

CHILD HEALTH



3/31/2015

Georgia Title V Needs Assessment



Child Health

SECTION 1: QUANTITATIVE ANALYSIS

INTRODUCTION

Improving the health and well-being of children is an essential priority across the nation. This section will explore the overall health status and other important indicators of children's health in Georgia, with a focus on children ages 1 through 17. By gaining a better understanding of the patterns and current health status of children in Georgia, the Georgia Department of Public Health (DPH) can be equipped to assess and address gaps and disparities, as well as determine the issues that need the most attention. In particular, this section will explore the following topic areas:

- Overall health status
- Mortality
- Emergency room visits
- Vaccinations
- Access to medical homes
- Asthma
- Physical activity and obesity
- Screen time
- Neighborhood and built environment
- Adverse childhood experiences
- Developmental screening
- School readiness

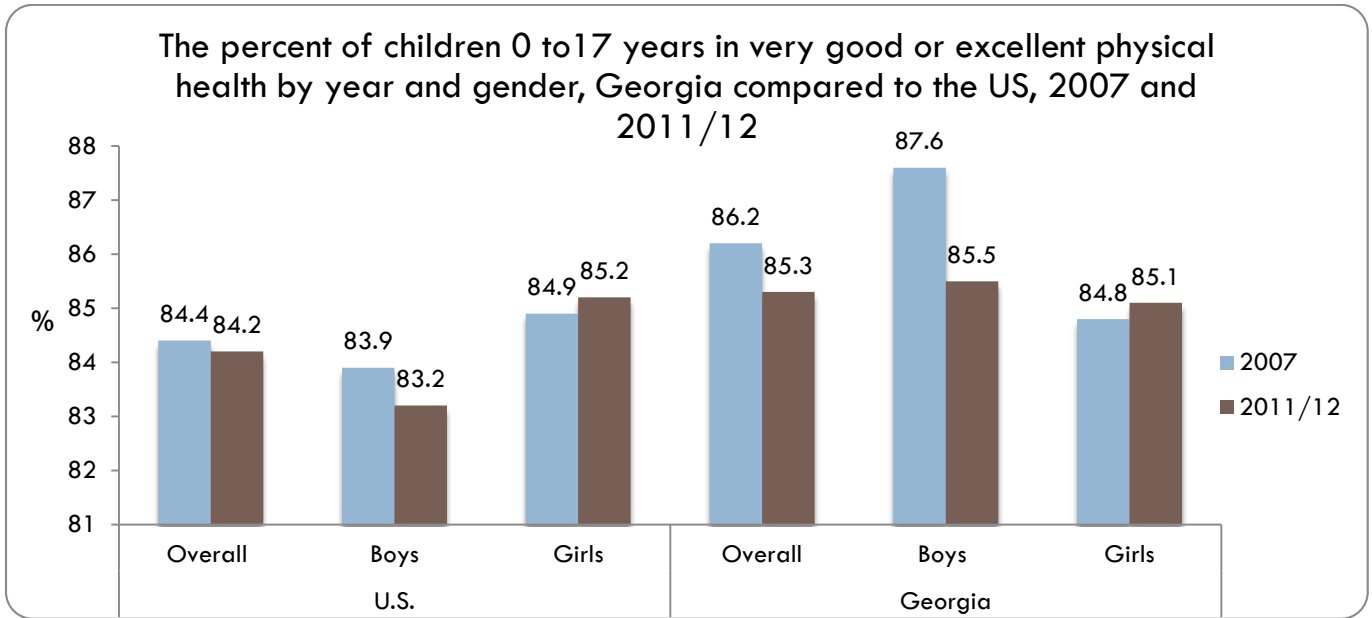
Since childhood is seen as a relatively healthy time, this section will focus on overall health status, leading causes of death, and social determinants of health. Evaluating social determinants of health for children can serve as predictors for health over the life course. Understanding the impacts of adverse childhood experiences (ACE), developing programs to support children with high ACE scores, and prevention of high ACE scores in at-risk children are necessary next steps for health departments and their partners.

Furthermore, this section will explore many of the aforementioned topics and examine how children in Georgia compare to the Healthy People (HP) 2020 objectives regarding these topics, and identify room for improvement. Recommendations will be included in the conclusion.

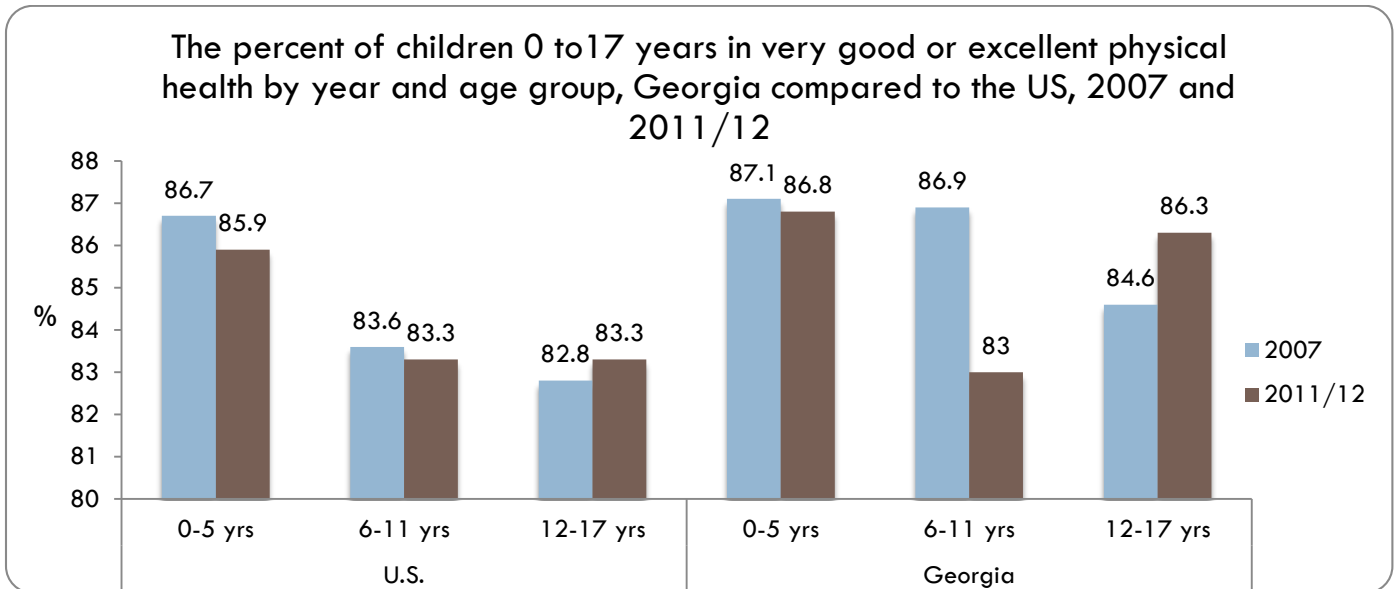
Data provided in this section are from the latest available National Survey of Children's Health (NSCH), Georgia Death Certificate, Centers for Disease Control and Prevention Flu Vaccine Report, National Immunization Survey, and National Center for Education Statistics.

OVERALL HEALTH STATUS

Nearly 85% of parents surveyed reported their child’s overall health to be either very good or excellent. On average, Georgia parents reported very good or excellent health at a slightly higher rate when compared to the national average. Of note, while the overall national health status of children decreased marginally from 2007 to 2011/12, the decrease was more dramatic for Georgia’s children. The decline in Georgia is mostly related to the decrease of nearly two percentage points for boys.



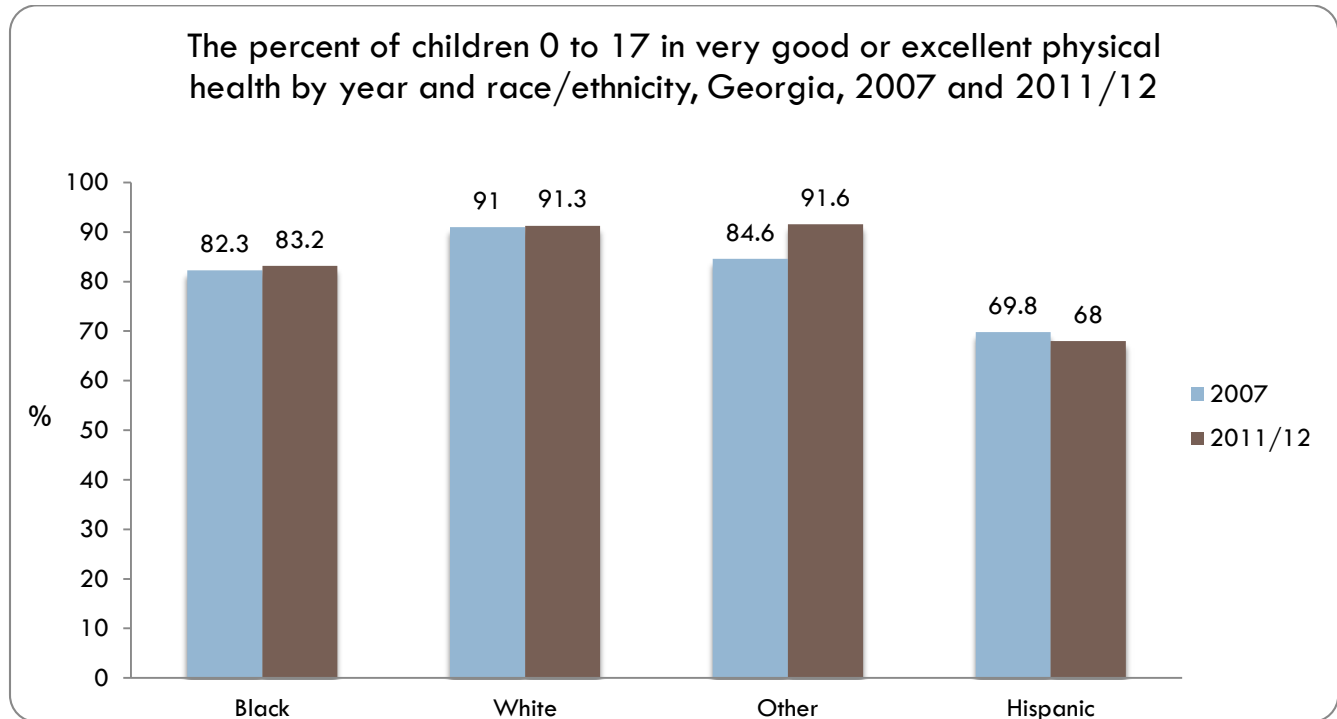
Source: NSCH 2007, 2011/12



Source: NSCH 2007, 2011/12

In the US, parents of the youngest age group of children (birth through 5 years old) generally reported a health status of very good or excellent more often than parents of older children. This remained consistent across both time points. In Georgia, the trend varied by year. For the

earlier time point, 2007, birth through 11 year olds experienced very good or excellent health at relatively the same rate (87%), with a decrease seen among the oldest age group (12 to 17), with 84% of them reporting very good or excellent health. In the latest available Georgia data, we see a U shape curve, with the age group fairing the worse being children between the ages of 6-11 years, only 83% of them reporting very good or excellent health.



Source: NSCH 2007, 2011/12

Over the five years of data represented, little change has occurred in the amount of parents reporting their children's health as very good or excellent when we stratified by race. However, we do see disparities, with Hispanic parents being the least likely to report that their child's health is very good or excellent, and parents of White children and children of "Other" races reporting the greatest percentages of very good and excellent health.

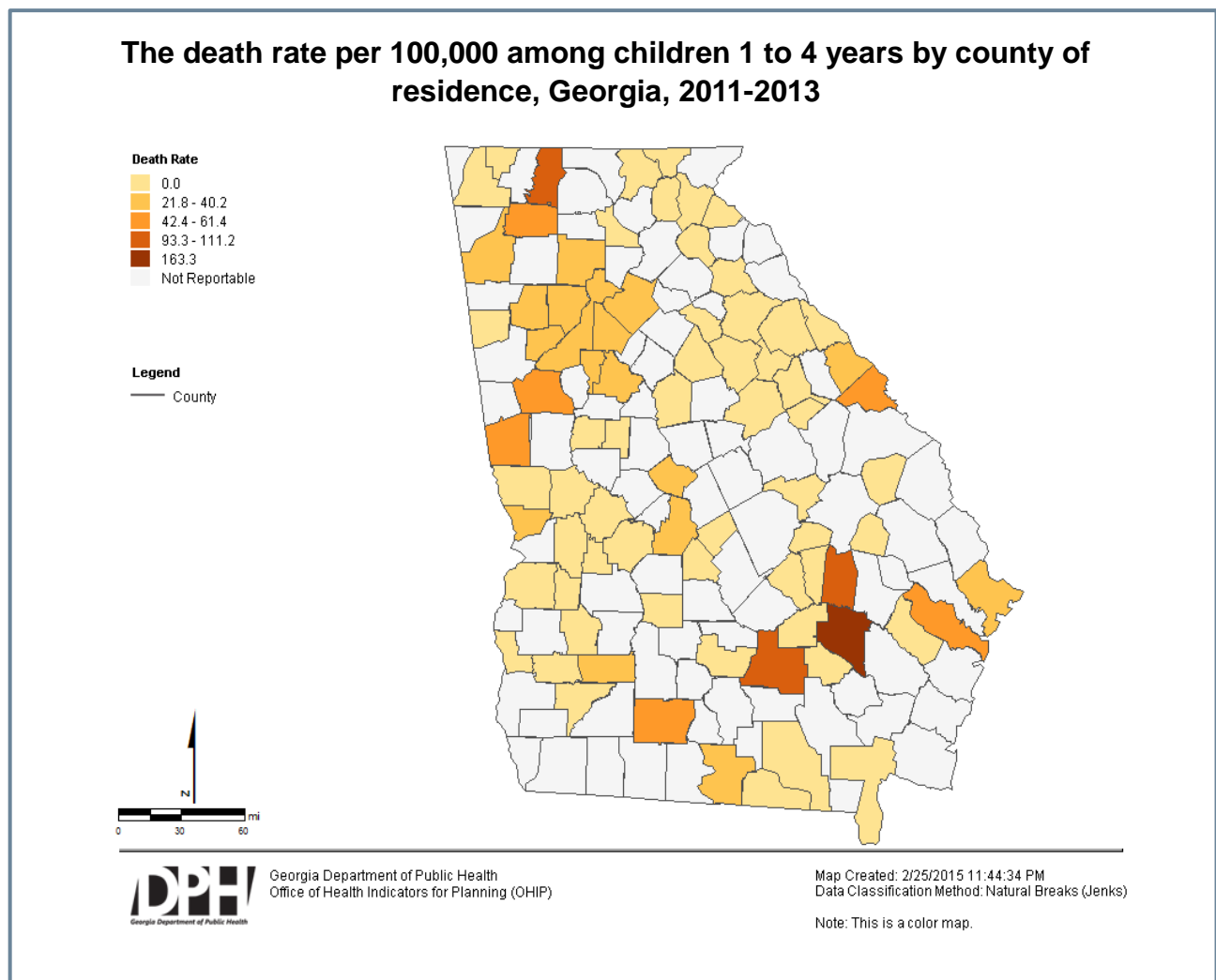
MORTALITY

In 2013, 4 children between the ages of 1-17 died each day in Georgia. This number is startling and increases dramatically when 18 and 19 year olds are considered (see adolescent health section for more details). Furthermore, more than 1,470 of Georgia's children die annually. About a tenth of these deaths are to children between the ages of one and four. When we look closely at cause of death we note the top 10 causes by age group in table below. Motor vehicle crashes are the number one leading cause of death for all age groups. In the older age groups, assault/homicide and suicide are the second and third leading causes of death. This is not surprising as the incidence of violence – both towards others as well as oneself – increases with age, yet it is still alarming and cause for concern.

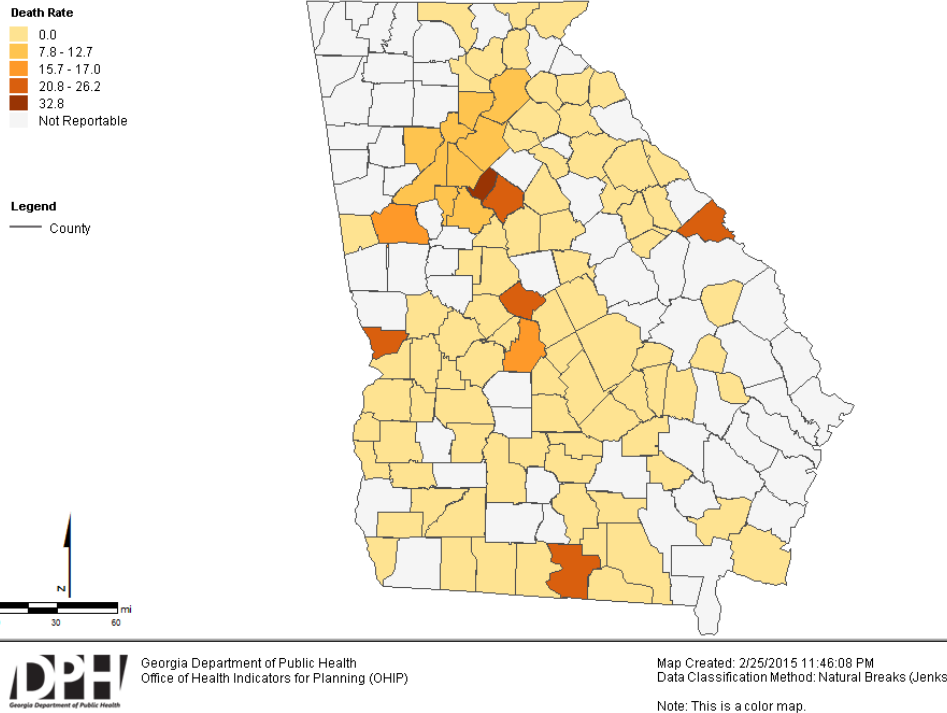
Top 10 Leading Causes of Death in Georgia, 2009-2013				
Rank	1-4 years	5-9 years	10-14 years	15-19 years
1	Motor Vehicle Crashes (n=101)	Motor Vehicle Crashes (n=108)	Motor Vehicle Crashes (n=100)	Motor Vehicle Crashes (n=443)
2	Congenital Malformations, Deformations and Chromosomal Abnormalities (n=81)	All Other Diseases of the Nervous System (n=40)	Intentional Self-Harm (Suicide) (n=47)	Assault (Homicide) (n=289)
3	Assault (Homicide) (n=81)	Accidental Drowning and Submersion (n=37)	All Other Diseases of the Nervous System (n=46)	Intentional Self-Harm (Suicide) (n=224)
4	Accidental Drowning and Submersion (n=74)	Malignant Neoplasms of Meninges, Brain and Other Parts of Central Nervous System (n=29)	Assault (Homicide) (n=46)	Accidental Poisoning and Exposure to Noxious Substances (n=82)
5	All Other Diseases of the Nervous System (n=45)	Congenital Malformations, Deformations and Chromosomal Abnormalities (n=24)	Leukemia (n=24)	All Other Diseases of the Nervous System (n=58)
6	Accidental Exposure to Smoke, Fire and Flames (n=38)	Assault (Homicide) (n=24)	Congenital Malformations, Deformations and Chromosomal Abnormalities (n=22)	Accidental Drowning and Submersion (n=42)
7	All Other Unintentional Injury (n=32)	Accidental Exposure to Smoke, Fire and Flames (n=20)	Accidental Drowning and Submersion (n=22)	All Other Unintentional Injury (n=39)
8	All Other Endocrine, Nutritional and Metabolic Diseases (n=28)	All Other Endocrine, Nutritional and Metabolic Diseases (n=17)	Asthma (n=18)	Congenital Malformations, Deformations and Chromosomal Abnormalities (n=36)
9	Suffocation (n=26)	All Other Unintentional Injury (n=13)	Malignant Neoplasms of Meninges, Brain and Other Parts of Central Nervous System (n=17)	Leukemia (n=23)
10	Malignant Neoplasms of Meninges, Brain and Other Parts of Central Nervous System (n=18)	Asthma (n=11)	All Other Endocrine, Nutritional and Metabolic Diseases (n=15)	All Other Endocrine, Nutritional and Metabolic Diseases (n=21)

Source: OASIS oasis.state.ga.us

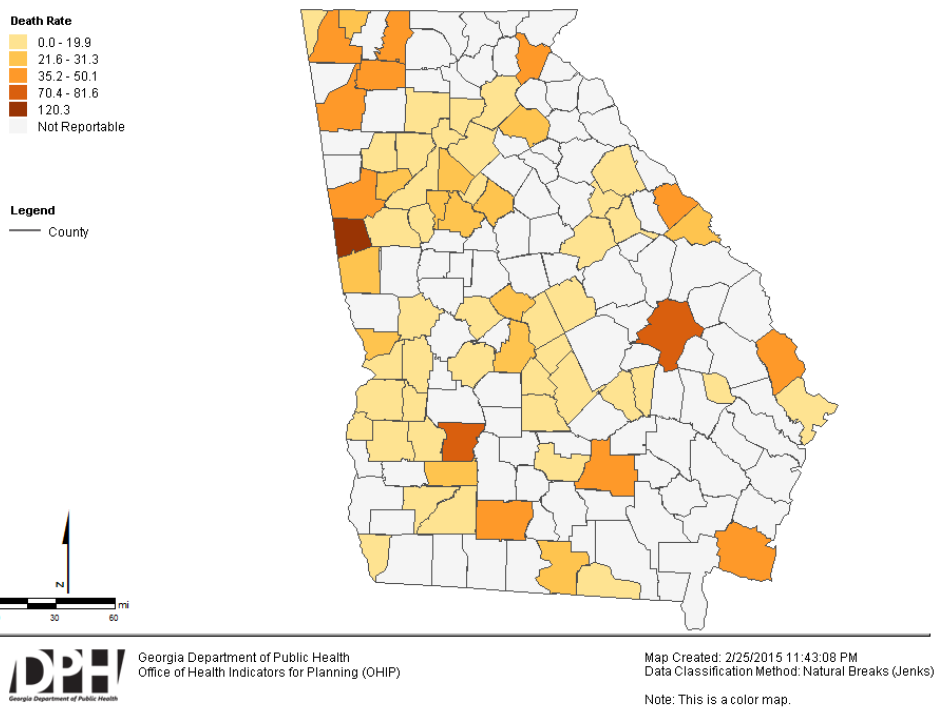
Disparities exist in terms of race, gender, and geography, with the majority of deaths occurring among boys. When examining the three maps below closely that depict three years of the death rate per 100,000 by age group, of note is the geographic distribution of childhood deaths based on the age of death. Deaths among children between the ages of 1 to 4 occur mainly in the southeast part and northwest corner of the state, more rural less populated areas. However, for 5 to 9 year olds, the metro areas of the state bare the largest burden of these deaths. While deaths to 10 to 17 year olds are mainly occurring near metropolitan areas, but not in metropolitan areas. It is important to work closely with the child fatality review committee to understand these deaths and determine appropriate and community specific interventions.



The death rate per 100,000 among children 5 to 9 years by county of residence, Georgia, 2011-2013



The death rate per 100,000 among children 10 to 14 years by county of residence, Georgia, 2011-2013



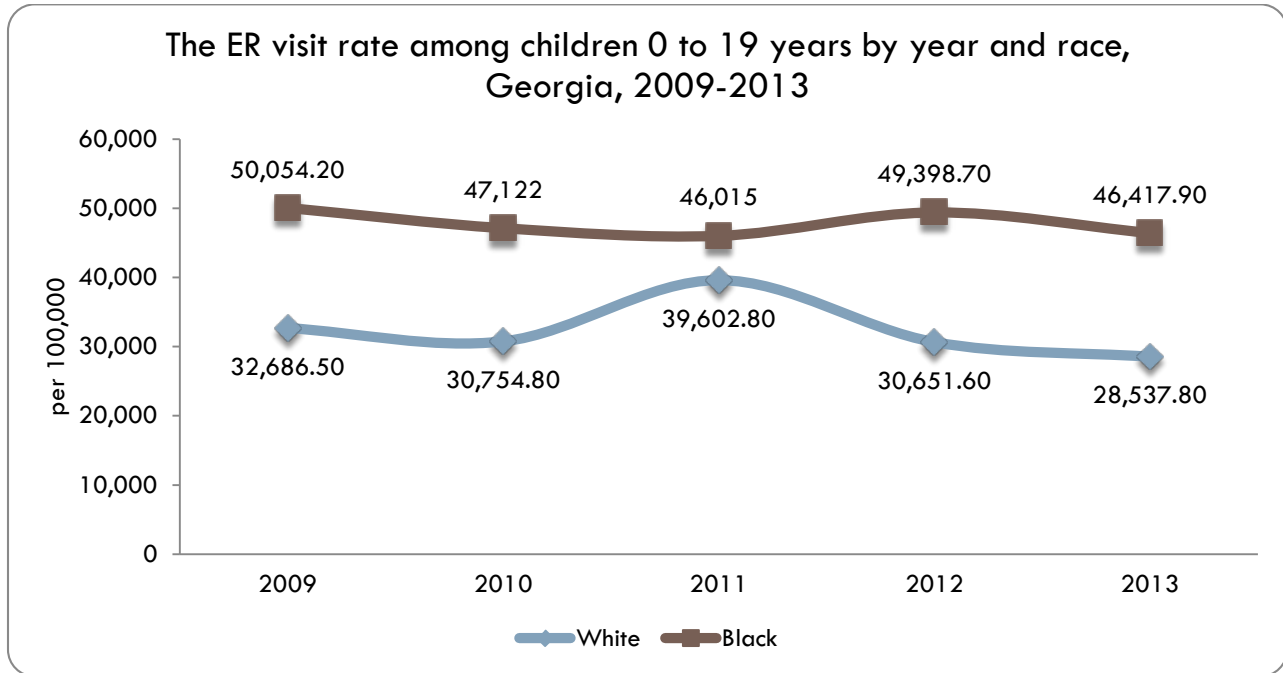
EMERGENCY ROOM VISITS AND HOSPITALIZATIONS

The number one cause of emergency room (ER) visits among children birth to 19 years of age in 2013 was injury, with the second leading cause being respiratory related. This is important to note later on as we analyze the state and national asthma data.

Leading causes of ER visits (rate per 100,000) among children 0 to 19 years, Georgia, 2013				
Rank	0 to 4 Years	5 to 9 years	10 to 14 Years	15 to 19 Years
1	Injury (167,523)	Injury (148,583)	Injury (182,560)	Injury (177,257)
2	Falls (129,327)	Falls (88,416)	Falls (81,619)	Genitourinary System (105,131)
3	Asthma (49,333)	Asthma (46,808)	Musculoskeletal System and Connective Tissue (33,929)	Pregnancy Related (73,312)
4	Pneumonia (47,576)	Genitourinary System (23,301)	Asthma (28,261)	Motor Vehicle Crashes (58,422)
5	Genitourinary (28,637)	Musculoskeletal System and Connective Tissue (18,743)	Motor Vehicle Accident (22,047)	Musculoskeletal System and Connective Tissue (55,606)
6	Influenza (25,327)	Influenza (18,184)	Genitourinary System Diseases (20,557)	Falls (51,501)
7	Conditions from Perinatal Period (20,906)	Motor Vehicle Crashes (15,747)	Mental and Behavioral Disorders (18,184)	Mental and Behavioral Disorders (41,392)
8	COPD excluding Asthma (19,395)	Pneumonia (14,066)	Diseases of the Nervous System (10,293)	Diseases of the Nervous System (21,268)
9	Musculoskeletal System and Connective Tissue (15,454)	COPD excluding Asthma (9,016)	Influenza (10,003)	Homicide (Assault) (20,511)
10	Poisoning and Exposure to Noxious Substances (13,700)	Diseases of the Nervous System (6,344)	Homicide (Assault) (7,476)	Asthma (17,908)

Source: OASIS oasis.state.ga.us

Overall, there has been a decrease of ER discharges from 2009 to 2013. Additionally, there is a significant racial disparity with respect to ER visits, with Black children visiting the ER 1.7 times more than White children.



Source: OASIS oasis.state.ga.us

The top causes for inpatient hospitalization among children ages 0 to 19 are listed. The rate of hospitalization is lowest among the 5 to 9 age category and highest among adolescents 15 to 19 years.

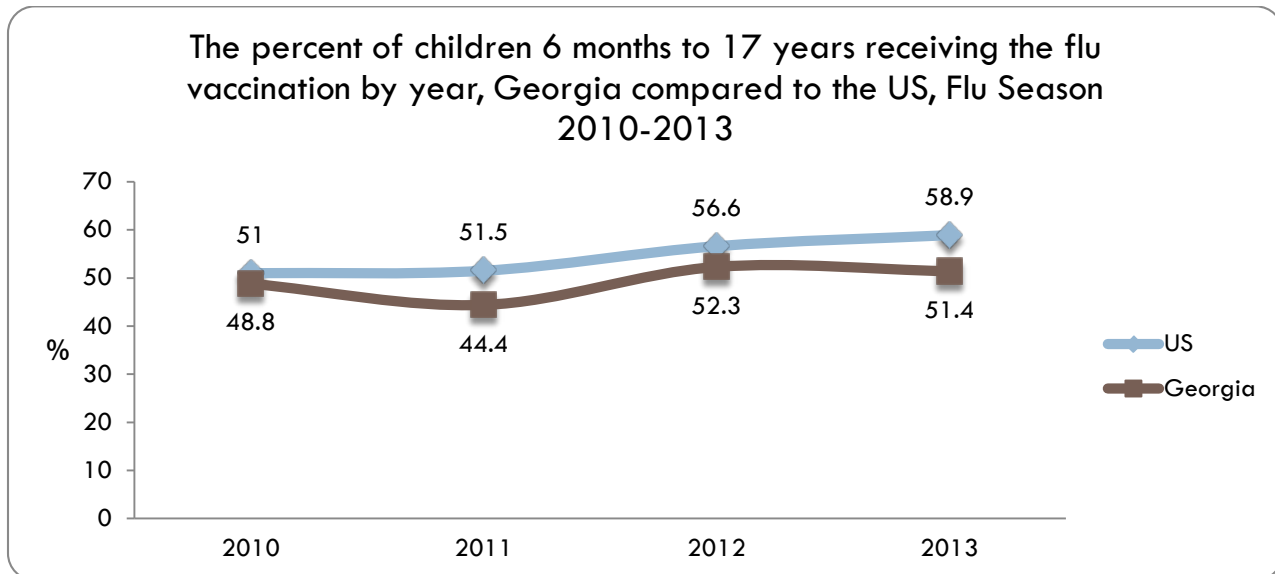
The leading causes of inpatient hospitalization (rate per 100,000) among children 0 to 19 years, Georgia, 2013				
Rank	0 to 4 Years	5 to 9 years	10 to 14 Years	15 to 19 years
1	Prenatal Conditions (13,954)	Asthma (5,398)	Mental / Behavioral Disorders (14,043)	Pregnancy Related (69,374)
2	Pneumonia (12,036)	Pneumonia (3,376)	Asthma (2,228)	Mental / Behavioral Disorders (25,391)
3	Congenital Malformations (9,654)	Nervous System (2,134)	Nervous System (2,195)	Anemia (3,464)
4	Asthma (7,054)	Mental / Behavioral Disorders (2,081)	Diabetes Mellitus (2,183)	Motor Vehicle Crashes (3,131)
5	Endocrine, Nutrition & Metabolic Diseases (5,351)	Anemia (1,844)	Anemia (2,076)	Diabetes Mellitus (2,982)
6	Nervous System (3,716)	Endocrine, Nutrition & Metabolic Diseases (1,754)	Musculoskeletal System (2,016)	Nervous System (2,442)
7	Genitourinary System (2,293)	Injury (1,152)	Pneumonia (1,425)	Musculoskeletal System and Connective Tissue (2,135)
8	Anemia (2,160)	Congenital Malformations (972)	Endocrine, Nutritional and Metabolic Disease (1,200)	Genitourinary System (1,869)
9	Injury (1,920)	Diabetes Mellitus (961)	Injury (1,152)	Endocrine, Nutritional and Metabolic Diseases (1,643)
10	Influenza (1,335)	Musculoskeletal System and Connective Tissue (849)	Pregnancy Related (981)	Suicide (1,633)

Source: OASIS oasis.state.ga.us

VACCINATIONS

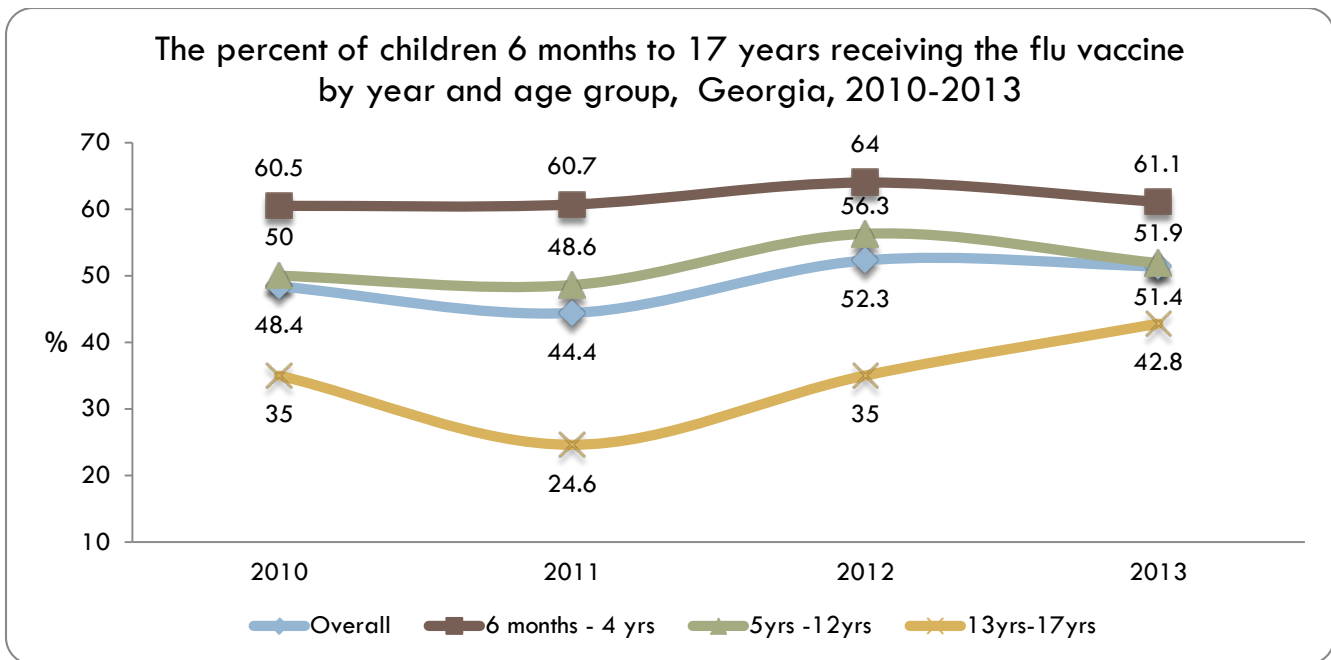
Influenza Vaccine

The overall percent of children receiving the flu vaccination nationally has been increasing over the course of 2010-2013. However, this trend is not the same for Georgia. In Georgia, the rate of childhood flu vaccinations varies with each season, with no clear trend. The highest rate achieved over this four season period was seen during the 2012 season, when over 52% of Georgia’s children received the vaccination. Most interestingly, the closest Georgia has been to the national average was in 2010, since then the gap has widened, with the national average climbing to 59% for flu season 2013.



Source: <http://www.cdc.gov/flu/fluview/reports/report1314/trends/index.htm>, 2010-2011 through 2013-2014 Season Trend Report

Influenza is considered most dangerous for the very young and the old, often leading to hospitalization and sometimes death among these populations. Both nationally and in Georgia, the highest percent of children to receive the flu vaccination were children in the youngest age range, 6 months to 4 years old, even though Georgia’s 2013 percentage (61%) continued to lag behind the national percentage (70%). Not surprisingly, the age group with the lowest percentage of flu vaccinations during each time point, for both the nation and Georgia were teenagers, aged 13-17 at 46.4% and 42.8%, respectively.



Source: <http://www.cdc.gov/flu/fluview/reports/reporti1314/trends/index.htm>, 2010-2011 through 2013-2014 Season Trend Report

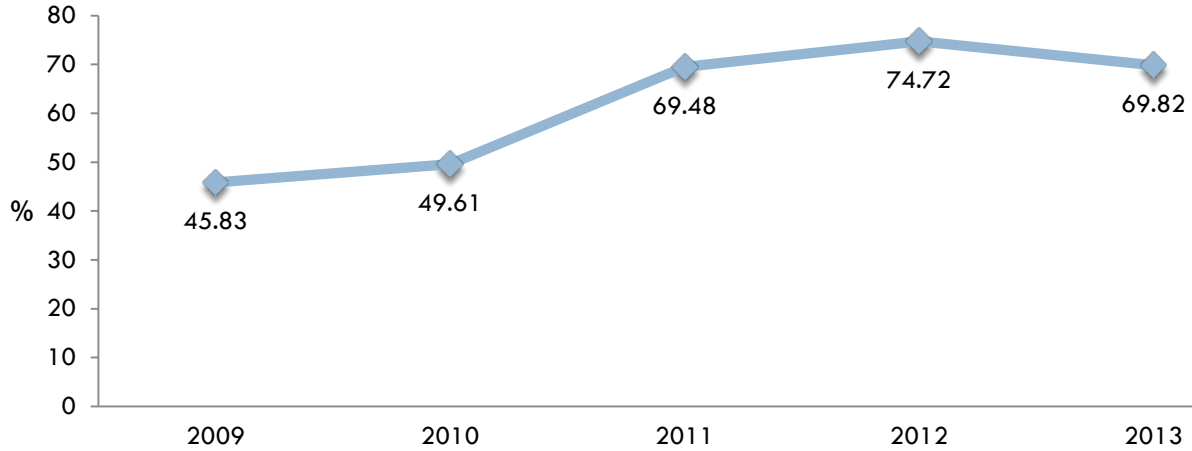
4:3:1:3(4):3:1:4 Series

Healthy People 2020 Goal

IID-8: Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine to 80%

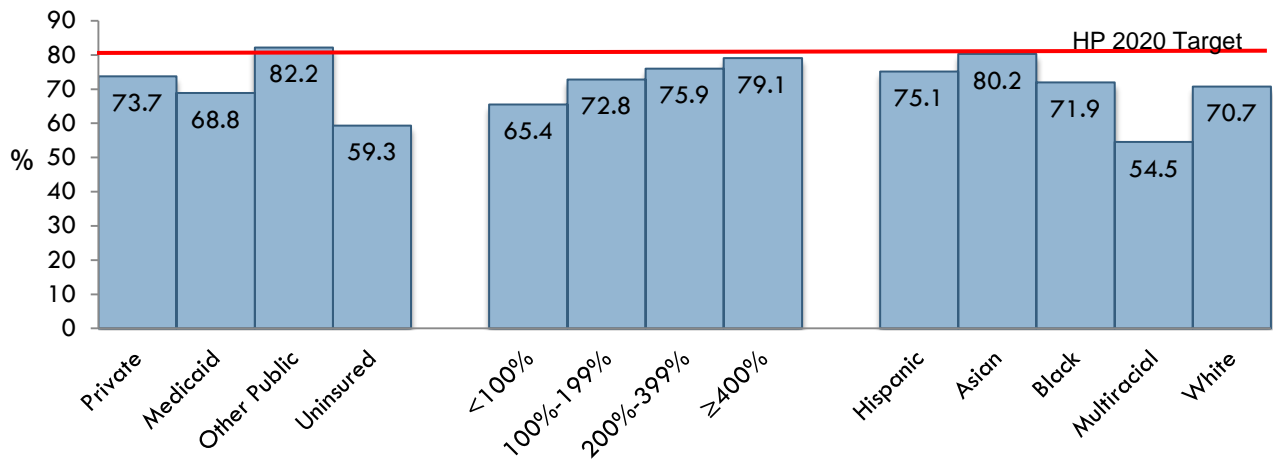
The percent of children 19 to 35 months up to date on recommended vaccines in Georgia in 2013 was 69.82%. Although the percent increased from 45.83% in 2009, the highest percentage of children vaccinated in Georgia was during 2012, with 74.72% of children being up-to-date with their vaccinations. As such, Georgia has not yet met the HP 2020 target for the percent of children vaccinated with the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV. Children who are uninsured are least likely to receive the vaccines, as well children who are below the federal poverty level and Multiracial children.

The percent of children ages 19 to 35 months who have received the 4:3:1:3(4):3:1:4 series of vaccines by year, Georgia, 2009-2013



Source: NIS 2009-2013

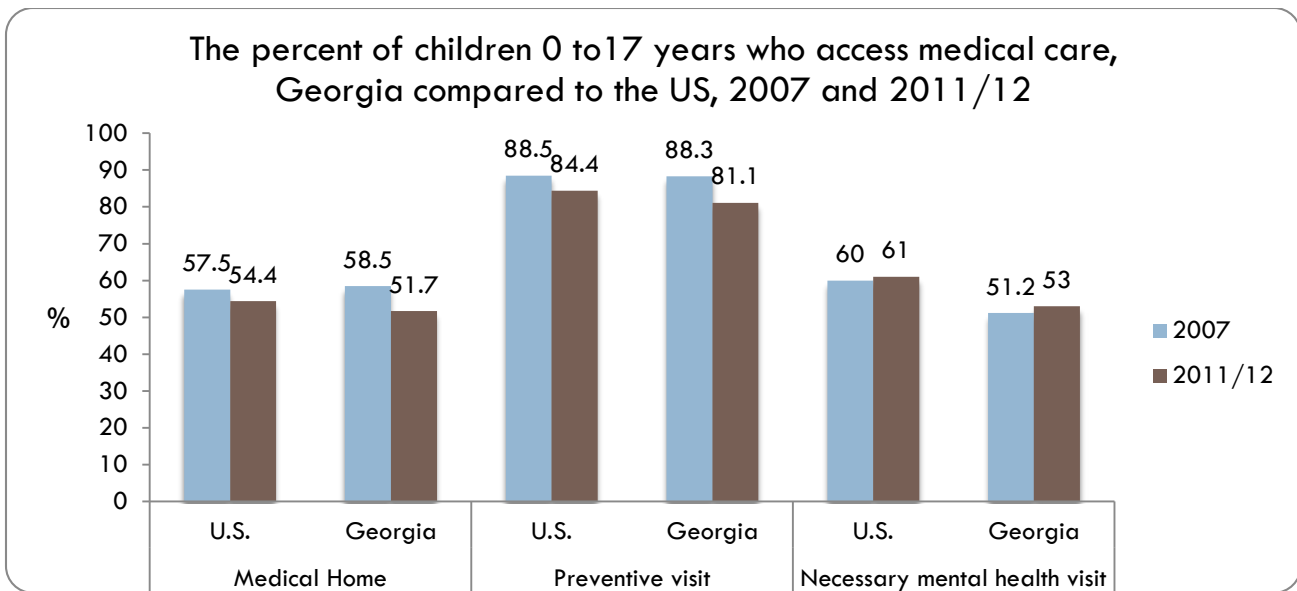
The percent of children ages 19 to 35 months who have received the 4:3:1:3(4):3:1:4 series of vaccines by insurance type, income and race/ethnicity, Georgia, 2013



Source: NIS 2009-2013

ACCESS TO MEDICAL CARE

The percent of children birth to 17 years who had a medical home or attended preventive health visits declined from 2007 to 2011/12 in Georgia. In 2007, 58.5% of children had a medical home while only 51.7% in 2011/12. Similarly, 88.3% of children had a preventive health visit in 2007 while only 81.1% in 2012. The percent of children who had a medical home or preventive health visit declined nationally, as well. Interestingly, the percent of children birth to 17 years who had a necessary mental health visit is on the rise both in Georgia and nationally.

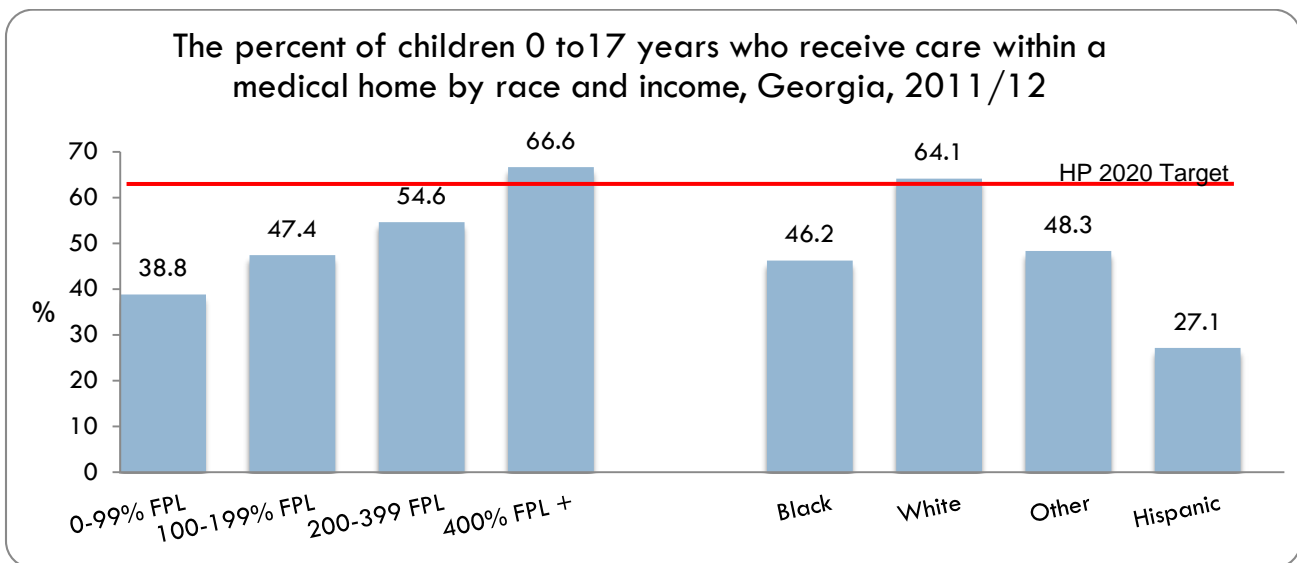


Source: NSCH 2007, 2011/12

Focusing specifically on the most recently available data for Georgia’s children, we assessed if disparities existed by income and race/ethnicity among the percent of children receiving care within a medical home. The lower the family income, the less likely it was that the child received medical care within a medical home. Hispanics and Blacks were least likely to receive care in a medical home when compared to Whites and children of “Other” races. In 2011/12, Georgia was 23% below the HP 2020 target.

Healthy People 2020 Goal

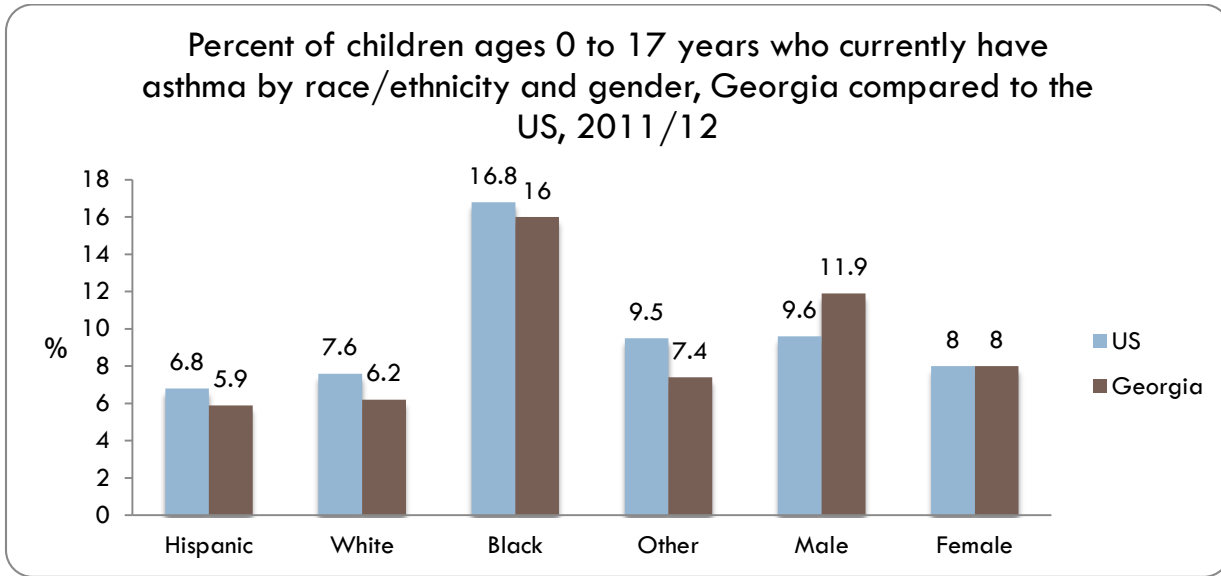
MICH 30.1: Increase the proportion of children who have access to a medical home to 63.3%



Source: NSCH 2011/12

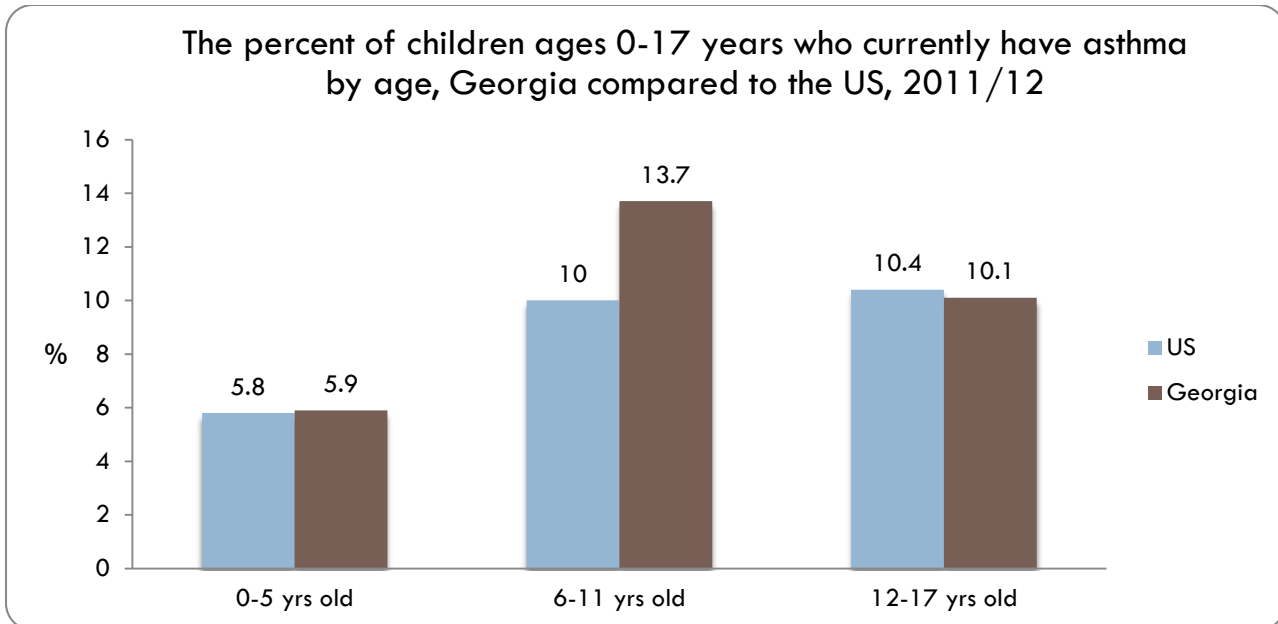
ASTHMA

Asthma prevalence in Georgia compared to the US is unremarkable, while there are some significant racial disparities in both national and state data, compared to other races. For example, Black children are 60% more likely to have asthma in Georgia, compared to their White peers.



Source: NSCH 2011/12

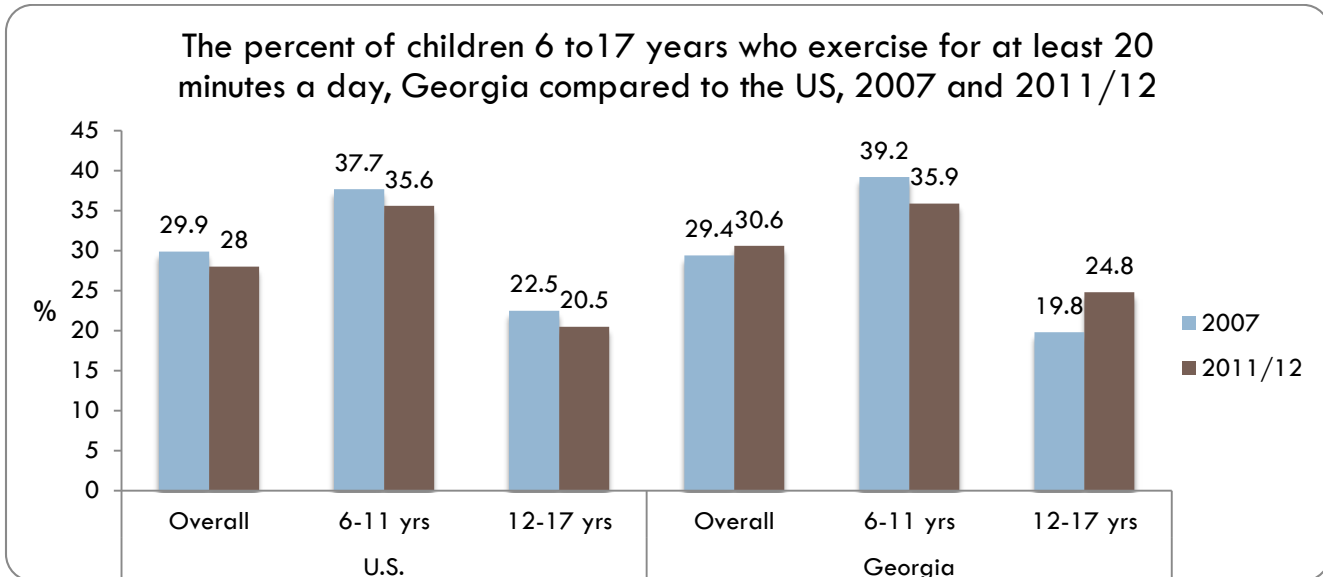
When stratified by age, one can see that the age group with the largest percentage of children who currently have asthma is 6-11 years old, with 13.7% of children ages 6-11 in Georgia and 10% of children ages 6-11 years nationally have asthma. Furthermore, children in this age group are 27% more likely to have asthma in Georgia, than compared to their peers nationally.



Source: NSCH 2011/12

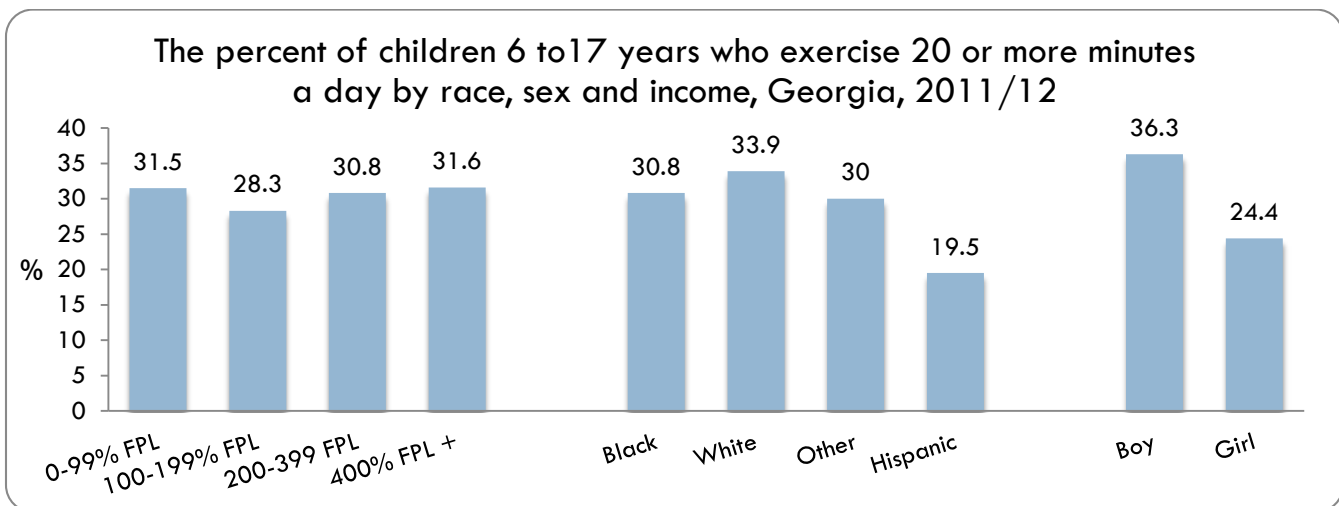
PHYSICAL ACTIVITY AND OBESITY

Nationally, the percent of children aged 6 to 17 years who exercise for at least 20 minutes a day has decreased from 2007 to 2011. However in Georgia, the overall percent has increased over time. During both 2007 and 2011/12, children aged 6 to 11 were the most likely to exercise for 20 minutes or more each day, both nationally and in Georgia. However, the 2011/12 rate for children in Georgia aged 6 to 11 decreased and became very similar to the overall national rate for this age group.



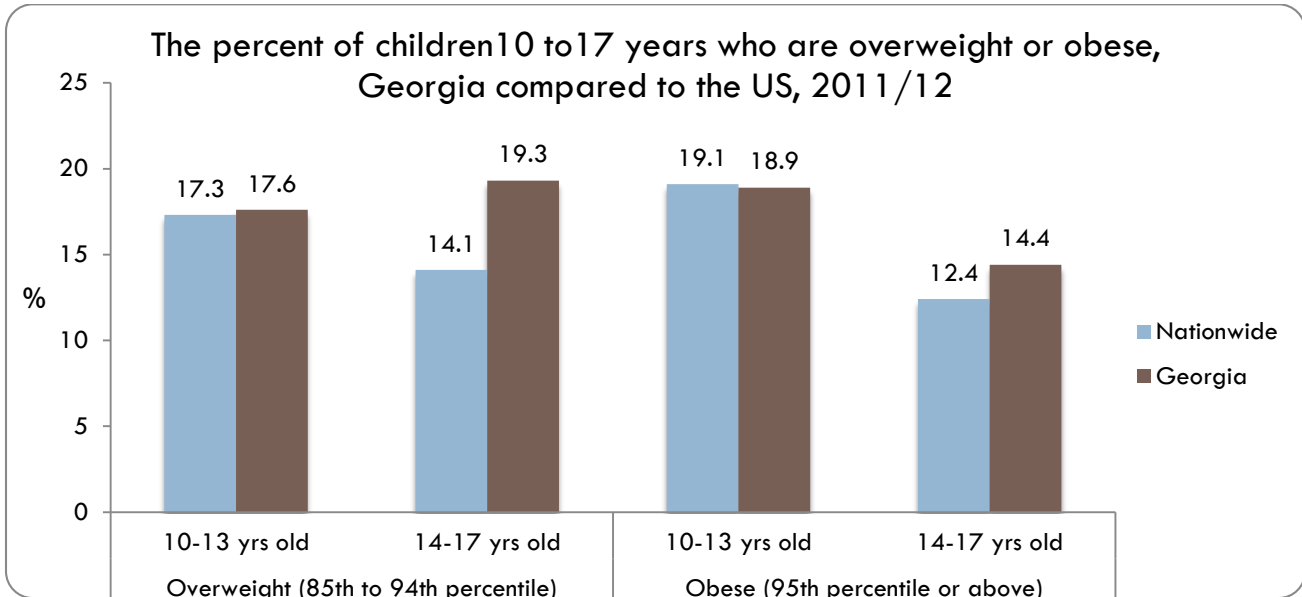
Source: NSCH 2007, 2011/12

When stratified across race/ethnicity, gender and income, it is clear that disparities present. While Georgia averaged 30.6% of all kids exercising for at least 20 minutes daily, only 19.5% of Hispanic children exercised 20 or more minutes a day. White children (33.9%) and Black children (30.8%) met the Georgia average in 2011/12. Children in all income brackets reported spending 20 minutes or more a day exercising at similar levels, with the exception of those within 100-199% of FPL who reported being less likely to exercise 20 minutes daily.

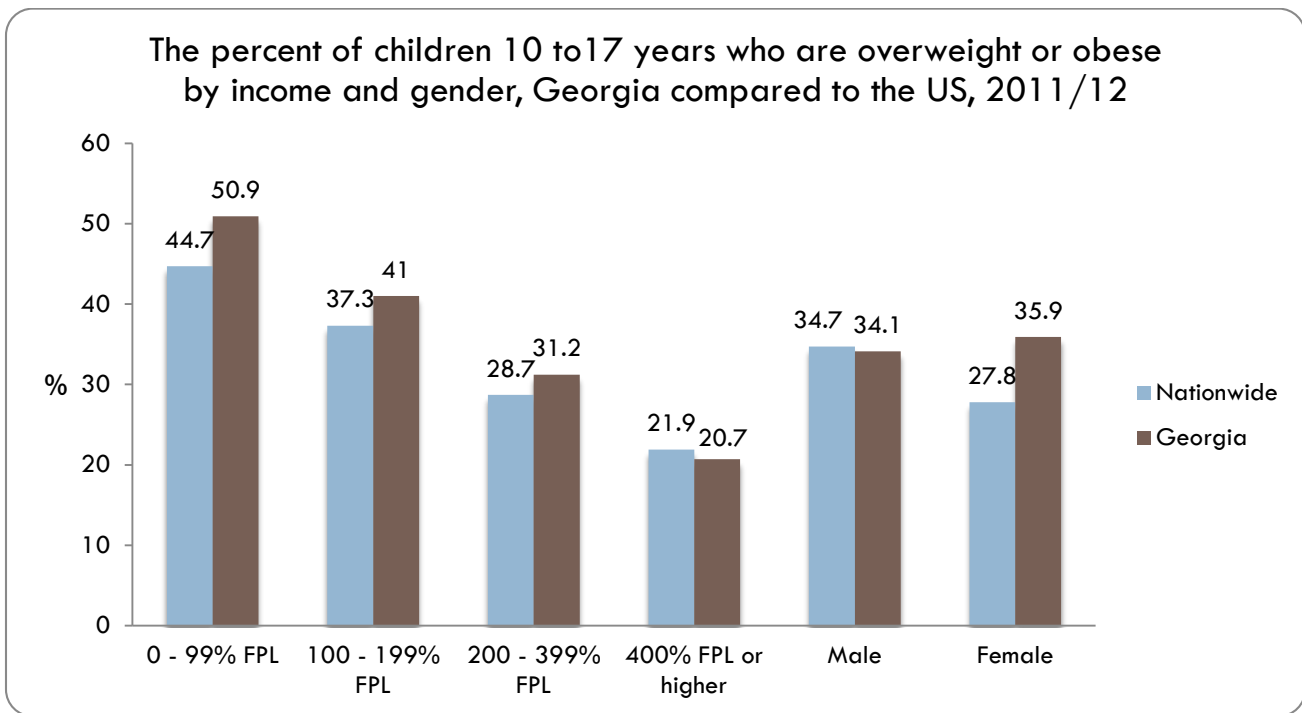


Source: NSCH 2011/12

Looking at the obesity and overweight data, we can see that the percent of overweight and obese children is slightly more in Georgia than the US, with the 26% more of children in Georgia being overweight than their peers in the US. Additionally, there are some interesting disparities with respect to income status, with the largest percentage of overweight and obese children in the lowest income brackets, both nationally and in Georgia. Furthermore, children in the lowest income bracket in Georgia were 12% more likely to be overweight or obese than their peers nationally. Likewise, females in Georgia were 22% more likely to be overweight or obese than their counterparts nationally.



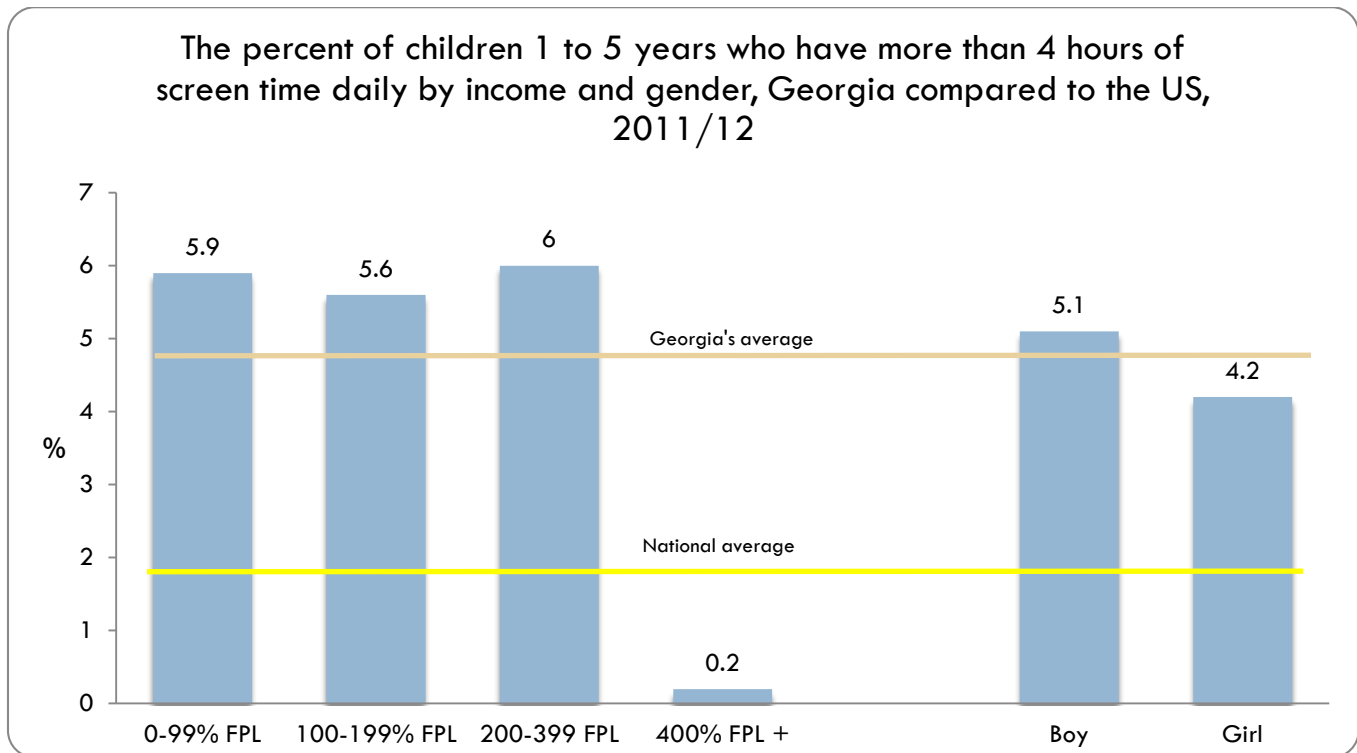
Source: NSCH 2011/12



Source: NSCH 2011/12

SCREEN TIME

In Georgia, the percent of children aged 1 to 5 who use computers, cell phones, handheld video games and other electronic devices four or more hours daily is 4.7%, approximately 2.5 times higher than the national average. Surprisingly, the gender disparity in screen time can be seen at such an early age, with boys more likely to spend four or more hours in screen time daily. When stratified by income levels, Georgia looks markedly different than the country as a whole. Nationally, as income increases, the likelihood of 4 hours or more of screen time decreases. In Georgia, the likelihood of 4 hours or more of screen time remains about the same until we get to an income of 400% above the FPL and greater. At that point the percentage drops from 6%, about 3 times greater than the national average, to 0.2%, nearly 10 times lower than the national average.



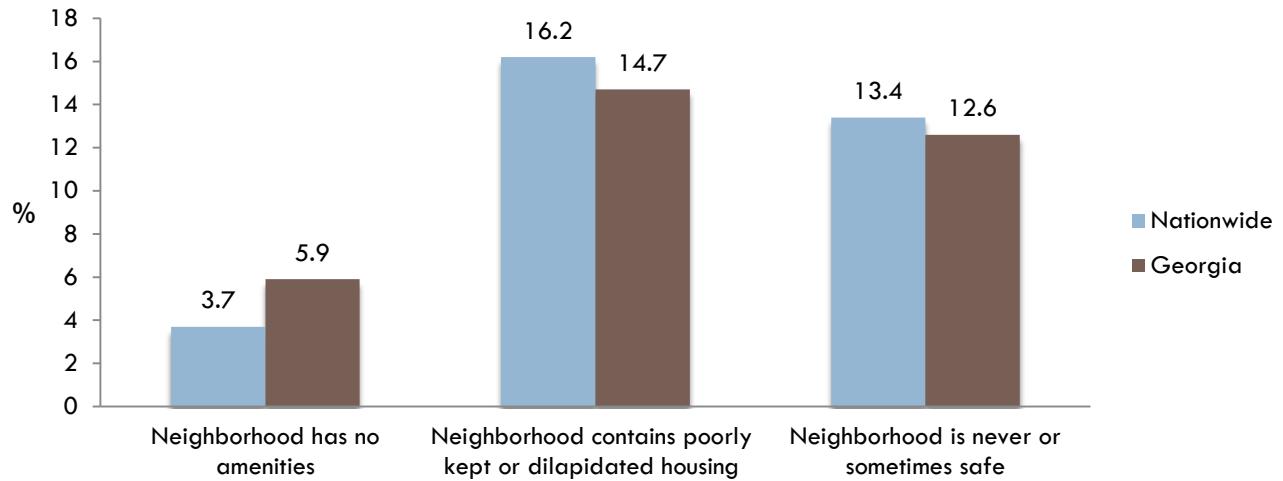
Source: NSCH 2011/12

NEIGHBORHOOD AND BUILT ENVIRONMENT

Much research, policy and programming recognizes that built environment (where we live, work, and play) can impact a community's physical activity levels and access to fresh fruits and vegetables. As such, the graph below looks at three indicators of a neighborhood: amenities (such as parks, libraries, recreation centers and sidewalks), dilapidated housing, and safety.

Children in Georgia are 37% more likely to live in neighborhoods void of any amenities, compared to their peers nationwide. Moreover, 14.7% of children live in neighborhoods with poorly kept or dilapidated housing and 12.6% of children live in neighborhoods that are considered never or only sometimes safe. This is an area of concern and can have many implications for the community's ability to be physically active and meet the Healthy People's objectives.

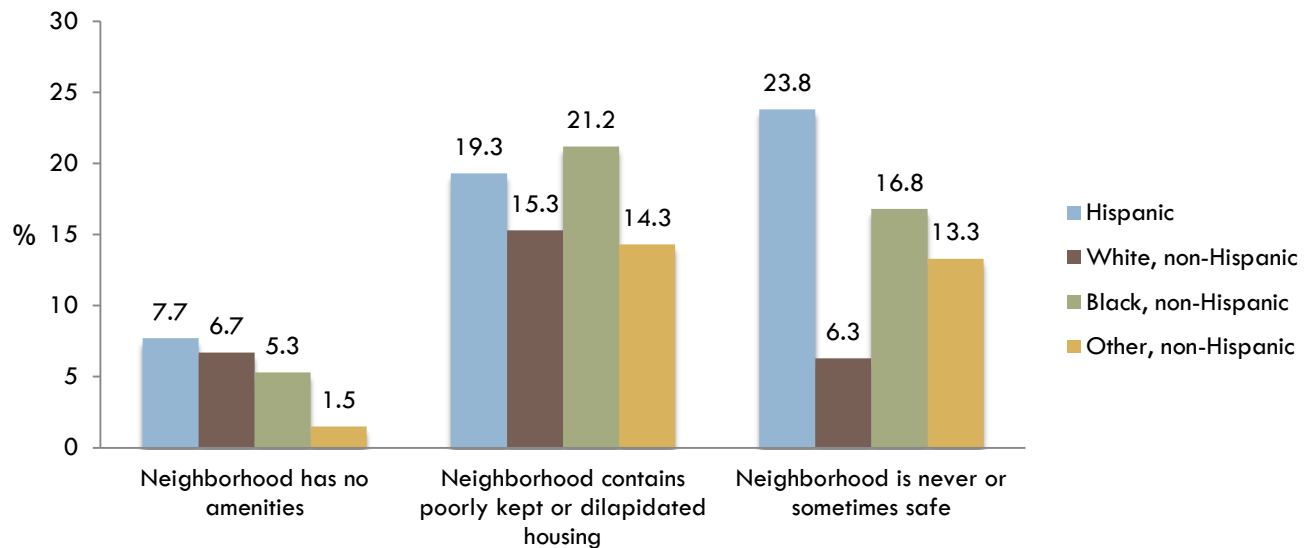
The percent of children living in neighborhoods with no amenities, dilapidated housing, or no safety, Georgia compared to the US, 2011/12



Source: NSCH 2011/12

Racial disparities are present for all three factors, particularly in neighborhood safety. It is evident that Hispanic children in Georgia are most likely to live in neighborhoods with no amenities, dilapidated housing and poor safety. Other non-Hispanic and White non-Hispanic children are least likely to live in poor built environments.

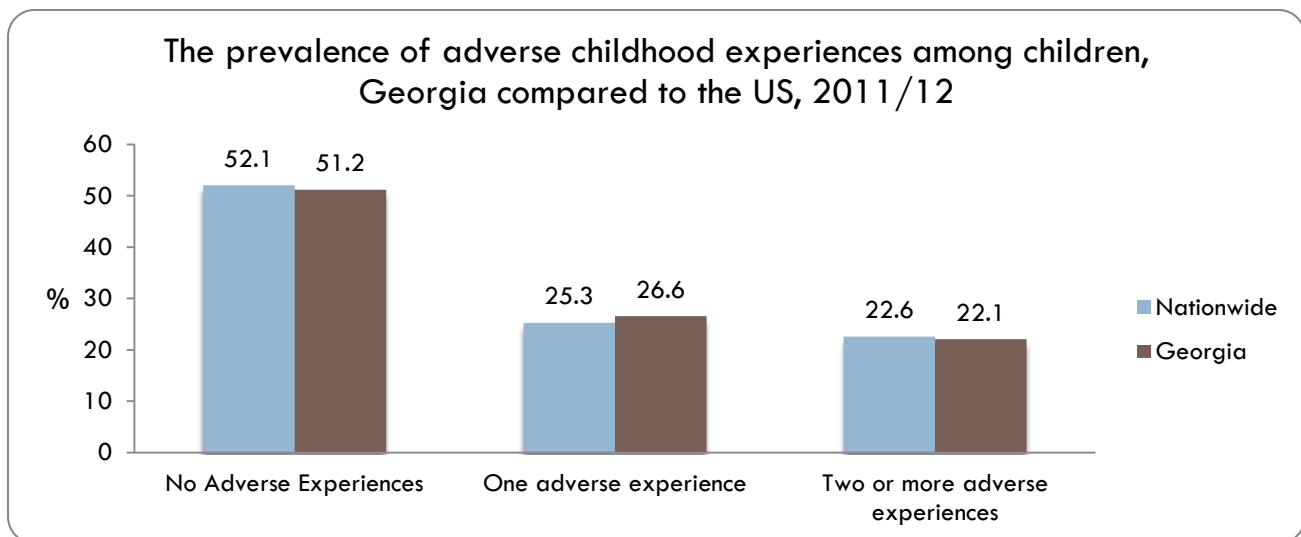
The percent of children living in neighborhoods with no amenities, dilapidated housing or no safety by race/ethnicity, Georgia, 2011/12



Source: NSCH 2011/12

ADVERSE CHILDHOOD EXPERIENCES

The number of adverse childhood experiences (ACE) can have a direct impact on an individual's emotional and physical health outcomes. An adverse childhood experience includes: abuse, neglect, household domestic violence, household substance abuse, parent separation or divorce or incarceration of a household member. As is evident in the graph below, there is no notable difference between the percent of children in Georgia experiencing adverse health outcomes compared to those nationally. Slightly more than half of children experience no adverse childhood experiences, while a quarter experience one adverse childhood experience and about 22.1% experience two or more adverse childhood experiences, in both Georgia, and nationally.

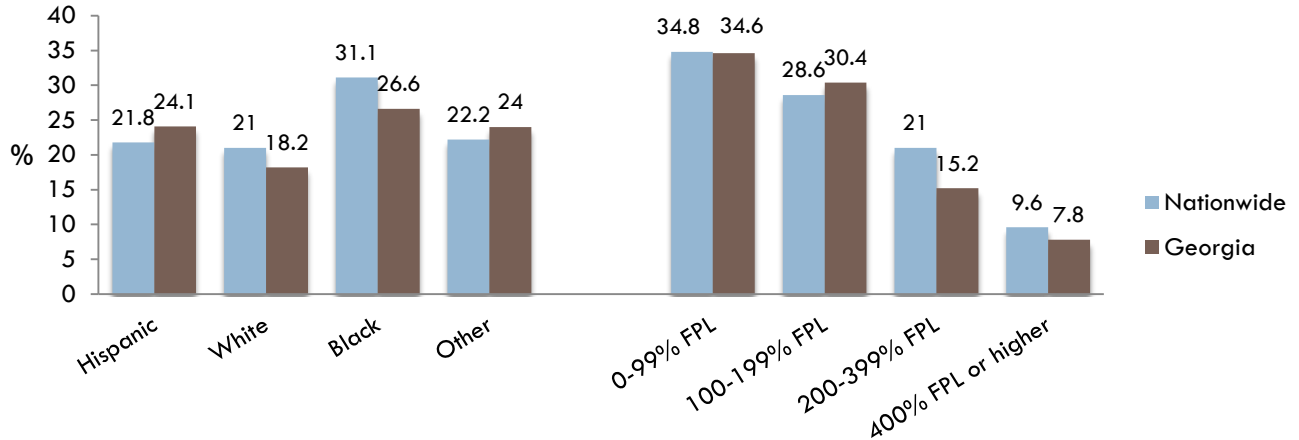


Source: NSCH 2011/12

When stratified by race/ethnicity and income, notable disparities are evident. White children in Georgia were less likely to report two or more adverse childhood experiences compared to any other race or ethnicity in 2011/12. Specifically, White children reported a prevalence of 18.2% for two or more ACEs compared to their peers of all other races and ethnicities that ranged from 24% to 26%.

The prevalence of two or more adverse childhood experiences decreased as income increased, both in Georgia as well nationally. Nearly 35% of children living in households with incomes of 0 to 99% FPL reported two or more adverse childhood experiences compared to under 10% of children of 400% FPL or higher, in both Georgia and nationally.

The prevalence of two or more adverse childhood experiences by race/ethnicity and income, Georgia, 2011/12

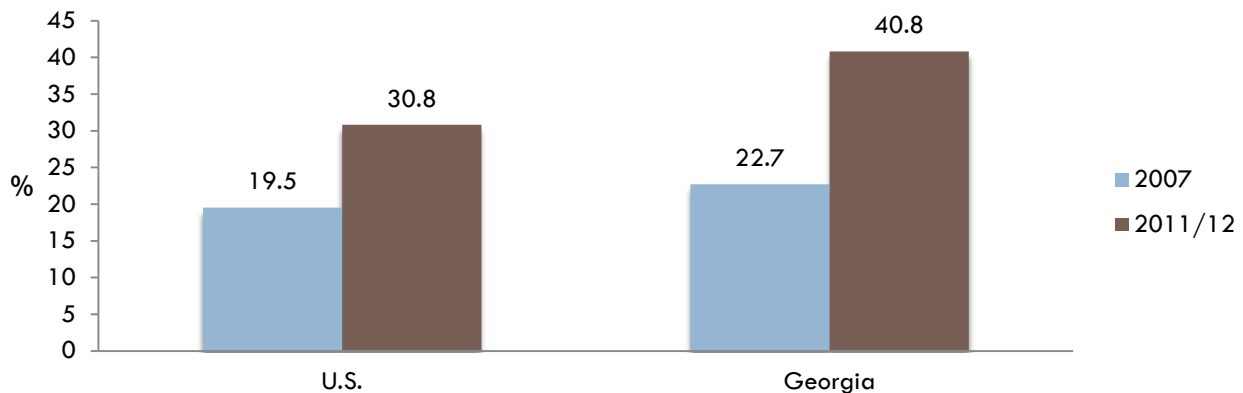


Source: NSCH 2011/12

DEVELOPMENTAL SCREENING

The percent of children 10 months to 5 years screened for developmental, behavioral, and social delays in Georgia is greater both in 2007 and 2011/12 compared to those screened nationally. Nationally in 2011/12, 30.8% of children were screened for developmental, behavioral and social delays while 40.8% of children were screened in Georgia in 2011/12. This is an increase of 79% increase in just five years. As such, Georgia is exceeding the national standards for screening children for developmental, behavioral and social delays.

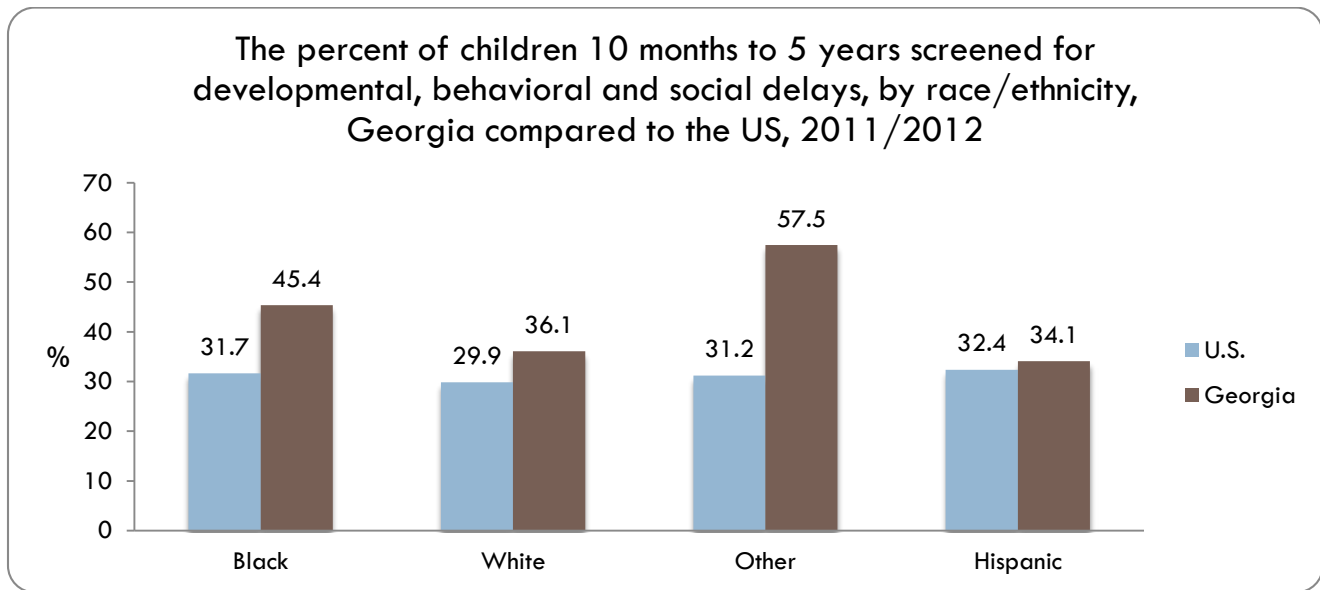
The percent of children 10 months to 5 years screened for developmental, behavioral and social delays, Georgia compared to the US, 2007 and 2011/2012



Source: NSCH 2007, 2011/12

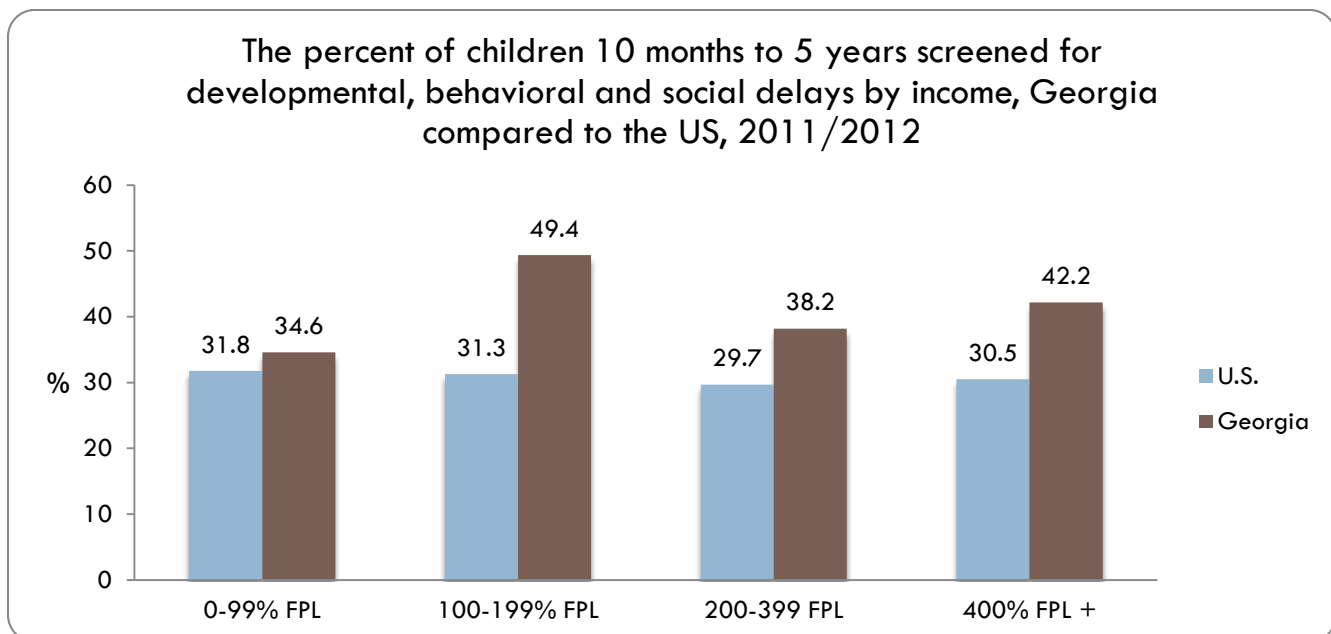
When stratified by race, there is some evidence of disparities in the percent of children screened for delays. As such, children of Hispanic ethnicity are the least likely to be screened for

developmental delays in both Georgia as well as nationally, while nearly 60% of children of “Other” race and 45.4% of Black children were screened for developmental delays in 2011/12.



Source: NSCH 2011/12

Income disparities exist when examining which children in Georgia are likely to be screened for developmental disabilities. Most likely to be screened are children living in families that are within 100 – 199% of the federal poverty level (FPL), the next highest group are children in the highest income families, those making 400% or more of the FPL. Most interesting is that there is no income disparity seen at the national level.

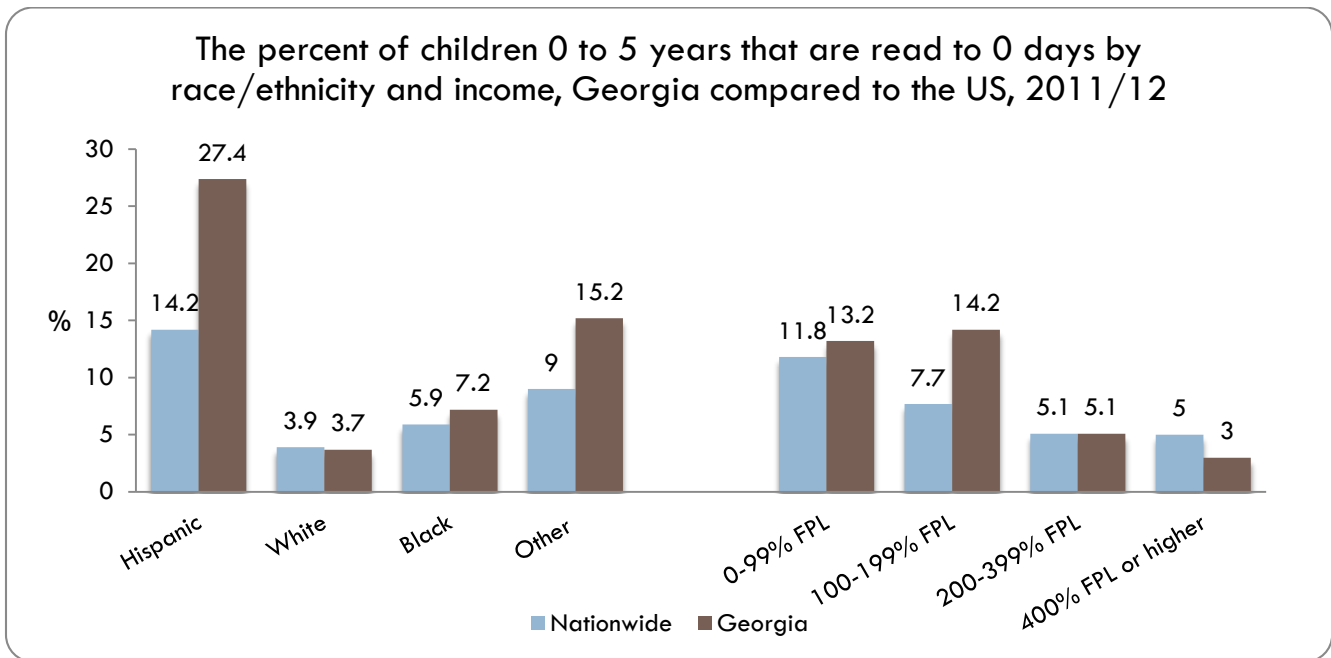


Source: NSCH 2011/12

SCHOOL READINESS

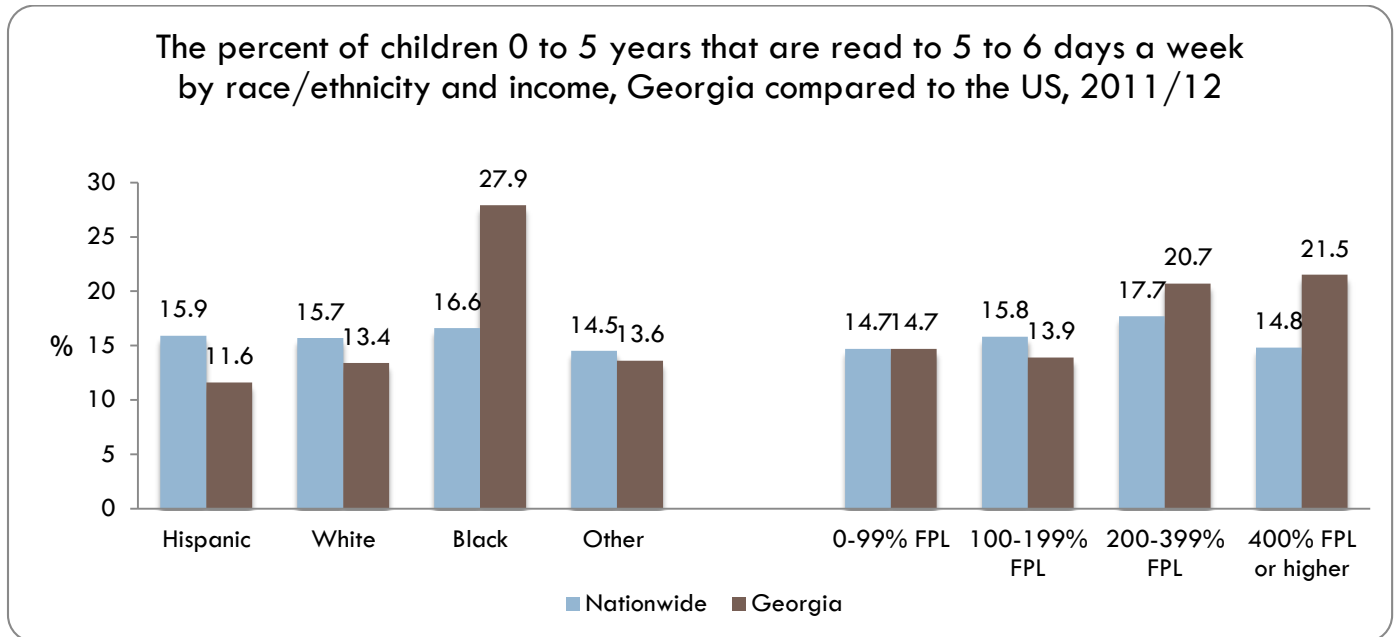
School readiness and proficiency is an important indicator for the well-being of children. Head Start defines school readiness as children possessing the skills, knowledge, and attitudes necessary for success in school and for later learning and life. This means that children are ready for school, families are ready to support their children’s learning, and schools are ready for children. As such, children who are unprepared for school often perform poorly in school, have low self-esteem, and are at higher risk to drop out of school, suffer unemployment, poverty and crime. School readiness often examines the social, physical and emotional environment around children in early childhood, to assess whether they are getting adequate exposure for proper language and cognitive development, literacy and math skills, and social skills. As such, Healthy People 2020 objectives explain that “there is increasing recognition in policy, research and clinical practice communities that early and middle childhood provide the physical, cognitive, and social-emotional foundation for lifelong health learning and well-being.” For a full qualitative report on school readiness, please refer to Section 2 of this report.

When evaluating national and Georgia specific data as it relates to school readiness, we looked at variables such as number of days children were read to, and fourth grade test scores. The percent of children birth to 5 years old that were read to for 0 days and 5 to 6 days in the past week reveals interesting patterns. Below, the graph shows pronounced disparities by race/ethnicity and income in 2011/12. For example, Hispanic children in Georgia were 9 times more likely to have been read to 0 days a week compared to their White peers. Even compared to national data, Hispanic children in Georgia were 48% more likely not to be read to than their counterparts nationally. Additionally, disparities also exist by income. As such, the likelihood of children birth to 5 never being read to decreased as income increased.



Source: NSCH 2011/12

Examining the data for the percent of children 0 to 5 years old that were read to 5 to 6 days a week, we see a similar pattern with respect to income. Children in higher income categories were more likely to be read to 5 to 6 days a week than children from lower income categories in Georgia in 2011/12. The Hispanic children were the least likely to be read to 5 to 6 days a week at only 11.6% compared to Black children, who were the most likely to be read to 5 to 6 days a week at 27.9%. Nationally, little racial/ethnic disparities exist in children being read to five to six days a week.



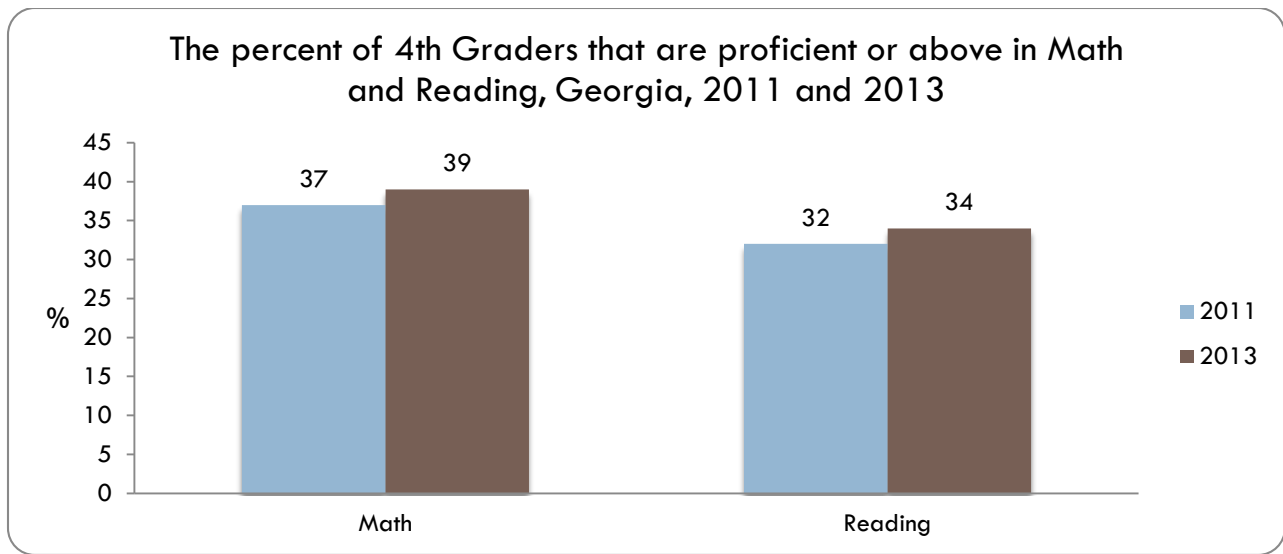
Source: NSCH 2011/12

Health People 2020 Goal

AH-5.3.1: Increase the proportion of 4th grade students whose reading skills are at or above proficient achievement level for their grade to 36.3%

AH-5.4.1: Increase the proportion of 4th grade students whose mathematics skills are at or above the proficient achievement level for their grade to 43%

Finally, we evaluated 4th grade proficiency in Math and Reading. While there has been a steady improvement in the percent of children proficient in Math and Reading in Georgia, the state still did not achieve the HP 2020 target in 2013. In 2013, 34% of 4th grade students were proficient in Reading while 39% of students were proficient in Math. As such, 4th grade students in Georgia are still 6-10% behind achieving the HP 2020 target in both Reading and Math, respectively.



Source: National Assessment of Educational Progress (NAEP) <http://nces.ed.gov/nationsreportcard/states/>

School Readiness

SECTION 2: QUALITATIVE ANALYSIS

INTRODUCTION

This section is a summary of the qualitative assessment conducted by DPH focused on school readiness. DPH conducted a series of focus groups and interviews throughout Georgia's 18 public health districts among members of the community. Domains of interest for the focus groups included: perinatal health, school readiness and children and youth with special health care needs (CYSHCN). To assess each of the aforementioned domains, DPH conducted qualitative data collection in each public health district (see Table 1). Individual interviews were used in DeKalb and East Metro among Hispanics. Focus groups were conducted in all other public health districts. Topics were assigned to ensure an equal representation of urban and rural districts for the assessment (see Table 1). Perinatal and CYSHCN focus groups were further categorized to ensure representation among participants according to their age and their child's age. Participants in the focus groups on school readiness were parents of children 4 to 7 years old.

TABLE 1: PUBLIC HEALTH DISTRICT BY DOMAIN

Perinatal	School Readiness	CYSHCN
≥30	Dalton	<8
Rome	Macon	Cobb Douglas
Fulton	LaGrange	Augusta
DeKalb	Valdosta	Columbus
<30	Waycross	≥8
Dublin		Gainesville
Albany		Clayton
Athens		Savannah
East Metro		

TABLE 2: PARTICIPANT DEMOGRAPHICS BY DISTRICT

	Dalton N=13 n (%)	Macon N=10 n(%)	LaGrange N=16 n(%)	Valdosta N=12 n(%)	Waycross N=11 n(%)
Age					
20-29	4 (31%)	2 (20%)	12 (75%)	5 (42%)	3 (27%)
30-39	8 (61%)	5 (50%)	4 (25%)	2 (17%)	4 (36%)
40-49	1 (8%)	2 (20%)	--	4 (33%)	1 (9%)
50-59+	--	1 (10%)	--	1 (8%)	3 (27%)
Highest level of education completed					
Less than High School					
High School/GED	1 (8%)	--	--	3 (25%)	--
Some College/Technical /Community College	6 (46%)	2 (20%)	7 (44%)	2 (17%)	4 (36%)
College graduate or more	4 (31%)	7 (70%)	4 (25%)	4 (33%)	2 (18%)
No response	1 (8%)	1 (10%)	5 (31%)	3 (25%)	4 (36%)
	1 (8%)	--	--	--	--
Race/Ethnicity					
Caucasian/White	3 (23%)	1 (10%)	2 (12%)	--	4 (36%)
African-American/Black	--	9 (90%)	13 (82%)	7 (58%)	7 (64%)
Latino/Hispanic	10 (77%)	--	1 (6%)	4 (33%)	--
Asian	--	--	--	--	--
Other	--	--	--	--	--
No response	--	--	--	1 (8%)	--
Health insurance status					
Private	5 (38%)	8 (80%)	4 (25%)	3 (25%)	3 (27%)
Public	7 (54%)	--	6 (37%)	5 (42%)	5 (45%)
(Medicaid/PeachCare/TriCare)	1 (8%)	2 (10%)	6 (37%)	4 (33%)	2 (18%)
None	--	--	--	--	1(9%)
No response	--	--	--	--	--
Number of children currently parenting					
1	3 (23%)	1 (10%)	4 (25%)	2 (17%)	3 (27%)
2	6 (46%)	3 (30%)	6 (37%)	4 (33%)	4 (36%)
3	1 (8%)	1 (10%)	5 (31%)	4 (33%)	2 (18%)
4	3 (23%)	2 (20%)	1 (6%)	--	1 (9%)
5	--	1 (10%)	--	1 (8%)	1 (9%)
6+	--	2 (20%)	--	1 (8%)	--
Pregnant					
Yes	1 (8%)	1 (10%)	--	1 (8%)	1 (9%)
No	12 (92%)	9 (90%)	16 (100%)	11 (92%)	10 (91%)
I don't know	--	--	--	--	--
Receiving WIC					
Yes	8 (61%)	2 (20%)	7 (44%)	6 (50%)	4 (36%)
No	5 (38%)	7 (70%)	9 (56%)	6 (50%)	7 (64%)
No response	--	1 (10%)	--	--	--

RESULTS: SCHOOL READINESS

Head Start defines school readiness as children possessing the skills, knowledge, and attitudes necessary for success in school and for later learning and life. This means that children are ready for school, families are ready to support their children's learning and schools are ready for children. For the purposes of the assessment, readiness was conceptualized in both a general sense and specifically related to children's health. Participants shared a variety of facilitators and barriers as it related to their child's readiness. The section will consist of these findings, beginning with parental perceptions of general school readiness for pre-K services; views related to specific programs offered in participants' respective districts will be presented later.

General School Readiness for Pre-K

Of the focus group participants with children enrolled in pre-K, an overwhelming majority were satisfied with these services. There was consensus among parents regarding the importance of these services in establishing a solid foundation for their child's academic progress in later years. Parents did however, express concern with access to these services, feeling children were being placed at a disadvantage due to a lack of capacity at local daycares. Parents mentioned overcrowding as one of the major barriers to accessibility for pre-K services, and found the existing lottery system that provided spots for children to be unfair. One parent stated, "Everybody deserves a chance to do the pre-K program." For parents with children enrolled in pre-K services, the majority were satisfied with the staff and preparation their children received prior to beginning kindergarten. One parent noted a pre-K program's existing familiarity with the school system and how this better ensured her child would be prepared for the transition to kindergarten—even noting the disparate outcomes between her older children that did not receive the services.

"Well, I got two boys, and my oldest one, like you, I had him in a different daycare, and the lady, she was familiar with the school system. So when he went there he had no problems. He went straight in. Everything I had no - I mean, he was on time. I didn't have nothin'. But when my youngest child, [I] had him a different daycare, and I, I guess they weren't familiar with what they needed to learn. So like her, he had problems when he started school, and um, the transition was, um, from that daycare to the school was um, challenging for him 'cause he was used to that being a play place. And the other daycare, the older son, she gave him time, taught him how to sit down, taught him ABCs, taught him colors, and you know, gave him structure where they know this is the time to be disciplined, this is the time to play. But the youngest one, all they did basically was play. So when he went to school, he would think "Ok, this is another play place."

Parental Involvement

Focus group participants believed that teaching begins in the home. Parents spoke in detail about measures taken to ensure their child's readiness for school, including engagement through “word walls”, flash cards, and “homemade” activities. Some participants spoke of the use of technology as a tool for instruction, particularly given children's growing affinity for technology in general. Reading was also identified as an integral part of building a child's confidence. An overarching theme among participants was the need to reinforce information the child learned in class. Parents felt this reinforcement was their responsibility—one parent describing it as a “double dose” of instruction. Parents were very aware of the challenges that teachers and school experienced, and saw their involvement as an important factor for their children to thrive. Parents also noted the expectations in kindergarten have changed, and that children are now expected to advanced competencies.

“Because at school there's going to be twenty kids and it's hard to reach every child if you're not working with them at home. So if you're working with them at home and at school they're working with them too it's a double dose. [Because] kindergarten isn't kindergarten anymore, it's first grade. So if your baby cannot read in kindergarten, they're not going to first grade. They have to be able to read and write three sentences with a picture. So it's tough kindergarten. It's not kindergarten anymore. It's not play-based.”

Latino parents expressed concern with the cultural competence of teachers, highlighting a prevalent assumption that teachers “automatically” make when learning that English is not the primarily language spoken in the child's home. Given this assumption, many participants felt the need to work diligently in the home with their child, not only ensure his or her success, but to also curtail any potential challenges associated with their child's progression in, and transition through, milestones in school.

“...whenever the kids go into school they expect, they always ask you if English or Spanish is our first language, and if it isn't, if one of the parents doesn't speak English, then they sort of put them to the side and they treat them differently...automatically. They assume that my daughter was going to struggle.”

Parents in the needs assessment felt socialization was very important skill for their children to learn at an early age. They mentioned being intentional in placing their children in settings with children of the same age, as well as with older children and adults. Parents offered a few examples of

ways in which their children have engaged with others, including interactions with older children in the home, involvement in children's church, or engagement with other children as part of their broader community.

Communication Between Schools and Parents

Participants felt communication to be an important factor in ensuring proper placement of their children in the classroom, particularly given many felt their children were being misdiagnosed with behavioral issues and subsequently being placed in classrooms that were not conducive for their learning needs. Participants felt there was a disconnect between parents and classroom teachers, ranging from placement of their children in appropriate classrooms to more frequent exchanges of communication regarding homework and classroom assignments. While parents understood the importance of placement tests, and assessments like individualized education programs (IEPs), many felt the results of these tests were futile and lead to their child being placed in a classroom with students that were not at the same academic level. Parents also expressed frustration with attempts to communicate with teachers about classroom and homework assignments, feeling they were sometimes overworked or inaccessible.

These lapses in communication were seen as major gap in children's transition to kindergarten, as well as their success while enrolled in kindergarten. This was a heightened concern for the parents of special needs children who felt their children were lost in the system, often times placed in classrooms that were not designed to meet their learning needs. As a result, children were disengaged during class, chose to isolate themselves, and sometimes left the classroom altogether. While school personnel may have identified these challenges as behavioral issues, many parents felt these behaviors were a result of children lost in a system that could not accommodate their learning needs.

"[She's] in the classroom with whatever child and what they working on, she got to work on. How are you going to put that on there when she don't know how to do nothing? She's just a body in a classroom just sitting there."

Of parents that were able to communicate with their children's teachers, whether in pre-K or kindergarten, the results of clear, ongoing communication was seen as mutually beneficial for parents and teachers.

Nutrition

Nutrition was identified as a challenge, as an awareness issue for parents, and as an accessibility issue for the community-at-large. Focus group participants noted the intersection of these challenges and the need for solutions to be offered in a different context—using a “big picture” approach. A lack of nutritional offerings in the community limited the extent to which parents could access nutritional options for their children. Fast food restaurants, although convenient and often offering low-cost items, were identified as a barrier for healthy food options for children. Further, parents were concerned about the quality and price of food offered in their local grocery stores—some of which neared expiration within days of purchase. The importance of education about nutrition given these challenges was a prevalent theme across focus groups.

“Being that we have this generation that’s more prone to diabetes and obesity, I think it’s a big deal to really prepare parents and provide information on ok, “What is healthy eating?” Do parents have access to nutritious fruit, foods, everything like that? Because that really does affect learning and readiness... having access to good food and healthy food is important to school readiness. I know as a parent I’m very passionate about that.”

Parents expressed a desire for schools to provide healthy options for children that were both appealing and filling. Focus group participants noted their children describing the food options as “nasty”, and often returned home at the end of the day hungry. Parents felt this was a result of the time at which their children were provided lunch at school, some as early as 10:30am. In many cases, this would be the only time the child had a meal during the school day. Afternoon snacks were not provided, unless the teacher covered this expense out-of-pocket. One parent questioned the food served in their child’s school, stating, “...even though they say that it’s healthy food. I don’t think so.” One recommendation among focus group participants was to offer a joint training with parents and school staff in order to work collaboratively on healthy menu items that were also appealing for children.

Health

Parents also expressed misdiagnosis of medical conditions as a barrier to their children’s school readiness, specifically citing attention-related problems, like attention deficit disorder (ADD), or attention deficit hyperactive disorder (ADHD). Parents also listed a variety of conditions that affected children in their communities, including: anemia, elevated levels of lead, asthma, seasonal allergies and obesity. Parents felt physical health was just as important as academic health, and

were disappointed that children did not have an opportunity to engage in physical activity as part of their school day. This, coupled with a host of other nutrition- and health-related concerns, was seen as a barrier to a child being healthy and well enough to be attentive and engaged during the school day. Lack of sleep was also identified as an issue affecting children's ability to learn.

- *"I think that a lot of kids are getting misdiagnosed... I have my daughter and they told me she was ADHD, the little one. And I also remember the doctor when she was like two, two and a half maybe, he said the red dye was probably causing for her to be- she's always been hyper, so he mentioned that and we sort of stopped her for a second and she was still the same. So we were like 'Yep, it's not that.' So a lot of kids I think are misdiagnosed."*
- *"I think children that don't get the proper rest are going to have a hard time learning because they're tired. They're in school doing one of these numbers. And I've seen it. I've been in the classroom where we've had children doing this, and it's not lunchtime yet, let alone time to take a nap. So the proper rest is definitely going to affect their learning."*

Bright from the Start – Early Head Start Program

Georgia's Department of Early Care and Learning (Bright from the Start) is responsible for meeting the childcare and early educational needs of Georgia's children and families. Bright from the Start oversees a wide variety of programs primarily focused on children from birth to school age and their families. These programs are under the oversight of Bright from the Start, which provide comprehensive early childhood and family development services to children from birth to five-years-old, pregnant women and families.

When participants were asked about their experiences enrolling their children into the Head Start, most mentioned they were satisfied. They also believed that Head Start was a good transition from pre-K to the classroom for their children. For example, participants said:

- *"My child was ready, just because I felt that the Head Start helped a lot. Because it's smaller classes and children begin to become more independent and they're not as afraid because it's kind of like a daycare in a way, but still they're structured the same way that you're supposed to go to school".*
- *"I used the Head Start for my son because his speech was delayed. That's why I put him in there because socially he was behind. He started talking at two and a half. So when he started pre-k- when he started Head Start he was three and that helped me with him socially. And the speech therapist goes to Head Start, so he got the speech. And just being involved with the other kids that helped me socially with him".*

They felt that teachers at Head Start were competent and prepared the students academically and socially for school. When participants were asked about their experience using the childcare, Head Start, Pre K or nutrition services, their responses were positive. Some parents however, had an unfavorable experience. Parents not eligible to enroll in the program expressed interest and a willingness to use the services based on their perceived value placed on the program.

These participants failed to qualify due to the income criteria and couldn't enroll their children into the program. They said:

- *“Another thing that I feel is that Head Start is for low income people, so people that are in middle class don't qualify. So they discriminate us for that reason because they say, “You make too much.” But then people that have Head Start are eligible for that, but then our kids are left”.*
- *“...don't make it so income based. [Because] I know my children- it was always, ‘Well you don't qualify for this [because] your income is too high.’ Which in my head it was not. It's still too low. But according to them and going on that gross income, it's like, ‘Well, no you're this much over, this much over.”*

These participants also expressed frustration at not qualifying for the Head Start programs and being left out with their children suffering significantly because they worked to maintain their household, despite being a low income family and eligible for programs including childcare, Head Start, pre-K or nutrition services.

During the discussions, some parents revealed that transportation was a barrier to receiving services as they don't always have someone to pick up their children, or the ability to cover the extra distance required to travel beyond their neighborhood to participate in the program.

Examples of some transportation challenges parent faced are shown below:

- *“We were saying that Head Start helps, but there's not a lot of transportation for low income families where they don't have reliable transportation. For me, I had to go pick her up around 1 or 2. They don't have a bus transportation for Head Start, so a lot of kids are not going to Head Start”.*
- *“More transportation. If they have to be bus stops to another Head Start, they need to provide transportation. Because they say you're responsible for your own transportation if you put them in another school out of the area. But if you don't have a car, then how are you going to go”?*

The lack of awareness by participants about Bright from the Start and other services programs provided were very obvious. There was a lot of confusion about Bright from the Start and Head Start, which was apparent in the responses of many participants. Many participants felt frustrated at the lack of communication from state on resources that were available. Parents shared that knowledge of most programs was through word-of-mouth, and that there wasn't a central place to learn about resources available to families. While most participants reported using Bright from the Start services for pre-K, they were not aware of the existence of other services and programs offered through Bright from the Start.

Here are some examples of their conversations:

"Bright from the Start? Is that the one that comes from the hospital?"

"I wasn't aware of it. I've heard of it, but I wasn't aware of what it consists of. "

"The fact that a lot of us parents don't know what programs are out there that we can get help on, it shouldn't be that way"

"P: Well I don't know about services, I just know that's the curriculum where the people who control pre-k. So as far as services, no services were offered."

Women, Infants, and Children (WIC) Program

The Women, Infants, and Children (WIC) Supplemental Nutrition Program is a federally-funded health and nutrition program for infants, children and fostered children from 1 to 5 years of age, pregnant women, breastfeeding mothers (up to a year) and postpartum women (up to 6 months).

Participants' Perceptions of Women, Infants, and Children (WIC) Program

Participants were asked if the WIC services received prepared their children for school. The majority of the responses from participants were positive. They were pleased the program offered healthy food choices to their children. Participants were appreciative that the program was made available to them and felt it was a good safety net when they ran out of food stamps. They also mentioned that nutrition education and food vouchers were beneficial to children's preparedness for school. We know that hungry children can't learn. These are examples of participants' comments:

“They’re pretty good nutritionists.”

“I do like that, because I know for sure and for certain that every month at least I’m going to have money for bananas, my oranges, you know the things that they like”.

“A really good experience. I thought they were like ‘Oh, here’s your voucher. Go on.’ And no, they’re actually really well informed and really good at nutrition, you know,”

Although overall utilization of the program was high, participant satisfaction with the program varied. Some parents were very pleased, others not so favorable. Reasons for dissatisfaction varied, some were about the quality and choice of food at the grocery stores especially the waiting time to receive food vouchers. Some mothers felt 1% or 2% low fat milk was watered down, and felt this was a result of WIC restricting funding for enrollees. Others mentioned a lack of clarity with approved items (i.e., brand, size). Participants spoke of being embarrassed going to the grocery store and unknowingly picking unapproved WIC items or brands which sometimes led to holding up the queue at the check-out while the cashier resolved the problem. Some participants found the vouchers to be complicated and weren’t satisfied with the choices offered.

Barriers to Utilizing Women, Infants, and Children (WIC) Program

Many participants found the waiting times for receiving services excessive, and were willing to forgo receiving services in the future from WIC as a result of these delays. Some participants expressed dissatisfaction on how brochures were handed over to them and the lack of adequate communication of useful information to go with it. They also felt a personalized nutrition education and more one-on-one counseling should be provided for parents. Below are some participants’ comments about their dissatisfaction with the quality and choice of food at the grocery stores, also waiting times to receive food vouchers:

- *“...not only are you wasting half of your day at the WIC office, you have to actually go to the supermarket, half of the things you’re able to get are not on the list. For example, the cereal. They tell you you’re allowed to get Rice Krispies. Ok, so Wal-Mart will allow you to get Rice Krispies. But [they] will tell you, ‘No. that’s not allowed. It’s not on the WIC.’ Or you’ll go to Publix and they will tell you, ‘Not this Rice Krispies. This Rice Krispies is the wrong size.’ So now you’re leaving with less cereal. They’ll have it to where you’re only able to get 30 ounces of cereal and you’re losing your other six. It’s not unanimous as to really what is on the list and what you’re able to get.”*
- *“But it’s not even necessary because like, again, I stopped using WIC with [my daughter] when I was working because taking off half a day of work to go pick up the checks, I mean it was costing me more money than to just go ahead and buy my own milk.”*
- *“I stopped using WIC...because taking off half a day of to go pick up checks...it was costing me more money than to just go ahead and buy my own milk.”*

During the discussion, some mothers suggested there was a need for nutritional services for children over the age of five and hoped WIC would provide this service in the future.

Referrals and Awareness of other Health Services and Programs

Most participants that used WIC services found them helpful, but many were not aware of the educational component of the program or the learning benefits it offered their children. Most participants didn’t know of WIC programs that taught them to read to their kids or provide books for their children. Most participants assumed the WIC program was essentially for food vouchers and nutrition education. When participants were asked if they got referred to other programs and services, none said yes. Here are some examples of participants’ comments:

- *“P: So they [WIC] provide books?
F: It’s a newer thing, but we’re just wondering if you experienced that.

P: I didn’t know they provide books.” (Conversation between a participant and facilitator)*
- *“That’s something that’s I feel some people might want to take advantage of, but because of lack of knowledge they are not able to do so.”*
- *“What I’m trying to say is that we as parents need to be educated on every program and know however to go for help.”*
- *“F: Did they refer you to other health care programs?
Whole Group: No”*

Health Screening

In Georgia, all children entering public school are required to have a vision, hearing, dental and nutrition screening before enrollment in public schools. When participants were asked about compliance, every one of them confirmed they had complied. However, several participants expressed how challenging they found the screening process.

Barriers and Challenges for Health Screening

The long wait to get appointments to see doctors at the health department or doctor’s office, the screening tests/exams not covered under Medicaid, being out of pocket and payment in cash for screening and the limited availability of dental care especially for young children were some of the issues raised by participants.

These comments express some of their dissatisfaction:

- *“ So another thing about the health department is sometimes you’re there for ten minutes, sometimes you’re there for two, three hours.”*
- *“That’s another thing like these are not free. Ok, like most of us are probably in here now are probably on Medicaid so we don’t have private insurance, so we’re going to have to pay to take them to the doctor. Then you’re going to take them to the dentist, that’s money.”*
- *“Yeah, but that’s the thing. It’s the health department. The services that they give are supposed to be because you don’t have the income to get it at a private office. So why are you charging what everybody else is charging when we can’t afford to go to a private doctor.”*
- *“It’s hard to get, like, if you don’t make an appointment before school starts, like a month or two in advance, they won’t give an appointment until like a month or two after school has already started, so if you can’t get your kid in school, what are you going to do now? The doctor’s office gives you an appointment, if school started August 1st, you get an appointment August 28th for the doctor’s office. “*
- *They don’t take insurance. You pay cash or you don’t get no services.”*
- *“Dental was the challenge for me as well.”*

Health Department

Some participants were surprised that the health department didn’t accept insurance. The majority of participants screened their children using private doctor’s and the dentist’s office, but not the health department. Most participants indicated a willingness to use the health department for future screening if the cost was lower, and if waiting times to see a doctor became reasonable.

A mother expressed the difficulties she faced and the need for the health department to assist.

“For some people who don’t have insurance, there’s some people who have three and four kids, and it becomes very costly. So you’re have to stretch your money, and don’t get me wrong, I feel that it is imperative that they get their health screenings, but also you’re having to deal with, well should I pay the light bill or get the health screening so they can go to school but then they’re going to come home to no power? So you’re in that situation where, you know, it would be a blessing if the health department does help but at a reasonable cost. Do you understand what I’m saying? Especially if you have more than one child. You know, for the first child we charged \$50. For the second one and third one, we’re going to charge you \$25 each. You know, something to where they’re working with the parents. Make it a little bit easier.”

Participants felt health screenings should be free or that they shouldn’t have to bear the full cost. For example, the participants said:

- *“That’s another thing like these are not free. Ok, like most of us are probably in here now are probably on Medicaid so we don’t have private insurance, so we’re going to have to pay to take them to the doctor. Then you’re going to take them to the dentist, that’s money. You’re going to take them to the doctor, that’s money.”*
- *“Yeah, but that’s the thing. It’s the health department. The services that they give are supposed to be because you don’t have the income to get it at a private office. So why are you charging what everybody else is charging when we can’t afford to go to a private doctor”*

Some participants suggested that offering screenings within the school system or using mobile dentist would make it easier for parents.

Recommendations

Georgia is also leading the nation in screening children for developmental delays, experiencing a 79% increase over a five-year period. Since many more activities have been conducted in this arena since data were collected in 2011/12, we expect to see continued success in future years.

Disparities are ever present in our state, either in terms of race/ethnicity, income, or geography. Throughout this document, we have seen income disparities present in Georgia even if they are absent when examining the rest of the country. We saw income disparities in the following areas:

- Access to medical homes,
- Children and screen time,
- Adverse childhood experiences,
- School readiness, and
- Even in likelihood of developmental screening, an area in which Georgia is excelling.

Specifically, we noted that children in Georgia who are most likely to be screened for developmental disabilities are children living in families that are within 100 to 199% of the federal poverty level (FPL), the next highest group are children in the highest income families, those making 400% or more of the FPL. Most interesting is that this is an example of an income disparity that exists in Georgia even though it does not exist at the national level. This may be a result of programs targeting specific groups. It is likely that the increase we have seen in screening rates over that five-year program came from targeted programs at children within the 100 to 199% of FPL. It may be helpful to examine the targeted programs and consider expanding them, at least to cover children less than 100% FPL.

Focusing specifically on the most available data for Georgia's children, we assessed disparities that existed by income and race/ethnicity among the percent of children receiving care within a medical home. The lower the family income, the less likely it was that the child received medical care within a medical home. Hispanics and Blacks were least likely to receive care in a medical home when compared to Whites and children of "Other" races. In an effort to increase the number of children receiving their medical care within a medical home, Georgia's Title V program could work closely with Georgia's Medicaid program in promoting medical homes and the use of such.

Data reflected in this document as it relates to physical activity were collected in 2011/12. Nationally, the percent of children aged 6 to 17 years who exercised for at least 20 minutes a day decreased between 2007 and 2012 while the percentage actually increased in Georgia. During and after this time frame, Georgia implemented the Georgia Shape program that encouraged schools to allow ample time for children to exercise. We expect to see marked improvements in the percent of children exercising daily as a result of this initiative as more recent data become available.

An analysis of the death rates for children in Georgia is alarming and a cause for concern. The leading causes of death across all age groups are motor vehicle accidents, with suicide and homicide being the second and third leading causes for older children in age group 15-19. While this is not surprising, as the incidence of violence and crime increases with age, this is a cause for

concern. One approach to reducing the rates of violence and preventable deaths is through increased funding toward mental health programs and violence prevention programs.

School readiness is an issue that Georgia's Health Department is recently tackling.

Through the qualitative data we found that it is of utmost importance for DPH to promote its programs and activities. For instance, most respondents did not know that programs such as WIC provided books for families, or that school screenings could be conducted at the health department. Resources need to be more readily available for families that describe what characteristics a school ready child possesses and the steps necessary to ensure that children are ready for school.