services to children, and pregnant women. The Oral Health Annex also requires school-based prevention programs, which include oral health education and/or screening, sealants, fluoride varnish and referrals. The Oral Health staff will present the importance of dental referrals for those children requiring dental treatment to the districts statewide and educate parents and school staff about the benefits of oral health prevention services in the upcoming year.

The Oral Health program will continue to maintain the high level of access to fluoridated water in Georgia. Each month all water systems adjusting their fluoride level report on the level of fluoride in the drinking water each day. By maintaining the fluoride level of water in the recommended range maximum benefits are achieved with minimal side effects.

In the coming year, the Oral Health Program will also target Hispanic children and mothers to promote good oral health habits, oral health screening and provide preventive services. As well as, educate medical providers on the effectiveness of assessment, anticipatory guidance and fluoride varnish application in the medical practice.

Cross-Cutting/Life Course - Annual Report

Annual Report

2015-2016 NPM 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth

Last Year's Accomplishments

During the reporting year, the Oral Health Program placed 6,132 dental sealants on 1,817 children. Using data from the Pregnancy Risk Assessment Monitoring System (PRAMS), Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBS), and the Head Start Oral Health, the Oral Health Program identified that dental caries generally start around age 3 and that there may be some differences for males compared to females.

During the reporting year, the Oral Health Program offered educational sessions via video conferencing and bridged a partnership with the Georgia Academy of Family Physicians (GAFP) to provide education and training on oral health risk factors, and fluoride varnish placement in medical practices.

Almost 97% of Georgia's community water systems have water fluoridation.

Current Activities

Through partnerships with districts, private practice, education at dental hygiene programs, and in partnership with the Augusta University School College of Dental Medicine, the Oral Health Program promote perinatal oral health screenings, education on caring for pregnant women's oral care needs, anticipatory guidance on infant oral health home care and dental visits.

Educational programs were also presented at a perinatal meeting and family planning meeting. The education contract with GAFP resulted in a January 2016 oral health article for the Georgia Academy of Family Physicians newsletter. The article was also posted on GAFP's website. The article is available to over 2300 members and medical students. A face-to-face training on oral health, risk factors, and fluoride varnish was offered March 5, 2016

at a conclave board meeting. Evaluations from the meeting suggested many of the attendees will be incorporating fluoride varnish into their routine visits.

A presentation was offered twice during the Region IV Head Start Association meeting in Atlanta educating Head Start staff on preventing oral disease and community water fluoridation.

In addition, the state staff are working with Georgia Institute of Technology industrial modeling team on access to services. The university has access to county Medicaid oral health data and they are using the data to determine needs, dentist access, barriers to services and assisting our oral health team in most efficient and effective preventive services for those in most need. This effort will support our ongoing needs assessment for the oral health priority need.

2015-2016 NPM 15: Percentage of women who smoke in the last three months of pregnancy

Last Year's Accomplishments

The Georgia Tobacco Quit Line continues to maintain the 10-call module that provides specialized tobacco cessation counseling services to assist pregnancy and postpartum women with quitting tobacco use. About half of Intensive Pregnancy Program callers had been abstinent from tobacco for 30 days or longer (9/19) and 7 days or longer (10/19).

Current Activities

The Georgia Cessation and Secondhand Smoke Television Media Campaign (Phase II) continues to partner with DPH's Division of Communication to carry out the Quit Line Communication Plan. During October 2015-Februray 2016, DPH aired a radio campaign encouraging tobacco user to make a quit attempt. The tobacco media covers the following markets via broadcast radio in Albany, Atlanta, Brunswick, Columbus, Savannah, and Waycross. Two rounds of 60 second spots were used in targeting adults, primarily men, for a total of 11 weeks. Air dates are as follows:

Round I: Pre-Holiday -- October 5 – November 22, 2015 (7 weeks)

Round II: Post-Holiday – Dec. 28, 2015 – Jan. 24, 2016 (4 weeks)

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

MCH is in the middle of a transformation. The purpose of the transformation was to create an organization structure for MCH that facilitated coordination across programs and across the agency. Reorganizing MCH will also result in clearly defined job roles and will allocate responsibilities in a way that builds capacity to provide more and improved services through the Title V program.Several new staff have been hired through the transformation. As a result, the workforce in MCH is very new to the organization and would benefit from workforce development.

Workforce

A survey was distributed to DPH employees of maternal and child health programs at the state, district and local level to determine their perceptions of workforce development needs. The majority of respondents indicated that they received their education in public health through on-the-job training. Very few indicated having no public health training or formal public health training.

The participants were also asked about the tenure of their employment with DPH and previous experience in public health. Over 20 percent indicated that they had worked in their current position for 1-5 and 6-10 years, at the

department for 1-5 years and more than 20 years and in public health for 1-5 years and more than 20 years.

Table 22. Tenure of DPH workforce

	Less than one year	1-5 years	6-10 years	11-15 years	16-20 years	More than 20 years
Worked in your current job title?	16.5%	34.5%	22.8%	9.7%	5.3%	11.2%
Worked with DPH?	9.0%	27.9%	15.4%	13.9%	11.9%	21.9%
Worked in public health?	7.1%	23.7%	17.2%	14.1%	13.1%	24.7%

Respondents were also asked what topics they were trained on when they started working at DPH. Participants were able to select multiple responses. The top three responses were public health issues, maternal and child health topics and cultural competency. The responses selected least often were fundraising/grant writing, epidemiology, budget development and program management. The results indicate that more training should be offered in these competencies.

Table 23. Type of training received when employees began their jobs

Type of training received at the beginning of employment	Percent
Public Health Issues	39.6%
Maternal and Child Health Topics	35.7%
Cultural Competency	30.9%
Leadership Training	24.2%
Management Skills	23.7%
I received no training when I began my job	23.2%
Health Education Methods	22.2%
Program Management	18.4%
Budget Development	10.6%
Fundraising/Grant Writing	5.3%
Epidemiology/Data Analysis	4.8%

Employees indicated that their agency most often provided their training (76.3 percent), while 35.3 percent indicated their agency pays for them to receive training and 17.9 percent indicated that an outside agency provides their training.

Overall, the majority of respondents agreed that they were able to perform the Public Health core competencies. On average, 60.3 percent of respondents Agreed or Strongly Agreed that they were able to perform the competencies listed compared to 11.4 percent of responses that Disagreed or Strongly Disagreed.

< 50 percent of participants AGREED with feeling competent in relation to the following skills:

- Identify internal and external facilitators and barriers that may affect the delivery of the 10 Essential Public Health Services (e.g., using root cause analysis)
- Contribute to the public health evidence base
- Describe public health funding mechanisms (eg. grants, tobacco taxes, third-party reimbursement)
- Describe the importance of community-based participatory research

> 20 percent of participants DISAGREED with competency in relation to the following skills:

- Describe public health funding mechanisms (eg. grants, tobacco taxes, third-party reimbursement)

Workforce Capacity·

In order to increase the capacity of the workforce, MCH leadership has determined the following areas of focus for workforce development efforts: leadership and systems thinking, public health sciences, financial planning and management skills and community dimensions of practice. One of the highest priorities is building financial planning skills. The MCH workforce reported low competency in the ability to perform financial planning and describe public health funding mechanisms.

In order to address these needs and build capacity among the Title V workforce, online training courses are continually offered through Saba, the training site for DPH. The Title V workforce will be encouraged to participate in all pertinent trainings. In-person trainings are offered every month through the agency's workforce educator. This position is currently vacant, but trainings will resume once it is filled. Trainings on topics such as grants, budgets and public health sciences will be encouraged among all Title V staff. Training and education on MCH and skills to facilitate the MCH mission will also be offered. Additionally, funds are in place for the workforce to attend conferences and trainings as needed. As part of the agency-wide Good to Great initiative, MCH will hold training sessions to connect the workforce development to the principles of Good to Great.

Reporting Year Accomplishments

During state fiscal year (SFY) 2016, MCH implemented several strategies to improve workforce development for state level staff, district staff, providers, families and public health students.

All MCH new hires participate in an onboarding process in which they are trained on each MCH program. All new hires are also required to attend DPH 101 training and DPH human resources training. A Title V presentation and cultural competency presentation was offered and will become a new requirement for new MCH employees. MCH staff also attended *Cultural Competency in the Public Health and Health Care Workforce* with the Region IV Public Health Training Center.

MCH program managers are required to provide training opportunities to district level staff, providers and families. Continuing education units (CEUs) are offered when deemed appropriate. Examples of district, provider and family training include: Positive Behavior Supports, Developmental Screening, Pyramid Model for Early Intervention, Motivational Interviewing, Asthma Control Tool, Transition from Pediatric to Adult-based Care, and Early Identification of Developmental Delays and Disabilities (Foster Parents and Professionals, Statewide Breastfeeding Training.

MCH now has two full-time equivalent (FTE) trainer positions in-house. In addition to training, MCH hosts a multitude of conferences for state and district staff, providers, families, and community partners.

MCH is making a conscious effort to hire student interns from local schools of public health to increase their MCH knowledge base and provide them with hands-on public health experience.

II.F.3. Family Consumer Partnership

MCH recognizes the value that family and consumer partnerships add to developing strategies that meet the needs of the populations they are intended to address. While there are several existing family/consumer partnerships engaged in planning activities, MCH will work to expand these partnerships in both number and substance. In order to develop a plan for engaging family/consumer partnerships, MCH staff developed a strategic plan to engage families. Staff from all programs, including but not limited to CYSHCN programs, participated in the development of the plan.

Staff developed the following goals, objectives and value statements to serve as the overarching framework for the

strategic plan and activities moving forward:

Goal: To increase family participation in all MCH programs

Objectives:

- Increase families' awareness of MCH and its programs
- Increase families' knowledge and capacity by providing MCH and Title V training
- Increase families' access to MCH programs and services
- Increase opportunities for families to participate in the work of MCH

Value Statements:

- We value our families
- We want families at the table (shared decision-making)
- We want MCH programs to be the best they can be
- Families are our target service recipients
- Families know best what they need
- Families have the ability to better assess programs and services
- Families are the key to improving health outcomes

MCH developed the following activities to be accomplished during the five-year reporting cycle to increase family and consumer partnerships:

Activity 1. Leverage partnerships with health districts/state agencies/grant contractors to increase family participation. This activity will be conducted by the MCH Director of Strategy in coordination with District Health Directors, and will be the primary method by which families are recruited to build partnerships. The health districts and family organizations that are used as contractors tend to have more direct contact with families than the state office currently does. MCH will utilize those assets to identify families that will be engaged in partnerships.

Activity 2. Use the MCH website to share information and resources. This activity will be conducted by the MCH Director of Community Outreach. The MCH website will be redone to be user-friendly and provide information about MCH services and opportunities for families to be involved.

Activity 3. Use the family engagement specialist to touch families and provide education. The MCH Family Engagement Specialist will begin to work directly with families in the upcoming years and provide education to them on MCH issues. Trainings will start with Family Leadership Training, Public Health 101 and MCH 101. More trainings will then be added to include Title V and other MCH program specific trainings as well as cultural competency. Each MCH program will be reviewed to determine challenges and opportunities for increasing family participation.

A formal BCW (early intervention) Parent Participation and Program Improvement Plan was developed to guide the BCW program in increasing family participation in program and advisory council activities. Enclosed is a sampling of family and professional trainings suggested based upon program review:

Parent-Specific Training/Webinars/Podcasts

- What to Expect at My Child's Evaluation
- My Child has "Special Needs"; Now What?
- Understanding the Primary Service Provider (PSP) Model
- Family's Role in IFSP Development
- Family Cost Participation
- Procedural Safeguards
- Parental Rights and Responsibilities
- Transition at Age 3
- Understanding Standard Evaluation Tools
- Early Intervention Services: Speech Therapy, Occupational Therapy, Physical Therapy, Vision Services, Nursing Services, Special Instruction, Family Training & Counseling, etc.

Parent and Professional Training/Webinars/Podcasts

- Developmental Milestones
- Medical/Dental Home
- Cultural Competency
- What is a Child's "Natural Environment"?
- What is "Child Find"?
- Educational Rights and Needs for the Homeless Population
- Emotional/mental health issues related to families
- Inclusion of children with special needs/disabilities in Early Head start, Head start and child care settings
- Who Wants To Be A Millionaire BCW Roles Game

Activity 4. Develop a communications plan. The MCH Director of Outreach is responsible for developing a communication plan for families. The communications plan will include marketing strategies and development of consistent messaging around MCH's values regarding family partnerships.

Activity 5. Make efficient use of MCH funding/redirect contract funds. All MCH Program contract owners will be responsible for efficiently using their funding to engage families and consumers. The administrative staff will work with contract owners to find opportunities to redirect contracts funds for efficient uses.

Activity 6. Training. The MCH Director of Quality will train MCH staff on building family/consumer partnerships and ensure compliance with the developed values and objectives.

Activity 7. Advisory Groups. Program Directors will work with the MCH Director of Strategy to build advisory groups to address each priority need. Each advisory group will have family representation. The purpose of the

advisory groups is to bring the needs of families to the forefront of program planning and to have families advise MCH staff on program strategies.

Activity 8. Gap Analysis. The MCH Director of Strategy and EPI Managers will perform a Gap Analysis to compare actual performance with desired performance regarding planned activities for increasing family/consumer partnerships.

Activity 9. Program experience/evaluations. The MCH Director of Strategy will perform program experience evaluations to assess how satisfied both families and program staff are with the family/consumer partnerships that were established.

Reporting Year Accomplishments

As MCH moves toward incorporating family participation in all of its programs, MCH staff and leadership intentionally work to support program managers as they take a major role in ensuring families become and remain an integral part of program activities.

In order to increase the capacity of MCH family leaders and to spread and sustain family engagement efforts, MCH took strategic steps to empower program directors and managers to develop family engagement plans and use contracts to increase family engagement within local communities.

Listed below are accomplishments attained during the first year of implementing the MCH Family Consumer Partnership Strategic Plan:

Activity 1. Partnerships: MCH works with the DPH health districts, other state agencies and grant contractors to increase family participation. Local health districts use their contacts and relationships with local community partners to recruit families to participate in program activities and local advisory councils. MCH Family Engagement Specialists support program and project managers/directors in these efforts, for example, MCH Family Engagement Specialists developed a thirty-page family engagement plan and three-hundred page resource notebook for the MCH Project Launch (Linking Actions for Unmet Needs in Children's Health) Team, who in turn used the information to work with local district staff to enhance family participation in project activities.

Activity 2. Website: The MCH Director of Community Outreach and the MCH Family Engagement Specialists worked with family leaders from the Children's Medical Services (CMS), Early Hearing Detection and Intervention (EDHI), Babies Can't Wait (BCW) and Newborn Screening (NBS) Programs to develop a family-friendly webpage wherein families could quickly access MCH program information and resources. Family leaders were compensated for their assistance. (http://dph.georgia.gov/mch-family-portal)

Activity 3. Family Engagement Specialist: MCH hired a second full time (FTE) Family Engagement Specialist to assist program efforts surrounding family engagement. MCH Family Engagement Specialists work directly with program directors and managers to develop program workplans to increase family engagement. The Family Engagement Specialists also assist managers with reaching families on the local level to participate in program activities, advisory groups, materials review, and program improvement.

Activity 5. MCH Funds: Program managers and special project directors are encouraged to make use of program

funds to increase family participation. Through contracts our programs have hired local parent partners, contracted with family-based organizations, and individual contractors. MCH is also able to reimburse families for incurred expenses, and compensate them appropriately for work done on behalf of MCH.
Activity 6. Training: In addition to MCH sponsored training, MCH supports the infrastructure and provides technical assistance to other programs and organizations that provide family training throughout the state. This is particular true for those that work directly with youth.

Activity 7. Advisory Groups: Three new family leaders were added to the MCH Newborn Screening Advisory Council, representing Cystic Fibrosis, Sickle Cell Disease, and Phenylketonuria (PKU). Family leaders and family organizations, including those serving children and youth with special health care needs, received invitations to join their regional Oral Health Coalitions. Family leaders that participate on the MCH EHDI Advisory Council were given the opportunity to co-train at the annual EDHI conference. MCH's goal is to have family representation on all of our standing and newly created advisory councils.

II.F.4. Health Reform

HB 943 continues to be in effect. The Title V MCH Block Grant Program is providing gap-filling health care services to MCH populations that do not have coverage for health care services, particularly for children and youth with special health care needs. Children's Medical Services (CMS) is the Title V CYSHCN program. For families that do not qualify for Georgia's Medicaid and SCHIP programs, CMS will serve as the payor of last resort for all health care and medical expenses.

II.F.5. Emerging Issues

There are several emerging issues that could impact the health status of women and children in Georgia that were not addressed by the state action plan. Adverse childhood experiences (ACE) is a topic gaining attention in Georgia. This was considered as a priority need, but was not selected due to low capacity within the agency to address the topic. Due to the large impact that ACEs can have on a child's health and well-being later in life, it is important to monitor data regarding ACEs and consider potential opportunities to partner with organizations.

Another emerging area impacting the health of women in the state is substance use during pregnancy. The topic emerged during focus groups conducted for the five-year needs assessment. Awareness has been increasing in other states as well, indicating that the topic could become of increasing importance throughout the reporting cycle.

II.F.6. Public Input

Public input was obtained using a variety of methods throughout the needs assessment process and in the development of the Application/Annual Report. Sections of the needs assessment were posted to the Georgia Title V website as they were completed and comments were accepted through email. Announcements were sent to partners, stakeholders, community members, District Health Directors and Board of Public Health members.

Although Emory University does not have a formal MCH Training Program, MCH contacted the Maternal and Child Health Certificate program to ensure students in their MCH concentration were aware of the public comment period and their opportunity to provide input.

Throughout the public comment period several comments were received. They were primarily related to>>>>

Below is a sample of comments that were received:

II.F.7. Technical Assistance

The State Action Plan Chart developed for this application was developed with technical assistance from Johns Hopkins and the Association of Maternal and Child Health Programs (AMCHP)/HRSA technical assistance webinars.

Technical assistance is requested to better understand the role that Title V programs can serve to address adolescent suicide and bullying.

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$16,171,317	$15,634,663	$15,882,994	$15,634,663
Unobligated Balance	$0	$0	$0	$0
State Funds	$134,212,376	$83,491,561	$126,369,205	$87,873,596
Local Funds	$0	$0	$0	$0
Other Funds	$144,614,443	$150,044,727	$150,133,658	$154,313,381
Program Funds	$19,965,354	$3,771,854	$18,316,838	$7,652,922
SubTotal	$314,963,490	$252,942,805	$310,702,695	$265,474,562
Other Federal Funds	$294,912,047	$294,912,047	$306,402,197	
Total	$609,875,537	$547,854,852	$617,104,892	$265,474,562

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$16,438,560	$16,611,128	$16,611,128	
Unobligated Balance	$0	$0	$0	
State Funds	$92,757,286	$91,825,080	$98,513,369	
Local Funds	$0	$0	$0	
Other Funds	$157,349,758	$141,371,383	$132,713,617	
Program Funds	$3,771,854	$9,133,504	$7,652,922	
SubTotal	$270,317,458	$258,941,095	$255,491,036	
Other Federal Funds	$275,603,567	$27,954,952	$25,324,930	
Total	$545,921,025	$286,896,047	$280,815,966	

	2017	
	Budgeted	**Expended**
Federal Allocation	$17,267,095	
Unobligated Balance	$0	
State Funds	$114,351,317	
Local Funds	$0	
Other Funds	$147,350,720	
Program Funds	$9,133,503	
SubTotal	$288,102,635	
Other Federal Funds	$33,098,697	
Total	$321,201,332	

III.A. Expenditures

EXPENDITURES

State and federal funds are allocated based on priority needs identified through the MCHBG development process. This process includes reviewing health status and outcomes for women and children, projecting future needs and assessing current capacity/infrastructure. As part of the Department of Public Health's budget process, recommendations are made for funding levels for services to women and children.

The state required match on our FFY 2015 MCHBG Budget of $16,611,128 is $12,458,346. A report from the Financial Services Division of DPH, reflects the match is $12,458,346. Georgia's maintenance of effort (MOE) level is $36,079,622. Our current MOE level is $44,899,416 for the FFY 2015 grant as of 1/29/16.

III.B. Budget

The Department of Public Health has a system of accountability to monitor the allocation and expenditures of funds provided to local health districts. The department utilizes the computer program, Uniform Accounting System (UAS), where the local health districts' administrative personnel input budget (funds that are allocated by programs such as Children with Special Health Care Needs) and expenditures. The MCH Section and Department of Public Health staff (Audit's), when necessary, monitor programs quarterly and provide technical assistance where needed.

The FFY 2017 Budget for the Federal-State block grant partnership sub- totals $288,102,635. Of this amount, $17,267,095 are the Title V funds. The remaining amounts represent State Funds totaling $114,351,317, and $147,350,720 in Other Funds, and $9,133,503 in Program Income. Other Federal funds that support Maternal and Child Health (MCH) activities in Georgia are estimated at $33,098,697. This represents a variety of Federal Programs including Temporary Assistance for Needy Families (TANF), Early Hearing Detection Initiative (EHDI), Pregnancy Risk Assessment Monitoring System (PRAMS), Preventive Health and Health Services Block Grant (PHHSBG), Basic Screening Oral Health, State Systems Development Initiative (SSDI), Universal Newborn Hearing

Screening and Intervention (UNHSI), Project LAUNCH, Early Identification and Intervention Infants and Toddlers, and Maternal and Infant Early Childhood Home Visiting. This brings the grand total for the State MCH Budget to $321,201,332 (see line 11 of Form 2).

For FFY 2017, $72,097,254 is budgeted for Direct Services, $43,168,908 for Enabling Services, and $181,505,611 for Public Health Services and Systems.

The total Federal-State Block Grant Partnership for FFY 2016 includes approximately $9,133,503 in Program Income (See Form 2, line 6). This income is derived from Medicaid earnings for services provided to pregnant and postpartum women, preventive health care services to children, and reproductive health services to women.

Of the Title V requested allocation ($17,267,095), $5,245,111 or 30.4% is earmarked for preventive and primary care for children. Infants less than one year old - Title V-leveraged services for this population include: Infant Mortality, Maternal Mortality, Neonatal Intensive Care Unit (NICU) Benefits and Administration - 6 tertiary centers statewide which provide clinical care and education services for high risk newborns, education and the prevention of Sudden Infant Death Syndrome (SIDS) and Other Infants Deaths (OID), single point of entry - Children 1st , and staffing for Local Health Districts; Children 1-22 years old: Title V funds are used in this area for Children 1st , Newborn Screening, Physical Activity, and Oral Health: contract with Richmond County Board of Health to provide dental services to mothers and children in the Augusta health district and to provide training opportunities for pediatric dental residents in a mobile clinic environment.

Approximately 49.8% or ($8,604,406), is earmarked for Children with Special Health Care Needs to support Genetic/Sickle and Children Medical Services. There is 6.9% or $1,193,791 earmarked for Title V administrative costs, used to support positions and administration. These positions provide data, quality assurance, technical assistance, policy, planning, and operational services that support and enhance the State's MCH system. These percentages are in keeping with the 30/30 required by Title V.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - DPH 2016027 Title V and XIX EXECUTED.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - 2016 Title V Block Grant References.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Georgia

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 17,267,095	
A. Preventive and Primary Care for Children	$ 5,245,111	(30.4%)
B. Children with Special Health Care Needs	$ 8,604,406	(49.8%)
C. Title V Administrative Costs	$ 1,193,791	(6.9%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 114,351,317	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 147,350,720	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 9,133,503	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 270,835,540	
A. Your State's FY 1989 Maintenance of Effort Amount $ 36,079,622		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 288,102,635	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 33,098,697	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 321,201,332	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 9,153,768
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 155,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 400,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sexually Transmitted Diseases (STD) Prevention	$ 3,615,632
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 310,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,089,366
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 2,785,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 798,586
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 14,311,871
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 133,000

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 16,438,560		$ 16,611,128	
A. Preventive and Primary Care for Children	$ 6,493,014	(39.5%)	$ 5,128,604	(30.9%)
B. Children with Special Health Care Needs	$ 7,954,988	(48.4%)	$ 8,307,643	(50%)
C. Title V Administrative Costs	$ 1,004,033	(6.1%)	$ 853,217	(5.1%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 92,757,286		$ 91,825,080	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 157,349,758		$ 141,371,383	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 3,771,854		$ 9,133,504	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 253,878,898		$ 242,329,967	
A. Your State's FY 1989 Maintenance of Effort Amount $ 36,079,622				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 270,317,458		$ 258,941,095	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 275,603,567		$ 27,954,952	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 545,921,025		$ 286,896,047	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 9,193,499
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 50,605
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 97,335
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 824,956
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 270,614
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 2,784,078
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	$ 296,933
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 47,596
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 228,723
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 100,000
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 198,264
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 13,862,349

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Expended more in Children with Special Health Care Needs vs Preventive and Primary Care for Children than budgeted. In addition, received more Title V funds than budgeted.	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Expended more in Children with Special Health Care Needs than budgeted. In addition, received more Title V funds than budgeted.	
3.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: WIC was included in the FFY 15 budget, however taken out of the expenditures as they are not under the control of MCH.	
4.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: The Program Income is a projection from FY13 Expenditures. The true Program Income is reflected in the next year's budget.	

Data Alerts: None

Form 3a

Budget and Expenditure Details by Types of Individuals Served

State: Georgia

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 2,123,787	$ 1,513,716
2. Infants < 1 year	$ 1,005,761	$ 484,735
3. Children 1-22 years	$ 4,239,350	$ 4,643,869
4. CSHCN	$ 8,604,406	$ 8,307,643
5. All Others	$ 100,000	$ 807,948
Federal Total of Individuals Served	$ 16,073,304	$ 15,757,911

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 25,209,559	$ 17,463,293
2. Infants < 1 year	$ 94,681,444	$ 89,058,523
3. Children 1-22 years	$ 125,297,561	$ 113,876,868
4. CSHCN	$ 20,925,071	$ 17,458,509
5. All Others	$ 4,721,905	$ 4,472,774
Non Federal Total of Individuals Served	$ 270,835,540	$ 242,329,967
Federal State MCH Block Grant Partnership Total	$ 286,908,844	$ 258,087,878

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: The Preventive and Primary Care for Children includes both Infants<1 AND Children 1-22.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Preventive and Primary Care for Children include both Infants <1 and Children 1-22 for Form 2 Line 1A.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Georgia

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 2,678,849	$ 3,218,308
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 339,963
B. Preventive and Primary Care Services for Children	$ 747,567	$ 509,879
C. Services for CSHCN	$ 1,931,282	$ 2,368,466
2. Enabling Services	$ 8,802,269	$ 6,638,153
3. Public Health Services and Systems	$ 5,785,977	$ 6,754,667
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 238,101
Physician/Office Services		$ 22,281
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 22,722
Dental Care (Does Not Include Orthodontic Services)		$ 509,879
Durable Medical Equipment and Supplies		$ 38,070
Laboratory Services		$ 24,282
Other		
Various Programs and Services		$ 2,362,973
Direct Services Line 4 Expended Total		$ 3,218,308
Federal Total	$ 17,267,095	$ 16,611,128

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 60,749,267	$ 50,354,832
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 48,599,098	$ 29,183,548
B. Preventive and Primary Care Services for Children	$ 3,481,031	$ 14,176,326
C. Services for CSHCN	$ 8,669,138	$ 6,994,958
2. Enabling Services	$ 34,366,639	$ 27,801,818
3. Public Health Services and Systems	$ 175,719,634	$ 162,692,892
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 318,731
Physician/Office Services		$ 29,826
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 30,417
Dental Care (Does Not Include Orthodontic Services)		$ 1,802,153
Durable Medical Equipment and Supplies		$ 50,961
Laboratory Services		$ 32,505
Other		
Various Programs and Services		$ 48,090,239
Direct Services Line 4 Expended Total		$ 50,354,832
Non-Federal Total	$ 270,835,540	$ 240,849,542

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Georgia

Total Births by Occurrence: 131,942

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	107,756 (81.7%)	7,218	285	285 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methyglutaric aciduria	Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, βeta-thalassemia	S,C disease
Biotinidase deficiency	Critical congenital heart disease	Cystic fibrosis	Classic galactosemia	

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Hearing Loss	125,347 (95.0%)	6,170	211	189 (89.6%)
Cystic Fibrosis Related Metabolic Syndrome	107,756 (81.7%)	268	3	3 (100.0%)
Hyperphe	107,756 (81.7%)	111	5	5 (100.0%)
Maternal 3-MCC Deficiency	107,756 (81.7%)	27	1	1 (100.0%)
Hypothyroidism, Secondary	107,756 (81.7%)	4,806	2	2 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Beginning January 1, 2014, all babies with confirmed hearing loss were provided an informed consent form to allow the DPH to track the child through 3rd grade. In collaboration with the Department of Education, DPH collects information on the intervention program, health status, and conducts in-home language assessments for families not participating in an intervention program. Education information will be collected when the cohort of children reach school age.

Beginning state fiscal year 2017 (July 2016-June 2017), all babies with confirmed metabolic disease will have their health outcomes tracked from birth to 5 years of age by Emory University.

For both hearing and metabolic long-term follow-up programs data is collected through survey and abstraction from intervention programs and specialty clinics. The data is entered into the newborn screening patient tracking database.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Hearing Loss - Referred For Treatment**
	Fiscal Year:	**2015**
	Column Name:	**Other Newborn**

Field Note:
Of the 211 newborns diagnosed with hearing loss 189 were documented as being referred for treatment by follow-up providers because some families moved out of state, some children were not eligible for IDEA Part C services, a death, and others were lost to documentation (final disposition was not entered in patient's file).

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Georgia

Reporting Year 2015

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	193	50.3	0.0	6.7	43.0	0.0
2. Infants < 1 Year of Age	205	20.7	0.0	2.0	0.0	77.3
3. Children 1 to 22 Years of Age	31,584	38.0	0.8	14.0	47.0	0.2
4. Children with Special Health Care Needs	15,672	51.2	3.8	38.5	6.5	0.0
5. Others	24,227	16.1	0.0	17.9	65.9	0.1
Total	71,881					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2015**
	Field Note: Data Source: Pregnant women receiving oral health services	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2015**
	Field Note: Data Source: Newborn screening data of children receiving a diagnostic test or loaner hearing aid covered by Title V because of insurance denials or uninsured	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2015**
	Field Note: Data Source: Newborn Screening, Oral Health, Children's Medical Services and Babies Can't Wait data of children receiving a treatment service	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2015**
	Field Note: Data Source: Children enrolled and receiving a health care service through Children's Medical Services Program	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Georgia

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	4,757
2. Infants < 1 Year of Age	131,942
3. Children 1 to 22 Years of Age	1,363,351
4. Children with Special Health Care Needs	16,047
5. Others	66,276
Total	1,582,373

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Georgia

Reporting Year 2015

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	132,430	70,090	45,777	199	3,319	2,570	2,241	8,234
Title V Served	15,143	5,843	7,767	16	282	24	249	962
Eligible for Title XIX	61,849	26,178	29,835	86	1,382	77	1,222	3,069
2. Total Infants in State	129,705	70,106	45,212	1,011	5,365	436	7,575	0
Title V Served	128,675	67,628	44,779	188	5,658	180	2,149	8,093
Eligible for Title XIX	62,466	26,184	29,467	437	2,234	13	4,131	0

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	112,801	19,629	0	132,430
Title V Served	11,745	3,398	0	15,143
Eligible for Title XIX	53,142	8,707	0	61,849
2. Total Infants in State	107,564	22,141	0	129,705

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
Title V Served	109,293	19,382	0	128,675
Eligible for Title XIX	52,644	9,821	0	62,465

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Georgia

A. State MCH Toll-Free Telephone Lines	2017 Application Year	2015 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(855) 707-8277	(855) 707-8277
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health Line	Maternal and Child Health Line
3. Name of Contact Person for State MCH "Hotline"	Johanna Pringle	Johanna Pringle
4. Contact Person's Telephone Number	(404) 657-2869	(404) 657-2869
5. Number of Calls Received on the State MCH "Hotline"		5,782

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names	PowerLine	PowerLine
2. Number of Calls on Other Toll-Free "Hotlines"		26,834
3. State Title V Program Website Address	http://dph.georgia.gov/MCH	http://dph.georgia.gov/MCH
4. Number of Hits to the State Title V Program Website		22
5. State Title V Social Media Websites	https://twitter.com/gadph, https://facebook.com/gadph	https://twitter.com/gadph, https://facebook.com/gadph
6. Number of Hits to the State Title V Program Social Media Websites		0

Form Notes for Form 7:

MCH is a subset of DPH Twitter and Facebook social media websites.

Form 8
State MCH and CSHCN Directors Contact Information

State: Georgia

1. Title V Maternal and Child Health (MCH) Director	
Name	Michelle Allen
Title	Maternal and Child Health Director
Address 1	2 Peachtree Street, NW 11th Floor
Address 2	
City/State/Zip	Atlanta / GA / 30303
Telephone	(404) 463-2579
Extension	
Email	Michelle.Allen@dph.ga.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Donna Johnson
Title	Children and Youth with Special Needs Director
Address 1	2 Peachtree Street, NW 11th Floor
Address 2	
City/State/Zip	Atlanta / GA / 30303
Telephone	(404) 657-2850
Extension	
Email	Donna.Johnson@dph.ga.gov

3. State Family or Youth Leader (Optional)	
Name	Sherry Richardson
Title	Family Engagement Coordinator
Address 1	2 Peachtree Street, NW 11th Floor
Address 2	
City/State/Zip	Atlanta / GA / 30303
Telephone	(404) 657-3151
Extension	
Email	Sherry.Richardson@dph.ga.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Georgia

Application Year 2017

No.	Priority Need
1.	Prevent maternal mortality
2.	Improve access to family planning services
3.	Prevent infant mortality
4.	Promote developmental screenings among children
5.	Promote physical activity among children
6.	Reduce suicide among adolescents
7.	Improve systems of care for children and youth with special health care needs
8.	Promote oral health among all populations
9.	Decrease maternal substance use
10.	Improve access to specialty care for CSHCN

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Prevent maternal mortality	New	
2.	Improve access to family planning services	New	This priority need is not associated with a National Performance Measure. It will be addressed by a State Performance Measure developed in the 2017 Application.
3.	Prevent infant mortality	New	
4.	Promote developmental screenings among children	New	
5.	Promote physical activity among children	New	
6.	Reduce suicide among adolescents	New	
7.	Improve systems of care for children and youth with special health care needs	New	
8.	Promote oral health among all populations	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Georgia

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	74.6 %	0.1 %	80,348	107,749
2013	73.6 %	0.1 %	80,053	108,806
2012	73.1 %	0.1 %	82,491	112,902
2011	72.0 %	0.1 %	79,004	109,704
2010	73.0 %	0.1 %	74,389	101,886
2009	73.0 %	0.1 %	73,094	100,098

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	183.0	3.9 %	2,256	123,287
2012	167.5	3.7 %	2,091	124,810
2011	164.5	3.6 %	2,080	126,486
2010	161.5	3.6 %	2,096	129,785
2009	160.1	3.5 %	2,190	136,797
2008	148.4	3.3 %	2,109	142,163

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2014	39.3	2.5 %	258	656,330
2009_2013	30.8	2.2 %	205	666,761
2008_2012	23.5	1.9 %	161	684,616

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	9.5 %	0.1 %	12,385	130,738
2013	9.5 %	0.1 %	12,064	127,627
2012	9.3 %	0.1 %	12,014	129,553
2011	9.4 %	0.1 %	12,333	131,791
2010	9.7 %	0.1 %	12,912	132,745
2009	9.4 %	0.1 %	13,190	140,396

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.8 %	0.0 %	2,321	130,738
2013	1.8 %	0.0 %	2,350	127,627
2012	1.7 %	0.0 %	2,218	129,553
2011	1.8 %	0.0 %	2,338	131,791
2010	1.8 %	0.0 %	2,361	132,745
2009	1.7 %	0.0 %	2,414	140,396

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.7 %	0.1 %	10,064	130,738
2013	7.6 %	0.1 %	9,714	127,627
2012	7.6 %	0.1 %	9,796	129,553
2011	7.6 %	0.1 %	9,995	131,791
2010	8.0 %	0.1 %	10,551	132,745
2009	7.7 %	0.1 %	10,776	140,396

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	10.8 %	0.1 %	14,058	130,764
2013	10.7 %	0.1 %	13,665	128,164
2012	10.9 %	0.1 %	14,139	129,705
2011	11.0 %	0.1 %	14,473	131,865
2010	11.4 %	0.1 %	15,093	133,000
2009	11.3 %	0.1 %	15,859	140,367

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	3.3 %	0.1 %	4,249	130,764
2013	3.3 %	0.1 %	4,192	128,164
2012	3.2 %	0.1 %	4,120	129,705
2011	3.2 %	0.1 %	4,254	131,865
2010	3.3 %	0.1 %	4,385	133,000
2009	3.2 %	0.1 %	4,526	140,367

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.5 %	0.1 %	9,809	130,764
2013	7.4 %	0.1 %	9,473	128,164
2012	7.7 %	0.1 %	10,019	129,705
2011	7.8 %	0.1 %	10,219	131,865
2010	8.1 %	0.1 %	10,708	133,000
2009	8.1 %	0.1 %	11,333	140,367

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	26.0 %	0.1 %	33,960	130,764
2013	26.1 %	0.1 %	33,440	128,164
2012	27.8 %	0.1 %	36,044	129,705
2011	28.5 %	0.1 %	37,579	131,865
2010	29.4 %	0.1 %	39,104	133,000
2009	31.1 %	0.1 %	43,614	140,367

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.4	0.2 %	957	129,227
2012	6.6	0.2 %	867	130,753
2011	6.7	0.2 %	894	132,892
2010	6.3	0.2 %	843	134,409
2009	7.0	0.2 %	993	141,829

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.0	0.2 %	899	128,748
2012	6.2	0.2 %	812	130,280
2011	6.9	0.2 %	908	132,409
2010	6.3	0.2 %	849	133,947
2009	7.3	0.2 %	1,036	141,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.8	0.2 %	619	128,748
2012	4.1	0.2 %	534	130,280
2011	4.3	0.2 %	570	132,409
2010	3.9	0.2 %	516	133,947
2009	4.9	0.2 %	696	141,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.2	0.1 %	280	128,748
2012	2.1	0.1 %	278	130,280
2011	2.6	0.1 %	338	132,409
2010	2.5	0.1 %	333	133,947
2009	2.4	0.1 %	340	141,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	282.0	14.8 %	363	128,748
2012	234.1	13.4 %	305	130,280
2011	216.8	12.8 %	287	132,409
2010	221.0	12.9 %	296	133,947
2009	258.2	13.5 %	365	141,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	105.6	9.1 %	136	128,748
2012	104.4	9.0 %	136	130,280
2011	125.4	9.7 %	166	132,409
2010	120.9	9.5 %	162	133,947
2009	96.9	8.3 %	137	141,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.4 %	1.1 %	2,852	64,607
2012	3.9 %	0.8 %	4,881	125,314
2011	6.2 %	1.1 %	7,842	127,353
2010	6.1 %	1.2 %	7,754	128,235
2009	5.1 %	1.1 %	6,938	134,961
2008	6.6 %	1.2 %	9,282	141,155
2007	4.9 %	1.2 %	7,094	144,786

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.9	0.2 %	479	123,347
2012	3.1	0.2 %	391	124,864
2011	2.4	0.1 %	305	126,542
2010	2.2	0.1 %	282	129,826
2009	1.5	0.1 %	199	136,799
2008	1.3	0.1 %	188	142,163

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	18.6 %	1.4 %	434,496	2,340,734

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	19.7	1.3 %	244	1,238,114
2013	21.9	1.3 %	271	1,240,503
2012	18.8	1.2 %	234	1,243,459
2011	20.2	1.3 %	251	1,245,086
2010	23.8	1.4 %	297	1,248,768
2009	22.4	1.3 %	279	1,247,044

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	31.5	1.5 %	443	1,405,878
2013	33.6	1.6 %	470	1,400,810
2012	29.1	1.4 %	408	1,402,316
2011	32.6	1.5 %	456	1,398,831
2010	35.4	1.6 %	495	1,399,683
2009	31.8	1.5 %	444	1,396,065

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	12.4	0.8 %	260	2,091,081
2011_2013	13.0	0.8 %	272	2,095,858
2010_2012	13.3	0.8 %	281	2,110,591
2009_2011	13.2	0.8 %	280	2,123,186
2008_2010	14.9	0.8 %	318	2,129,778
2007_2009	18.8	0.9 %	398	2,114,902

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	6.8	0.6 %	143	2,091,081
2011_2013	6.7	0.6 %	141	2,095,858
2010_2012	6.0	0.5 %	126	2,110,591
2009_2011	6.1	0.5 %	129	2,123,186
2008_2010	6.1	0.5 %	130	2,129,778
2007_2009	5.4	0.5 %	114	2,114,902

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.2 %	1.3 %	477,055	2,484,940
2007	20.7 %	1.5 %	523,281	2,525,483
2003	18.7 %	1.1 %	428,295	2,287,060

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	17.4 %	1.6 %	66,655	383,614

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.6 %	0.5 %	33,320	2,094,067
2007	1.2 %	0.5 %	23,940	2,085,157

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	8.7 %	1.0 %	182,043	2,092,833
2007	6.5 %	0.9 %	134,785	2,088,073

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	53.4 %	6.4 %	96,846	181,360
2007	52.3 %	7.5 %	75,483	144,363
2003	60.5 %	6.2 %	82,809	136,847

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	85.3 %	1.2 %	2,116,791	2,481,524
2007	86.2 %	1.4 %	2,177,204	2,525,404
2003	85.4 %	1.1 %	1,953,122	2,287,060

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	35.0 %	2.5 %	363,667	1,039,152
2007	37.3 %	2.9 %	378,229	1,014,035
2003	31.7 %	2.1 %	300,612	948,122

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	28.4 %	0.1 %	30,818	108,721

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	29.8 %	1.4 %	128,714	431,995
2011	30.7 %	1.4 %	135,064	439,590
2009	27.0 %	1.5 %	120,245	444,782
2007	31.7 %	1.5 %	142,398	448,896
2005	27.1 %	1.5 %	113,963	420,547

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.5 %	0.3 %	187,590	2,490,299
2013	9.5 %	0.3 %	236,951	2,487,378
2012	8.9 %	0.4 %	221,352	2,490,232
2011	9.5 %	0.4 %	236,836	2,488,159
2010	9.8 %	0.3 %	245,304	2,492,676
2009	10.7 %	0.3 %	277,133	2,583,204

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	74.0 %	3.9 %	142,195	192,050
2013	69.8 %	5.0 %	133,873	191,743
2012	74.7 %	3.5 %	146,814	196,476
2011	69.5 %	3.3 %	143,703	206,821
2010	49.6 %	3.5 %	108,443	218,575
2009	45.8 %	3.8 %	102,118	222,822

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2015	58.0 %	2.0 %	1,344,382	2,319,499
2013_2014	51.4 %	2.0 %	1,197,580	2,328,179
2012_2013	52.3 %	2.4 %	1,209,331	2,310,105
2011_2012	44.4 %	2.7 %	1,077,374	2,425,933
2010_2011	48.8 %	2.7 %	1,173,494	2,404,700
2009_2010	36.0 %	2.2 %	885,197	2,458,880

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	65.4 %	4.6 %	225,530	344,809
2013	53.7 %	5.5 %	182,469	339,975
2012	52.3 %	5.5 %	175,971	336,241
2011	48.4 %	4.6 %	163,472	337,969
2010	43.5 %	4.0 %	141,115	324,413
2009	38.6 %	4.2 %	130,355	337,460

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	41.2 %	4.6 %	148,198	359,724
2013	40.5 %	5.9 %	144,219	356,096
2012	19.5 %	4.3 %	68,607	352,408
2011	7.3 %	1.9 %	25,719	353,467

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	86.1 %	2.4 %	606,772	704,533
2013	82.0 %	3.4 %	570,798	696,071
2012	80.5 %	3.1 %	554,543	688,649
2011	68.0 %	3.0 %	470,206	691,435
2010	62.2 %	3.0 %	412,380	662,735
2009	50.8 %	3.1 %	350,121	689,156

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	74.9 %	3.1 %	527,722	704,533
2013	76.9 %	3.6 %	535,512	696,071
2012	73.1 %	3.5 %	503,360	688,649
2011	67.7 %	3.0 %	467,831	691,435
2010	63.5 %	2.9 %	420,582	662,735
2009	53.3 %	3.1 %	367,515	689,156

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Georgia

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	62.1	62.1	63.0	63.5	64.0	65.0

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	68.1 %	1.8 %	1,252,401	1,839,932
2013	68.1 %	1.5 %	1,261,902	1,852,487
2012	67.1 %	1.9 %	1,239,926	1,849,086
2011	69.4 %	1.5 %	1,247,498	1,797,224
2010	75.8 %	1.7 %	1,412,726	1,863,237
2009	73.9 %	1.8 %	1,373,616	1,859,677

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	81.8	82.8	83.9	84.9	85.1	85.3

FAD not available for this measure.

Field Level Notes for Form 10a NPMs:

None

NPM 4 - A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	79.3	80.9	82.5	84.1	85.5	85.9

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	73.7 %	4.1 %	93,023	126,212
2011	70.3 %	5.0 %		
2010	72.3 %	3.6 %		
2009	66.1 %	3.3 %		
2008	67.4 %	3.0 %		
2007	61.2 %	3.1 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 4 - B) Percent of infants breastfed exclusively through 6 months

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	20.2	21.6	23.2	24.8	25.5	25.9

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	18.9 %	3.5 %	23,213	122,970
2011	14.5 %	3.6 %		
2010	6.9 %	1.6 %		
2009	11.7 %	1.9 %		
2008	9.9 %	1.7 %		
2007	9.5 %	1.5 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	42.8	45.0	47.2	49.6	51.0	52.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	40.8 %	3.2 %	257,898	632,599
2007	22.7 %	2.8 %	158,483	697,543

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	36.6	37.3	38.1	38.8	39.5	39.8

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	35.9 %	2.8 %	309,751	863,401
2007	39.2 %	3.3 %	320,877	819,218
2003	39.4 %	2.5 %	299,200	759,189

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	25.3	25.0	25.0	24.5	24.5	24.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	16.4 %	2.3 %	129,553	790,591
2007	17.0 %	2.7 %	144,095	846,092

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	25.1 %	1.6 %	110,846	442,284
2011	24.9 %	1.9 %	112,919	454,357

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	34.2	34.6	34.9	35.3	35.6	36.0

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	33.9 %	3.4 %	48,646	143,452
2005_2006	37.0 %	3.2 %	43,123	116,600

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 13 - A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	39.5	41.1	42.7	43.0	43.5	44.5

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	29.3 %	2.7 %	18,443	63,060
2012	38.0 %	2.0 %	47,208	124,225

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	76.7	77.4	78.2	79.0	79.8	79.9

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	75.9 %	1.5 %	1,773,709	2,337,183
2007	80.3 %	1.5 %	1,892,253	2,357,427

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Georgia

SPM 1 - Improve access to family planning services

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	11.0	12.0	13.0	14.0	15.0

Field Level Notes for Form 10a SPMs:

None

SPM 2 - Improve access to specialty care for CSHCN

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.3	1.5	1.7	1.9	2.0

Field Level Notes for Form 10a SPMs:

None

SPM 3 - Decrease congenital syphilis

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	13.0	12.7	12.4	12.0	11.7

Field Level Notes for Form 10a SPMs:

None

SPM 4 - Decrease Neonatal Abstinence Syndrome (NAS)

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	3.2	2.9	2.6	2.3	2.0

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or-Informed Strategy Measures (ESMs)

State: Georgia

ESM 1.1 - 1.1.1. Promote well-woman visits through marketing and media

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	5.0	10.0	15.0	18.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.2 - 1.2.1. Train staff on preconception health appraisals

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	25.0	50.0	75.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 3.1 - 3.5.1. Promote compliance with neonatal level of care requirements

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	15.0	40.0	60.0	75.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.1 - 3.1.1 Promote breastfeeding through the 5-STAR Hospital Initiative

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	10.0	20.0	30.0	40.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - 6.1.1. Identify new methods to administer developmental screens

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	1.0	2.0	3.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.2 - 6.1.2. Partner attitudes and beliefs toward developmental screening

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	30.0	50.0	60.0	75.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.3 - 6.2.1. Promote developmental screening among local communities

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	16.0	22.0	30.0	36.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - 7.1.1. Improve aerobic capacity of students in grades 4-12

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	61.0	62.0	63.0	64.0	65.0

Field Level Notes for Form 10a ESMs:

None

ESM 9.1 - 8.1.1. Promote bullying prevention among youth

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	No	No	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 9.2 - 8.2.1. Increase the number of schools participating in whole school bullying prevention initiatives

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	0.0	2.0	4.0	6.0	8.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - 12.1.1 Promote health care transition through education and training

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	10.0	15.0	20.0	25.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.2 - 12.2.1 Promote health care transition through marketing and media

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	25.0	35.0	50.0	75.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.1 - 11.1.1. Promote oral health for pregnant women among health care professionals

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	8.0	12.0	16.0	20.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2 - 11.1.2. Promote oral health for pregnant women among health care professionals

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	8.0	12.0	16.0	20.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Georgia

SPM 1 - Improve access to family planning services
Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health

Goal:	Increase the percentage of women (ages 15-44) served in the Georgia Family Planning Program (GFPP) who use long-acting reversible contraceptives (LARC)
Definition:	**Numerator:** Number of women ages 15-44 that used a LARC **Denominator:** Total number of women ages 15-44 served in GFPP **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Family Planning (FP) Objective 1: Increase the proportion of pregnancies that are intended
Data Sources and Data Issues:	Data Source: Georgia Family Planning Program Clinic Data
Significance:	The availability of family planning services allows individuals to achieve desired birth spacing and family size, and contributes to improved health outcomes for infants, children, women, and families. In 2002, 51% of all pregnancies were intended in the U.S. In Georgia unplanned births increased in percentage from 52.6% to 54.8% between 2009 and 2011. According to the American College of Obstetricians and Gynecologists, intrauterine devices and contraceptive implants, long-acting reversible contraceptives (LARCs), are the most effective reversible contraceptives. The major advantage of LARCs compared with other reversible contraceptive methods is that they do not require ongoing effort on the part of the user for long-term and effective use, and return fertility quickly after removal.

SPM 2 - Improve access to specialty care for CSHCN
Population Domain(s) – Children with Special Health Care Needs

Goal:	Increase the rate of children and youth with special health care needs that have accessed their specialty health care visit through a telehealth clinic
Definition:	**Numerator:** Number of children and youth that have seen a specialty provider within the last 12 months at the Children's Medical Services (CMS) Program telehealth clinic **Denominator:** Total number of children and youth with special health care needs **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive and coordinated systems Related to Access to Health Services (AHS) Objective 5.2: Increase the proportion of children and youth age 17 years and under who have a specific source of ongoing care
Data Sources and Data Issues:	Data Sources: Georgia Children's Medical Services Program Database, Kids Count Data Center
Significance:	According to the American Telemedicine Association, telemedicine/telehealth has been used to bring health care services to patients in distant locations, improving access to patients in both rural and urban areas.Georgia's CSHCN families travel on average 300 miles round trip for specialty care visits. Often resulting in missed appointments, disruption in health care, missed school, and increased emergency room visits. Telehealth is a proven effective tool in providing specialty care services and care coordination to children with special health care needs.

SPM 3 - Decrease congenital syphilis
Population Domain(s) – Perinatal/Infant Health

Goal:	Decrease the rate of infants born with congenital syphilis
Definition:	**Numerator:** Number of infants born with congenital syphilis **Denominator:** Total number of live births **Unit Type:** Rate **Unit Number:** 100,000
Healthy People 2020 Objective:	Sexually Transmitted Diseases-Objective 8: Reduce congenital syphilis
Data Sources and Data Issues:	Data Source: State Electronic Notifiable Disease Surveillance System (SendSS)
Significance:	Congenital syphilis can cause miscarriage, stillbirth, deformed bones, meningitis, and nerve problems leading to blindness or deafness. The CDC considers Congenital Syphilis to be a winnable battle, partly because it can be prevented by testing the mother in the first and third trimesters and providing treatment at least 30 days before delivery. In 2014, Georgia ranked 12th in the U.S. for the congenital syphilis case rate (13 cases per 100,000 live births). There were 20 U.S. states with no congenital syphilis cases reported. Between 2010-2015, Georgia has had no less than 11 cases in a given year.

SPM 4 - Decrease Neonatal Abstinence Syndrome (NAS)
Population Domain(s) – Perinatal/Infant Health

Goal:	Decrease the rate of infants diagnosed as having NAS
Definition:	**Numerator:** Number of infants discharged with NAS **Denominator:** Total number of live births **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 11: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women
Data Sources and Data Issues:	Data Source: Georgia Resident Hospital Discharges, Georgia Resident Births, State Electronic Notifiable Disease Surveillance System (SendSS)
Significance:	There has been a significant increase in the prevalence of NAS, from 1.20 per 1,000 U.S. hospital births in 2000 to 3.39 per 1,000 U.S. hospital births in 2009. In Georgia, NAS increased from 1.4 per 1000 live births in 2010 to 3.2 per 1000 live births in 2014. A public health approach to NAS that includes averting maternal substance use and routine screening for unhealthy substance use in women at every health care visit will help increase the opportunities for primary prevention. According to the Association of State and Territorial Health Officials (ASTHO), state health agencies play a key role in linking various resources and providers by tracking substance-exposed infants through screening, assessment, and service delivery.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Georgia

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets

State: Georgia

ESM 1.1 - 1.1.1. Promote well-woman visits through marketing and media
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Increase the number of public health districts that air the Every Woman video
Definition:	**Numerator:** Number of public health districts with the Every Woman video in circulation **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 18
Data Sources and Data Issues:	Data Source: Perinatal/Women's Health Section Program Data
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.

ESM 1.2 - 1.2.1. Train staff on preconception health appraisals
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	Increase the proportion of staff that have been trained on preconception health appraisals
Definition:	**Numerator:** Number of staff trained on preconception health appraisals **Denominator:** Number of family planning staff **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Perinatal/Women's Health Program Data
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.

ESM 3.1 - 3.5.1. Promote compliance with neonatal level of care requirements
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Goal:	Increase the proportion of birthing hospitals that are in compliance with neonatal level of care requirements
Definition:	**Numerator:** Number of birthing hospitals that are in compliance with neonatal level of care requirements **Denominator:** Total number of birthing hospitals **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Perinatal Health Program Data
Significance:	Very low birth weight infants (<1,500 grams or 3.25 pounds) are the most fragile newborns. Although they represented less than 2% of all births in 2010, VLBW infants accounted for 53% of all infant deaths, with a risk of death over 100 times higher than that of normal birth weight infants (≥2,500 grams or 5.5 pounds). VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a subspecialty facility equipped to handle high-risk neonates. In 2012, the AAP provided updated guidelines on the definitions of neonatal levels of care to include Level I (basic care), Level II (specialty care), and Levels III and IV (subspecialty intensive care) based on the availability of appropriate personnel, physical space, equipment, and organization. Given overwhelming evidence of improved outcomes, the AAP recommends that VLBW and/or very preterm infants (<32 weeks' gestation) be born in only level III or IV facilities. This measure is endorsed by the National Quality Forum (#0477).

ESM 4.1 - 3.1.1 Promote breastfeeding through the 5-STAR Hospital Initiative
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	Increase the number of birthing hospitals that participate in the 5-STAR Hospital Initiative
Definition:	**Numerator:** Number of birthing hospitals participating in the 5-STAR Hospital Initiative **Denominator:** Number of birthing hospitals **Unit Type:** Count **Unit Number:** 40
Data Sources and Data Issues:	North Carolina Maternity Center Breastfeeding Friendly Designation Program
Significance:	Preventing infant mortality is a clear need that came out of the Needs Assessment. Quantitative analysis showed that Georgia's infant mortality rate increased from 6.3 in 2010 to 7.2 in 2013. Strong racial disparities are present and should be addressed to achieve health equity. Although preventing infant mortality was not independently ranked at the Stakeholder Meetings, factors impacting infant mortality were considered. Low birth weight and preterm deliveries were among the highest ranked needs, displaying strong community support to address the overarching issue of infant mortality. Although breastfeeding, perinatal regionalization and safe sleep received lower ratings, quantitative analysis revealed that Georgia needs to make significant improvements to be comparable to national averages and achieve Healthy People 2020 goals. Strong community support to address breastfeeding was displayed through the public input period.

ESM 6.1 - 6.1.1. Identify new methods to administer developmental screens
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Increase the number of innovative and effective strategies to administer developmental screens
Definition:	**Numerator:** Number of innovative and effective strategies to administer developmental screens **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 4
Data Sources and Data Issues:	Data Source: Child Health Program Data
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.

ESM 6.2 - 6.1.2. Partner attitudes and beliefs toward developmental screening
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Increase the proportion of trained individual partners that have positive attitudes and beliefs toward developmental screening
Definition:	**Numerator:** Number of trained individual partners with positive attitudes and beliefs toward developmental screening **Denominator:** Number of individual partners trained on developmental screening tools **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Child Health Program Data
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.

ESM 6.3 - 6.2.1. Promote developmental screening among local communities
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	Increase the number of communities that become aware of developmental screens and resources to access them
Definition:	**Numerator:** Number of community outreach events **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Child Health Program Data
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.

ESM 8.1 - 7.1.1. Improve aerobic capacity of students in grades 4-12
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	Increase aerobic capacity of students in grades 4-12 by 4%
Definition:	**Numerator:** Aerobic capacity, HFZ measure, for students grades 4-12 **Denominator:** Total HFZ measure for students assessed **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Georgia SHAPE
Significance:	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

ESM 9.1 - 8.1.1. Promote bullying prevention among youth
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Goal:	Create a communications plan to promote awareness of bullying and bullying prevention among youth
Definition:	<table><tr><td>**Numerator:**</td><td>Communications plan to promote awareness of bullying and bullying prevention among youth</td></tr><tr><td>**Denominator:**</td><td>Not applicable</td></tr><tr><td>**Unit Type:**</td><td>Text</td></tr><tr><td>**Unit Number:**</td><td>Yes/No</td></tr></table>
Data Sources and Data Issues:	Data Source: Adolescent Health Program Data
Significance:	Bullying, particularly among school-age children, is a major public health problem. Current estimates suggest nearly 30% of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. Specifically, of a nationally representative sample of adolescents, 13% reported being a bully, 11% reported being a victim of bullying, and 6% reported being both a bully and a victim. Studies indicate bullying experiences are associated with a number of behavioral, emotional, and physical adjustment problems. Adolescents who bully others tend to exhibit other defiant and delinquent behaviors, have poor school performance, be more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation; poor school performance; suicidal ideation; and suicide attempts. Evidence further suggests that people who are the victims of bullying and who also perpetrate bullying (i.e., bully-victims) may exhibit the poorest functioning, in comparison with either victims or bullies. Emotional and behavioral problems experienced by victims, bullies, and bully-victims may continue into adulthood and produce long-term negative outcomes, including low self-esteem and self-worth, depression, antisocial behavior, vandalism, drug use and abuse, criminal behavior, gang membership, and suicidal ideation.

ESM 9.2 - 8.2.1. Increase the number of schools participating in whole school bullying prevention initiatives
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Goal:	Expand the Step Up Step In Sexual Bullying Prevention Initiative to 5 additional schools
Definition:	**Numerator:** Number schools participating in the Step Up Step In Sexual Bullying Prevention Initiative **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 15
Data Sources and Data Issues:	Data Source: Adolescent Health Program Data
Significance:	Bullying, particularly among school-age children, is a major public health problem. Current estimates suggest nearly 30% of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. Specifically, of a nationally representative sample of adolescents, 13% reported being a bully, 11% reported being a victim of bullying, and 6% reported being both a bully and a victim. Studies indicate bullying experiences are associated with a number of behavioral, emotional, and physical adjustment problems. Adolescents who bully others tend to exhibit other defiant and delinquent behaviors, have poor school performance, be more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation; poor school performance; suicidal ideation; and suicide attempts. Evidence further suggests that people who are the victims of bullying and who also perpetrate bullying (i.e., bully-victims) may exhibit the poorest functioning, in comparison with either victims or bullies. Emotional and behavioral problems experienced by victims, bullies, and bully-victims may continue into adulthood and produce long-term negative outcomes, including low self-esteem and self-worth, depression, antisocial behavior, vandalism, drug use and abuse, criminal behavior, gang membership, and suicidal ideation.

ESM 12.1 - 12.1.1 Promote health care transition through education and training
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

<table>
<tr><td>Goal:</td><td>Increase health care transition education and training opportunities for youth, families and professionals</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>number of youth, families, professionals trained on health care transition</td></tr>
<tr><td>Denominator:</td><td>number of health care transition education opportunities offered</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>25</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Six core elements of health care transition</td></tr>
<tr><td>Significance:</td><td>Data examined during the Needs Assessment identified several areas where the system of care for CYSHCN should be improved. Therefore, this priority need was phrased to reflect the need to improve the overarching system that families engage with. Themes from qualitative data revealed that families are not aware of existing services, provide their own care coordination and medical home, lack access to specialty providers and do not feel prepared to transition to adulthood.</td></tr>
</table>

ESM 12.2 - 12.2.1 Promote health care transition through marketing and media
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Increase
Definition:	**Numerator:** Number of materials distributed **Denominator:** Number of materials developed **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Florida Hata
Significance:	Data examined during the Needs Assessment identified several areas where the system of care for CYSHCN should be improved. Therefore, this priority need was phrased to reflect the need to improve the overarching system that families engage with. Themes from qualitative data revealed that families are not aware of existing services, provide their own care coordination and medical home, lack access to specialty providers and do not feel prepared to transition to adulthood.

ESM 13.1 - 11.1.1. Promote oral health for pregnant women among health care professionals
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Goal:	Increase the number of health professionals caring for pregnant women that encourage a dental visit
Definition:	**Numerator:** Number of comprehensive webinars/presentations offered **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	Data Source: Oral Health Program Data
Significance:	Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases. Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care. State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.

ESM 13.2 - 11.1.2. Promote oral health for pregnant women among health care professionals
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

<table>
<tr><td>Goal:</td><td>Increase the number of health professionals caring for pregnant women that encourage a dental visit</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of health care professionals that attend a comprehensive webinar/presentation</td></tr>
<tr><td>Denominator:</td><td>Not Applicable</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Oral Health Program Data</td></tr>
<tr><td>Significance:</td><td>Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.

State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.</td></tr>
</table>

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Georgia

Form Notes for Form 10d NPMs and SPMs

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	99.6	96.4	99.2	100.0	100.0
Numerator	230	268	264	265	285
Denominator	231	278	266	265	285
Data Source	Newborn Screening Program	Newborn Screening Program	Emory Dept of Human Genetics & State Elec Surv Sys	Emory Dept of Human Genetics & State Elec Surv Sys	Emory Dept of Human Genetics & State Elec Surv Sys
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Data is supplied by the Emory Department of Human Genetics Follow-up Program. The numerator is total number of diagnosed infants who received treatment. The denominator is the total number of diagnosed cases for infants born in 2014. Hearing screening data were not included to maintain consistency in reporting.	
2.	**Field Name:**	**2013**
	Field Note: 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.	
3.	**Field Name:**	**2012**

Field Note:
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.

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	56.2	57.3	69.4	69.4	69.4
Annual Indicator	67.6	67.6	67.6	67.6	67.6
Numerator	269,705	283,239	283,089	269,566	281,747
Denominator	398,972	418,993	418,771	398,767	416,785
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2014 was projected using data from 2000 to 2013.	
2.	**Field Name:**	**2014**
	Field Note: Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2014 was projected using data from 2000 to 2013.	
3.	**Field Name:**	**2013**
	Field Note: 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.	
4.	**Field Name:**	**2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	53.1	54.1	53.1	53.1	53.1
Annual Indicator	45.7	45.7	45.7	45.7	45.7
Numerator	182,330	194,762	191,378	182,236	190,471
Denominator	398,972	426,175	418,771	398,767	416,785
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2014 was projected using data from 2000 to 2013.	
2.	**Field Name:**	**2014**
	Field Note: Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2014 was projected using data from 2000 to 2013.	
3.	**Field Name:**	**2013**
	Field Note: 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.	
4.	**Field Name:**	**2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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
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

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	63.7	64.9	63.7	63.7	63.7
Annual Indicator	62.3	62.2	62.2	64.4	62.2
Numerator	248,160	248,377	260,476	256,913	259,240
Denominator	398,091	399,320	418,771	398,767	416,785
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2014 was projected using data from 2000 to 2013.

2. **Field Name:** **2014**

   Field Note:
   Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2014 was projected using data from 2000 to 2013.

3. **Field Name:** **2013**

   Field Note:
   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.

4. **Field Name:** **2012**

   Field Note:
   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.

5.	**Field Name:**	**2011**

Field Note:
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 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

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	94.7	96.6	98.5	75.0	75.0
Annual Indicator	69.5	69.5	69.5	69.5	69.5
Numerator	277,285	296,192	291,046	287,065	305,427
Denominator	398,972	426,175	418,771	413,043	439,464
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2014 was projected using data from 2000 to 2013.	
2.	**Field Name:**	**2014**
	Field Note: Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2014 was projected using data from 2000 to 2013.	
3.	**Field Name:**	**2013**
	Field Note: 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.	
4.	**Field Name:**	**2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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

Data Alerts: None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	38.5	39.3	37.7	37.7	37.7
Annual Indicator	33.9	33.9	33.9	69.5	69.5
Numerator	134,953	135,369	141,963	277,285	296,192
Denominator	398,091	399,320	418,771	398,972	426,175
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2014 was projected using data from 2000 to 2013.	
2.	**Field Name:**	**2014**
	Field Note: Population estimate for children aged 0-17 years was obtained from the OASIS website. The estimate for 2014 was projected using data from 2000 to 2013.	
3.	**Field Name:**	**2013**
	Field Note: 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.	
4.	**Field Name:**	**2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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

Data Alerts: None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	75.1	76.6	79.7	81.3	83.7
Annual Indicator	83.9	77.9	81.1	76.4	79.9
Numerator	164,312	150,748	155,210	144,924	161,388
Denominator	195,843	193,515	191,381	189,691	201,987
Data Source	NIS	NIS	NIS	NIS	NIS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
Numerator- The numerator was calculated using the annual indicators and the denominator.

Annual indicator- The annual indicator was retrieved from http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/index.html on June 29, 2015. Series 4:3:1:3:3:1 for Georgia. This file can be downloaded (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- Linear projections were used to derive population estimates and the annual indicator for 2014. The numerator for 2014 was derived by multiplying the annual indicator with the denominator.

2. **Field Name:** **2013**

Field Note:
Numerator data were calculated using the annual indicators and the denominator.

Annual indicator was updated based on the annual indicators retrieved from http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/data/tables-2012.html on June 29, 2015. Series 4:3:1:3:3:1 for Georgia. This file can be downloaded (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 2013 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

3.	**Field Name:**	**2012**

Field Note:
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.

4.	**Field Name:**	**2011**

Field Note:
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

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	25.4	24.7	20.4	12.8	12.5
Annual Indicator	18.9	15.8	13.7	12.6	9.9
Numerator	3,814	3,196	2,762	2,549	2,127
Denominator	202,149	202,252	201,549	202,481	214,103
Data Source	Vital Records	OASIS (birth data, pop/census data)	OASIS (birth data, population/census data)	OASIS (birth data, population/census data)	OASIS (birth data, population/census data)
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: The numerator is dervied from the provisional vital records file; the denominator is derived from projections using 2000 through 2013 data retrieved from OASIS. 2013 was updated with final data from OASIS.	
2.	**Field Name:**	**2013**
	Field Note: 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 The numerator is derived from 2013 VR provisional birth file; the denominator is derived from a linear projection using 2000 through 2012 final data. Denominator (2000-2012) updated in accordance with intercensal and/or postcensal updates.	
3.	**Field Name:**	**2012**

Field Note:
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.

4. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	37.6	37.8	37.4	37.4	37.4
Annual Indicator	37.4	37.4	37.4	37.4	37.4
Numerator	48,113	48,341	49,036	50,146	51,491
Denominator	128,645	129,253	131,113	134,081	137,677
Data Source	Basic Screening Survey	Basic Screening Survey	Basis Screening Survey	Basic Screening Survey	Basic Screening Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

   Field Note:
   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 for 2014 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.

2. **Field Name:** **2013**

   Field Note:
   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.

3. **Field Name:** **2012**

Field Note:
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.

4. **Field Name:** **2011**

Field Note:
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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	3.0	2.9	2.8	2.1	1.9
Annual Indicator	2.9	2.3	2.8	2.3	1.4
Numerator	61	47	58	48	30
Denominator	2,076,584	2,078,585	2,077,631	2,076,929	2,149,092
Data Source	Vital Records	OASIS (death data, pop/census data	OASIS (death data, population/census data)	OASIS (death data, population/census data)	OASIS (death data, population/census data)
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: The numerator is derived from provisional data. The denominator is estimated using a linear projection of 2000 through 2013 data. 2013 data were updated with final data from OASIS.	
2.	**Field Name:**	**2013**
	Field Note: 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 The 2000-2012 denominators were retrieved from OASIS. The numerators from 2000-2011 were also retrieved from OASIS. The 2013 denominator is projected, because these data were not available. Numerators for 2012 and 2013 were derived from provisional death data.	
3.	**Field Name:**	**2012**

Field Note:
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.

4. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	40.4	41.6	44.2	40.1	41.2
Annual Indicator	33.9	33.0	35.8	40.4	41.2
Numerator	44,829	42,886	46,007	52,834	53,014
Denominator	132,239	129,959	128,511	130,776	128,675
Data Source	NIS	NIS	NIS	NIS	NIS
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
Indicator estimates for 2012 to 2014 are based on projections using 2004-2011 data
The denominator, number of births for 2004 - 2013 was obtained from OASIS. The number of births for 2014 were obtained from provisional data
The numerators were obtained by multiplying the indicators and the denominators for each year.

2. **Field Name:** **2013**

Field Note:
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 were obtained from provisional data.

The numerators were obtained by multiplying the indicators and the denominators for each year.

3. **Field Name:** **2012**

Field Note:
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.

4. **Field Name:** **2011**

Field Note:
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

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	99.7	99.8	99.9	99.1	99.1
Annual Indicator	86.6	92.2	98.5	99.6	99.6
Numerator	117,588	125,975	124,308	126,433	124,562
Denominator	135,781	136,606	126,174	126,957	125,049
Data Source	Newborn Hearing Program Data	Newborn Hearing Program Data	Newborn Hearing Program Data	Newborn Hearing Program Data	Newborn Hearing Program Data
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Numerator data are the number of births screened as reported by hospitals. The data is collected in SendSS. Denominator data are total occurrent births. The data is collected by Vital Records.	
2.	**Field Name:**	**2013**
	Field Note: 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 in SendSS.	
3.	**Field Name:**	**2012**
	Field Note: 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	
4.	**Field Name:**	**2011**

Field Note:
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

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	11.2	11.2	11.2	11.2	11.1
Annual Indicator	10.0	12.8	12.8	7.2	6.6
Numerator	248,531	319,408	319,031	179,445	169,288
Denominator	2,493,574	2,495,375	2,492,428	2,492,293	2,564,966
Data Source	Current Population	Current Population Survey/OASIS	Current Population Survey/OASIS	Current Population Survey/OASIS	Current Population Survey/OASIS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
2014 statistic is unavailable and is estimated using linear projection of 2003 through 2013 data.

Prior to September 2014, the table HI-05 was produced using the Current Population Survey (CPS). This table is now produced using the American Community survey (ACS) so Table HI-05 was not used this year. 2013 annual indicators were updated using CPS tables: http://www.census.gov/cps/data/cpstablecreator.html only. 2013 population estimate was updated using final 0 to 17 year old population data from OASIS.

2. **Field Name:** **2013**

Field Note:
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.

3. **Field Name:** **2012**

Field Note:
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.

4. **Field Name:** **2011**

Field Note:
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

Data Alerts: None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	28.8	28.3	27.8	27.8	27.8
Annual Indicator	33.2	31.3	30.2	31.6	29.2
Numerator	36,278	44,650	39,084	33,117	27,984
Denominator	109,303	142,560	129,626	104,673	95,712
Data Source	WIC report	WIC Performance Measure Report	WIC Performance Measure Report	WIC Performance Measure Report	WIC Performance Measure Report
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Data provided is for Federal Fiscal Year 2014	
2.	**Field Name:**	**2013**
	Field Note: Source: WIC Performance Measure Report: June 2013-Child Weight Rpt 1 Cnty/Clinic Yearly SFY	
3.	**Field Name:**	**2012**
	Field Note: Source: WIC Performance Measure Report: June 2012-Child Weight Rpt 1 Cnty/Clinic Yearly SFY	

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	8.7	8.5	8.1	6.5	6.1
Annual Indicator	6.2	7.0	4.9	3.3	2.4
Numerator	8,212	9,097	6,297	4,316	3,088
Denominator	132,239	129,959	128,511	130,776	128,675
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
The numerators are calculated by multiplying the annual Indicator and the denominator.

The denominators for 2007-2013 come from OASIS. The denominator for 2014 comes from the 2014 provisional birth file.

The 2012 annual indicator from the PRAMS survey was 4.2. The 2013-2014 annual indicators have been estimated based on trend data from 2007-2012.

2. **Field Name:** **2013**

Field Note:
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.

3. **Field Name:** **2012**

Field Note:
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.

4. **Field Name:** **2011**

Field Note:
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

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	4.6	4.6	5.2	6.3	6.2
Annual Indicator	5.7	5.3	8.6	6.0	4.9
Numerator	40	37	60	42	36
Denominator	700,944	699,648	695,266	696,167	734,823
Data Source	Vital Records	OASIS (death data, pop/census data)	OASIS (death data, population/census data)	OASIS (death data, population/census data)	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
Final 2014 statistic is unavailable. The numerator is derived from the provisional 2014 death file (linear projection of 2000 through 2013 data was used to verify that the provisional data were on trend- 43 deaths) and the denominator is derived from linear projection of 2000 through 2013 data.

2013 population estimate was updated using final 15 to 19 year old population data from OASIS. 2013 number of suicide deaths to children aged 15-19 years was updated using final death data from OASIS.

2. **Field Name:** **2013**

Field Note:
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

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.

3. **Field Name:** **2012**

Field Note:
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.

4. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	73.3	73.6	77.8	80.0	80.7
Annual Indicator	77.8	78.5	78.9	79.6	83.2
Numerator	1,868	1,840	1,894	1,870	2,036
Denominator	2,400	2,343	2,400	2,350	2,446
Data Source	Vital Records	Data Warehouse (final data)	Vital Records	Vital Records	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Linear projection using data from years 2000-2011 was used to derive the annual indicator and provisional birth data for 2014 were used to determine the denominator. The numerator for 2013 was updated with a projection. 2013 numerator could not be updated since birth location is not yet available. The denominator for 2013 was updated to reflect final data.	
2.	**Field Name:**	**2013**
	Field Note: Used a combination of linear projection to derive the numerator (2008-2012 see note from previous year) AND 2013 VR provisional birth file to derive the denominator. 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.	
3.	**Field Name:**	**2012**

Field Note:
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.

4. **Field Name:** **2011**

Field Note:
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) facilitaties. 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 recaculated as follows:

2007: numerator 1931; denominator 2682; and annual indicator 69.5.

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	81.8	82.6	83.5	81.8	82.6
Annual Indicator	70.3	71.0	73.4	72.2	76.1
Numerator	74,810	77,745	76,900	79,146	83,621
Denominator	106,350	109,432	104,708	109,660	109,908
Data Source	Vital Records	Vital Records	OHIP-Repository	OHIP-Repository	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

   Field Note:
   2014 denominator and numerator are provisional. The annual indicator for 2014 was calculated.

   2013 numerator and denominator were updated.

2. **Field Name:** **2013**

   Field Note:
   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.

3. **Field Name:** **2012**

   Field Note:
   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.

4.	**Field Name:**	**2011**

Field Note:
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.

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Georgia

SPM 1 - Percent of high school students who are obese (BMI > or = 95th percentile)

	2011	2012	2013	2014	2015
Annual Objective	12.3	12.2	12.0	11.9	11.8
Annual Indicator	15.0	15.0	12.7	12.7	12.7
Numerator	69,186	69,043	59,462	60,726	62,183
Denominator	461,237	460,287	468,205	478,160	489,631
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
The numerators are calculated by multiplying the annual Indicator and the denominator.

The denominators for 2009-2014 were calculated adding student enrollments for grades 9-12 found at the following link: https://app3.doe.k12.ga.us/ows-bin/owa/fte_pack_enrollgrade.entry_form . Per YRBS Coordinator, the surveys were conducted during the Spring semester. Thus, Spring (March) enrollments were used as denominators.

Data come from Georgia YRBS. Actual surveys were conducted in 2007, 2009, and 2011. For years where the survey was not conducted the same estimate was maintained.

2. **Field Name:** **2013**

Field Note:
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.

3. **Field Name:** **2012**

Field Note:
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.

4. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

SPM 2 - Infant mortality rate among infants born weighing 1,500 grams or more who survive past the first 27 days of life

	2011	2012	2013	2014	2015
Annual Objective	1.9	1.9	1.9	1.7	1.7
Annual Indicator	1.8	1.7	1.7	1.7	1.6
Numerator	257	245	247	248	236
Denominator	143,046	144,084	145,123	146,161	147,199
Data Source	Linked Birth-Deaths	Linked Birth-Deaths	Linked Birth-Deaths	Linked Birth-Deaths	Linked Birth-Deaths
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Data were derived from a projection of years 2000-2010.	
2.	**Field Name:**	**2013**
	Field Note: Data for 2000-2010 are final; 2012 not included in OHIP B-D linked records. 2011 onward derived from linear projections.	
3.	**Field Name:**	**2012**
	Field Note: 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.	
4.	**Field Name:**	**2011**
	Field Note: 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	

Data Alerts: None

SPM 3 - Number of abstracts submitted, reports prepared, presentations made, and publications submitted for peer review where MCHP staff are authors or coauthors

	2011	2012	2013	2014	2015
Annual Objective	5.0	7.0	12.0	15.0	15.0
Annual Indicator				8.0	5.0
Numerator	8	6	15	8	5
Denominator	1	1	1	1	1
Data Source	Office of MCH Epi	Office of MCH Epi	Office of MCH Epi	Office of MCH Epi	Office of MCH Epi
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

   Field Note:
   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.

2. **Field Name:** **2013**

   Field Note:
   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.

3. **Field Name:** **2012**

   Field Note:
   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.

4. **Field Name:** **2011**

   Field Note:
   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.

Data Alerts: None

SPM 4 - Deaths to children ages 15 to 17 years caused by motor vehicle crashes per 100,000 children

	2011	2012	2013	2014	2015
Annual Objective	14.5	14.3	8.0	8.0	7.4
Annual Indicator	10.1	7.9	11.1	8.9	7.4
Numerator	42	33	46	39	33
Denominator	416,990	416,790	414,797	438,966	444,698
Data Source	Vital Records	OASIS	Vital Records/OASIS	Vital Records/OASIS	Vital Records
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
Final 2014 statistic is unavailable and is estimated using linear projection of 2000 through 2013 data from OASIS (denominator) and 2014 provisional death data from Vital Records (numerator).

2013 population estimate was updated using final 15 to 17 year old population data from OASIS. 2013 number of MVC deaths to children aged 15-17 years was updated using final death data from OASIS.

2. **Field Name:** **2013**

Field Note:
The 2000-2012 denominators were collected from OASIS. The numerators from 2000-2011 were collected from OASIS. The 2013 denominator is projected, because these data were not available. Numerators 2012 and 2013 were collected from provisional data.

3. **Field Name:** **2012**

Field Note:
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.

4. **Field Name:** **2011**

Field Note:
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

Data Alerts: None

SPM 5 - Among children five years of age and younger who received services through the MCH Program, the percent who received a developmental screen

	2011	2012	2013	2014	2015
Annual Objective	35.0	35.0	35.0	90.0	96.7
Annual Indicator	38.6	38.6	86.3	66.8	85.3
Numerator	7,490	7,490	16,246	12,453	15,660
Denominator	19,382	19,382	18,823	18,637	18,358
Data Source	Children 1st quarterly reports	Children 1st quarterly report	Children 1st quarterly report	Children 1st quarterly report	Children 1st quarterly report
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Final data for 2014 is not available. The numerator is derived from the Children 1st quarterly report. The denominator was derived from a projection of years 2011-2013.	
2.	**Field Name:**	**2013**
	Field Note: 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 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.	
3.	**Field Name:**	**2012**
	Field Note: 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.	
4.	**Field Name:**	**2011**

Field Note:
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.

Data Alerts: None

SPM 6 - Percent of pediatricians and family physicians who have positive attitudes toward treating children with special health care needs

	2011	2012	2013	2014	2015
Annual Objective	25.0	25.0	25.0	25.0	25.0
Annual Indicator			0.0	0.0	0.0
Numerator	0	0			
Denominator					
Data Source	Survey not yet implemented	Survey not yet implemented	Survey not implemented	Survey not implemented	Survey not implemented
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Survey was not implemented

2. **Field Name:** **2014**

   Field Note:
   As a result of delays in implementing a survey to measure pediatrician and family physician attitudes toward treating children with special health care needs, Georgia is currently unable to report this measure.

3. **Field Name:** **2013**

   Field Note:
   As a result of delays in implementing a survey to measure pediatrician and family physician attitudes toward treating children with special health care needs, Georgia is currently unable to report this measure. The implementation of a survey has been terminated and a new nomination process is being developed.

4. **Field Name:** **2012**

   Field Note:
   As a result of delays in implementing a survey to measure pediatrician and family physician attitudes toward treating children with special health care needs, Georgia is currently unable to report this measure.

5. **Field Name:** **2011**

Field Note:
As a result of delays in implementing a survey to measure pediatrician and family physician attitudes toward treating children with special health care needs, Georgia is currently unable to report this measure.

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2011 SPM 6. Please review your data to ensure this is correct.
2.	A value of zero has been entered for the numerator for year 2012 SPM 6. Please review your data to ensure this is correct.

SPM 7 - Percent of very low birth weight infants (<1,500 grams at birth) enrolled in First Care

	2011	2012	2013	2014	2015
Annual Objective	25.0	25.0	25.0	10.0	10.0
Annual Indicator	21.5	19.2	11.8	13.5	12.1
Numerator	516	445	282	317	291
Denominator	2,400	2,322	2,400	2,350	2,404
Data Source	Children 1st quartery reports	Children 1st quarterly reports	Children 1st quarterly reports	Children 1st quarterly reports	Children 1st quarterly reports
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
The numerator was taken from the count of infants with birth weight <1500g enrolled in 1st Care in 2014 and the denominator was obtained from the provisional birth file.

Denominator data for 2013 were updated using final data from OASIS.

2. **Field Name:** **2013**

Field Note:
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.

The decrease in the percentage of children with low birth weights (<1500 grams) that received C1st services from 19% in 2012 to 10.3% for the year 2013 was likely due to a cut in C1st funding during 2013. There were also only 12 of the 18 health districts that offered the services of C1st during 2013.

3. **Field Name:** **2012**

Field Note:
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.

4. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

Form 11
Other State Data

State: Georgia

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

State Action Plan Table

State: Georgia

Please click the link below to download a PDF of the full version of the State Action Plan Table.
State Action Plan Table

Abbreviated State Action Plan Table

State: Georgia

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Prevent maternal mortality	NPM 1 - Well-Woman Visit	ESM 1.1 ESM 1.2	
Improve access to family planning services			SPM 1

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Prevent infant mortality	NPM 4 - Breastfeeding	ESM 4.1	
Prevent infant mortality	NPM 3 - Risk-Appropriate Perinatal Care	ESM 3.1	
Decrease maternal substance use			SPM 4
Prevent infant mortality			SPM 3

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Promote developmental screenings among children	NPM 6 - Developmental Screening	ESM 6.1 ESM 6.2 ESM 6.3	
Promote physical activity among children	NPM 8 - Physical Activity	ESM 8.1	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce suicide among adolescents	NPM 9 - Bullying	ESM 9.1 ESM 9.2	

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Improve systems of care for children and youth with special health care needs	NPM 12 - Transition	ESM 12.1 ESM 12.2	
Improve access to specialty care for CSHCN			SPM 2

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Promote oral health among all populations	NPM 13 - Preventive Dental Visit	ESM 13.1 ESM 13.2	