

State Action Plan Table (Georgia)

Women/Maternal Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Prevent maternal mortality	<p>1.1. Develop 1 Maternal Mortality Report each year for five years</p> <p>1.2. Educate 40 hospitals on passive surveillance protocol by 2020</p> <p>1.3. Develop and implement 1 translational project based on findings by 2020</p> <p>1.4. By 2020, increase the number of public health districts promoting well-woman visits in family planning clinics to 18</p>	<p>1.1.a. Write a Maternal Mortality Report each year with recommendations for interventions 1.1.b. Assess policies and procedures for the Maternal Mortality Review Committee and update as needed</p> <p>1.2.a. Develop strategic plan for training hospitals 1.2.b. Train hospitals on passive surveillance protocol</p> <p>1.3.a. Identify a data to action team 1.3.b. Develop and implement translational project with the data to action team and MMRC</p> <p>1.4.a. Collaborate with district offices to develop and implement marketing strategies 1.4.b. Provide training</p>	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>Maternal mortality rate per 100,000 live births</p> <p>Percent of low birth weight deliveries (<2,500 grams)</p> <p>Percent of very low birth weight deliveries (<1,500 grams)</p> <p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <p>Percent of preterm births (<37 weeks)</p> <p>Percent of early preterm births (<34 weeks)</p> <p>Percent of late preterm births (34-36 weeks)</p> <p>Percent of early term births (37, 38 weeks)</p>	Percent of women with a past year preventive medical visit		

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		to district offices and local departments on well-woman visits and proper coding methods	Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			
Improve access to family planning services	2.1. Collaborate with 18 public health districts to promote family planning services by 2020 2.2. Ensure family planning providers in all 18 public health districts have been trained to provide care to teens by 2020	2.1.a. Collaborate with district offices to develop promotional campaigns for family planning services 2.1.b. Implement promotional campaigns 2.2.a. Provide in-person trainings to public health providers on providing				

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	2.3. Increase the percentage of women (ages 15 – 44) served in public health family planning clinics who use Long-acting reversible contraception (LARC) to 15% by 2020	appropriate care to teens 2.3.a. Develop LARCs educational packets for parents and providers 2.3.b. Increase the inventory of LARCs in public health family planning clinics				

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Perinatal/Infant Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Prevent infant mortality	3.1. Increase the number of birthing hospitals participating	3.1.a. Recruit hospitals through in-person presentations on the	Post neonatal mortality rate per 1,000 live births	A) Percent of infants who are ever breastfed and B) Percent of		

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	<p>in the Georgia 5-STAR Hospital Initiative to 40 by 2020</p> <p>3.2. Partner with WIC to conduct 1 training per year for public health workers on breastfeeding for five years</p> <p>3.3. Educate 20 employers on the Business Case for Breastfeeding by 2020</p> <p>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</p>	<p>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</p> <p>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</p> <p>3.3.a. Educate employers on the Business Case for Breastfeeding</p> <p>3.4.a. Recruit birthing hospitals by providing staff with a step by step guide on implementing a Safe to Sleep</p>	<p>Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>	<p>infants breastfed exclusively through 6 months</p>		

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Perinatal/Infant Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
		<p>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</p> <p>3.4.d. Collect pre and post crib audits and policy statements from participating hospitals</p> <p>3.4.e. Recognize hospitals for implementing a Safe to Sleep Program and policy</p>				
Prevent infant mortality	3.5. Ensure all birthing hospitals have been educated on the requirements for neonatal level of care by 2020	<p>3.5.a. Assess neonatal level of care requirement compliance</p> <p>3.5.b. Develop strategic plan for the Regional Perinatal Centers</p> <p>3.5.c. Collaborate with the</p>	<p>Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <hr/> <p>Infant mortality rate per 1,000 live births</p> <hr/> <p>Neonatal mortality rate per 1,000 live births</p>	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)		

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Perinatal/Infant Health

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		Department of Community Health to promote neonatal level of care requirements	Preterm-related mortality rate per 100,000 live births			

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Child Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Promote developmental screenings among children	<p>4.1. Ensure all 18 public health districts are documenting developmental screenings by 2020</p> <p>4.2. Educate 20 partner organizations and primary care provider offices on developmental screenings by 2020</p>	<p>4.1.a. Develop a standardized process for documenting and submitting developmental screening data to state office</p> <p>4.1.b. Develop and implement process to identify and follow-up with children who need further assessments</p> <p>4.1.c. Develop and implement evaluation plan to assess data</p>	<p>Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)</p> <p>Percent of children in excellent or very good health</p>	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool		

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Child Health

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		quality (completeness, accuracy etc.) 4.2.a. Enhance partnership with DECAL, primary care providers, GA-AAP and GA-AFP 4.2.b. Develop and implement a community and provider outreach strategic plan to provide trainings to primary care providers on a standardized screening tool and the referral process 4.2.c. Collect developmental screening data from DECAL and primary care providers				
Promote physical activity among children	5.1. Increase the percentage of Georgia's Fitnessgram	5.1.a. Use existing coalitions to reach Churches, Community	Percent of children in excellent or very good health	Percent of children ages 6 through 11 and adolescents 12 through		

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Child Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	assessed student population that fall in the Healthy Fitness Zone for Body Mass Index by 1% each year for 5 years	Clubs, Afterschool Care, Parks and Recreation, to promote and implement county level best practices 5.1.b. Identify outlets (Farm to school, school nutrition, etc) to cross promote Shape Initiatives 5.1.c. Create plan of action to reach disparate populations and promote FG and Pu30	Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	17 who are physically active at least 60 minutes per day		

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Adolescent Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Reduce suicide among adolescents	6.1. Develop a bullying prevention and mental health resource website	6.1.a. Compile and develop fact sheets on bullying, mental health	Adolescent mortality rate ages 10 through 19 per 100,000	Percent of adolescents, ages 12 through 17, who are bullied or who		

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Adolescent Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	<p>by 2020</p> <p>6.2. Increase capacity through developing one inter-agency task force for bullying prevention by 2020</p> <p>6.3. Develop and implement 1 anti-bullying intervention by 2020</p>	<p>and suicide prevention</p> <p>6.1.b. Create a listing of evidence-based interventions</p> <p>6.1.c. Develop a repository of all programmatic efforts to prevent bullying and promote mental health throughout the state</p> <p>6.2.a. Identify and recruit partners to actively participate in the task force</p> <p>6.2.b. Develop a strategic plan for the task force</p> <p>6.3.a. With input from federal, state and local partners, identify 1 evidence-based intervention to implement in MCH</p> <p>6.3.b. Implement intervention</p>	<p>Adolescent suicide rate, ages 15 through 19 per 100,000</p>	<p>bully others</p>		

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Children with Special Health Care Needs

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Improve systems of care for children and youth with special health care needs	<p>7.1. Increase by 5 the number of organizations at the state, local and community level that are active partners by 2020</p> <p>7.2. Increase awareness of services provided to CYSHCN through the development and promotion of 1 resource portal by 2020</p> <p>7.3. Educate students in 8 schools of health professions (medical schools, dental schools, nursing schools, physician assistant schools, etc.) on medical homes, available supporting resources for CYSHCN, pediatric and adult specialty care for CYSHCN by 2020</p> <p>7.4. Produce 1 report of an environmental scan of the state to show the</p>	<p>7.1.a. Build collaboration with 5 family physician and/or internal medicine practices on transitioning youth with special health care needs to adult health care</p> <p>7.1.b. Expand the systems of care advisory committee, Interagency Director's Team, to include medical care partners</p> <p>7.2.a. Revise DPH Child Health Interventions website to include educational and user-friendly information about medical homes, transition, available resources and FAQs by district in Spanish and English</p> <p>7.2.b. Develop app for CYSHCN resources with Georgia Tech</p> <p>7.2.c. Host 1 educational event in each public health</p>	<p>Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system</p> <p>Percent of children in excellent or very good health</p>	<p>Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care</p>		

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Children with Special Health Care Needs

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	<p>number of telehealth sites that provide specialty care by 2020</p> <p>7.5. Ensure all 18 public health districts use a standardized transition plan for YSHCN by 2020</p>	<p>district to educate communities (e.g. health fairs, walk-a-thons, Parent cafes, snack and learns)</p> <p>7.3.a. Develop and implement curriculum for participating schools on treating patients with special health care needs</p> <p>7.4.a. Conduct an environmental scan identifying telehealth sites providing specialty care</p> <p>7.5.a. Develop and implement standardized transition plan protocol for CMS 7.5.b. Monitor patient and family satisfaction of the development and strategies outlined in their transition plan</p>				

State Action Plan Table (Georgia)

Cross-Cutting/Life Course

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
<p>Promote oral health among all populations</p>	<p>8.1. Engage active partners working with MCH to promote perinatal oral health by 2020</p> <p>8.2. Develop 1 oral health resource database for CYSHCN by 2020</p>	<p>8.1.1. Partner with districts, private practice, education at dental hygiene programs, the Georgia Regents University (GRU) School College of Dental Medicine to promote perinatal oral health screenings</p> <p>8.1.2. Educate and update district oral health staff on special considerations and treatment needs for special needs patients</p> <p>8.1.3. Offer comprehensive educational webinars/presentations</p> <p>8.2.1. Determine data sources and begin collecting data to develop a special needs dental access database with location of practices serving</p>	<p>Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months</p> <p>Percent of children in excellent or very good health</p>	<p>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</p>		

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Cross-Cutting/Life Course

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
		special needs children and adults/special services offered, such as general anesthesia, orthodontics, insurance accepted and other specialties				