

**Maternal and Child  
Health Services Title V  
Block Grant**

**Georgia**

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## I. General Requirements

### I.A. Letter of Transmittal



Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

2 Peachtree Street NW, 15th Floor  
Atlanta, Georgia 30303-3142  
dph.ga.gov

July 15, 2015

Morrisa B. Rice  
Division of State and Community Health  
Maternal and Child Health Bureau  
5600 Fishers Lane  
Rockville, MD 20857

**Grantee Name:** Georgia Department of Public Health  
**Grant Name:** Maternal and Child Health Services Title V Block Grant  
**Grant Number:** B04MC28093  
**Reference:** Notification of Submittal

Dear Ms. Rice,

This is a letter of transmittal informing you that a grant application requesting funding for the FY 2016 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 Seema Csukas, Director of Maternal and Child Health. Dr. Csukas can be reached at 404-657-2850 or Seema.Csukas@dph.ga.gov.

Sincerely,

A handwritten signature in blue ink that reads 'Seema Csukas'.

Seema Csukas, MD, PhD  
Director, Maternal and Child Health  
Georgia Department of Public Health

A handwritten signature in blue ink that reads 'Kathryn Pfirman' with 'ON BEHALF OF KATHRYN PFIRMAN' written below it.

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



**We Protect Lives.**

## **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 2014 Annual Report/2016 Application 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 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 was accomplished:

- The Maternal Mortality Review Committee (MMRC) completed a review of all 2012 cases and developed the first report on their findings. The MMRC's important work continues to add to the knowledge around maternal deaths and will inform future interventions.
- The Five-STAR program was initiated to recognize hospitals that take steps toward becoming breastfeeding friendly. Hospitals are already participating in the initiative, and several more are expected to join.
- The Safe to Sleep campaign continues to be promoted throughout the state to alter community perceptions of safe sleep practices.
- Critical Congenital Heart Defect screening was added to the Newborn Screening Program.
- Parents as Partners has linked parents of children and youth with special health care needs to other parents for support.
- Georgia Shape continues to promote fitness assessments and school policies among middle schools and high schools.

### **Needs Assessment Summary**

In accordance with the guidance requiring states to conduct a needs assessment every five years, Georgia conducted a comprehensive needs assessment that included a thorough review of all available quantitative data sources and collection of qualitative data among members of the community and key leaders in MCH throughout Georgia beginning in 2014. After reviewing the data collected, MCH program and epidemiology staff identified a set of needs. Stakeholders were then given the opportunity to review the findings and assist MCH in prioritizing the identified needs. Throughout the entire process, stakeholders were able to give input into the selection of priorities and development of strategies to address priority needs through a survey, participation in stakeholder meetings and an ongoing public comment period. A SWON (Strength, Weakness, Opportunity, Need) analysis was used to determine program capacity and ensure that the Title V program had sufficient capacity and authority to properly address the need.

Eight priority needs were identified: (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) prevent suicide among adolescents (7) improve systems of care for children and youth with special health care needs and (8) promote oral health among all populations. A summary of the findings and rationale supporting each priority need, as well as a description of activities to address each priority need are as follows.

#### Prevent maternal mortality

Maternal mortality is a topic of increasing importance to public health professionals in Georgia. Georgia has been ranked among states with the highest maternal mortality ratio, with the most recent data for 2013 showing a ratio of 43.6. The MMRC has provided the state with rich data on factors leading to maternal death and determined that poor health status prior to pregnancy is a primary contributor. Other data show that morbidity is prevalent among women of reproductive age in Georgia, with about half of women entering pregnancy obese.

The strategies implemented over the next five years to address this need will center around two primary activities: improving the MMRC's policies and procedures to improve data quality and promoting well-woman visits to promote excellent health status in the pre and interconception periods. As the MMRC is just beginning, it is critical to ensure that all maternal deaths are identified accurately and that there is access to sufficient case information, as well as to ensure that a process for implementing data to action projects is in place. MCH plans to build on the existing infrastructure in the public health family planning clinics to promote preventive medical visits. It is intended that linking women of reproductive age to preventive care will improve the overall health status of women before they enter pregnancy and prevent maternal death.

#### Improve access to family planning services

Unplanned pregnancies are associated with poor outcomes for both mothers and infants. In Georgia, approximately half of all births are unplanned. By improving access to family planning services, there is an opportunity for MCH to improve the health of both women and infants throughout the state. MCH plans to increase the number of women accessing services through local family planning clinics, as well as improve the quality of the services provided. MCH will also increase the supply of long-acting reversible contraception (LARC) in the family planning clinics to ensure the availability of reliable forms of contraception.

#### Prevent infant mortality

Georgia's infants experience a higher rate of mortality than the average nationally. The needs assessment showed that breastfeeding and safe sleep practices, behaviors that impact infant morbidity and mortality, are underperformed in the state. Although a perinatal regionalization system is in place, it is recognized that all high-risk infants are not ultimately receiving care in a facility most equipped to treat their conditions.

To prevent infant mortality, MCH will promote breastfeeding initiation and duration, safe sleep practices and neonatal level of care guidelines to improve perinatal regionalization. MCH will continue to support and recognize hospitals that take steps toward becoming breastfeeding friendly and increase the number of worksite lactation programs using the Business Case for Breastfeeding. In order to change community norms regarding safe sleep practices, Georgia plans to ensure consistent messaging and encourage hospitals to teach safe sleep. MCH will promote neonatal level of care guidelines among birthing hospitals to ensure that all infants are born in a facility with the resources needed.

#### Promote developmental screenings among children

Developmental screenings are an area of success and need in Georgia. While Georgia is leading the nation in offering developmental screenings, less than half of children receive this important service.

Steps have been taken to ensure that child in the public health system are screened for developmental delays, however there is an opportunity to raise awareness for children who receive services outside of public health. MCH's programmatic efforts will target improving data collection systems at the public health districts and promoting the use

of the Ages and Stages Questionnaire throughout primary care settings in Georgia.

#### Promote physical activity among children

With the increase in obesity and chronic conditions seen across the nation in the past decades, it is important that public health promote physical activity among children to instill a healthy lifestyle at an early age. Approximately 35% of Georgia's children are currently performing the recommended amount of physical activity. Although on par with national averages, opportunity for improvement remains.

DPH's initiative to promote physical activity is Georgia Shape. Shape, a collaborative effort between state agencies and private partnerships, works with the school system to promote overall health and fitness by assessing children's performance on five components of physical activity and empowering schools to incorporate physical activity into their school day. MCH will continue to provide support to this program to promote childhood physical activity.

#### Prevent suicide among adolescents

Suicide is an important emerging need identified through Georgia's needs assessment. The adolescent suicide death rate was 5.1 in 2013. The issue is of particular concern due to the prevalence of bullying as well. Addressing adolescent health is an important new initiative for MCH. MCH will partner with Adolescent and School Health to address bullying in the school systems by encouraging schools to implement anti-bullying campaigns. MCH will also look to expand partnerships throughout the reporting period and fill an important gap in public health work being done to address this issue.

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

Georgia will be working to improve the overall system of care for children and youth with special health care needs (CYSHCN) to ensure they are able to navigate the system and receive needed services. Results from the needs assessment show that families are unaware of available services, lack a medical home and are unprepared to transition their CYSHCN to adulthood.

The Title V program will address all aspects of a well-functioning system for CYSHCN, with a particular focus on transitions to adulthood. MCH will focus on ensuring that all children in Children's Medical Services (CMS), the state program for CYSHCN, have a satisfactory transition plan are linked with a medical home prior to discharge from the program. In order to increase awareness about available services, MCH will create a resource database for CYSHCN. Access to specialty care will be improved through promoting the use of telehealth.

#### Promote oral health among all populations

Oral health is an important need affecting all populations throughout the state. There are racial disparities among pregnant women who access dental services during pregnancy and only three-fourths of children are receiving preventive dental care each year. Increasing oral health care utilization during pregnancy can impact the likelihood that the child will receive appropriate oral health care.

MCH will continue to promote oral health among everyone by continually supporting the community water fluoridation program and specifically focusing on outreach to pregnant women and children. In order to assist CYSHCN find oral health care providers, a resource database listing all locations of CYSHCN providers will be developed.

#### National Performance Measures

Eight national performance measures (NPM) were selected to address the priority needs. The table below shows Georgia's current annual indicator for each of these measures and the national average if possible. These data will continue to be updated throughout the reporting cycle to assess the impact of programmatic approaches and refine activities based on noted trends.

National Performance Measure	Data Source	Year Available	Georgia	United States
Percent of women with a past year	Behavioral Risk	2013	68.1%	65.2%

preventive medical visit	Factor Surveillance System			
Percent of very low birth weight infants born in a Level III facility with a Neonatal Intensive Care Unit (NICU)	Vital Records	2012	78.4%	Data not available
A. Percent of infants who are ever breastfed B. Percent of infants breastfed exclusively through 6 months	National Immunization Survey	A. 2011 B. 2011	A. 70.3% B. 14.5%	A. 79.2% B. 18.8%
Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	National Survey of Children's Health	2011/12	40.8%	30.8%
Percent of children ages 6 through 11 who are physically active at least 60 minutes per day	National Survey of Children's Health	2011/12	35.9%	35.7%
Percent of adolescents, 12 through 17, who are bullied or who bully others	Youth Risk Behavioral Surveillance System	2013	25.1%	25.3%
Percent of adolescents with special health care needs who receive services necessary to make transitions to adult health care	National Survey of Children with Special Health Care Needs	2009/10	33.9%	40.0%
A. Percent of women who had a dental visit during pregnancy B. Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	A. Pregnancy Risk Assessment Monitoring System B. National Survey of Children's Health	A. 2012 B. 2011/12	A. 38.0% B. 75.9%	A. 50.3% B. 77.2%

### 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 to impact the identified priority needs.

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 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

#### 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 24<sup>th</sup> 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<sup>1</sup>:

1. Albany
2. Athens-Clarke County
3. Atlanta-Sandy Springs-Roswell
4. Augusta-Richmond County (GA-SC)
5. Brunswick
6. Chattanooga (TN-GA)
7. Columbus (GA-AL)
8. Dalton
9. Gainesville
10. Hinesville
11. Macon
12. Rome
13. Savannah
14. Valdosta
15. Warner-Robins

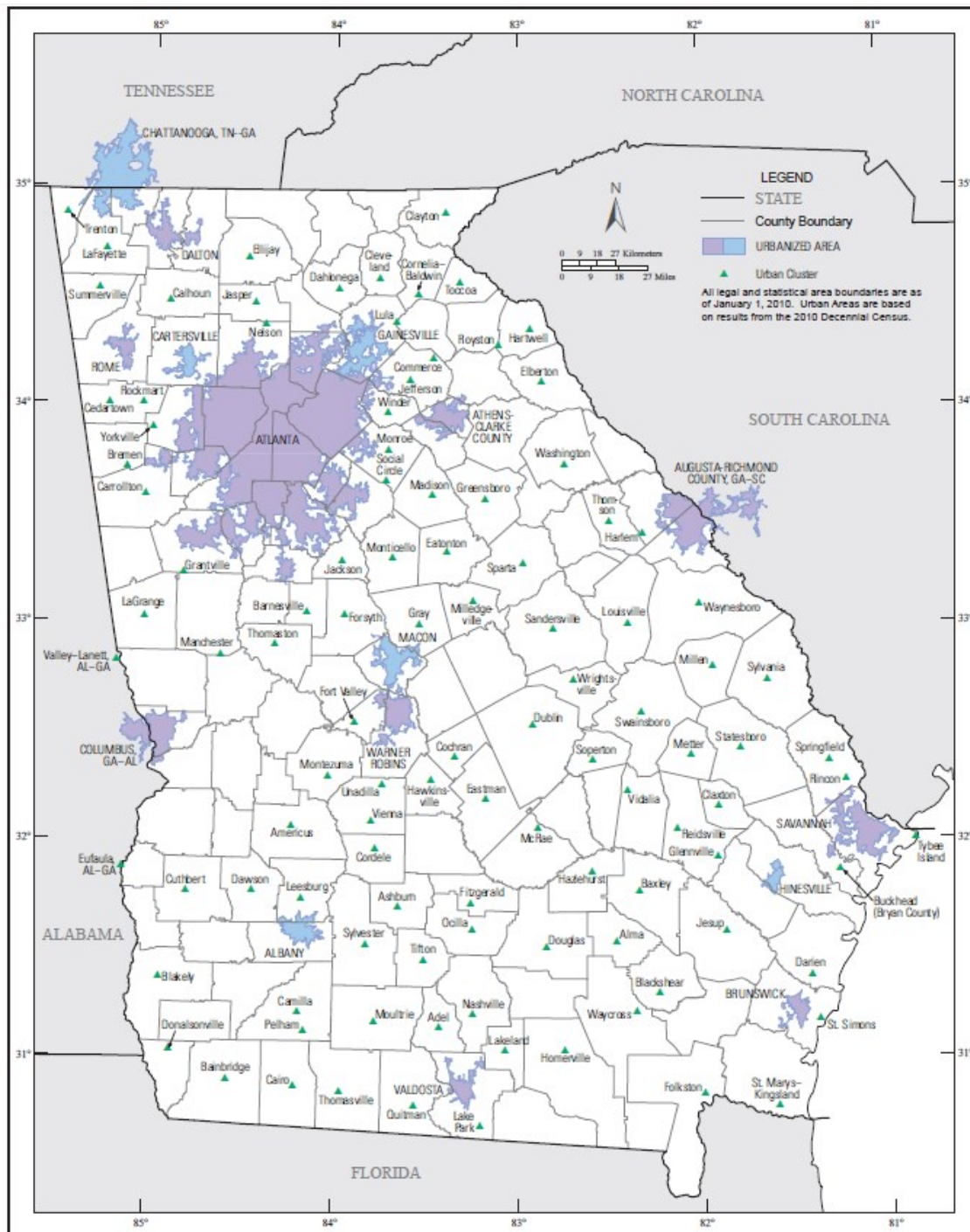
Atlanta, the state capitol, is the economic, cultural and demographic center of Georgia. It is the largest city in the state, with an estimated population of 450,000 people in 2013. The population grew 6.6% from 2010 to 2013, and is expected to continue to do so. Over 6% of residents are under 5, 19.4% 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<sup>2</sup>.

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 has become increasingly challenging, and as such it is essential for DPH to accommodate the needs of the rural population. Telemedicine and other innovative strategies can alleviate disparities.

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 the state of Georgia, US Census 2010



Source: US Census Bureau, 2010

## Population

As of 2014, Georgia had an estimated population of 10.1 million people<sup>2</sup>. It is ranked the 8<sup>th</sup> largest state with respect to population based on 2014 estimates<sup>3</sup>. Georgia is the 14<sup>th</sup> fastest growing state in the nation, with a 4.2% increase from 2010 to 2014<sup>3</sup>, and is 4<sup>th</sup> highest among states with the largest numeric population increase<sup>3</sup>. It is estimated that Georgia's population will increase to 11.3 million by 2020<sup>4</sup>. As with any population growth, there are increasing demands on state and local governments to provide necessary services, including health and social services.

## 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				
Population Characteristic	2000 Census		2010 Census	
	Number	Percent	Number	Percent
<b>Total Population</b>	8,186,453	-----	9,687,653	-----
<b>Race/Ethnicity</b>				
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)	4,352,273	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 4<sup>th</sup> highest for the percentage of the population under age 18. The median age in the state is 35.3<sup>5</sup>. According to 2009-2013 estimates, 6.9% of Georgia's population is under 5 years old<sup>6</sup>.

#### Immigration

From 2000 to 2009, the Department of Homeland Security estimates that the number of unauthorized immigrants in Georgia increased by 115%, ranking Georgia as 6<sup>th</sup> 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<sup>7</sup>.

#### Place of Birth and Language Proficiency

In 2009-2013, 9.7% of Georgia residents were born outside of the United States<sup>6</sup>. Over 13% of Georgia residents speak a language other than English<sup>6</sup>. 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<sup>6</sup>. 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 15.8% of the population and 8.9% of these households contained children under the age of 18; 4.9% were male family households, 2.2% of which had 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<sup>8</sup>.

#### 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 12<sup>th</sup> 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<sup>9</sup>. 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%)<sup>2</sup>.

#### Income

Georgia's per capita income was below the national average from 2009 to 2013 with a per capita income of \$25,182 relative to the U.S. average of \$28,155; at the same time, the state's poverty level was above the national average<sup>2</sup>. In 2013, median household income in Georgia was \$47,829 a major decrease from the median income of \$55,027 in 2008<sup>6</sup>.

Table 2. Median Household Income in Georgia and the US, 2008-2013

Year	Georgia	United States
2013	\$47,829	\$52,250
2012	\$47,895	\$52,117
2011	\$47,650	\$52,306

<b>2010</b>	\$49,605	\$53,469
<b>2009</b>	\$51,684	\$54,541
<b>2008</b>	\$55,027	\$56,290

### Poverty

Poverty is more prevalent in Georgia than in many states across the nation. In 2009-2013, 18.2% of Georgians were living below the poverty line, compared with 14.5% for the U.S. overall. Over 8% 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<sup>6</sup>.

### Employment

In April 2015, Georgia's unemployment rate was 6.3%, ranking it 41<sup>st</sup> in the United States. Nebraska, the state with the lowest unemployment rate, only 2.5% of the labor force was unemployed<sup>10</sup>. 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<sup>11</sup>. 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

Uninsurance and underinsurance affects the health status of women and children in Georgia. Eight percent of Georgia's children are uninsured, making it the state with the 8<sup>th</sup> highest rate of uninsured children. Sixteen percent of the total state's population is uninsured, ranking it 7<sup>th</sup> highest<sup>12</sup>. 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 2015 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 541,080 Georgians acquired health insurance through the marketplace at the end of 2015 open enrollment<sup>13</sup>. It is estimated that half of Georgians eligible through the marketplace have received coverage<sup>14</sup>. HB 943 is in effect, which prohibits government agencies from advocating for Medicaid expansion, from operating insurance exchanges and from providing navigator programs<sup>15</sup>.

### 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<sup>16</sup>, this is indeed not the case. The state still experiences one of the highest unemployment rates and median household income continues to decline.

Furthermore, there are many state budgets that have been significantly cut. The Department of Community Health

faces a significant budget decline in 2016. The proposed 2016 budget directs \$2.45 billion to the Department of Community Health, not including money for agencies attached for administrative purposes – which is a \$27.8 million decline from the 2015 budget approved last spring. 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<sup>17</sup>. A decreased budget has many implications for the Medicaid and PeachCare population.

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<sup>18</sup>. 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 multifactorial. 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 is currently developing 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 four 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 wellbeing.** Increase access to care throughout the State of Georgia and educate the public, practitioners, and government to promote health and wellbeing 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

### II.B.1. 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, direct services, 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.

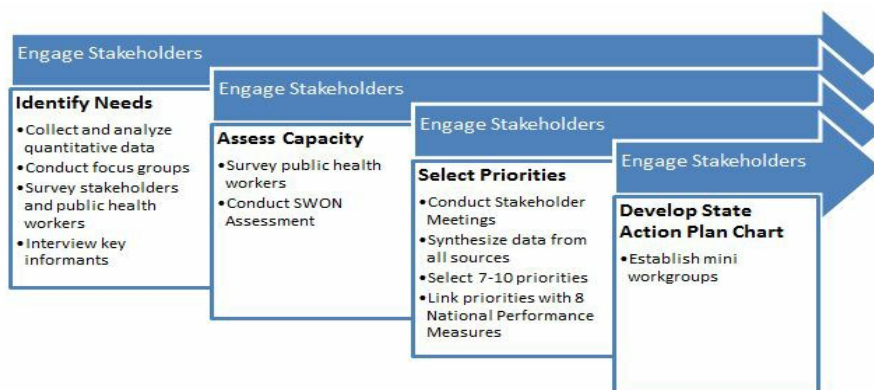


Figure 1. Georgia Title V Needs Assessment Process

### Methods and Data Sources

#### 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
- Universal Newborn Hearing and Screening Program
- Youth Risk Behavior Surveillance System
- Youth Tobacco Survey
- Water Fluoridation Reporting System

#### Qualitative Methods

##### 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		Clayton
Athens		Savannah

DeKalb		
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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 attended 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
	Improve 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](http://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 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 managing chronic conditions prior to pregnancy.

#### 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 percentage of low-risk cesarean section deliveries in Georgia increased from 27.8% in 2009 to 28.7% in 2013.

During the same time period, the national average decreased from 28.0% to 26.8% (Figure 8). Disparities exist 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).

### Qualitative Findings

Table 3. Maternal/Women’s Health Qualitative Findings

<b>Focus Groups: Perinatal Health</b>	
<b>Individual-Level Factors</b>	<ul style="list-style-type: none"> <li>• Incorrect/inconsistent use of contraception</li> <li>• Limited or no preparation for a healthy pregnancy</li> <li>• Confusion about birth spacing recommendations</li> <li>• Preference for private vs. public services</li> </ul>
<b>Structural-Level Factors</b>	<ul style="list-style-type: none"> <li>• Long wait times for appointments</li> <li>• Lack of transportation</li> </ul>
<b>Key Informant Interviews</b>	
<b>Priority Needs</b>	<ul style="list-style-type: none"> <li>• Preventive medical visits</li> <li>• Breastfeeding</li> <li>• Maternal mortality</li> <li>• Infant mortality</li> <li>• Teen birth rates</li> <li>• Repeat teen birth rates</li> <li>• Sexually transmitted infections</li> </ul>
<b>Individual-Level Factors</b>	<ul style="list-style-type: none"> <li>• Little awareness on the importance of managing chronic conditions before pregnancy</li> </ul>
<b>Structural-Level Factors</b>	<ul style="list-style-type: none"> <li>• Lack of insurance between pregnancies</li> <li>• Lack of facilities/clinics for prenatal care</li> <li>• Lack of access to mental health care</li> <li>• Reimbursement systems need to be updated</li> <li>• Programs providing birth control for low-income women between pregnancies are not well marketed</li> <li>• Shortages of Maternal and Fetal Medicine and Obstetric providers, especially in rural areas</li> <li>• Labor and Delivery Unit closures</li> </ul>

### 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

##### Areas 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).

#### Qualitative Findings

Table 4. Perinatal Health Qualitative Findings

<b>Focus Groups: Perinatal Health</b>	
<b>Individual-Level</b>	<ul style="list-style-type: none"> <li>• Familiarity with provider encourages care-seeking behavior</li> <li>• Lack of knowledge on available parenting classes and resources</li> </ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"> <li>• Support systems encourage breastfeeding</li> <li>• Lack of transportation</li> </ul>
<b>Key Informant Interviews</b>	
<b>Priority Needs</b>	<ul style="list-style-type: none"> <li>• Perinatal regionalization system</li> <li>• Safe sleep</li> <li>• Breastfeeding, especially for high-risk infants</li> </ul>
<b>Individual-Level</b>	<ul style="list-style-type: none"> <li>• Lack of awareness on the benefits of breastfeeding</li> </ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"> <li>• Lack of public transportation</li> <li>• Lack of access to specialized care in rural areas</li> <li>• Insurance reimbursement prevents transfer of high-risk neonates to appropriate hospital</li> <li>• Lack of a donor breast milk program in the state</li> </ul>

#### 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

##### Areas to be Continued

- The Five-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

##### 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).

## Qualitative Findings

Table 5. Child Health Qualitative Findings

<b>Focus Groups: School Readiness</b>	
<b>Individual-Level</b>	<ul style="list-style-type: none"> <li>• Lack of cultural competency among teachers</li> <li>• Lack of parental knowledge surrounding nutrition</li> <li>• Lack of knowledge about school readiness services</li> <li>• Parental involvement at home is key to success in school</li> </ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"> <li>• Middle class is ineligible for services</li> <li>• Transportation to schools of choice is not available</li> <li>• Long waiting times at the health department</li> <li>• Mandated screenings are difficult to finance</li> <li>• Fruits and vegetables are provided through WIC</li> </ul>
<b>Key Informant Interviews</b>	
<b>Priority Needs</b>	<ul style="list-style-type: none"> <li>• Physical activity</li> </ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"> <li>• Lack of pediatricians in rural areas</li> </ul>



## 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 is 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

### Areas 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 9<sup>th</sup> grade students reported that they were involved in bullying than those in the 12<sup>th</sup> 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 12<sup>th</sup> 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 urban 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).

### Qualitative Findings

Table 6. Adolescent Health Qualitative Findings

Key Informant Interviews	
<b>Priority Needs</b>	<ul style="list-style-type: none"> <li>• Physical activity</li> <li>• Bullying</li> <li>• Sexual and reproductive health</li> </ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"> <li>• Lack of teen clinics</li> <li>• Providers need to provide teen-friendly services</li> </ul>

### Strength 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

#### Areas to be Continued

- Adolescent and School Health’s Step Up. Step In. campaign promotes the implementation of anti-bullying campaigns in schools

#### Areas of Opportunity

- There is an opportunity to make public health family planning clinics teen-friendly

### 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).

Qualitative Findings

Table 7. CYSHCN Qualitative Findings

Focus Groups: CYSHCN	
<b>Individual-Level</b>	<ul style="list-style-type: none"> <li>• Lack of knowledge about services</li> <li>• Poor communication between parents and providers</li> <li>• Lack of knowledge about medical home</li> <li>• Families are responsible for care coordination</li> <li>• Concerns over transition to adulthood</li> </ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"> <li>• Lack of a centralized resource center</li> <li>• Lack of providers/specialists in rural areas</li> <li>• Eligibility restrictions</li> <li>• Lack of safe recreational places</li> <li>• Long wait times for appointments</li> <li>• Transportation</li> <li>• Lack of employment opportunities for CYSHCN and resources to aid with transition</li> </ul>
Key Informant Interviews	
<b>Priority Needs</b>	<ul style="list-style-type: none"> <li>• Medical homes</li> <li>• Access to primary and subspecialty care</li> </ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"> <li>• No pediatric specialists</li> <li>• Lack of centralized body that serves as an information clearinghouse for CSYHCN</li> <li>• Challenge finding comprehensive homes for CYSHCN and helping them to transition</li> </ul>

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

Areas 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).

#### Qualitative Findings

Table 8. Cross-Cutting Qualitative Findings

Key Informant Interviews	
<b>Priority Needs</b>	<ul style="list-style-type: none"> <li>• Oral health of adolescents</li> <li>• Perinatal oral health</li> <li>• Early childhood caries</li> <li>• Racial disparities in prevalence of gingivitis and the early stages of periodontal disease among African Americans</li> <li>• Increased number of caries in the Hispanic population</li> </ul>
<b>Individual-Level</b>	<ul style="list-style-type: none"> <li>• Parents are unaware children should see a dentist before the age of one</li> <li>• Smoking and poor nutrition are impacting oral health</li> </ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"> <li>• Reimbursement for dental care for special needs population is extremely low for dental work</li> <li>• Limited number of Medicaid providers</li> </ul>

	<ul style="list-style-type: none"> <li>• Limited number of caregivers capable of taking care of oral health for CYHSCN</li> <li>• Dentist shortages</li> <li>• Uninsured clients cannot pay for care</li> </ul>	<p>Strengths and Needs Georgia has shown improvements</p>
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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

Areas 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**

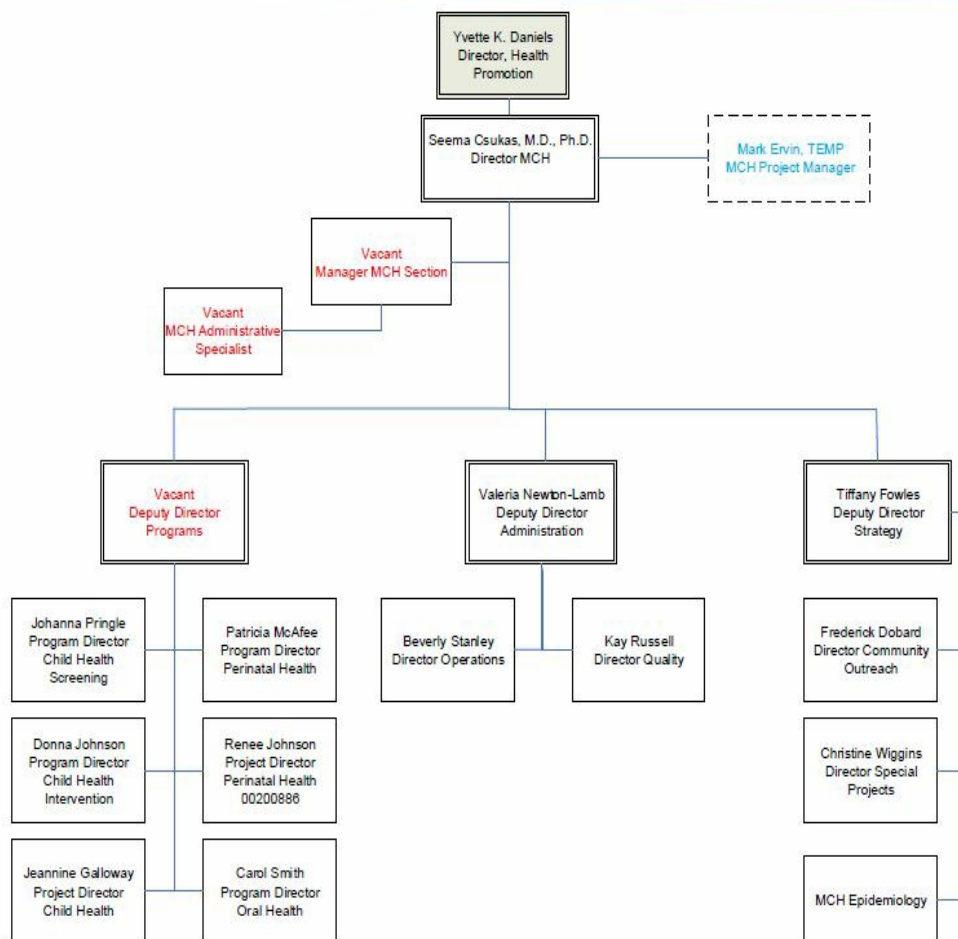
**II.B.2.b.i. Organizational Structure**

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 Projects, Child Health Screenings, Child Health Interventions (CYSHCN programs) 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 assurance.



Division of Health Promotion  
Maternal and Child Health Section



7/15/2015

Title V provides funding to Injury Prevention and Georgia SHAPE, which are located outside of MCH. The following is a list of 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 for hearing loss in the birthing hospital and links infants to appropriate intervention.
- Family Planning improves the health of women and infants by enabling families to plan and space pregnancies and prevents unplanned pregnancy.
- Georgia Shape promotes greater fitness and nutrition among children and adolescents.
- 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 ensures 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 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. Since adolescent health programs are located outside of MCH, a partnership with the Injury Prevention and Adolescent and School Health Sections is required to address the needs of this population. 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 preventive services. 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, Healthy Mothers, Healthy Babies, Georgia Obstetrical and Gynecological Society (GOGS) and March of Dimes 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. Grant-in-Aid funds assists with outreach activities. 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 Healthy Mothers, Healthy Babies.

#### **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. Georgia Shape promotes physical activity. Title V supports the work of these programs, however they rely on additional funding sources as well. 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 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

There is no program dedicated to adolescent health within MCH, which provides a new opportunity for MCH to partner with other sections of DPH. Georgia's adolescent health program is located in Adolescent and School Health (ASH) to address and improve the health of adolescents. MCH will also partner with Injury Prevention to decrease suicide among adolescents.

#### 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 survey, CMS and 3<sup>rd</sup> 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 currently 39 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. Dr. Fowles received her doctorate degree from University of Georgia. She currently oversees MCH Epidemiology, Community Outreach, Title V Block grant, Special Projects and Operations. Dr. Fowles is responsible for working with senior MCH leadership and stakeholders to define and implement MCH strategic direction, monitor progress and compliance against the strategic plan.



Beverly Stanley, BA is the Director of Operations. She earned her BA in Human Resource Management at the University of South Carolina and has over 20 years of experience working in the governmental and private sectors providing management of day to day operations. Ms. Stanley is responsible for overseeing all operational functions of MCH, including grants, contracts, budgets and human resources.

Donna Johnson is the Director of Child Health Intervention. She has over 12 years 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.

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 Competence

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, Pregnancy Risk Assessment Monitoring System 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 CoIINs: 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 Parent Consultant 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 diversity 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

MCH estimates the following numbers of parents have been engaged within the past year: 20 in BCW, 40 in Shape, 5 in Newborn Screening, 10 in EHDI and 6 in CMS.

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. Families who are engaged in CMS activities are compensated for their involvement in various ways and depend on the activity and responsibilities. The CMS Parent Consultant 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. Program managers and directors recognize 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 Parent Consultant 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. 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	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	

### Selection Process

When selecting priority needs, Georgia was looking for a gap in the health status of the population due to trend or disparities 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 needs identified in the assessment 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 corroborate findings. 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. Ratings for each criteria were averaged, multiplied by their weight, and added together to determine the final rating score for each priority need.

Table 1. Priority Need Rating

Rank	Potential Need Rated 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 improving 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	Addressed by improving systems of care for CYSHCN
5	Reduce the number of infants born preterm	59.8	Addressed by preventing maternal mortality, infant mortality and improving 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	Not selected: Preventing infant and maternal mortality were seen as higher priorities. This need could possibly be addressed through increasing access to family planning services and increasing well-woman visits
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
			Not selected: Although strongly considered as a priority need, percentages have been declining and there is a program outside of

11	Decrease the percent of mothers smoking during pregnancy	58.0	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
14	Decrease tobacco use among adolescents	56.7	Not selected: Although strongly considered as a priority need, there is a program outside of MCH to address this need. Tobacco cessation messages will be incorporated into oral health promotion
15	Reduce unplanned teen pregnancies	55.6	Addressed through improving 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
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	Will be addressed by an SPM
28	Increase the percent of 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 and stable trends
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 and declining rates
	Increase the number of		



33	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

### 1. 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.

### 2. Improve 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.

### 3. 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.

### 4. 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.

### 5. 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.

## 6. 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.

## 7. 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.

## 8. 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
Improve 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
	Reduce motor vehicle crash mortality

No similar need	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) has a common theme with increasing physical activity (2016-2020) as an avenue for decreasing obesity. An increase in developmental screening has remained a priority for the state. Although there have been some improvements, there are considerable gaps across different populations in the state and efforts from 2016-2020 will target all children, not just those in need. Preventing maternal mortality, preventing suicide among adolescents and promoting oral health among all populations are priority needs for 2016-2020 that are not related to a similar need 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**

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	62.1	61.5	60.9	60.3	59.6

**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
Annual Objective	81.8	82.8	83.9	84.9	85.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.5	79.3	80.1	80.9	81.6

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	19.1	19.3	19.5	19.7	19.8

**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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.9	45.9	45.9	45.9	51.6

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

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

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	25.3	24.6	24.6	24.0	24.0

**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
Annual Objective	34.2	34.6	34.9	35.3	35.6

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.5	39.9	40.3	40.7	41.1

**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
Annual Objective	79.0	79.8	80.6	81.4	82.2

Eight national performance measures were selected to address priority needs based on their relevance to factors related to the priority needs, as well as considering the national outcome measures they impact. The selected NPMs and their corresponding priority are displayed in Table 3. Improving 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	Improve 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 1: 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 measures to address in Georgia and it should be noted that by promoting well-woman visits these outcomes will be impacted as well.

**NPM 3: 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 4: 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 6: 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 promote developmental screenings 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 8: 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 9: 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.

**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 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 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 as CYSHCN transition to adulthood will impact the overall health status of CYSHCN in Georgia.

**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 concern 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**

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

## 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 time periods are reported:

- Last Year's Accomplishments: October 1, 2013 to September 30, 2014
- Current Activities: October 1, 2014 to September 30, 2015
- Plans for Upcoming Year: October 1, 2015 to September 30, 2016

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Prevent maternal mortality	1.1. Develop 1 Maternal Mortality Report each year for five years	1.1.a. Write a Maternal Mortality Report each year with recommendations for interventions	Rate of severe maternal morbidity per 10,000 delivery hospitalizations	Percent of women with a past year preventive medical visit		
	1.2. Educate 40 hospitals on passive surveillance protocol by 2020	1.1.b. Assess policies and procedures for the Maternal Mortality Review Committee and update as needed	Maternal mortality rate per 100,000 live births			
	1.3. Develop and implement 1 translational project based on findings by 2020	1.2.a. Develop strategic plan for training hospitals	Percent of low birth weight deliveries (<2,500 grams)			
		1.2.b. Train	Percent of very low birth weight deliveries (<1,500 grams)			

State Action Plan Table

Women/Maternal Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	<p>1.4. By 2020, increase the number of public health districts promoting well-woman visits in family planning clinics to 18</p>	<p>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 to district offices and local departments on well-woman visits and proper coding methods</p>	<p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <p>Percent of preterm births (&lt;37 weeks)</p> <p>Percent of early preterm births (&lt;34 weeks)</p> <p>Percent of late preterm births (34-36 weeks)</p> <p>Percent of early term births (37, 38 weeks)</p> <p>Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>Infant mortality rate per 1,000 live births</p> <p>Neonatal mortality rate per 1,000 live births</p> <p>Post neonatal mortality rate per 1,000 live births</p> <p>Preterm-related mortality rate per 100,000 live births</p>			

**State Action Plan Table**

**Women/Maternal Health**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Improve access to family planning services	<p>2.1. Collaborate with 18 public health districts to promote family planning services by 2020</p> <p>2.2. Ensure family planning providers in all 18 public health districts have been trained to provide care to teens by 2020</p> <p>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</p>	<p>2.1.a. Collaborate with district offices to develop promotional campaigns for family planning services 2.1.b. Implement promotional campaigns</p> <p>2.2.a. Provide in-person trainings to public health providers on providing appropriate care to teens</p> <p>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</p>				

**Women/Maternal Health**

**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 in the upcoming year. A Maternal Mortality Review Committee (MMRC) was recently established. The committee reviewed cases from 2012 and is currently reviewing 2013 cases. There is currently only one data abstractor. MCH plans to work with Georgia Obstetrical and Gynecological Society (GOGS), the organization which administers the review committee to train additional data abstractors in the coming year.

MCH and the MMRC recently completed the first Maternal Mortality Report with cases from 2012. In the upcoming year, each member of the committee will receive presentation slides and educational packets to ensure that the data is presented consistently.

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. In the upcoming year, MCH Epidemiology will develop a strategic plan for training facilities on the requirement and identify facilities to educate.

Data to Action is an important component of the MMRC that has not been fully realized. In the upcoming year, the MMRC will identify a Data to Action team that will be responsible for planning and implementing translational activities based on the review committee’s findings.

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 first year working with district offices to develop strategic plans for marketing strategies.

**Priority Need: Improve access to family planning services**

Improving access to family planning services will be a focus of MCH for the new reporting cycle. 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 long-acting reversible contraception (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**

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	62.1	61.5	60.9	60.3	59.6

**2011-2015 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. PCM continues to occur in DPH’s public health districts. Clients who receive PCM are referred to OB providers, WIC and Medicaid to receive services to assist with their pregnancy.

CenteringPregnancy is a model of group prenatal care where pregnant women of similar gestational age participate in prenatal care together. At the sessions, individual health assessments are performed, but women receive

education as a group and provide support to one another. MCH has worked with stakeholders to consider how to expand the CenteringPregnancy model in Georgia in order to improve overall access to and utilization of prenatal care. Quarterly conference calls with stakeholders were held to discuss how to build capacity for expanding CenteringPregnancy.

Current Activities

MCH recently hired a perinatal nurse, who is responsible for partnering with March of Dimes to increase CenteringPregnancy sites in Georgia. United Way of Greater Atlanta hosted a conference to raise awareness about CenteringPregnancy and generate interest in the program. MCH participated in the conference.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Prevent infant mortality	<p>3.1. Increase the number of birthing hospitals participating in the 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</p>	<p>3.1.a. Recruit hospitals through in-person presentations on the 5-STAR Hospital Initiative</p> <p>3.1.b. Provide in-person trainings to hospitals participating in the initiative</p> <p>3.1.c. Recognize hospitals for participating in the 5-STAR Hospital initiative</p> <p>3.2.a. Using evaluation forms from previous trainings, identify topics to educate public health workers on</p> <p>3.2.b. Conduct VICS trainings for public health workers</p>	<p>Post neonatal mortality rate per 1,000 live births</p> <p>Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>	<p>A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months</p>		

**State Action Plan Table**

**Perinatal/Infant Health**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	<p>have policies and education that adhere to the American Academy of Pediatrics (AAP) safe sleep guidelines</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 Program</p> <p>3.4.b. Provide in-person trainings to hospitals participating in the program</p> <p>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>				

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Prevent infant mortality	3.5. Ensure all birthing hospitals have been educated on the requirements for neonatal level of care by 2020	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	Perinatal mortality rate per 1,000 live births plus fetal deaths <hr/> Infant mortality rate per 1,000 live births <hr/> Neonatal mortality rate per 1,000 live births <hr/> Preterm-related mortality rate per 100,000 live births	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)		

**Perinatal/Infant Health**

**Perinatal/Infant Health - Plan for the Application Year**

**Priority Need: Prevent infant mortality**

In order to reduce the high infant mortality rate in Georgia, work is being done to address several causes of infant mortality including breastfeeding, safe sleep and perinatal regionalization.

The 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, a conference is planned to educate hospitals on the process for becoming breastfeeding-friendly and to encourage participation in the initiative. MCH will continually provide support to those hospitals that are participating by providing training on the 5-STAR process and recognizing hospitals for all steps taken. MCH also plans to educate public health workers on the importance of breastfeeding promotion and strategies to address community misperceptions regarding breastfeeding. Three virtual trainings for public health workers have been planned for this year. The purpose of the trainings is to empower public health workers at all levels to promote breastfeeding.

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 DP, 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. Examples of partnerships that will be sought are universities, grocery stores and retailers. The Center for Black Women’s Wellness and other non-hospital providers will be engaged for the specific purpose of reducing disparities. Educational materials will be distributed to ensure consistent messaging throughout Georgia regarding safe sleep practices. 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. Additional funding will be sought to implement a crib/bassinet distribution program.

The perinatal regionalization 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. Hospitals with a Level I designation provide the lowest level of neonatal care and should only provide care for low-risk pregnancies and healthy infants. In order to ensure that hospitals are operating at their designated level of neonatal care, a Perinatal Capacity Survey was disseminated in July 2014. The purpose of the survey was to compare neonatal level of care designations and operational level of care. The data is currently being reviewed and will be eventually used to promote compliance with neonatal level of care requirements with the Department of Community Health, the agency responsible for assigning neonatal levels of care. Data will also be used to inform strategies developed at a Perinatal Regionalization strategic meeting occurring in FFY2015. The strategic planning meeting will include all Regional Perinatal Centers. The purpose of the planning meeting is to develop consensus on the purpose and benefits of the perinatal regionalization system and identify areas to be improved.

In the upcoming year, efforts will also be made to reduce preterm births and their impact on infant mortality. MCH will continue to partner with the March of Dimes banner program that recognizes hospitals achieving 5% or fewer early elective deliveries. Nearly twenty hospitals in Georgia have been awarded the banner and several more are in the application process. Additionally, MCH is beginning an AMCHP grant focused on preterm labor assessments. Targeted efforts will be made to prevent preterm births in areas with higher percentages by collaborating with GOGS, a CMO and ASTHO to encourage immediate postpartum LARC placement.

**Perinatal/Infant Health - Annual Report**

**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
Annual Objective	81.8	82.8	83.9	84.9	85.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.5	79.3	80.1	80.9	81.6

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	19.1	19.3	19.5	19.7	19.8

**2011- 2015 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 Newborn Screening Follow-up Coordinators complete Children First referrals on all diagnosed cases. The Children First referrals are made to assess the newborn's eligibility for IDEA Part C Babies Can't Wait or the Children's Medical Services Program. In 2014, 724 infants diagnosed were referred to appropriate CSHCN programs.

The NBS Program supports the diagnosis and treatment of children birth to 21 with metabolic disorders. Beyond the assistance to provide specialized dieticians to assess patients, the NBS Program provided \$49,960 for special formula and low-protein modified foods.

The Georgia Public Health Lab and the Newborn Screening Program collaborate routinely on the development of policies, procedures, budget, data exchange, evaluation and education. MCH Epidemiology continues to analyze data on Newborn screening results and link with electronic birth certificates in the State Electronic Notifiable Disease Surveillance System (SendSS). Through monitoring and reporting of hospital performance, hospitals have access to hospital specimen reports through SendSS. The reports display a list of unsatisfactory screens and the cause of the unsatisfactory determination and statistical measures on the hospitals comparative performance to the state. This report is used to monitor hospital performance and identify specimens needing to be repeated. Emory University, Georgia Regents University, 18 public health districts and now Children's Healthcare of Atlanta are contracted to conduct follow-up on abnormal results. Each of the contractors utilize a database to track newborns through diagnosis, utilize follow-up protocols and have at least 12 steps to locating families and providers.

NBS also provides NBS information to each parent via the hospital, doctor's office or health department prior to having a metabolic, critical congenital heart disease and hearing screen completed. NBS also partners with the Georgia Hospital Association, and published information on the website and through social media, and through webinars.

NBS created a CCHD tool kit to assist hospitals in designing CCHD programs. MCH is currently working with the Georgia Perinatal Quality Collaborative (GaPQC) to improve perinatal outcomes and is working with several hospitals on the CCHD component. Genetic counseling services are provided to all newborns identified through newborn screening who have sickle cell "trait" through a contract with Grady Memorial Hospital and the Sickle Cell Foundation of Georgia. Other carriers, cystic fibrosis carrier and galactosemia carriers are offered counseling through Emory University.

To communicate progress and results, the Georgia Newborn Screening and Genetics Advisory Committee meets twice a year.

Current Activities

CCHD screening is occurring in approximately 99% of birthing hospitals with 92% reporting results to DPH. Follow-up for SCID has been established and the TREC assay has been tested and validated. Universal screening is

expected to happen October 2015. 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. As a result, less than 31% of all hospitals had less than 1% unsatisfactory screens. There was also an overall increase in compliance with timeliness and specimen quality. Telephone consultations and on-site in-services with birthing hospitals continue. The Georgia Public Health Laboratory continues to notify providers when an unsatisfactory specimen has been submitted. The largest birthing hospitals actively request repeats on all unsatisfactory specimens submitted by their facility.

Another major activity is the education of pre- and postnatal families and healthcare professionals about newborn screening and the importance of follow-up of positive results by disseminating information via multiple communication methods, including the NBS brochure, DPH website, social networking sites, newsletter articles and training/professional development. As a result of these efforts, each parent receives a brochure in the hospital, doctor's office or health department prior to having a metabolic, critical congenital heart disease and hearing screen completed. Provider education is completed in a variety of ways. The Georgia NBS Program contracts with professional organizations such as American Academy of Pediatrics Georgia Chapter, Georgia Academy of Family Physicians, and Georgia Obstetric and Gynecologic Society to educate providers. The SendSS team, NBS Program staff and MCH Epidemiology meet bi-weekly to discuss needed improvements, build new requirements and monitor the progress of any changes. Hearing and CCHD results have been incorporated into the provider report. New functionalities in the hospital specimen report have been added and a pending report for cases currently in follow-up was created to monitor the length of time to close cases.

### **2011-2015 NPM 11: Percent of mothers who breastfed their infants at 6 months of age**

#### Last Year's Accomplishments

MCH began a strategic plan with WIC and Worksite Wellness colleagues focused on breastfeeding initiation.

#### Current Activities

MCH has been leading efforts to maintain breastfeeding coalitions and collaborative efforts at the state and district level. In collaboration with Healthy Mothers Healthy Babies and the GA-AAP, breastfeeding training is provided to physicians. MCH also participates in work with Reaching Our Sisters Everywhere (ROSE) and Association of State and Territorial Health Officials' (ASTHO) Breastfeeding State Learning Community. The Georgia Five-STAR initiative was implemented to reward hospitals for taking steps toward becoming breastfeeding-friendly. Seven hospitals have joined so far. A breastfeeding consultant was hired to conduct trainings with 20 hospitals in May 2015 to educate hospitals on the initiative and encourage participation. Two agency-wide virtual trainings were conducted to educate public health staff on breastfeeding benefits and how to address myths and stigma with three more scheduled for this year. Georgia Shape promotes breastfeeding in their presentations to the community to prevent obesity. There continues to be a lactation room in the state office building that is managed by Worksite Wellness.

### **2011-2015 NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge**

#### Last Year's Accomplishments

Hospitals are now electronically reporting quarterly data into SendSS, the newborn screening data system. This allows hospitals to view a performance measure report that includes additional information (e.g., percent screened and referred before discharge, percent rescreened by 1 month and percent babies lost to follow up born at that facility). Lost-to-follow up measures were included to inform facilities on how well they educate families on the importance of follow up for babies not passing newborn hearing screen. Outreach continues to hospitals that have high referral rates (>5%) or extremely low referral rates (<1%). The Early Hearing Detection and Intervention (EHDI) Program Coordinator presented at the Georgia Association of Young Children (GAYC) Conference in October 2013.

The EHDI Stakeholders Committee Meetings continue to be held quarterly and health districts hold local stakeholder meetings bi-annually. The EHDI website serves as a resource for hospitals, audiologists and others in following best practices for newborn hearing screening. Many districts contract with audiologists who provide technical guidance and yearly training to hospital staff conducting newborn hearing screening. The Georgia AAP has published two articles on newborn hearing screening and follow-up as well as facilitated a webinar on newborn hearing screening. Finally, newborn hearing screening results and risk factors for late onset hearing loss are to be added to the state's Electronic Birth Certificate (EBC) and to the Newborn Screening bloodspot card. Newborn hearing screening results are shared on the report for primary care physicians with the newborn screening bloodspot report when available.

#### Current Activities

The EHDI Program is moving towards more efficient ways to document all hearing screening. Hearing screening is occurring in all birthing hospitals. Most hospitals are reporting all screens to DPH. An EHDI resource guide for the state with several districts including the information in social media messaging and on local health department websites was developed to provide general education and awareness around EHDI and the importance of follow-up screening. In order to reduce the percentage of babies who are lost to follow-up/documentation, targeted outreach in districts that have a high lost to follow up rate was conducted. The training included provider outreach, technical training and site visits. Individualized reporting of newborn hearing screening results and automated reporting of results through newborn screening bloodspot card was implemented.

MCH has also been working with hospitals not currently using newborn screening cards to report newborn hearing screening results. Targeted outreach to facilities that have increased number of babies missing newborn hearing screening results on newborn hearing screening cards has occurred. A system of reporting for those babies not reported on newborn hearing screening card to be sent to the program for data entry is being developed. Finally, curriculum has been developed for audiologists on diagnostic audiology procedure on newborns not passing newborn hearing screening and providing a mentorship, if desired, with large pediatric audiology practice.

### **2011-2015 NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates**

#### Last Year's Accomplishments

A standardized reporting tool for the Regional Perinatal Centers was developed by MCH Epidemiology to assist Regional Perinatal Centers as they report data to MCH. The Perinatal Nurse attended orientation visits at the Regional Perinatal Centers. The Perinatal Capacity Survey was implemented to assess the current functioning level of neonatal hospitals.

#### Current Activities

The standardized reporting tool for the Regional Perinatal Centers is currently being revised. Once revisions are completed the tool will be implemented across all Regional Perinatal Centers. The findings from the Perinatal Capacity Survey are being analyzed and results will inform the process of ensuring perinatal level of care designations match performance level. Site visits of the Regional Perinatal Centers will start in FY2016 with a mock visit in the first half of the year and a site visit in FY2017. A strategic planning meeting for the Regional Perinatal Centers will occur in FY2016 to develop a plan for improving the perinatal regionalization system.

### **2011-2015 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

All efforts to prevent infant mortality were led by the Infant Mortality Reduction Initiative Task Force. MCH actively participated in all five Collaborative Improvement and Innovation Network (CoIIN) teams. MCH funded and provided

technical assistance to two home visitation programs throughout the state to address high-risk women and infants by providing intensive case management. The Georgia Perinatal Quality Collaboration (GaPQC) was developed to improve pediatric care.

Injury Prevention staff were able to implement a policy change. Department of Early Care and Learning (DECAL) changed its safe sleep recommendations for all infants in licensed daycare facilities.

Current Activities

GaPQC continues to meet regularly. A Leadership Retreat was held to plan and discuss the procedures and policies of the collaborative.

The Safe Sleep Coordinator is currently framing safe sleep messaging and identifying areas where safe sleep messaging is not consistent. An Education Flipchart was developed and has begun to be distributed. Georgia Department of Families and Children (DFCS) adopted the flipchart and created a policy requiring case managers to discuss safe sleep with their clients. Additionally, they produced an awareness video on safe sleep. A community toolkit is under development for SIDS Awareness Month held in October. Contact was made with La Leche League of Georgia to align messages on safe sleep regarding bed sharing. Faith-based communities are also engaged in safe sleep discussions. A webinar with the Director of the National Safe to Sleep Campaign, Dr. Artis, was hosted in February 2015. Community norms continue to be impacted through numerous presentations that have been made to communities throughout the state on Safe to Sleep. The “Implementing a Hospital-Based Safe to sleep Program- An Education and Policy Development Guide” was completed in April 2015. A meeting was held with the Georgia Hospital Association to solicit support. The Safe Sleep Coordinator continues working to identify a contractor to conduct a program evaluation.

State Action Plan Table						
Child Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Promote developmental screenings among children	4.1. Ensure all 18 public health districts are documenting developmental	4.1.a. Develop a standardized process for documenting and submitting	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	Percent of children, ages 10 through 71 months, receiving a		

**State Action Plan Table**

**Child Health**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	<p>screenings by 2020</p> <p>4.2. Educate 20 partner organizations and primary care provider offices on developmental screenings by 2020</p>	<p>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 quality (completeness, accuracy etc.)</p> <p>4.2.a. Enhance partnership with DECAL, primary care providers, GA-AAP and GA-AFP</p> <p>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</p> <p>4.2.c. Collect</p>	<p>Percent of children in excellent or very good health</p>	<p>developmental screening using a parent-completed screening tool</p>		

**State Action Plan Table**

**Child Health**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
		developmental screening data from DECAL and primary care providers				
Promote physical activity among children	5.1. Increase the percentage of Georgia's Fitnessgram assessed student population that fall in the Healthy Fitness Zone for Body Mass Index by 1% each year for 5 years	5.1.a. Use existing coalitions to reach Churches, Community 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 in excellent or very good health  Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day		

**Child Health**

**Child Health - Plan for the Application Year**

**Priority Need: Promote developmental screenings among children**

The primary focus of activities related to developmental screenings will be improve and document screenings

occurring in public health programs and encourage developmental screenings among pediatricians outside of the public health system. In the upcoming year, MCH will work with the districts to standardize the process for documenting developmental screenings. MCH will also work with the districts and MCH Epidemiology in order ensure a seamless data collection process.

In order to promote developmental screenings outside of the public health system, MCH plans to enhance partnerships with DECAL and primary care providers in the upcoming year. The partnerships will be used to develop a strategic plan for educating primary care providers on the importance of a developmental screen and information on the screening tools with the highest positive predictive values.

**Priority Need: Promote physical activity among children**

In the upcoming year, Georgia Shape will continue evaluation efforts using Power Up for 30 data and consider policy recommendations to be made based on the findings. In fall of 2015, the first Georgia Shape Public Health Reports special supplement is scheduled. Researchers from across the state have submitted original work for publication in this special supplement. Entries will support and inform the Georgia Shape Overarching Evaluation Project that is currently underway. A formal in-person symposium will take place on October 5th at Georgia Shape’s partner academic institution, The University of Georgia. This exciting symposium will also serve as the yearly state of Georgia Shape meeting. Georgia Shape has begun promoting nutrition as well as physical activity. Georgia Shape and partners from Cornell University, the University of Georgia, and Children’s Healthcare of Atlanta will continue to move the Smarter Lunchroom movement further. Nutritionists across the state will be trained on how to effectively create healthy nutrition behaviors in school lunchrooms. Strong4Life (Children’s Healthcare of Atlanta) is serving as the implementation partner in training schools across the state with this content.

**Child Health - Annual Report**

**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
Annual Objective	45.9	45.9	45.9	45.9	51.6

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

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

**2011-2015 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

Monthly classes are held to train caregivers. Car seats are distributed in the classes, including car seats for children with special health care needs.



IP staff worked with counties on the 2014 CPS Mini-Grant guidelines. One hundred twenty-eight Mini-Grant applications were received. The Child Occupant Safety Program (COSP) staff worked with 16 families to arrange for appointments, seat distributions and Medicaid coverage processing.

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. The stickers are then submitted back to Injury Prevention (IP) staff after a crash. In 2014, IP staff received 18 Teddy Bear Stickers.

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

- “You have the Power in Your Pen” – 79 attendees
- CPST Class- 10 people certified
- CPST recertification class for current CPSTs- 17 attendees
- “Transporting Children with Special Health Care Needs Training”

The child fatality review team report was reviewed in January 2014. Recommendations were made for CFR team and to GOHS for purposes of minority outreach data collection. The COSP will be hiring a bilingual Spanish Program Consultant position to determine what type of minority CPS education and outreach is being offered in Georgia.

### 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. Monitoring is done quarterly to determine the number of seats distributed. The number of lives saved continue 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. Child passenger safety trainings to internal and external stakeholders continue. A Special Needs training was conducted in Hall County. 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.

### **2011-2015 NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85<sup>th</sup> percentile**

#### Last Year's Accomplishments

Georgia Shape funded Strong 4 Life and Georgia WIC Strong 4 Life Training: “Improving the Effectiveness of Childhood Obesity Counseling and Goal Setting”. Training has been completed in all districts in 2014-15. This training advances VENA (Value Enhanced Nutrition Assessment) in Georgia with motivational interviewing and goal setting skills development as well as assures that Georgia WIC providers are providing similar messages as medical providers in Georgia. In addition to the training, Georgia WIC versions of the Strong 4 Life materials have been provided to all public health districts. These materials include posters, handouts, counseling tools and class outlines. A Strong 4 Life WIC Champions program is in progress with local staff in the role of coach (Champion) to facilitate ongoing skills development for staff providing this program through observations. These observations are also being used to evaluate the program’s success with improving motivational interviewing and goal setting skills. The final evaluation on goal documentation is currently in progress. Georgia WIC continues to support the expansion of group nutrition education classes throughout the state. WIC Districts continue to provide creative nutrition education and healthy cooking demonstrations following lesson plans that include motivational interviewing. The LaGrange Health District implemented grocery store tours open to WIC participants and the local community. Tours were led by public health dietetic interns. Georgia WIC Online has been approved for all districts. WIC recently competed a new breastfeeding lesson in addition to starting the procurement process to purchase a physical activity lesson plan. Districts were provided printed resources on how to utilize the online participant nutrition education system to share with participants. District feedback overall has been very positive with interest in expanding access to more clinics around the state.

## Current Activities

After conducting extensive research, a comprehensive communication plan was developed and approved to increase participation in WIC. The plan provides traditional (radio, television, and out-of-home) and new (email and web) methods of outreach and proposes using social media (Facebook, Twitter, Instagram, etc.). Also, the plan outlines community outreach events Georgia WIC staff will attend. Additionally, Georgia WIC has been represented at various professional conferences to promote the program and encourage partnerships, including the Breastfeeding Conference, Georgia Public Health Association Annual Meeting and Georgia American Academy of Pediatrics. WIC has secured a breast pump purchasing contract with WSCA. The contract provides access to breast pumps at a reduced contract price. Georgia WIC will begin purchasing breast pumps quarterly at the state level and districts will have the opportunity to expand the availability of breast pumps to WIC clients across the state. The Georgia WIC program continues to support creativity in providing nutrition education to WIC participants. An expansion of cooking demonstrations across the state over the next year in addition to off-site education utilizing grocery store tours in a limited number of districts is anticipated. Georgia WIC has expanded peer counseling services to include all 18 public health districts and 1 contract agency (Grady Hospital). The Fulton Health district was the last health district to receive funding and to hire peer counselors. Georgia WIC has an estimated 117 Peer Counselors providing breastfeeding support services across the state.

## **2011-2015 SPM 01: Percent of high school students who are obese (BMI > or = 95<sup>th</sup> percentile)**

### Last Year's Accomplishments

The Georgia Shape/Early Care and Learning Quality Rated recognition program identified early care facilities that have excelled in 14 measures of physical activity and healthy nutrition through the Quality Rated Assessment administered via the GA Department of Early Care and Learning (DECAL). Georgia Shape piloted and implemented Power Up for 30 in 2013-2015. This program is available to all elementary public schools across the state (private funds help implement this large scale statewide program). Currently over 550 elementary schools have agreed to participate and over 465 have implemented the program. A secondary school setting pilot for this work is currently underway and initial focus group work has commenced. Each school team works with experts to create a Coordinated School Physical Activity Plan (CSPAP, aligned with CDC best practices) that each team then implements. The goal of Power Up for 30 is to create 30 minutes of physical activity time for every child, everyday (in addition to Physical Education class). Technical assistance, free and low cost resources and continuing education is available to participants. To date 580 elementary schools have signed up for the program, over 465 have been through the training component (whereby touching over 275,000 children so far).

### Current Activities

A physical activity and nutrition toolkit created by Georgia Shape and partners that teaches early care providers how to implement related best practices and create change in their setting(s) was developed. This work was piloted in late 2014 and early 2015. The first large scale training (29 centers in rural Georgia) will commence summer of 2015. This work allows early care centers to analyze their environment and create policies that increase physical activity and healthy nutrition in a way that fits each center's diverse needs and wants. The long standing relationship between Georgia Shape, the Department of Education, Atlanta Falcons, Children's Healthcare of Atlanta, HealthMPowers, and academic agencies has proven to be very fruitful in getting this work accomplished. Three years of Fitness assessment data have been collected and the fourth year (school year 2014-2015) is currently being analyzed. Over a million students enrolled in 1-12 grade, public school physical education classes are assessed across the state each year. Last year Georgia was recognized by the President's Council of Fitness, Sports and Nutrition as the first state in the nation to adhere to the Presidential Youth Fitness Program. The Georgia Shape Grantee program has now awarded over 79 mini grants and expert technical assistance to schools across the state, including elementary, middle and high school settings.

## **2011-2015 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

Enhancements to the SendSS-NB web-based data system were made to add data from the Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire: Second-Edition (ASQ:SE) data. Efforts to conduct web-based ASQ screenings were put on hold until a universal screening tool was selected by the collaborative agencies.

Current Activities

Currently, collaboration is occurring with district child health programs to assure that all data for ASQs and ASQ:SEs are being included in one centralized data system. Children First and Babies Can't Wait staff enter ASQ and ASQ-SE results into SendSS. Between October 1, 2014 and December 31, 2014, 2,863 ASQs were documented and 512 ASQ-SEs were documented. Children First Coordinators review data quarterly in SendSS and identify issues in documentation for developmental screens. As a result of reviewing the data, some districts are identifying ways to better coordinate documentation into SendSS.

State Action Plan Table						
Adolescent Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Reduce suicide among adolescents	6.1. Increase the number of schools participating in the "Step Up and Step In" Awareness Campaign to 20 by 2020	6.1.a. Revise and improve the DPH Adolescent and School Health "Step Up. Step In." Awareness campaign website 6.1.b. Partner with Adolescent and School Health to provide support for schools as they develop and implement innovative communication techniques for schools to address bullying in middle and high school (e.g. pep rally awareness,	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Percent of adolescents, ages 12 through 17, who are bullied or who bully others		

State Action Plan Table						
Adolescent Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
		morning PSAs etc.) 6.1.c Increase partnership with local schools to address bullying				

### Adolescent Health

#### Adolescent Health - Plan for the Application Year

##### Priority Need: Prevent suicide among adolescents

Addressing suicide will be a new activity for MCH. The upcoming year will provide MCH the opportunity to build collaboration with the Step Up. Step In. Campaign through Adolescent and School Health (ASH). Regular meetings will be held with MCH and ASH to determine areas where MCH can partner in ongoing activities. One planned activity for the coming year is to revise and improve the Step Up. Step In. website to raise awareness about the campaign, as well as emphasize the bullying aspects of the campaign. The website will serve as a promotional tool to schools that are looking to participate in the mini-grants offered to schools that implement anti-bullying campaigns.

#### Adolescent Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	25.3	24.6	24.6	24	24

There were no activities primarily administered by the Title V program in FY 2015 addressing adolescent health. All partnership activities related to adolescent health will be discussed under Other Programmatic Activities.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs

**State Action Plan Table**

**Children with Special Health Care Needs**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
<p>Improve systems of care for children and youth with special health care needs</p>	<p>7.1. Increase by 5 the number of organizations at the state, local and community level that are active partners by 2020</p> <hr/> <p>7.2. Increase awareness of services provided to CYSHCN through the development and promotion of 1 resource portal by 2020</p> <hr/> <p>7.3. Educate students in 8 schools of health</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 care7.1.b. Expand the systems of care advisory committee, Interagency Director’s Team, to include medical care partners</p>	<p>Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system</p> <hr/> <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>		

**State Action Plan Table**

**Children with Special Health Care Needs**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
	<p>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 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>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 7.2.b. Develop app for CYSHCN resources with Georgia Tech 7.2.c. Host 1 educational event in each public health 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</p>				

**State Action Plan Table**

**Children with Special Health Care Needs**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
		with special health care needs 7.4.a. Conduct an environmental scan identifying telehealth sites providing specialty care 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				

**Children with Special Health Care Needs**

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

**Priority Need: Improve systems of care for children and youth with special health care needs**

A Systems of Care Advisory Committee will be expanded this year to include input from medical care providers. The purpose of the committee is to provide input into plans related to improving care for CYSHCN both inside and outside of MCH CYSHCN programs.

In order to increase awareness of the services available to CYSHCN in Georgia, DPH’s Child Health website will be revised in the upcoming year. The website will be user-friendly and provide information about medical homes, transition and district-level resources. In the coming year, DPH will begin conversations with Georgia Institute of Technology to discuss the development of an app that would provide resources to families. MCH will also plan educational events in public health districts to personally educate families about resources and services that are available to them.

MCH will expand partnerships with academic institutions this year to eventually incorporate training on providing

services to CYSHCN into their curriculum. MCH will reach out to medical schools, dental schools and nursing and physician's assistant programs to solicit interest.

Efforts specific to equipping CYSHCN to transition to adulthood will be implemented in the coming year. A standardized transition plan protocol for CMS will be developed. CMS Coordinators in all public health districts will be trained on the Health Care Transition Curriculum. The transition plan protocol will be piloted with 2 to 3 public health districts in the upcoming year and revised prior to implementation across all public health districts.

**Children with Special Health Care Needs - Annual Report**

**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
Annual Objective	34.2	34.6	34.9	35.3	35.6

**2011-2015 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

An unduplicated count of 10,983 CMS families and 16,411 BCW families were served in FY2013. BCW collaborated with families to develop individual family service plans IFSP(s). Parent to Parent of Georgia (P2PGA) provided 165 online training opportunities for families of children with disabilities or chronic medical conditions. P2PGA completed a second round of transition to adulthood webinars with youth as presenters or co-presenters alongside professionals. Also, the MCH Parent Consultant developed an online family leadership training module which was added to the CYSHCN webpage. Based on the client surveys conducted, it was determined that early intervention services have helped BCW families know their rights, communicate their children's needs and help their children develop and learn. There were several other findings from families participating in Genetics and Sickle Cell clinics such as satisfaction ratings of services, timeliness of getting an appointment, and provision of adequate information about their child's condition. Finally, families were chosen to participate as team members in several program planning activities, and families and youth were an integral part of the D70 Youth Summit.

Current Activities

All CMS patients are receiving Care Coordination services, which includes the development of a Plan of Care. During FY15, 8,696 families received services from CMS. The Care Plan is developed during the initial visit with the CMS Care Coordinator and updated at a minimum every 6 months. There is now a Parent Consultant on staff that supports child health services programmatic activities and quality assurance projects. There is ongoing formal collaboration with Parent to Parent of Georgia to support CMS and BCW programmatic activities. There is also family involvement in the Plan of Care/Care Coordination process which incorporates evaluation and monitoring, elicits feedback in regards to service satisfaction, and any new and ongoing needs. 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. Families receiving support through the pilot are surveyed on their satisfaction of the services received. Finally, there will be three Transition to Adult Care Youth Summits. Marketing materials created to promote youth summit participation was distributed to CMS Coordinators and they were able to share with their families.

**2011-2015 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. A total of 95% of CMS families reporting having a primary care provider and referrals to a primary care provider when needed. Through the Integrated Community Systems for CSHCN Grant (D70), knowledge and awareness of the medical home concept was increased. Medical and dental home curricula were developed by Parent to Parent of Georgia based upon booklets created through our previous Early Childhood and Comprehensive Systems (ECCS) Grant. Progress has been made in increasing the number of certified medical home providers. Within a period of about two years, Georgia saw an increase from approximately 250 certified medical home providers/ practices to over 1,000. DPH has engaged clinicians to provide education where Dr. Jeffrey White, Georgia's first pediatric practice to receive national Medical Home certification, presented on medical home and transition. GA-AAP created a page on the Chapter's website regarding transition and archived webinars pertaining to transition and medical home.

### Current Activities

Ongoing professional development occurs through The National Center for Medical Home Implementation webpage and listserv to educate state and district level staff and medical and non-medical providers on the definition and components of a medical home. New BCW and CMS clients are assessed for a primary care provider, and referrals are made for clients without a medical home. As a result, 97% of CMS families currently report having a primary health care provider.

## **2011-2015 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

Among CMS clients, 72% have Medicaid, 5% have PeachCare for Kids (SCHIP), 9% have private insurance, 1% has Tricare and 13% are uninsured. CMS is the primary source of insurance coverage for clients who are uninsured. Approximately 32% of CMS clients receive SSI. The CMS and BCW Program Managers were invited to participate on the Medicaid Georgia Families 360 Taskforce to migrate children receiving foster care and/or adoptive assistance to Care Managed Organizations (CMOs). As a result of their participation, children and youth with special needs within this population were allowed to be exempted from coverage through the CMO. It was determined that CYSHCN with more intensive medical needs would receive a higher level of care coordination through fee-for-service Medicaid and CMS. Also, BCW providers were added as CMO network providers, thereby reducing delays in services for children receiving early intervention services. Lastly, the CMO provided training to providers and state and district staff.

### Current Activities

Insurance status is assessed for all newly enrolled CMS members. CMS Care Coordinators utilize the CYSN Financial Analysis form to collect family income as well 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 Medicaid and SCHIP programs and assist with the applications. For families that do not qualify for Medicaid or SCHIP programs, CMS will serve as the payor of last resort for all healthcare and medical expenses. 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, the entity responsible for Medicaid and SCHIP program enrollment, are contacted to provide guidance and resolution.

## **2011-2015 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

Care coordination services, which include referrals to community resources, are provided to all CMS patients/families.

### Current Activities

The Parent as Partners Pilot 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 CMS. 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 the department of Environmental Health. There are five 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. The Newborn Screening and CMS programs are working together to expand telemedicine services in Valdosta, Macon, Waycross and Dublin. Finally, CMS Care Coordinators connect families with existing support groups facilitated by Parent to Parent of Georgia.

## **2011-2015 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

The primary accomplishments include collecting data on percent of clients and families with a transitional plan of care. Of CMS clients aged 16-21, 94% had active transition plans. Parent to Parent of GA conducted 4 statewide focus groups on revising the CMS Transition Manual, one of which was held in Spanish, and one which was held with youth only. MCH developed a webinar series to train families, professionals, and district coordinators on transition of youth with special health care needs to all aspects of adulthood. Dr. David Levine was identified as the GA-AAP Chapter Champion for transition services to assist in facilitating and promoting the Integrated Community Systems for CYSHCN to society membership. DPH in collaboration with GA-AAP and GAFP developed a "Physicians Guide to Transitioning Youth from Pediatric Primary Care to Adult Primary Care" to assist practitioners in implementing the six core elements of health care transition. GA-AAP created a page on the Chapter's website regarding transition and archived webinars pertaining to transition and medical home. DPH contracted with Parent to Parent to develop and conduct peer leadership and transition to adulthood trainings for youth peer mentors, and to train transition-aged youth to serve as peer mentors for others dealing with transition to adulthood issues such as accessing insurance, being successful in college, etc. Through the D70 Grant, MCH partnered with Georgia State University's Center for Leadership in Disability (GA Lend Program) to host a statewide youth transition summit. Over 100 youth, family members and professionals attended the summit.

### Current Activities

Of CMS patients ages 16 to 21, 85% currently have a transition plan. The state partnered with Parent to Parent to revise The CMS Transition Manual. 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 CMS. 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 Title V 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.

**2011-2015 SPM 06: Percent of pediatricians and family physicians who have positive attitudes toward treating children with special health care needs**

A survey was not developed to track this measure.

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Promote oral health among all populations	<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</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>		

**State Action Plan Table**

**Cross-Cutting/Life Course**

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

**Cross-Cutting/Life Course**

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

**Priority Need: Promote oral health among all populations**

The Oral Health program will continue to promote oral health among all populations, with a special emphasis on promoting oral health care services among pregnant women and preventive visits for children. The Oral Health Annex (contract) the state has with the health districts in FY2015 included a recommendation to include perinatal oral health services for WIC and other public health patients. In FY16 Annex perinatal oral health education and/or screening, treatment or referral is a required service.

The Oral Health Annex (contract) the state has with the health districts included their participation on school-based prevention programs like: oral health education and/or screening, placing sealants, fluoride varnish and referral is a required service. The Oral Health staff will present the important of dental referrals for those children that need dental treatment to the districts statewide and educate parents, school staff about the benefits of oral health prevention services to avoid dental decay.

In order to increase access to oral health services for CYSHCN, the Oral Health program will begin 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. Two comprehensive 2 hour presentations will be offered to educate and update district oral health staff on special considerations and treatment needs for special needs patients.

The Oral Health program will continue to maintain the current 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.

**Cross-Cutting/Life Course - Annual Report**

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

**Annual Objectives**

	2016	2017	2018	2019	2020
Annual Objective	39.5	39.9	40.3	40.7	41.1

**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
Annual Objective	79.0	79.8	80.6	81.4	82.2

**2011-2015 NPM 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth**

Last Year's Accomplishments

The oral health school based prevention program placed 7,149 dental sealants on 2,105 children in FY2013. Later in 2014, information will be available evaluating the cost of public health's preventive services/cost of averted caries or cost of restorations prevented. Sharing best practices through quarterly Oral Health Coordinators' meetings with dental public health providers throughout the state has occurred through "Oral Health, Oral Cancers and HPV", "Essential Services of Public Health", Dental Sealants: Evidence-Based Recommendations, School-based Sealant Program Funding and partnership, Data collection for the Oral Health program. A Fluoridation Specialist spoke at a virtual class with district personal April 2014 on community water fluoridation. Ongoing consultative support and technical assistance, including monitoring and evaluation, is provided to the district offices. The state is in constant contact with the districts to provide updates on best practices and surveillance data. Each district reports monthly on the Oral Health Database data on populations served with preventive services. Current school-based/linked sealant programs using Grant-in-aid and Title V resources are maintained. Targeted outreach was conducted among schools that are 50% or higher on free and reduced lunch program and other high risk factors including the percentage of the vulnerable student populations. Additionally, training materials for school nurses on dental preventive measures were developed along with screening for oral diseases while referring and educating children on good oral health and home care. Eleven of the fifteen action steps of the State Oral Health Plan developed by the Coalition were achieved. The plan was disseminated around the state, posted on the ASTDD website and can be found on the Coalition website. Implementation of fluoride varnish application during routine well baby and toddler visits has been slow although training of medical providers was offered. The medical community has expanded CE opportunities for medical professionals. The oral health state office team has offered updated training to all district staff. A Head Start Oral Health survey was conducted. Finally, the water fluoridation program has been very successful. Georgia serves over 96% of the population on community water fluoridation. The Fluoridation Specialist (FS) educates water plant operators on the value, safety, and benefits of the community water fluoridation program, supporting their work in ensuring the fluoridation levels are within the recommended range and that they understand the value of community water fluoridation. During this time period the FS spoke at the GRWA fall conference and held 6 fluoride training classes for water plant operators. FS also spoke to a metro dental hygiene class on CWF.

Current Activities

Oral health surveillance capacity was increased using PRAMS, BRFSS, YRBS, and the Head Start Oral Health Survey data sources. The surveillance data has been placed in a Burden Document and a Surveillance Plan was updated. The data is placed on the CDC National Oral Health Surveillance System (NOHSS) and ASTDD State

Synopsis database. PEW has used the data for state comparisons on oral health preventive visits. The oral health program uses the data to plan population projects. The Oral Health Program staff has also been working with an Economist at CDC on sealant data in Georgia for school based programs and to measure effectiveness. We have also met with a team at Georgia Institute of Technology (GT) to research Medicaid data, shortages of dental practitioners, location of Medicaid dental providers, and access issues. Through Coalition Work Advantage Medicare dental coverage policies were reviewed for cost/covered services and dentists on the plans. A TIPS CDC tobacco initiative was shared with the Coalition to assist with dissemination and a teaching and planning packet for a dental hygiene program to assist students with tobacco prevention and cessation chair side education for patients. The FS held 6 training classes for water plant operators on CWF, spoke to a GDHA group on fluorides and at GPHA annual meeting. FS spoke at the GRWA spring conference on the HHS and CDC revised fluoride levels and spoke to district staff at the latest coordinators' meeting.

### **2011-2015 NPM 13: Percent of children without health insurance**

#### Last Year's Accomplishments

A Central Intake Information and Referral Center was used to provide insurance screening and referral to at-risk families and to monitor and report the percentage of children without healthcare insurance. All children receiving the MCH Integrated Health Assessment are screened for insurance coverage and linked/referred to Medicaid or PeachCare for Kids (CHIP), as appropriate. All data for these activities are entered into SendSS-NB data system for tracking.

#### Current Activities

Current activities include continued use of the Central Intake Information and Referral Center to provide insurance screening and referral to at-risk families. Between October and September, more than 10% of children were referred without health insurance. All children receiving the MCH Integrated Health Assessment are screened for insurance coverage and linked/referred to Medicaid or PeachCare for Kids (CHIP), as appropriate. All data are entered into the SendSS-NB data system for tracking. Nearly 3000 infants received Medicaid or PeachCare for Kids after initial assessment.

### **2011-2015 SPM 03: Number of abstracts submitted, reports prepared, presentations made, and publications submitted for peer review where MCHP staff are authors or coauthors**

#### Last Year's Accomplishments

MCH Epidemiology presented 5 presentations and were co-authors on 2 publications during the reporting period.

#### Presentations:

1. From Good to Great: Using Research and Epidemiologic Methods to Drive Program Improvement—AMCHP Conference, January 2014
2. A Statewide Assessment of Worksite Lactation Support Programs, GA 2013—Discussion Session, 9th Breastfeeding and Feminism International Conference, March 2014
3. Linking PRAMS and final birth certificate data to determine the association of preconception healthy behaviors and pregnancy intention in Georgia women, 2009-2011—2014 CTSE Annual Conference, March 2014
4. Access to Dental Care and Dental Needs Among 3rd Grade Children, Georgia 2010-2011—National Oral Health Conference, April 2014
5. Factors Association with Repeated failures to redeem WIC food vouchers among Georgia WIC participants—CityMatCH Leadership and MCH Epidemiology Conference, September 2014
6. Exploring the Perceived Needs and Barriers to Service Utilization of Clients in Georgia's Family Planning Program - CityMatCH Leadership and MCH Epidemiology Conference, September 2014

#### Publications:

1. Adedinesewo DA, Noory L, Bednarczyk RA, Steinhoff MC, Davis R, Ogbuanu C, Omer SB. (2013 Dec). Impact of Maternal Characteristics on the Effect of Maternal Influenza Vaccination on Fetal Outcomes Vaccine, 31(49), 5827-33.
2. Namageyo-Funa, A., Rimando, M., Brace, A. M., Christiana, R. W., Fowles, T. L., Davis, T.L., Martinez, L.M., & Sealy, D. (2014). Recruitment in qualitative public health research: Lessons learned during dissertation sample recruitment. The Qualitative Report, 10(How to Article 1), 1-17.

### Current Activities

One presentation was made by MCH Epidemiology this year:

Georgia's Family Planning Male Clients: Utilization, Experiences, Perception and Practices - American Public Health Association, November 2014

MCH Epidemiology met weekly to work on research or evaluation projects that would benefit MCH programs. These projects are currently under development. In order to allow for more capacity to prepare presentations and publications, the MCH Epidemiology team is currently going through a restructure. Efforts are being made to ensure access to peer-reviewed journal articles for the Epidemiology staff.

### **Other Programmatic Activities**

#### **Plan for Application Year**

##### **Newborn and Hearing Screening**

The Newborn Screening program (NBS) plans to implement statewide screening and reporting for severe combined immunodeficiency (SCID), critical congenital heart disease (CCHD) and hearing impairment by incorporating these conditions into the six part newborn screening program and adding them to the Georgia NBS panel. The compliance date for screening newborns for CCHD and hearing impairment is July 1, 2015. All hospitals are currently screening infants and reporting results to the NBS Program. Screening results are now on SendSS, the state's website allowing healthcare providers access to screening results. A revised NBS policy and procedure manual and CCHD tool kit will also give support to birthing facilities and providers on collection and monitoring procedures needed for the success of the new screening panel. The state laboratory continues to prepare equipment for SCID testing and screening will begin late 2015.

NBS plans to reduce the number of unsatisfactory specimens (unsats) in the upcoming year through identifying hospitals who submit unsats, notifying those submitters of their specimen collection performance and conducting site visits and offering technical assistance and training to improve specimen collection techniques. Monthly monitoring through SendSS NB module has shown a consistent annual unsatisfactory screening rate for the past 2 years between 2.80-3.90%. The unsatisfactory screening rate for January – May 2015, was 3.43%. Telephone consultations, hospital site visits continue to reduce the rate. Another cause attributing to the stagnant unsatisfactory screening rate is number of delayed and batched specimens and specimen transit times. Through extensive telephone consultations, site visits and articles in partner organizations newsletters and continued monitoring, we were able to reduce the transit day rate from 4.33% in 2014 to an average of 2.12% for the first 4 months in 2015.

Education to pre- and postnatal families and healthcare professionals about newborn screening and the importance of follow-up of positive results will also occur by disseminating information via multiple communication methods including, the NBS brochure, DPH website, social networking sites, newsletter articles and training/professional development. Education helps improve all outcomes when providers and parents are knowledgeable about newborn screening and its aims.

Due to the recent mandate, CCHD reporting on the NBS bloodspot card will continue to be improved.

EHDI plans to continue to improve the referral process from diagnosis to early intervention. Georgia still does not have 100% of diagnosed cases with confirmed entry into early intervention services. This is a priority to achieve improved outcomes in development for hearing impaired children. EHDI also plans to improve communication from screening, diagnosis and referral of intervention by creating scripts and utilizing alternative methods of contact. Unified messaging will improve the percentage diagnosed by 90 days, percentage enrolled by 6 months and percentage loss to follow-up. Now that hearing screening is mandated, EHDI plans to improve individual reporting on the NBS bloodspot card.

## **Annual Report**

### **2011-2015 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**

#### Last Year's Accomplishments

The PHBPP mailed printed copies of the Immunization Action Coalition's e-book, "Hepatitis B: What Hospitals Need to Do to Protect Newborns", to all Georgia birthing facilities. The mailing also included lab interpretation guides, triage flow charts and other educational tools. An article regarding the importance of the hepatitis B birth dose, Hepatitis B Birth Dose Save Lives, was published in the GA AAP's Winter 2014 newsletter, *The Georgia Pediatrician*. The Immunization program through collaboration with the GA Chapter of AAP promotes Healthcare Provider Immunization education, and the AAP Immunization Coordinator attends quarterly PH Immunization Coordinators meeting.

#### Current Activities

Currently, childhood immunizations are promoted through collaboration with GA Chapter of AAP, which promotes Healthcare Provider Immunization education. The AAP Immunization Coordinator attends quarterly PH Immunization Coordinators meeting. Infants exposed to HBV are identified and tracked at birth to ensure completion of the HepB vaccine series and post-vaccination serologic testing. As a result, 312 HBV-exposed infants born in birth cohort 2013 are receiving case management services. A total of 226 (72.4%) infants completed post-vaccination serologic testing by 12/31/2014. Currently, the PHBPP is tracking 356 cases born in 2013-2015 and 140 pregnant cases due in 2015-2016.

### **2011-2015 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 was 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 participants 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 have been provided to teen moms with the intent to reduce second/multiple pregnancies.

### **2011-2015 NPM 15: Percentage of women who smoke in the last three months of pregnancy**

#### Last Year's Accomplishments

The Georgia Tobacco Cessation and Secondhand Smoke Television Media Campaign aired from April 2014 through June 30, 2014. 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. Effective 3/26/14, the Georgia Tobacco Quit Line began offering 8 weeks for NRTs in the form patches or gum to adult members of vulnerable population groups including non-breastfeeding postpartum women, uninsured Medicaid beneficiaries as well as adults with lower levels of education.

The PRAMS data pertaining to smoking prevalence and smoking behaviors among women before, during and after pregnancy were reviewed. Plans include reviewing PRAMS data with epidemiology team for data summary development.

A total of six webinars were developed and posted on the Georgia Department of Public Health (DPH) state agency website in the Georgia cAARds Program- Webinars and Training Section. A total of three additional webinars are scheduled.

The second annual evaluation report customized for pregnant and postpartum participants was ordered.

The Tobacco Cessation Resources for Pregnant and Postpartum Women Section was developed and launched on the Georgia DPH state agency website. Printed materials have been disseminated to clinics, hospitals and county health departments upon request.

The Georgia Quit Line Healthcare Provider Fax Referral form was updated to include Perinatal Case Management and Medicaid Provider referrals.

#### Current Activities

DPH is in the preliminary phase of moving the 18 health districts to electronic health records. Expanding the Georgia cAARds program in 18 health districts will begin concurrently to the new EMR system change. The GTQL and the Quit Line vendor, Alere, have formed an online provider training to increase knowledge and tools of navigating through the Georgia cAARds program.

The GTQL received the 3<sup>rd</sup> annual evaluation report. Findings from the evaluations are under review. The GTQL continues to provide a 10 call tobacco cessation specialty program for women who are pregnant or post-partum. These services are advertised on the DPH website section, Ready to Quit. Other media messages are available to build awareness to the issues of smoking while pregnant.

A data summary on smoking during pregnancy is in the development stage.

## **2011-2015 NPM 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19**

### Last Year's Accomplishments

GVDRS produced a fact sheet for adolescents ages 8 to 19 to be distributed to the school systems every two years. 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.

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

## **2011-2015 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.

## **2011-2015 SPM 07: Percent of very low birth weight infants (<1500 grams at birth) enrolled in First Care**

### Last Year's Accomplishments

State program staff monitored implementation of districts providing home visiting to infants weighing less than 1500 grams. State program staff also provides review of monthly data in a web-based data tracking system. Staff worked toward improving data system to include all standardized forms.

### Current Activities

Staff completed enhancements of SendSS-Newborn data system to include increased data monitoring of district performance in 1<sup>st</sup> Care service delivery. Staff also implement quality assurance/quality improvement protocol in the district.

## **II.F.2 MCH Workforce Development and Capacity**

DPH continues to undergo the Good to Great process throughout the agency. As a part of this effort, MCH has undergone reorganization in the past year resulting in a shift of the Title V workforce. The reorganization began in October 2014 and is expected to be completed December 2015. Reorganizing MCH will 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. As a result, the workforce funded by Title V is relatively new to MCH. This is a critical period to promote the development of the workforce.

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. The Family Engagement Specialist and Title V

manager will be conducting education on block grant activities and equipping the workforce to develop family/consumer partnerships in all programs. 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 Good to Great training sessions to develop the capacity of the workforce.

Another focus of developing the workforce will be on implementing strategies specific to adolescent health. Title V currently has no workforce specifically dedicated to adolescent health programs, however MCH will be expanding in the upcoming reporting cycle to reach this population. There is no designated adolescent health program or staff within MCH. In order to address this population, MCH will partner with Adolescent and School Health to assist with bullying prevention programs.

### **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 do. MCH will utilize those assets to reach 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. Trainings currently planned are:

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

**Objective 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 advise on program strategies.

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

**Objective 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.

#### **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 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 needs assessment. Awareness has been increasing in other states as well and could become an important topic 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 Annual Report/Application. 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. In order to solicit as much awareness as possible about the public comment, presentations were made to the Board of Public Health and District Health Directors. The presentation included a toolkit for these groups to use to solicit awareness. The toolkit contained a schedule of the timing that sections of the needs assessment would be posted and instructions for submitting comments. The toolkits also contained a fact sheet on Title V in Georgia and the needs assessment process. The Title V Manager presented an overview of Title V and the importance of the public comment process to LEND trainees. 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 the priority selection process and helped inform decisions. Several of the comments related to the importance of breastfeeding and developmental screening. The comments were primarily positive and stakeholders were grateful for the opportunity to provide input and participate in the development of the State Action Plan.

Below is a sample of comments that were received:

"As a neonatologist, I like the fact that infant mortality is high on the list. However, the incredible benefits of breastfeeding will help all children. The data is impressive with reductions in illness (short term) and long term. In

addition to reductions in common pediatric ailments, there is a reduced rate of childhood cancer. Later, reductions in adult onset diabetes, Chron's disease and Ulcerative colitis have been documented. Further, women who breastfeed have a 25% reduction in breast cancer and roughly a 30% reduction in ovarian cancer. We could spend another couple of pages summarizing the available data but suffice it to say, we would be a far healthier society if all our children are breast fed.

For those women who cannot breast feed for whatever reason, donor milk programs have bridged the need in our preterm population. Benefits to the term population are documented and there is a push towards placing all children on human milk with a priority being mom's own milk with donor milk serving as needed. The closest donor milk program remains in North Carolina and it be helpful to establish a program in our State."

"I fully believe that breastfeeding should be a public health **priority** in Georgia. Our very own mission statement begins by saying that we are here to prevent disease..... Breastfeeding has been proven to help in the prevention of many diseases that not only plague Georgians but numerous Americans. "

"Please make breastfeeding a public health priority in Georgia. I have spent the last 20 years as a breastfeeding professional and 11 years before that as a volunteer breastfeeding advocate and have seen the physical, emotional, and financial benefits of breastfeeding in action. It would be a huge mistake not to have breastfeeding promotion a recipient of Title V dollars."

"I really would like to see Developmental Screening selected. I know in our southern stakeholder's meeting, we all said we wanted to continue the work of insuring children received a developmental screening."

"Furthermore, while Georgia did see some improvements to the rate of children receiving developmental screenings in recent years, according to the National Survey of Children's Health (NSCH), less than *half* of all Georgia children have been screened for developmental delays over the previous 12 months. In fact, this data would suggest that a majority of children have not received a developmental screening that could help detect serious health and developmental delays. Disparities also exist when the data is stratified by race and ethnicity. Georgia still needs to make significant strides to ensure that most, if not all, children receive these critical screenings. The NSCH data also presumes that children receive valid, accurate, and age-appropriate developmental screenings, which in practice we have found to often not be the case."

"It would be nice to have an emphasis on reproductive health/family planning in the well-women visit."

"Secondly, there is a health care disparity in the grant dollars directed toward maternal care in Georgia. Currently, only 1% of patient care dollars in the Maternal and Infant care (M&I) grant are directed to maternity care, whereas 99% of the patient care dollars are directed toward pediatric/neonatal care. It is essential that this disparity be addressed, and that 50% of the health care dollars be directed to maternity care. Correcting this disparity will provide increased funding to address risk factors for poor maternal health outcomes, such as geographic isolation, patient/provider education and maternal transport. Lastly, the declining number of OB providers and maternal-fetal medicine providers has reached a crisis point. Legislative initiatives to provide financial incentives for OB providers to practice in rural areas have been ineffective. GA DPH must make a priority to create alternatives for providing prenatal care in rural counties which do not have a hospital or do not have a hospital with OB services. Currently, 113 of the 146 counties in Georgia do not provide hospital maternity services. Approximately 20% of the state's population now lives in a county that does not provide hospital OB services. Several measures which may prove effective are re-entry educational programs for outpatient OB providers, reducing malpractice insurance costs to primary care providers who resume outpatient prenatal care and increased use of telemedicine.

I appreciate the opportunity to provide public response to the 2016 budget for the Georgia Department of Public Health."

### **II.F.7. Technical Assistance**

The State Action Plan Chart developed for this application is considered interim until the FY 2017 Application when states will expand their action plans to include State Performance Measures (SPM) and Evidence-based or -informed Strategy Measures (ESM). Although possible SPMs have been identified, Maternal and Child Health (MCH) seeks technical assistance in developing ESMs and performance objectives.

As outlined in the Adolescent Health domain narrative, the Maternal and Child Health section will begin a new endeavor to address adolescent health through partnering with Adolescent and School Health to address suicide and bullying prevention. Since this is a new endeavor for MCH, technical assistance is requested to better understand the role that Title V programs can serve to address adolescent suicide and bullying.

### III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$ 16,171,317	\$ 15,882,994	\$ 16,171,317	\$ 15,634,663
<b>Unobligated Balance</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>State Funds</b>	\$ 126,369,206	\$ 126,369,205	\$ 134,212,376	\$ 83,491,561
<b>Local Funds</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>Other Funds</b>	\$ 150,633,658	\$ 150,133,658	\$ 144,614,443	\$ 150,044,727
<b>Program Funds</b>	\$ 18,316,838	\$ 18,316,838	\$ 19,965,354	\$ 3,771,854
<b>SubTotal</b>	\$ 311,491,019	\$ 310,702,695	\$ 314,963,490	\$ 252,942,805
<b>Other Federal Funds</b>	\$ 293,089,815	\$ 292,876,542	\$ 294,912,047	\$ 294,912,047
<b>Total</b>	\$ 604,580,834	\$ 603,579,237	\$ 609,875,537	\$ 547,854,852

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$ 15,882,994	\$ 15,634,663	\$ 16,438,560	\$
<b>Unobligated Balance</b>	\$ 0	\$ 0	\$ 0	\$
<b>State Funds</b>	\$ 126,369,205	\$ 87,873,596	\$ 92,757,286	\$
<b>Local Funds</b>	\$ 0	\$ 0	\$ 0	\$
<b>Other Funds</b>	\$ 150,133,658	\$ 154,313,381	\$ 157,349,758	\$
<b>Program Funds</b>	\$ 18,316,838	\$ 7,652,922	\$ 3,771,854	\$
<b>SubTotal</b>	\$ 310,702,695	\$ 265,474,562	\$ 270,317,458	\$
<b>Other Federal Funds</b>	\$ 306,402,197		\$ 275,603,567	\$
<b>Total</b>	\$ 617,104,892	\$ 265,474,562	\$ 545,921,025	\$

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.



	2016	
	Budgeted	Expended
<b>Federal Allocation</b>	\$ 16,611,128	\$
<b>Unobligated Balance</b>	\$ 0	\$
<b>State Funds</b>	\$ 98,513,369	\$
<b>Local Funds</b>	\$ 0	\$
<b>Other Funds</b>	\$ 132,713,617	\$
<b>Program Funds</b>	\$ 7,652,922	\$
<b>SubTotal</b>	\$ 255,491,036	\$
<b>Other Federal Funds</b>	\$ 25,324,930	\$
<b>Total</b>	\$ 280,815,966	\$

### 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 2014 MCHBG Budget of \$15,634,663 is \$11,725,997. A TeamWorks report from the Budget Section in the Financial Services Division of DPH, reflects the match is \$11,725,997. Georgia's maintenance of effort (MOE) level is \$36,079,622. Our current MOE level is \$42,797,723 for the FFY 2014 grant as of 6/30/14.

### 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 monitors programs quarterly and provides technical assistance where needed.

The FFY 2016 Budget for the Federal-State block grant partnership sub- totals \$255,491,036. Of this amount, \$16,611,128 is Title V funds. The remaining amounts represent State Funds totaling \$98,513,369, and \$132,713,617 in Other Funds, and \$7,652,922 in Program Income. Other Federal funds that support Maternal and Child Health (MCH) activities in Georgia are estimated at \$25,324,930. 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, Integrated Community Systems for CSCHN, and Early Identification and Intervention Infants and Toddlers. This brings the grand total for the State MCH Budget to \$280,825,966 (see line 11 of Form 2).

For FFY 2016, \$55,903,261 is budgeted for Direct Services, \$37,893,915 for Enabling Services, \$161,693,667 for Public Health Services and Systems.

The total Federal-State Block Grant Partnership for FFY 2016 includes approximately \$7,652,922 in Program Income (See Form 2, line 6). This income is derived from Medicaid earnings for services provided to pregnant and post partum women, preventive health care services to children, and reproductive health services to women.

Of the Title V requested allocation (\$16,611,128), \$6,211,948 or 37.4% 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 to prevent Sudden Infant Death Syndrome (SIDS) and Other Infants Deaths (OID), single point of entry - Children 1<sup>st</sup>, and staffing for Local Health Districts; Children 1-22 years old: Title V funds are used in this area for Children 1<sup>st</sup>, 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 53.2% or (\$8,838,889), is earmarked for Children with Special Health Care Needs to support Genetic/Sickle and Children Medical Services. There is 9.4% or \$1,560,290, 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 - [S599 Contract \(Read-Only\).pdf](#)

## V. Supporting Documents

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

Supporting Document #01 - [Reference Sheet.pdf](#)

Supporting Document #02 - [Needs Assessment Graphs.pdf](#)

## VI. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

**State: Georgia**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>1. FEDERAL ALLOCATION</b>	\$ 16,611,128	\$ 15,634,663
<i>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)</i>		
A. Preventive and Primary Care for Children	\$ 6,211,948	\$ 5,197,420
B. Children with Special Health Care Needs	\$ 8,838,889	\$ 9,157,782
C. Title V Administrative Costs	\$ 1,560,290	\$ 1,279,461
<b>2. UNOBLIGATED BALANCE</b>	\$ 0	\$ 0
<i>(Item 18b of SF-424)</i>		
<b>3. STATE MCH FUNDS</b>	\$ 98,513,369	\$ 87,873,596
<i>(Item 18c of SF-424)</i>		
<b>4. LOCAL MCH FUNDS</b>	\$ 0	\$ 0
<i>(Item 18d of SF-424)</i>		
<b>5. OTHER FUNDS</b>	\$ 132,713,617	\$ 154,313,381
<i>(Item 18e of SF-424)</i>		
<b>6. PROGRAM INCOME</b>	\$ 7,652,922	\$ 7,652,922
<i>(Item 18f of SF-424)</i>		
<b>7. TOTAL STATE MATCH</b>	\$ 238,879,908	\$ 249,839,899
<i>(Lines 3 through 6)</i>		
A. Your State's FY 1989 Maintenance of Effort Amount	\$ 36,079,622	
<b>8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL</b>	\$ 255,491,036	\$ 265,474,562
<i>(Same as item 18g of SF-424)</i>		
<b>9. OTHER FEDERAL FUNDS</b>		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
<b>10. OTHER FEDERAL FUNDS</b>	\$ 25,324,930	
<i>(Subtotal of all funds under item 9)</i>		
<b>11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL</b>	\$ 280,815,966	\$ 265,474,562
<i>(Partnership Subtotal + Other Federal MCH Funds Subtotal)</i>		

**FY14 Annual Report Budgeted**

<b>1. FEDERAL ALLOCATION</b>	\$ 15,882,994
A. Preventive and Primary Care for Children	\$ 7,656,756
B. Children with Special Health Care Needs	\$ 7,200,199
C. Title V Administrative Costs	\$ 699,732
<b>2. UNOBLIGATED BALANCE</b>	\$ 0
<b>3. STATE MCH FUNDS</b>	\$ 126,369,205
<b>4. LOCAL MCH FUNDS</b>	\$ 0
<b>5. OTHER FUNDS</b>	\$ 150,133,658
<b>6. PROGRAM INCOME</b>	\$ 18,316,838
<b>7. TOTAL STATE MATCH</b>	\$ 294,819,701

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**FY16 Application  
Budgeted**

**9. OTHER FEDERAL FUNDS**

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;	\$ 136,464
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS);	\$ 145,248
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant;	\$ 450,000
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;	\$ 799,177

US Department of Education > Office of Special Education Programs > Early Identification and Intervention Infants/Toddlers;	\$ 13,856,300
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > D70;	\$ 128,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > GA OH Prevention Pro;	\$ 310,599



**Form Notes For Form 2:**

This year's budget does not include WIC and Healthy Start since it is not under the control of the Title V Administrator. However, we continue to collaborate and partner with them for services to the MCH population.

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>5. OTHER FUNDS</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	VFC projected amount for FFY 16 has slightly decreased .
2.	<b>Field Name:</b>	<b>Federal Allocation, A. Preventive and Primary Care for Children:</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	More funds were expensed in CSCHN
3.	<b>Field Name:</b>	<b>Federal Allocation, B. Children with Special Health Care Needs:</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Funds were expensed here for CSHCN
4.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs:</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Increased staff in the MCH Epi area slightly
5.	<b>Field Name:</b>	<b>3. STATE MCH FUNDS</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Could not use Family Connection or MATCH Program because of matched already
6.	<b>Field Name:</b>	<b>6. PROGRAM INCOME</b>

**Fiscal Year:** 2014

**Column Name:** Annual Report Expended

**Field Note:**

In FFY 14 overstated amount to be reimbursed

**Data Alerts:**

None

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**

**State: Georgia**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>I. TYPES OF INDIVIDUALS SERVED</b>		
<b>IA. Federal MCH Block Grant</b>		
1. Pregnant Women	\$ 2,020,456	\$ 1,338,859
2. Infants < 1 year	\$ 731,947	\$ 192,223
3. Children 1-22 years	\$ 3,459,546	\$ 3,666,337
4. CSHCN	\$ 8,838,889	\$ 9,157,782
5. All Others	\$ 516,827	\$ 207,076
<b>Federal Total of Individuals Served</b>	<b>\$ 15,567,665</b>	<b>\$ 14,562,277</b>
<b>IB. Non Federal MCH Block Grant</b>		
1. Pregnant Women	\$ 17,245,813	\$ 13,674,613
2. Infants < 1 year	\$ 86,372,259	\$ 80,603,174
3. Children 1-22 years	\$ 108,812,245	\$ 100,056,498
4. CSHCN	\$ 18,560,101	\$ 31,202,923
5. All Others	\$ 236,568	\$ 16,649,769
<b>Federal Total of Individuals Served</b>	<b>\$ 231,226,986</b>	<b>\$ 242,186,977</b>
<b>Federal State MCH Block Grant Partnership Total</b>	<b>\$ 246,794,651</b>	<b>\$ 256,749,254</b>

**Form Notes For Form 3a:**

Budgeted and expended amounts for preventive and primary care for children on Form 2, Line 1A equals budgeted and expended amounts for pregnant women, infants < 1 year and children 1-22 years.

**Field Level Notes for Form 3a:**

1.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1-22 years</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	In Form 2 Line 1A equals Pregnant Women, Infants<1 and Children 1-22.
2.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1-22 years</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Form 2 line 1A equals Pregnant Women, Infants <1, and children 1-22

**Data Alerts:**

None

**Form 3b**  
**Budget and Expenditure Details by Types of Services**

**State: Georgia**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>I. TYPES OF SERVICES</b>		
<b>IIA. Federal MCH Block Grant</b>		
1. Direct Services	\$ 3,285,659	\$ 3,658,443
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 387,647	\$ 237,504
B. Preventive and Primary Care Services for Children	\$ 517,362	\$ 708,093
C. Services for CSHCN	\$ 2,380,650	\$ 2,712,846
2. Enabling Services	\$ 7,433,302	\$ 6,709,494
3. Public Health Services and Systems	\$ 5,892,167	\$ 5,266,726
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		\$ 418,418
Physician/Office Services		\$ 56,032
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 96,661
Dental Care (Does Not Include Orthodontic Services)		\$ 575,284
Durable Medical Equipment and Supplies		\$ 476,531
Laboratory Services		\$ 52,641
Other		
Various Programs and services		\$ 1,982,876
Direct Services Total		\$ 3,658,443
<b>Federal Total</b>	<b>\$ 16,611,128</b>	<b>\$ 15,634,663</b>

**IIB. Non-Federal MCH Block Grant**

1. Direct Services	\$ 52,617,602	\$ 67,349,189
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 29,782,289	\$ 40,296,656
B. Preventive and Primary Care Services for Children	\$ 15,340,872	\$ 14,011,472
C. Services for CSHCN	\$ 7,494,441	\$ 13,041,061
2. Enabling Services	\$ 30,460,614	\$ 34,494,953
3. Public Health Services and Systems	\$ 155,801,692	\$ 147,995,757
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		\$ 560,109
Physician/Office Services		\$ 75,006
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 129,394
Dental Care (Does Not Include Orthodontic Services)		\$ 2,157,064
Durable Medical Equipment and Supplies		\$ 637,900
Laboratory Services		\$ 70,468
Other		
Various Programs and services		\$ 63,719,248
Direct Services Total		\$ 67,349,189
<b>Non-Federal Total</b>	<b>\$ 238,879,908</b>	<b>\$ 249,839,899</b>

**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**

132,078

**1a. Core RUSP Conditions**

<b>Program Name</b>	<b>(A) Number Receiving at Least One Screen</b>	<b>(B) Number Presumptive Positive Screens</b>	<b>(C) Number Confirmed Cases</b>	<b>(D) Number Referred for Treatment</b>
Propionic acidemia	97,738 (74.0%)	73	1	1 (100.0%)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	97,738 (74.0%)	73	1	1 (100.0%)
Isovaleric acidemia	97,738 (74.0%)	64	0	0 (0%)
3-Methylcrotonyl-CoA carboxylase deficiency	97,738 (74.0%)	18	2	2 (100.0%)
3-Hydroxy-3-methylglutaric aciduria	97,738 (74.0%)	18	0	0 (0%)
$\beta$ -Ketothiolase deficiency	97,738 (74.0%)	10	0	0 (0%)
Glutaric acidemia type I	97,738 (74.0%)	28	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	97,738 (74.0%)	216	0	0 (0%)
Medium-chain acyl-CoA dehydrogenase deficiency	97,738 (74.0%)	20	6	6 (100.0%)
Very long-chain acyl-CoA dehydrogenase deficiency	97,738 (74.0%)	71	7	7 (100.0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	97,738 (74.0%)	7	1	1 (100.0%)
Argininosuccinic aciduria	97,738 (74.0%)	26	0	0 (0%)
Citrullinemia, type I	97,738 (74.0%)	26	0	0 (0%)



Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Maple syrup urine disease	97,738 (74.0%)	316	1	1 (100.0%)
Homocystinuria	97,738 (74.0%)	314	0	0 (0%)
Classic phenylketonuria	97,738 (74.0%)	121	3	3 (100.0%)
Tyrosinemia, type I	97,738 (74.0%)	87	0	0 (0%)
Primary congenital hypothyroidism	97,738 (74.0%)	4,571	74	74 (100.0%)
Congenital adrenal hyperplasia	97,738 (74.0%)	407	5	5 (100.0%)
S,S disease (Sickle cell anemia)	97,738 (74.0%)	98	98	98 (100.0%)
Biotinidase deficiency	97,738 (74.0%)	26	0	0 (0%)
Cystic fibrosis	97,738 (74.0%)	282	24	24 (100.0%)
Classic galactosemia	97,738 (74.0%)	310	1	1 (100.0%)
S,C disease	97,738 (74.0%)	47	42	42 (100.0%)
Hearing loss	129,436 (98.0%)	4,612	215	204 (94.9%)
S, $\beta$ -thalassemia	97,738 (74.0%)	5	5	5 (100.0%)
Holocarboxylase synthase deficiency	97,738 (74.0%)	18	0	0 (0%)

**1b. Secondary 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
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Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
3-Methylglutaconic aciduria	97,738 (74.0%)	18	1	1 (100.0%)
Short-chain acyl-CoA dehydrogenase deficiency	97,738 (74.0%)	67	5	5 (100.0%)
Benign hyperphenylalaninemia	97,738 (74.0%)	121	2	2 (100.0%)
Various other hemoglobinopathies	97,738 (74.0%)	16	13	13 (100.0%)

## 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
Newborn Hearing	129,950 (98.4%)	4,612	215	204 (94.9%)

## 3. Screening Programs for Older Children & Women

### 4. Long-Term Follow-Up

Georgia does not currently conduct long-term follow-up on infants with a confirmed diagnosis, but is considering implementing a long-term follow-up program.

**Form Notes For Form 4:**

Column A is determined by an algorithm to match newborn screens to vital records. The automatic match was 74% and 26% required manual matching. The position responsible for manual matching was vacant during the reporting year. The Georgia Public Health Laboratory tested over 132,000 blood samples in the reporting year.

**Field Level Notes for Form 4:**

None

**Form 5a**  
**Unduplicated Count of Individuals Served under Title V**

**State: Georgia**

**Reporting Year 2014**

		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	0	0.0	0.0	0.0	0.0	100.0
2. Infants < 1 Year of Age	0	0.0	0.0	0.0	0.0	100.0
3. Children 1 to 22 Years of Age	0	0.0	0.0	0.0	0.0	100.0
4. Children with Special Health Care Needs	21,912	74.0	4.4	9.4	12.2	0.0
5. Others	0	0.0	0.0	0.0	0.0	100.0
<b>Total</b>	<b>21,912</b>					

**Form Notes For Form 5a:**

None

**Field Level Notes for Form 5a:**

1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Direct services are not provided to pregnant women. The percentage of those with unknown insurance is 100% because there are no individuals to report.
2.	<b>Field Name:</b>	<b>Infants Less Than One YearTotal Served</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Direct services are not provided to infants. The percentage of those with unknown insurance is 100% because there are no individuals to report.
3.	<b>Field Name:</b>	<b>Children 1 to 22 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Direct services are not provided to children. The percentage of those with unknown insurance is 100% because there are no individuals to report.
4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Data are the total number of children enrolled in Children's Medical Services (CMS) and Babies Can't Wait (BCW) in SFY 2014. Not all children in CMS receive direct services, however individual-level data are not available.
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Direct services are not provided to other populations. The percentage of those with unknown insurance is 100% because there are no individuals to report.

**Form 5b**  
**Total Recipient Count of Individuals Served by Title V**  
**State: Georgia**

**Reporting Year 2014**

<b>Types Of Individuals Served</b>	<b>Total Served</b>
1. Pregnant Women	12,906
2. Infants < 1 Year of Age	128,426
3. Children 1 to 22 Years of Age	1,131,237
4. Children with Special Health Care Needs	21,912
5. Others	113,237
<b>Total</b>	<b>1,407,718</b>

**Form Notes For Form 5b:**

None

**Field Level Notes for Form 5b:**

1.	<b>Field Name:</b>	<b>Pregnant Women</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Pregnant women received enabling services through the Regional Perinatal Centers and Oral Health program. Estimates were obtained as follows: Regional Perinatal Centers- Provisional 2014 data were used. The counts are based on deliveries at Perinatal Centers. This is an estimate of those women who received direct services from Title V during the prenatal, intrapartum, or postpartum periods. The regional perinatal centers support prenatal, intrapartum and postpartum services to high risk and underserved women. Oral Health Program- The count came from final data reported by the Oral Health Program. The count includes pregnant women who received dental care through the Oral Health program in SFY 2014.
2.	<b>Field Name:</b>	<b>Infants Less Than One Year</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	All births to residents of Georgia are included as receiving a Title V service because all receive newborn screening services, as required in statute (Ga. Code Ann. § 31-12-6 and 31-12-7). Total infants in the state was derived from a projection.
3.	<b>Field Name:</b>	<b>Children 1 to 22 Year of Age</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Children received enabling services through the Oral Health program, Georgia Shape and the Child Occupant Safety Program (COSP). Estimates were obtained as follows: Oral Health Program- The Oral Health Database collects the following age groups: 0-5, 6-18, 19 and older. Clients 0-18 years of age were included in this estimate. Data are for SFY 2014. Georgia Shape- Data included are the number of children assessed through Fitnessgram in the 2013-2014 school year. COSP- Data are the number educated through the program and those that received car seats. The database collects the following age groups: <1, 1-17, >17. Only children 1-17 were included in this estimate.
4.	<b>Field Name:</b>	<b>Children With Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Data include the total served through Children's Medical Services and Babies Can't Wait in SFY 2014.
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Field Note:</b>	Other populations received enabling services through the Oral Health program and Family Planning clinics in

2014. Estimates were obtained as follows: Oral Health Program- Data are the number of individuals over 18 served through the Oral Health Program in SFY 2014. Therefore, some individuals included in this estimate may be between the ages of 18 and 22. Family Planning Program- Data are the number of unduplicated encounters at family planning clinics in calendar year 2014.



**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

**State: Georgia**

**Reporting Year 2014**

**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	128,426	65,604	44,159	172	5,308	206	3,062	9,915
Title V Served	12,414	4,194	7,119	10	315	15	322	439
Eligible for Title XIX	63,226	26,165	30,376	94	1,308	99	1,575	3,609
2. Total Infants in State	131,225	72,155	45,260	1,077	4,847	441	7,445	0
Title V Served	128,426	65,604	44,159	172	5,308	206	3,062	9,915
Eligible for Title XIX	65,735	28,778	31,133	589	1,194	212	3,829	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	108,847	19,579	0	128,426
Title V Served	11,802	612	0	12,414
Eligible for Title XIX	54,362	8,864	0	63,226
2. Total Infants in State	108,553	22,672	0	131,225
Title V Served	108,847	19,579	0	128,426
Eligible for Title XIX	55,471	10,264	0	65,735

**Form Notes For Form 6:**

None

**Field Level Notes for Form 6:**

1.	<b>Field Name:</b>	<b>1. Total Deliveries in State</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	The total resident delivery counts and breakdown by race are from the Georgia Vital Records Birth File (2014 from Vital Records provisional birth data).
2.	<b>Field Name:</b>	<b>1. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Provisional 2014 data were used . The counts are based on deliveries at Perinatal Centers. This is an estimate of those women who received direct services from Title V during the prenatal, intrapartum, or postpartum periods. The regional perinatal centers support prenatal, intrapartum and postpartum services to high risk and underserved women.
3.	<b>Field Name:</b>	<b>1. Eligible for Title XIX</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	These counts are from the 2014 provisional birth file for residents only where payor is Medicaid. (Vital Records 2014 Birth Record).
4.	<b>Field Name:</b>	<b>2. Total Infants in State</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Population estimates for children less than 1 year of age in the year 2014 are unavailable. The total number of children less than 1 year of age was projected using population estimates of children less than 1 year of age for the years 2010 through 2013. The breakdown of race and ethnicity was also projected using 2010 through 2013 data.
5.	<b>Field Name:</b>	<b>2. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>

---

**Field Note:**

All births to residents of Georgia are included as receiving a Title V service because all receive newborn screening services, as required in statute (Ga. Code Ann. § 31-12-6 and 31-12-7). Total infants is a projection while births are event counts (which also do not take into account differences in immigration and emigration), and so there are times where births exceed infants in the state.

6.	<b>Field Name:</b>	<b>2. Eligible for Title XIX</b>
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	<b>Fiscal Year:</b>	<b>2014</b>
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	<b>Column Name:</b>	<b>Total All Races</b>
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**Field Note:**

For the number of infants eligible for Medicaid, the proportion of deliveries eligible for Medicaid is applied to the total infants in state.

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**

**State: Georgia**

**Application Year 2016**

**Reporting Year 2014**

**A. State MCH Toll-Free Telephone Lines**

1. State MCH Toll-Free "Hotline" Telephone Number	(800) 300-9003	(800) 300-9003
2. State MCH Toll-Free "Hotline" Name	The PowerLine	The PowerLine
3. Name of Contact Person for State MCH "Hotline"	Susan Milne	Susan Milne
4. Contact Person's Telephone Number	(770) 451-0020 x205	(770) 451-0020 x205
5. Number of Calls Received on the State MCH "Hotline"		17,462

**B. Other Appropriate Methods**

1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	www.dph.georgia.gov/MCH	www.dph.georgia.gov/MCH
4. Number of Hits to the State Title V Program Website		129
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

**Form Notes For Form 7:**

None

**Form 8**  
**State MCH and CSHCN Directors Contact Information**

**State: Georgia**

**Application Year 2016**

**1. Title V Maternal and Child Health (MCH)  
Director**

Name	Seema Csukas, MD, PhD
Title	Maternal and Child Health Section Director
Address 1	2 Peachtree St NW 11th Floor
Address 2	
City / State / Zip Code	Atlanta / GA / 30303
Telephone	(404) 657-2872
Email	Seema.Csukas@dph.ga.gov

**2. Title V Children with Special Health Care  
Needs (CSHCN) Director**

Name	Donna M. Johnson
Title	Child Health Intervention Director
Address 1	2 Peachtree St NW 11th Floor
Address 2	
City / State / Zip Code	Atlanta / GA / 30303
Telephone	(404) 230-1630
Email	Donna.Johnson@dph.ga.gov

**3. State Family or Youth Leader (Optional)**

Name	Sherry Richardson
Title	Parent Consultant
Address 1	2 Peachtree St NW 11th Floor
Address 2	
City / State / Zip Code	Atlanta / GA / 30303
Telephone	(404) 657-4857
Email	Sherry.Richardson@dph.ga.gov

**Form Notes For Form 8:**

None

**Form 9  
List of MCH Priority Needs**

**State: Georgia**

**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 and NOMs:**

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
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

2012	167.5	3.7 %	2,091	124,810
2011	164.5	3.6 %	2,080	126,486
2010	161.5	3.5 %	2,096	129,785
2009	160.1	3.4 %	2,190	136,797
2008	148.4	3.2 %	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
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
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
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
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
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
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
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
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
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

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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 a confidence interval width >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
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
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
2013	33.6	1.6 %	470	1,400,810
2012	29.1	1.4 %	408	1,402,316

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2011_2013	13.0	0.8 %	272	2,095,858
2010_2012	13.3	11.8 %	281	2,110,591
2009_2011	13.2	11.6 %	280	2,123,186
2008_2010	14.9	13.3 %	318	2,129,778
2007_2009	18.8	17.0 %	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
2011_2013	6.7	5.6 %	141	2,095,858
2010_2012	6.0	4.9 %	126	2,110,591
2009_2011	6.1	5.0 %	129	2,123,186
2008_2010	6.1	5.1 %	130	2,129,778
2007_2009	5.4	4.4 %	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

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

Year	Annual Indicator	Standard Error	Numerator	Denominator
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**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
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 have received the 4:3:1:3(4):3:1:4 series of routine vaccinations**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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) - Female

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
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) - Male

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	40.5 % ⚡	5.9 % ⚡	144,219 ⚡	356,096 ⚡
2012	19.5 %	4.3 %	68,607	352,408



Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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
Annual Objective	62.1	61.5	60.9	60.3	59.6

**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
Annual Objective	81.8	82.8	83.9	84.9	85.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.5	79.3	80.1	80.9	81.6

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	19.1	19.3	19.5	19.7	19.8

**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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.9	45.9	45.9	45.9	51.6

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

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

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	25.3	24.6	24.6	24.0	24.0

**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
Annual Objective	34.2	34.6	34.9	35.3	35.6

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.5	39.9	40.3	40.7	41.1

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

Annual Objectives					
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	2016	2017	2018	2019	2020
Annual Objective	79.0	79.8	80.6	81.4	82.2

**Form 10b**  
**State Performance/Outcome Measure Detail Sheet**  
**State: Georgia**

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

**Form 10c**  
**Evidence-Based or Informed Strategy Measure Detail Sheet**  
**State: Georgia**

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

**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	
Numerator	230	268	264	265	
Denominator	231	278	266	265	
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	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

- |  |                    |             |
|--|--------------------|-------------|
| 1.   | <b>Field Name:</b> | <b>2014</b> |
| <b>Field Note:</b><br>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.   | <b>Field Name:</b> | <b>2013</b> |
| <b>Field Note:</b><br>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.   | <b>Field Name:</b> | <b>2012</b> |
| <b>Field Note:</b><br>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	
Numerator	269,705	283,239	283,089	279,217	
Denominator	398,972	418,993	418,771	413,043	
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	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.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	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.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	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.
4.	<b>Field Name:</b>	<b>2011</b>

**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	
Numerator	182,330	194,762	191,378	188,761	
Denominator	398,972	426,175	418,771	413,043	
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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.	<b>Field Name:</b>	<b>2013</b>
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**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.

3.	<b>Field Name:</b>	<b>2012</b>
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**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.

4.	<b>Field Name:</b>	<b>2011</b>
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**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	62.2	
Numerator	248,160	248,377	260,476	256,913	
Denominator	398,091	399,320	418,771	413,043	
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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.	<b>Field Name:</b>	<b>2013</b>
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**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.

3.	<b>Field Name:</b>	<b>2012</b>
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**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.

4.	<b>Field Name:</b>	<b>2011</b>
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**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	
Numerator	277,285	296,192	291,046	287,065	
Denominator	398,972	426,175	418,771	413,043	
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	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.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	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.
3.	<b>Field Name:</b>	<b>2012</b>

**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.

4. **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	33.9	
Numerator	134,953	135,369	141,963	140,022	
Denominator	398,091	399,320	418,771	413,043	
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	

	2011	2012	2013	2014	2015
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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.	<b>Field Name:</b>	<b>2013</b>
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**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.

3.	<b>Field Name:</b>	<b>2012</b>
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**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.

4.	<b>Field Name:</b>	<b>2011</b>
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**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	81.2	
Numerator	164,312	150,748	155,210	165,514	
Denominator	195,843	193,515	191,381	203,727	
Data Source	NIS	NIS	NIS	NIS	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Numerator- The numerator was calculated using the annual indicators and the denominator. Annual indicator- The annual indicator was retrieved from <a href="http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/index.html">http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/index.html</a> 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.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Numerator data were calculated using the annual indicators and the denominator. Annual indicator was updated based on the annual indicators retrieved from <a href="http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/data/tables-2012.html">http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/data/tables-2012.html</a> 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](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](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](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](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	9.7	
Numerator	3,814	3,196	2,762	2,077	
Denominator	202,149	202,252	201,549	214,259	
Data Source	Vital Records	OASIS (birth data, pop/census data)	OASIS (birth data, population/census data)	OASIS (birth data, population/census data)	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b> The numerator is derived 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.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b> 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.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b> 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.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b> 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: numerator 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

	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	
Numerator	48,113	48,341	49,036	50,146	
Denominator	128,645	129,253	131,113	134,081	
Data Source	Basic Screening Survey	Basic Screening Survey	Basis Screening Survey	Basic Screening Survey	
Provisional Or Final ?				Final	

#### Field Level Notes for Form 10d NPMs:

1.	<b>Field Name:</b>	<b>2014</b>
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**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](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.	<b>Field Name:</b>	<b>2013</b>
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**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](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.	<b>Field Name:</b>	<b>2012</b>
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**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 enrollments. Denominators for previous years were updated so that all denominators reflect Fall enrollments for 3rd graders for the respective years.

4.	<b>Field Name:</b>	<b>2011</b>
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**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: 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 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	2.1	
Numerator	61	47	58	44	
Denominator	2,076,584	2,078,585	2,077,631	2,146,176	
Data Source	Vital Records	OASIS (death data, pop/census data)	OASIS (death data, population/census data)	OASIS (death data, population/census data)	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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.	<b>Field Name:</b>	<b>2013</b>
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**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.	<b>Field Name:</b>	<b>2012</b>
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**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.	<b>Field Name:</b>	<b>2011</b>
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**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 breastfed 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	35.5	
Numerator	44,829	42,886	46,007	45,591	
Denominator	132,239	129,959	128,511	128,426	
Data Source	NIS	NIS	NIS	NIS	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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

	2011	2012	2013	2014	2015
Annual Indicator	86.6	92.2	98.5	98.0	
Numerator	117,588	125,975	124,308	129,436	
Denominator	135,781	136,606	126,174	132,078	
Data Source	Newborn Hearing Program Data	Newborn Hearing Program Data	Newborn Hearing Program Data	Newborn Hearing Program Data	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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.	<b>Field Name:</b>	<b>2013</b>
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**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.	<b>Field Name:</b>	<b>2012</b>
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**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.	<b>Field Name:</b>	<b>2011</b>
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**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	11.6	
Numerator	248,531	319,408	319,031	298,027	
Denominator	2,493,574	2,495,375	2,492,428	2,566,643	
Data Source	Current Population	Current Population Survey/OASIS	Current Population Survey/OASIS	Current Population Survey/OASIS	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	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: <a href="http://www.census.gov/cps/data/cpstablecreator.html">http://www.census.gov/cps/data/cpstablecreator.html</a> only. 2013 population estimate was updated using final 0 to 17 year old population data from OASIS.
2.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	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: <a href="http://www.census.gov/cps/data/cpstablecreator.html">http://www.census.gov/cps/data/cpstablecreator.html</a> and table HI05. 2012 population estimate was updated using final 0 to 17 year old population data from OASIS.
3.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	



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.	<b>Field Name:</b>	<b>2011</b>
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**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	
Numerator	36,278	44,650	39,084	33,117	
Denominator	109,303	142,560	129,626	104,673	
Data Source	WIC report	WIC Performance Measure Report	WIC Performance Measure Report	WIC Performance Measure Report	
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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	4.2	
Numerator	8,212	9,097	6,297	5,394	
Denominator	132,239	129,959	128,511	128,426	
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Provisional Or Final ?				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 pregnancies (births) the estimate for 2013 was obtained from the provisional birth file.

3.	<b>Field Name:</b>	<b>2012</b>
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**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.	<b>Field Name:</b>	<b>2011</b>
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**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	5.6	
Numerator	40	37	60	41	
Denominator	700,944	699,648	695,266	736,148	
Data Source	Vital Records	OASIS (death data, pop/census data)	OASIS (death data, population/census)	Vital Records	

	2011	2012	2013	2014	2015
			data)		
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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.	<b>Field Name:</b>	<b>2013</b>
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**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 population 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.	<b>Field Name:</b>	<b>2012</b>
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**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.	<b>Field Name:</b>	<b>2011</b>
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**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	75.6	
Numerator	1,868	1,840	1,894	1,722	
Denominator	2,400	2,343	2,400	2,278	
Data Source	Vital Records	Data Warehouse (final data)	Vital Records	Vital Records	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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.	<b>Field Name:</b>	<b>2013</b>
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**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.	<b>Field Name:</b>	<b>2012</b>
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**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.	<b>Field Name:</b>	<b>2011</b>
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**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) facilities. The exact date these became level 3's is unknown, but they were included in the analysis for 2008 to 2010 as level 3's.

The 2007 data was recalculated as follows:

2007: numerator 1931; denominator 2682; and annual indicator 69.5.

**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	69.4	
Numerator	74,810	77,745	76,900	71,186	
Denominator	106,350	109,432	104,708	102,639	
Data Source	Vital Records	Vital Records	OHIP- Repository	Vital Records	
Provisional Or 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	
Numerator	69,186	69,043	59,462	60,726	
Denominator	461,237	460,287	468,205	478,160	
Data Source	YRBS	YRBS	YRBS	YRBS	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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](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.	<b>Field Name:</b>	<b>2013</b>
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**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 following link: [http://app.doe.k12.ga.us/ows-bin/owa/fte\\_pack\\_enrollgrade.entry\\_form](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.	<b>Field Name:</b>	<b>2012</b>
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**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	
Numerator	257	245	247	248	
Denominator	143,046	144,084	145,123	146,161	
Data Source	Linked Birth-Deaths	Linked Birth-Deaths	Linked Birth-Deaths	Linked Birth-Deaths	
Provisional Or 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 using 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 using 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	
Numerator	8	6	15	8	
Denominator	1	1	1	1	
Data Source	Office of MCH Epi	Office of MCH Epi	Office of MCH Epi	Office of MCH Epi	
Provisional Or 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 annual 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	8.4	
Numerator	42	33	46	37	
Denominator	416,990	416,790	414,797	438,966	
Data Source	Vital Records	OASIS	Vital Records/OASIS	Vital Records/OASIS	
Provisional Or 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.	<b>Field Name:</b>	<b>2012</b>
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**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.	<b>Field Name:</b>	<b>2011</b>
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**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	66.6	
Numerator	7,490	7,490	16,246	12,408	
Denominator	19,382	19,382	18,823	18,637	
Data Source	Children 1st quarterly reports	Children 1st quarterly report	Children 1st quarterly report	Children 1st quarterly report	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	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.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	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.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	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.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	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	
Numerator	0	0			
Denominator					
Data Source	Survey not yet implemented	Survey not yet implemented	Survey not implemented	Survey not implemented	

	2011	2012	2013	2014	2015
Provisional Or Final ?				Final	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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.

2.	<b>Field Name:</b>	<b>2013</b>
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**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.

3.	<b>Field Name:</b>	<b>2012</b>
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**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.

4.	<b>Field Name:</b>	<b>2011</b>
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**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.
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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.
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**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	13.7	

	2011	2012	2013	2014	2015
Numerator	516	445	282	311	
Denominator	2,400	2,322	2,400	2,278	
Data Source	Children 1st quarterly reports	Children 1st quarterly reports	Children 1st quarterly reports	Children 1st quarterly reports	
Provisional Or Final ?				Provisional	

**Field Level Notes for Form 10d SPMs:**

1.	<b>Field Name:</b>	<b>2014</b>
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**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.	<b>Field Name:</b>	<b>2013</b>
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**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.	<b>Field Name:</b>	<b>2012</b>
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**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.	<b>Field Name:</b>	<b>2011</b>
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**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 FY 2016 application and FY 2014 annual report.



## State Action Plan Table

State: Georgia

Please click the link below to download a PDF of the State Action Plan Table.

[State Action Plan Table](#)