

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

**State Narrative for
Georgia**

CSHCN

**Application for 2014
Annual Report for 2012**

National Performance Measures

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	55	56	55.1	56.2	56.2
Annual Indicator	54.0	67.6	67.6	67.6	67.6
Numerator	190386	279435	269486	269705	283239
Denominator	352567	413365	398648	398972	418993
Data Source	NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	58.5	60	61.2	62.4	

Notes - 2011

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

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

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

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

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

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

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

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

Notes - 2010

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

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

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

Notes - 2009

Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available. Numerator and denominator estimates based on the point estimate. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows.

a. Last Year's Accomplishments

CMS Coordinators developed a plan of care (POC) for 100% of CSHCN clients with families participating to determine the priority for their child's needs. CMS Coordinators review the POC with the family every 6 months.

Parent to Parent (P2P) of GA completed webinars on all of the 5 contracted topics of: Employment, Education, Community Living, Recreation, and Healthcare Financing. P2P completed 5 factsheets on Medical Home, SSI, Health Transition, Children Medical Services, and Healthcare Financing. P2P also presented a 2-hour training on transition to all district staff and state CMS staff. MCH contracted with P2P under GA's new Integrating Community Systems for CYSHCN Grant to complete a series of 7 transition webinars using youth as trainers. P2P was also contracted to develop a Spanish version of their Transition to Adulthood curriculum. Parent trainers and navigator teams from P2P conduct local and regional trainings for parents on parental rights throughout the year at various locations in the state.

Some districts provided stipends or scholarships for parents to attend BCW local council meetings.

Three children with diabetes attended Camp Kudzu in summer 2012. Through our contract with Hemophilia of Georgia (HOG), approximately 150 children with bleeding disorders attended camp. Through contracted partner agencies, women of reproductive age and children and youth were funded to attend a week-long metabolic camp, as well as a summer camp.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing family participation through development of CMS care coordination plan of care.		X		
2. Conducting CMS family satisfaction surveys statewide every three years as well as an ongoing survey as part of CMS quality assurance programmatic/ fiscal review (three year cycle).				X
3. Conducting client satisfaction surveys annually in the Genetics and Sickle Cell clinics. Surveys are offered in English and Spanish.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

CMS Coordinators developed a plan of care (POC) for 100% of CSHCN clients with families participating in the determination of the priority for their child's needs. CMS Coordinators review the POC with the family every 6 months.

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

One hundred seventy-one families were provided online training to support other families of children with disabilities or chronic medical conditions. P2PGA also provided one-on-one assistance to 2,502 families of CYSHCN. They also conducted 118 presentations throughout the state. To enhance ease of use for families, P2PGA hosts two Hispanic Support Groups and an East African support group in Metro Atlanta. P2PGA also supported two new startup support groups for families.

Activity 3: Provide funding for families to attend local BCW council meetings.

Some districts provide stipends or scholarships for parents to attend BCW local and state council meetings. Parent-attended LICC activities included approximately 2,650 total participants.

Activity 4: Provide funding for CSHCN and their families to attend metabolic, genetics, and asthma camps.

Due to budget constraints, several CMS districts were unable to offer funding to camps. However, parents were given information about camps, and many attended.

Activity 5: Host a planning meeting with state agencies and advocates concerned about juvenile diabetes to develop a partnership and work plan.

Work on this activity has been discontinued due to limited state office staff and other competing priorities.

c. Plan for the Coming Year

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

Output Measure(s): Percent of families with input on plans of care

Monitoring: Quarterly reports.

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

Output Measure(s): Work plan developed; contract to develop technical aspects of the training module.

Monitoring: Quarterly reports.

Activity 3: Provide funding and opportunities for families to attend local BCW council meetings, trainings and community activities.

Output Measure(s): Number of families in attendance; percent increase in the number attending.

Monitoring: Quarterly reports.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	51	51	52	53.1	53.1
Annual Indicator	51.0	45.7	45.7	45.7	45.7
Numerator	179809	188908	182182	182330	194762
Denominator	352567	413365	398648	419440	426175
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional

	2013	2014	2015	2016	2017
Annual Performance Objective	55.2	56.3	57.4	57.4	

Notes - 2011

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

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

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

Notes - 2010

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

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

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

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

Notes - 2009

Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available. Numerator and denominator estimates based on the point estimate. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows.

a. Last Year's Accomplishments

Medical and dental home brochures were mailed to all 18 health districts. CMS Coordinators assess medical home status on CMS enrollment and every 6 months thereafter. Coordinators made referrals for clients without a medical home. CMS Program Manager and CYSN Unit Director attended Learning Collaborative conference. State office engaged Sheltering Arms/GA Training Institute to develop training for Medical/Dental home booklet. The CYSN Parent Consultant provided a face-to-face Medical Home training for CMS district staff.

CMS coordinators and BCW Service Coordinators assess all clients for having a primary care provider (PCP) upon enrollment and every six months thereafter. Ninety-nine percent of BCW clients reported having a Primary Care Physician during SFY13.

CMS staff attended and participated in quarterly meetings with GA-AAP and GAFP. GA-AAP and AFP were contracted to increase information, education and availability of medical homes throughout Georgia via the newly awarded Integrated Community Systems for Children and Youth with Special Health Care Needs Grant. Georgia now has 277 certified Medical Home providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing CSHCN participation in MCH Early Childhood Comprehensive Systems (ECCS) grant. One component of the grant is the planning and implementation of infrastructure for a statewide Medical Home initiative for all children.				X
2. Continuing to facilitate CSHCN program enrollees accessing a medical home.		X		
3. Documenting the percentage of CSHCN enrollees who have a documented medical home.		X		
4. Referring CSHCN without a medical home to a primary care provider.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Work with GA-AAP and GAFP to provide professional development to state and district level staff, families, and medical and non-medical providers on the definition and components of a medical home.

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

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

CMS Coordinators and BCW Service Coordinators assess whether or not clients have a primary care provider (PCP) upon enrollment and every six months thereafter. Coordinators make referrals for those clients who do not have a PCP. In the second quarter of SFY 2013, 76% of CMS clients reported having a PCP. 2013 data are unavailable for BCW. DPH epi staff is researching the use of a data system for several programs, including CMS.

Activity 3: Meet with leadership from GA-AAP and GAFP to develop a strategy to increase the availability of medical homes throughout Georgia.

Meetings with representatives from GA AFP and GA AAP to review contract deliverables and timelines have occurred. Through our Integrated Community Systems for CSHCN contracts with GA AFP and GA AAP, both organizations will require a minimum of 10 of its members to complete an online webinar module on "Health Care Training Program for Health Care Professionals". Each will provide updates and information on Transition Planning and Medical Home for youth with special health care needs.

c. Plan for the Coming Year

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

Output Measure(s): Number of trainings; number of staff trained; positive change in baseline knowledge; number of medical/dental home brochures distributed.

Monitoring: Training registration; training schedule and plan.

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

Output Measure(s): Number of clients who have been assessed for a primary care provider; number of referrals made to clients who did not have a primary care provider; percent of clients who have an identified primary care provider; percentage of clients who have had at least one visit to their PCP in past year.

Monitoring: Quarterly reports.

Activity 3: Partner with Parent to Parent to provide training to families on the definition and importance of a medical home.

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

Monitoring: Quarterly program reports from Parent to Parent of Georgia.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
---------------------------------------	------	------	------	------	------

Annual Performance Objective	62	62	62.4	63.7	63.7
Annual Indicator	61.2	62.2	62.2	62.2	62.2
Numerator	215771	257113	247959	248160	265081
Denominator	352567	413365	398648	398972	426175
Data Source	NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because					
therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	66.2	67.5	68.9	69.3	

Notes - 2011

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

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

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

Notes - 2010

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

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

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

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

Notes - 2009

Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available. Numerator and denominator estimates based on the point estimate. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows.

a. Last Year's Accomplishments

CMS Coordinators and BCW Service Coordinators assessed 100% of clients for insurance coverage upon enrollment and will every six months thereafter. In the third quarter of FY 2012, 100% of CMS clients were covered by insurance: 71% covered by Medicaid, 10% covered by private insurance and 14% covered by CMS only. 31% of clients received SSI.

CMS Coordinators and BCW Service Coordinators refer clients identified as uninsured to the Division of Family and Children Services (DFCS) to apply for Medicaid. Approximately 70% of CMS clients are covered by Medicaid. Leadership met with Medicaid office to discuss problems and solutions for CYSN families who are served by both Medicaid and CYSN programs.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

CMS Coordinators and BCW Service Coordinators assess clients for insurance coverage upon enrollment and every six months thereafter. In the first quarter of SFY 2013, 100% of CMS clients were covered by insurance or another health care financing payment source: 72% were covered by Medicaid, 4% were covered by SCHIP, 9% were covered by private insurance and 1% of clients received Tricare, and 13% were covered by CMS only. CMS is the payor of last resort for those without insurance.

Activity 2: Assist CMS and BCW clients to apply for Medicaid and other insurance benefits

CMS Coordinators and BCW Service Coordinators refer clients identified as uninsured to the Department of Community Health to apply for Medicaid. Approximately 72% of CMS clients are covered by Medicaid; 31% of CMS clients are receiving SSI. CMS made 168 family referrals to financial resources and other agencies or supports. Leadership is currently participating on the Medicaid Taskforce focused on moving children in foster care to a managed care model.

c. Plan for the Coming Year

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

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

Activity 2: Assist CMS and BCW clients to apply for Medicaid and other insurance benefits.

Output Measure(s): # of uninsured clients referred by type of coverage.

Monitoring: Quarterly reports.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	92	92	92.8	94.7	94.7
Annual Indicator	91.0	69.5	69.5	69.5	69.5
Numerator	320836	287289	277060	277285	296192
Denominator	352567	413365	398648	398972	426175
Data Source	NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	98.5	100	100	100	100

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001

CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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

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

Notes - 2010

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

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

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

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

Notes - 2009

Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available. Numerator and denominator estimates based on the point estimate. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows.

a. Last Year's Accomplishments

CMS Coordinators and BCW Service Coordinators assist client with identifying and connecting to needed available resources. CMS served 8,896 clients in the second quarter of SFY 2012. BCW annual child count as of 12/31/11 was 6,640 infants and toddlers receiving services. CMS Coordinators made over 300 referrals to community resources and served over 26,000 total clients in the second, third and fourth quarters of FY 2012.

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

districts provided data reports detailing clinic enrollment and the number of families served during the fourth quarter.

Two rural health districts are using telemedicine to provide specialty care. Two hundred and thirty-seven patients were enrolled in these clinics. Valdosta has 4 specialty clinics and Waycross has 2. Plans to expand telemedicine services to other health districts are being developed. Telemedicine equipment was purchased by one of GA's other public health programs and installed in each health district. The CMS state program will have access to this infrastructure and plans to enhance and increase the use of telemedicine for specialty clinics throughout the state.

A contract was implemented with P2PGA to assist with family satisfaction surveys. P2PGA launched a telephone translation service which will allow them to conduct surveys with diverse CMS families. P2PGA conducted a family survey on CMS Program satisfaction in 5 districts and 6 CYSHCN National Performance Measures. Ten percent of the surveys were conducted in Spanish.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Gathering data from other states and MCHB sponsored contracts that have completed previous work in this area.				X
2. Conducting CMS family satisfaction surveys statewide every three years as well as ongoing data collection as part of CMS				X
quality assurance programmatic/fiscal review (three year cycle).				
3. Sponsoring campers to attend the annual Metabolic Camp at Emory University for patients with Maple Syrup Urine Disease and Phenylketonuria.		X		
4. Promoting the use of Federally Qualified Health Centers to clients with Sickle Cell Disease (through Sickle Cell Foundation of Georgia).		X		
5. Providing funds to the public health districts to assist patients with the cost of genetic testing.	X			
6. Providing funds to the public health districts to increase the number of genetic clinics offered.	X			
7. Offering Transcranial Doppler (TCD) ultra-sonograms to pediatric Sickle Cell patients ages 2 to 16 years in 10 pediatric Sickle Cell outreach clinics.	X			
8. Holding telemedicine clinics in Waycross and Valdosta to enable families to see medical specialists at Georgia Health Sciences University in Augusta, Georgia and Shands Hospital in Jacksonville, Florida.	X			
9.				
10.				

b. Current Activities

Activity 1: Assist families served in CMS and BCW with accessing available community resources.

CMS Coordinators and BCW Service Coordinators assist clients with identifying and connecting to needed available resources. CMS served 8806 clients in the first quarter and 8846 clients in the second. BCW child enrollment was 6640 and 7519 infants and toddlers in the first and second quarters, respectively. CMS Coordinators made have made a total of 675 referrals in the first and second quarters. Through our BCW contract with P2PGA, BCW and CMS families have access to

online and one-on-one support to help find resources for families of children and youth with special needs.

Activity 2: Conduct specialty clinics for CSHCN in areas with limited specialty providers/services.

The CMS program conducts clinics in 9 of the 18 health districts. Clinics located in rural areas of the state provided access to communities with limited specialty services. CMS's Program Improvement Project Team is reviewing the use and cost of clinics. DPH is reviewing the feasibility of using telemedicine to replace face-to-face clinics where appropriate.

Activity 3: Identify current telemedicine services in health districts and specialties utilized and explore opportunities for expansion.

Two rural health CMS districts are using telemedicine to provide specialty care. A telehealth director was hired to monitor and expand telemedicine and telehealth services throughout the state. DPH began distributing 13 telemedicine carts to health districts around the state. To expand the network, DPH is recruiting doctors and dentists in the GA Volunteer Health Care Program to enroll them in the telemedicine program and get them the necessary audio and video equipment to start seeing patients.

Activity 4: Conduct a survey of CMS client families to measure understanding of the availability of community-based services and barriers to accessing these services.

A plan was developed to work with DPH epi staff to design survey. The state office updating the statewide family satisfaction surveys, and has integrated those activities into the newly awarded Integrated Community systems for CYSHCN grant.

c. Plan for the Coming Year

Activity 1: Coordinate services for families served in CMS and BCW to assist with accessing available community resources.

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

Monitoring: Quarterly reports.

Activity 2: Conduct specialty clinics for CSHCN in areas with limited specialty providers/services.

Output Measure(s): Number of enrolled clients; number of clinics conducted.

Monitoring: Quarterly reports.

Activity 3: Expand telemedicine services in health districts based on data and need.

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

Monitoring: Quarterly reports.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	38	38	37.7	38.5	38.5
Annual Indicator	37.0	33.9	33.9	33.9	33.9
Numerator	130450	140131	135142	135251	144473
Denominator	352567	413365	398648	398972	426175
Data Source	NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	40	40.9	41.7	42.5	

Notes - 2011

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

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

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

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

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

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006

CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

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

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

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

Notes - 2009

Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available. Numerator and denominator estimates based on the point estimate. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows.

a. Last Year's Accomplishments

CMS Coordinators are required to develop a transition plan with the family and the client beginning no later than 16 years of age and reviewed every 6 months. A MOU between CMS Coastal Health District and Memorial Hospital in Savannah has been executed for the development and implementation of a transition program/service plan for youth 16-21 years of age with SCD. HRSA State Implementation Grant for CYSHCN was awarded. The focus of the funding will be to support the transition efforts statewide. A new grant Program Coordinator was hired.

A nurse consultant and parent consultant were hired at the state office to assist with updating CMS Transition Manual. P2PGA was contracted to host groups with youth and families to provide input to updates needed for the Transition Manual.

Vocational Rehabilitation staff was invited to present to the CMS program state and district staff, information on their program mission and services available to assist CYSN in obtaining employment. CMS staff attended quarterly GA Statewide Transition Council Meetings.

A contract with P2PGA was implemented to assist with family satisfaction survey that includes assessment of satisfaction with transition planning and transitioning. Ten percent of enrolled families in 5 districts have completed surveys. A workplan was developed to update the survey for families and providers and to integrate our Title V and Integrate Community Systems for CYSHCN transition activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
------------	--------------------------

	DHC	ES	PBS	IB
1. Continuing to provide literature and updates on transition services to district coordinators.		X		
2. Developing a packet of transition materials for district coordinators to use with clients and families.				X
3. Collecting data on percent of clients and families with a transitional plan of care.				X
4. Developing webinar series to train district coordinators on transition of youth with special health care needs to all aspects of adulthood.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

CMS coordinators are required to develop a transition plan with the family and the client beginning no later than 16 years of age and reviewed every six months. Ninety-two percent of CMS clients ages 16-21 have a transition plan.

Activity 2: Update CMS Transition Manual and provide training to district staff on use of manual.

The contract with P2PGA was executed to conduct family and youth focus groups to gather input for updating the Transitional Manual. Focus groups planned for fall of 2013.

Activity 3: Schedule meeting with Family Voices, Department of Education, Department of Labor/Rehabilitation Services, Department of Juvenile Justice, Division of Family and Children Services, Governor's Council on Developmental Disabilities and other relevant agencies to develop strategies to improve transition.

A transition stakeholder meeting with contract grantees and other community partners has been scheduled for Summer 2013.

Activity 4: Conduct a survey of CMS client families and providers to measure understanding of transition planning and transitioning.

Plans were developed to create a survey specifically for transition to adulthood. CMS epi staff was hired June 1, 2013.

c. Plan for the Coming Year

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

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

Monitoring: Quarterly reports from CMS staff.

Activity 2: Partner with Parent to Parent to revise the CMS Transition Manual based on input from clients (youth) and their families.

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

Monitoring: Quarterly reports on progress of manual update; statewide training plan; invitations distributed for focus groups; quarterly reports on registration status.

Activity3: Partner with GAAAP and GAFP to provide information and training opportunities to physicians to increase their understanding of transition planning.

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

Monitoring: Quarterly program reports.

State Performance Measures

State Performance Measure 6: Percent of pediatricians and family physicians who have positive attitudes toward treating children with special health care needs

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				25	25
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	2013	2014	2015	2016	2017
Annual Performance Objective	25	25	25	25	25

Notes-2012

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.

Notes - 2010

The survey used to measure this indicator is currently in development. It is anticipated that this survey will be implemented and this measure populated prior to the next annual report. As this is a new measure and survey that is without any previous data, the projection of an annual performance objective is difficult. A goal of 25 percent has been established, but this will likely change as the data are gathered and reported.

a. Last Year's Accomplishments

Staff met with MCH epidemiology staff to discuss the survey to measure physician attitudes to treating children with special health care needs.

Letters were sent to CMS clinic providers requesting participation in providing medical students experience in treating CSHCN. Two responses were received. Leadership had a meeting to discuss additional strategies to engage medical student and residency programs to help implement this project.

MCH-CYSN partnered with Georgia State University/Center for Leadership Development in their pursuit of an AMCHP grant that would sustain their “Parents as Detailers” Program in which parents of CYSN are used as trainers to visit primary care offices bringing information on child development and early identification. MCH’s CYSN Parent Consultant will be a participant in these activities.

Awards were presented to physicians at the GA-AAP meetings.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to work with GA-AAP and GAFFP.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Design and implement a survey in partnership with the GA-AAP and GAFFP to measure physician attitudes towards treating children with special health care needs.

This activity was to be conducted with a multiple survey to health care providers. Staff met with MCH Epidemiology staff to discuss the survey. A new MCH Epidemiologist has been hired effective June 1, 2013.

Activity 2: Meet with leaders in Georgia medical schools to develop a strategy to expose medical students to treating children with special health care needs.

A letter was sent. The next step is to contact the medical schools.

Activity 3. Work with GA-AAP and GAFFP to develop an awards recognition program for providers who excel at providing treatment for children with special health care needs.

DPH Program staff developed criteria for selecting physicians for the recognition award. The criteria was shared with GA AAP and GA AFP.

c. Plan for the Coming Year

Activity 1: Continue to work with the Georgia Chapter of the American Academy of Pediatrics and the Georgia Association of Family Physicians to develop an awards and recognition program for providers who excel at providing services for children with special health care needs.

Output Measure(s): Awards and recognition program plan developed; number of providers recognized.

Monitoring: Implementation plan and timeline.