

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

**Georgia**

**FY 2015 Application/  
FY 2014 Annual Report**

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# Executive Summary

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Georgia Department of Public Health Maternal and Child Health Section (MCH) administers the Maternal and Child Health Services Title V Block Grant. The mission of MCH is to implement measurable and accountable services and programs that improve the health of women, infants, children, fathers, and families in Georgia.

Georgia conducted a comprehensive needs assessment to assess the health status of women, infants and children in Georgia in order to determine priority needs for the Title V Maternal and Child Health Block Grant. The assessment provided an opportunity for the Title V program to continually plan for activities that are currently implemented, as well as strategically plan for new initiatives. The assessment also provided the opportunity for MCH to focus on activities that should receive the highest priority.

## Needs Assessment Summary

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. Needs were identified by MCH program and epidemiology staff. Stakeholders were then given the opportunity to review the findings and assist MCH in prioritizing the identified needs. Throughout the entire process, stakeholders throughout the state were able to give input into the selection of priorities and development of strategies to address priority needs. Stakeholders and partners were given the opportunity to provide input through a survey, an ongoing public comment period and participation in stakeholder meetings.

A SWON (Strength, Weakness, Opportunity, Need) analysis was used to determine program capacity and ensure that all the priorities selected were best addressed through the Title V program.

Eight priority needs were identified:

1. Prevent maternal mortality
2. Increase 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
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 has become a topic of increasing importance in Georgia. With the implementation of a Maternal Mortality Review Committee (MMRC) in 2011, the topic has gained greater awareness among public health professionals. Additionally, Georgia has been shown to be among states with the highest maternal mortality ratios. It was found that the rate increased from 17.7 in 2012 to 43.6 in 2013. The review committee found that poor health status prior to pregnancy could be attributed to the high maternal mortality ratio.

For this reason, preventing maternal mortality is a priority need of the Title V program in Georgia. The strategies implemented over the next five years to address this need will focus around two primary activities: support and improvements to the Maternal Mortality Review and promotion of well-woman visits to promote excellent health status in the pre and interconception period. As the MMRC is just beginning, it is a crucial time to refine policies and procedures and implement quality improvement in the data collection process to ensure that all maternal deaths are captured. There is also the potential for data to action pieces to be implemented. MCH plans to build on the existing infrastructure in the family planning clinics to promote well-woman visits. It is hoped that linking women of reproductive age to preventive care will improve the overall health status of women before they enter pregnancy, and reduce maternal mortality.

### **Increase access to family planning services**

Unplanned pregnancies are associated with poor birth outcomes for both mothers and infants. Approximately half of all pregnancies in Georgia are unplanned. This is an area for the Title V program to have a significant impact through increasing the number of women accessing services through the local health departments. From 2016-2020, MCH will focus on promoting utilization of the services provided through family planning clinics and improving the quality of the services provided.

### **Prevent infant mortality**

The rate of infant mortality is increasing in Georgia. Breastfeeding, safe sleep practices and perinatal regionalization all have the potential to prevent infant mortality. However, too few infants are ever breastfed or breastfed exclusively for the recommended amount of time. Only about half of infants in Georgia are placed to sleep on their back. The perinatal regionalization system could be improved to ensure that high-risk infants are being born in facilities that have specialized care to treat their conditions.

For these reasons, MCH will focus on improving the perinatal regionalization system to ensure that all hospitals are operating within their defined level of perinatal care. The focus will also be on increasing breastfeeding through encouraging breastfeeding-friendly hospitals and promoting worksite lactation programs using the Business Case for Breastfeeding. Georgia will also focus on changing community norms and ensuring consistent messaging regarding safe sleep practices.

### **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. There is a need to create awareness for children not receiving services through the public health system.

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.

### **Prevent suicide among adolescents**

Suicide is an important emerging issue identified through Georgia's needs assessment. Recent data show that the rate of death due to suicide is increasing among adolescents. The area is of particular concern due to the prevalence of bullying in the state. Addressing adolescent health is an important new initiative for the MCH Title V program in Georgia. 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 transition 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. Georgia will focus on ensuring that all children in CMS have a satisfactory transition plan and ensure that they are linked with a medical home prior to discharge from the program. Other areas of focus throughout the reporting year are around increasing telehealth sites to improve access to specialty care and increasing awareness of the services that are available.

### Promote oral health among all populations

Promoting oral health is an important need affecting all populations throughout the state. Data show that fewer children are receiving preventive dental visits. Additionally, there are racial disparities among pregnant women who access dental services during pregnancy. Accessing oral health care during pregnancy can impact the likelihood that the child will receive appropriate health care.

MCH will continue to promote oral health among everyone by continually supporting the community water fluoridation program and specifically focusing on pregnant women and children. A database listing locations for all CYSHCN will be developed.

### National Performance Measures

Eight national performance measures were selected to address these priority areas. 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. Activities supporting these national performance measures were outlined with the priority needs

National Performance Measure	Data Source	Year Available	Georgia	United States
Percent of women with a past year preventive medical visit	Behavioral Risk Factor Surveillance System	2013	68.1%	65.2%
Percent of VLBW infants born in a Level III facility with a Neonatal Intensive Care Unit (NICU)	Vital Records			Data not available
A. Percent of infants who are ever breastfed B. Percent of infants breastfed exclusively through 6 months	National Immunization Survey	2011	70.3% 14.5%	79.2% 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%	25.2%
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. 38.0% B. 75.9%	A. Data not available B. 77.2%

### Next Steps

The Title V needs assessment provided an opportunity for MCH to redefine priorities based on the most current data available, as well provide time to strategically plan to address these priority needs. Georgia will continue to rely on input from stakeholders and families in the strategic planning process, and assess the impact of specific programmatic approaches throughout the five year cycle. The needs assessment has resulted in new priorities, new partnerships and an action plan that will move the needle on the eight selected national performance measures and 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. A. Overview of the State

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### 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 does not define rural, but does define urban. Two types of urban areas are defined: urbanized areas of 50,000 people or more and urban clusters of at least 2,500 and less than 50,000 people. Of the 159 counties, 108 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. The majority of the state's rural counties are located in the southern half of the state.

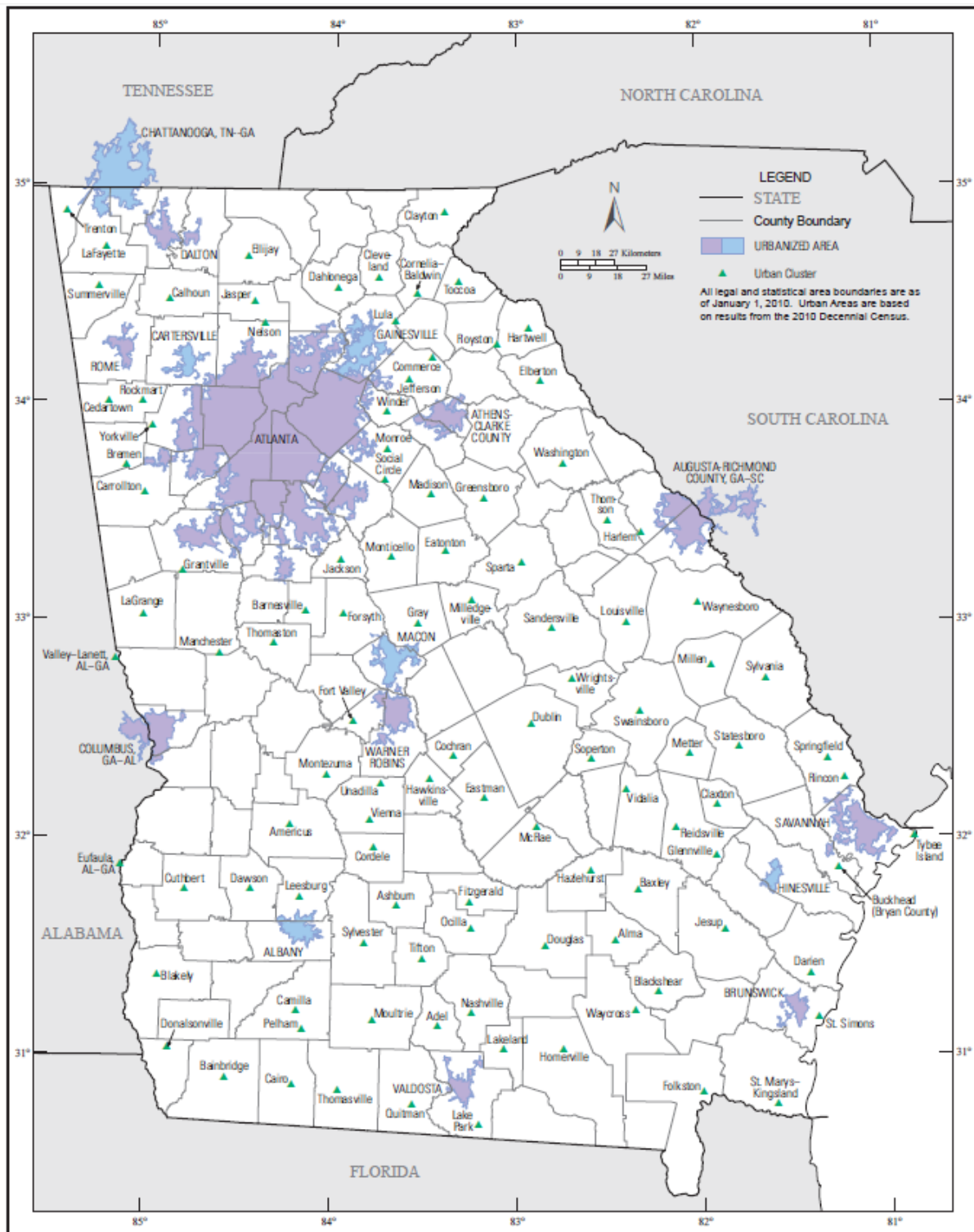
According to the 2010 census, the US Census Bureau lists the following 15 Metropolitan Statistical Areas in Georgia: <sup>i</sup>

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 is the state's largest metropolitan area, serving as the state capitol. It is the economic, cultural and demographic center of Georgia. In 2013, the population estimate for Atlanta was just under 450,000, a 6.6% increase from 420,000 in 2010. Over six percent of these were people under 5, 19.4% were under 18 and 9.8% were over 65. The city also has a high percentage of minorities, with 54% of residents identifying as Black or African American, 5% as Hispanic, 3% as Asian and 38% as White. 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>ii</sup>.

The following map generated by the US Census Bureau based on population data for 2010 depicts the urbanized and non-urbanized areas in the state of Georgia.

Figure 2: Urbanized areas in the state of Georgia, US Census 2010



Source: US Census Bureau, 2010



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. Growing rural areas are those that are experiencing population and economic growth due to the areas being attractive for tourism or retirees. A declining rural area is one that is experiencing a decline in population due to downturns in economy. As such 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.

## Population

As of 2014, Georgia had an estimated population of 10.1 million people<sup>iii</sup>. It is ranked the 8<sup>th</sup> largest state with respect to population based on 2014 estimates<sup>iv</sup>. Georgia is the 14<sup>th</sup> fastest growing state in the nation, with a 4.2% increase from 2010 to 2014<sup>v</sup>. Georgia was ranked 4<sup>th</sup> among states with the largest numeric population increase from July 2013 to July 2014<sup>vi</sup>. It is estimated that Georgia's population will increase to 11.3 million by 2020<sup>vii</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 is Black. In 2010, 30.5% of Georgians were Black. The number of Hispanics in Georgia doubled between 2000 and 2010. The number of Asians nearly doubled, with the highest increases seen among Asian Indian, Korean and Vietnamese populations. Such a growth in diversity and population necessitates the availability of culturally-competent health, education and human services.

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

Georgia Population Estimates				
	2000 Census		2010 Census	
Population Characteristic	Number	Percent	Number	Percent
<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>viii</sup>. According to 2009-2013 estimates, 6.9% of Georgia's population is under 5 years old<sup>ix</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> in having the largest number of undocumented immigrants. However, data from 2009-2012 shows 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>x</sup>.

### Place of Birth and Language Proficiency

In 2009-2013, 9.7% of Georgia residents were born outside of the U.S.<sup>xi</sup>. Over 13 percent of Georgia residents speak a language other than English<sup>xii</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>xiii</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

In 2010, 47.8% of Georgia households were composed of husband-wife, with 21.1% of these households having children under the age of 18. Female headed households comprised of 15.8% of the population and 8.9% of these households contained children under the age of 18; 4.9% were male family households, with 2.2% with children under the age of 18. Finally, 25.4% of households were one-person households, with 7.5% being 65 or older. The average number of people per household was 2.6 and 3.2 per family<sup>xiv</sup>. These numbers are comparable to national data.

### Educational Attainment

Public schools are the primary source of education in Georgia. In nursery school and preschool, 61.3% were in public school and 38.7% were in private school. From 2009-2013, 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 among Hispanics and 65.3 among Blacks<sup>xv</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 2009-2013. 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>xvi</sup>.

### Income

Georgia's per capita income was below the U.S. average in 2009-2013 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>xvii</sup>. In 2013, median household income in Georgia was \$47,829 a major decrease from the median income of \$55,027 in 2008<sup>xviii</sup>.

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

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

### Poverty

Poverty is more prevalent in Georgia than in many states across the nation. In 2009-2013, 18.2% of Georgians were living below the poverty line, compared with 14.5% for the U.S. overall. Over eight percent 8.3% 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 25.3% as of 2013. In 2009, only 1 in 5 children under the age of 18 were in poverty. Poverty disproportionately affects ethnic minorities, with 26.5% of African-Americans and 32.2% of Hispanics living below the FPL, relative to 13.2% of Whites<sup>xix</sup>.

### Employment

In April 2015, Georgia's unemployment rate was 6.3%, ranking it 41<sup>st</sup> in the United States, compared to Nebraska with the lowest unemployment rate at 2.5%<sup>xx</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>xxi</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. About 38% had a disability. Four hundred and fifty, or 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>xxii</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 effects of health reform remain to be seen. The Affordable Care Act signed in 2010 went into effect in 2014. It is a state decision to participate in the Medicaid expansion or not, and as of 2015 Georgia will not expand. Although implementation of the health reform law will be complex and challenging, analysts do estimate that by 2019, 1.17 million Georgia residents that were currently uninsured will obtain coverage. Approximately 541,080 Georgians acquired health insurance through the marketplace at the end of 2015 open enrollment<sup>xxiii</sup>. It is estimated that half of Georgians eligible through the

marketplace have received coverage<sup>xxiv</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>xxv</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>xxvi</sup>, this is indeed not the case. The state still experiences one of the highest unemployment rates, and median household income is still declining.

Furthermore, there are many budgets that have been significantly cut. The Department of Community Health faces a significant budget decline in 2016. The Governor's 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>xxvii</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>xxviii</sup>. These reductions are concerning as school readiness and adequate education for older children has 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.

In Georgia, four children between the ages of 1-17 die each day. Nearly three of the four are dying from 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.

## II.B. Five Year Needs Assessment Summary

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### II.B.1. Process

#### Goals, Framework and Methodology Guiding Needs Assessment Process

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

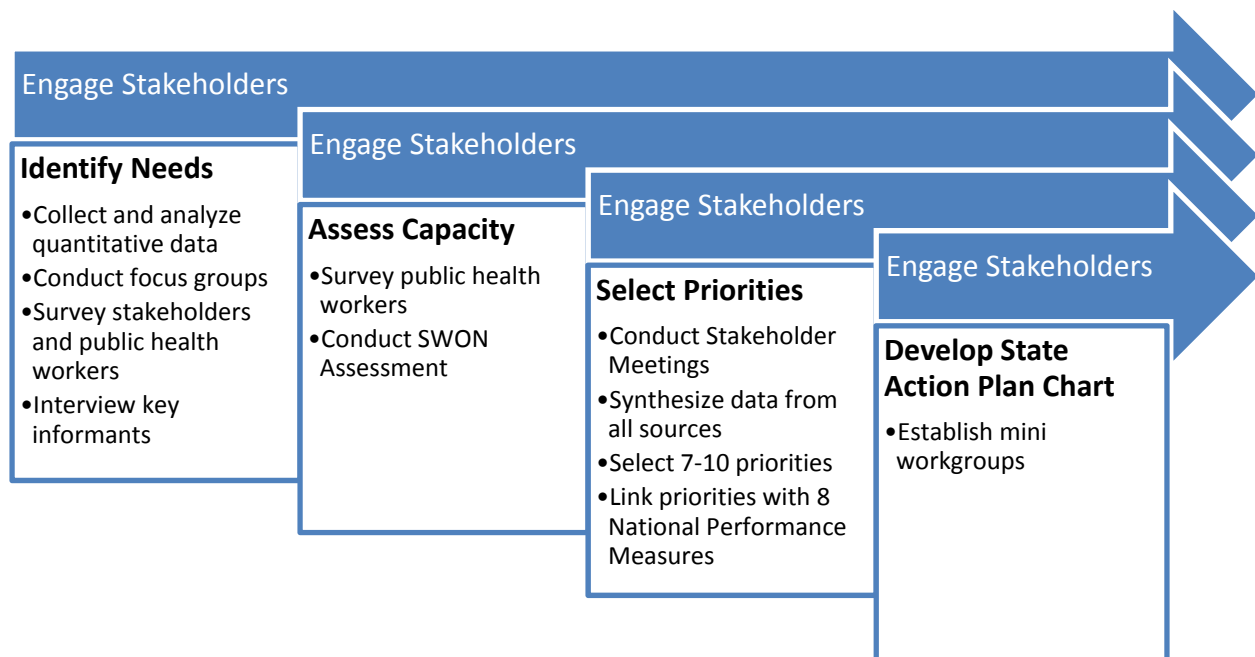


Figure 1. Georgia Title V Needs Assessment Process

### Stakeholder Involvement

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. Over one hundred stakeholders participated in the prioritization process. 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.

### 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 Data  
 Current Population Survey  
 Family Planning Program  
 Georgia Comprehensive Cancer Registry  
 Hospital Discharge Data  
 HIV Surveillance Program  
 National Immunization Survey  
 National Survey of Children's Health  
 National Survey of Children with Special Health Care Needs  
 Online Analytical Statistical Information System  
 Pregnancy Risk Assessment Monitoring System  
 State Vital Records  
 STD Surveillance Program  
 Universal Newborn Hearing and Screening Program  
 Youth Risk Behavior Surveillance System  
 Vital Statistics System  
 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 services. Data were collected through focus groups in 16 districts and through key informant interviews in 2 districts. Key informant interviews were used as a culturally appropriate method of gaining insight into the Hispanic community. Community members with prior experience conducting focus groups were responsible for recruitment and facilitation. Facilitators were asked to recruit potential or current users of services in their respective districts.

Table 1. Needs Assessment Focus Groups by Location and Topic

Perinatal Health*	School Readiness**	CYSHCN***
Rome (≥ 30 yrs.)	Waycross	Cobb Douglas (≤7 yrs.)
Fulton (≥ 30 yrs.)	Valdosta	Augusta (≤7 yrs.)
East Metro † (≥ 30 yrs.)	Macon	Columbus (≤7 yrs.)
Dublin (< 30 yrs.)	Dalton	Gainesville (≥8 yrs.)
Albany (< 30 yrs.)		Clayton (≥8 yrs.)
Athens (< 30 yrs.)		Savannah (≥8 yrs.)
DeKalb † (< 30 yrs.)		

\*Participants were pregnant women or had a child within the past year and either over 30 years or under 30 years of age

\*\*Participants were parents of children ages 4 to 7 years of age

\*\*\*Participants were parents of CYSHCN 7 or younger or 8 and older

† Key Informant Interviews conducted in Spanish among Latinas

### Key Informant Interviews

Interviews were conducted with six leaders in the MCH workforce in Georgia. One interview was conducted per population domain. The key areas discussed during the interviews included identification

of needs and priorities, barriers to accessing services, areas of disparity, and needs of the public health workforce.

#### **Stakeholder Survey**

An electronic survey was disseminated to stakeholders throughout the state to identify needs and priorities. Respondents were asked to rank the National Performance Measures (NPM) and identify needs specific to Georgia that are outside the scope of the NPMs.

#### **Public Health Workforce Survey**

A separate, but similar, electronic survey was disseminated to employees of DPH at the state, district and local level. Respondents were asked to rank the NPMs and identify additional needs related to MCH populations, workforce development and agency capacity.

#### **Public Comment**

Throughout the process, public input was solicited through an online public comment format. The Title V Needs Assessment findings were posted to the DPH Title V website. Notifications were emailed to partners, Board of Public Health members and known stakeholders with an invitation for comments. Comments were emailed directly to DPH staff for review and applied to the documents as necessary.

#### **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 Maternal and Child Health had the capacity and authority to address the need and if the need was measurable. 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
	Increase access to family planning services	None
Perinatal Health	Prevent infant mortality	Breastfeeding Perinatal regionalization



Child Health	Promote developmental screenings among children	Developmental screening
	Promote physical activity among children	Physical activity
Adolescent Health	Prevent suicide among adolescents	Bullying
Children and Youth with Special Health Care Needs	Improve systems of care for CYSHCN	Transition
Cross-Cutting	Promote oral health among all populations	Oral health

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

## II.B.2. Findings

### 11.B.2.a. MCH Population Needs

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 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/tilev](http://www.dph.ga.gov/tilev)).

## Maternal/Women's Health

### Maternal Mortality

The maternal mortality ratio (number of pregnancy-related deaths per 100,000 live births) increased from 11.5 (n=16) in 2004 to 43.6 (n=56) in 2013. 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. Of the deaths that were related to pregnancy, 17 of the women were Black, 6 were White, 1 was Hispanic and 1 was unknown. 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. Almost 77% of non-Hispanic Black women reported having seen a provider, while only 62.4% of Hispanic women attended such a visit. The percentage of women receiving a preventive visit was higher among women with a higher educational attainment.

## Family Planning

The percentage of births that were not planned in Georgia increased from 52.6% in 2009 to 54.8% in 2011. The percentage of unplanned births was 29.4% among women over the age of 35 and 82.3% among women 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%). Only 50.6% of women in urban areas in Georgia reported an unplanned birth compared to 66.1% of women in rural areas.

## 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%. Disparities exist by maternal age and education level. Specifically, 58.0% 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%).

## Qualitative Findings

Table 3. Maternal/Women's Health Qualitative Findings

Focus Groups: Perinatal Health	
<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>
Key Informant Interviews	
<b>Priority Needs</b>	<ul style="list-style-type: none"><li>• Well-woman 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 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

From 2010 to 2013, the infant mortality rate increased from 6.3 to 7.2. 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.

### 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. The percentage of Non-Hispanic White VLBW infants born at the appropriate level of care (68.5%) was lower than the percentage for both non-Hispanic Black and Hispanic VLBW infants (80.1% and 80.5% respectively). 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.

## Breastfeeding

### Ever Breastfed

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. 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 over 30 years of age 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 is 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.

### Exclusively Breastfed at Six Months

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%). 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% respectively).

### Safe Sleep

Healthy People 2020's safe sleep objective is to increase the percent 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%. 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 61.0% compared to non-Hispanic Black (43.0%) and Hispanic mothers (42.6%). 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.

## Qualitative Findings

Table 4. Perinatal Health Qualitative Findings

Focus Groups: Perinatal Health	
Individual-Level	<ul style="list-style-type: none"><li>Familiarity with provider encourages care-seeking behavior</li><li>Lack of knowledge on available parenting class and resources</li></ul>
Structural-Level	<ul style="list-style-type: none"><li>Support systems encourage breastfeeding</li><li>Lack of transportation</li></ul>
Key Informant Interviews	
Priority Needs	<ul style="list-style-type: none"><li>Perinatal regionalization system</li><li>Safe sleep</li><li>Breastfeeding, especially for high-risk infants</li></ul>
Individual-Level	<ul style="list-style-type: none"><li>Lack of awareness on the benefits of breastfeeding</li></ul>

**Structural-Level**

- Lack of public transportation
- Lack of access to specialized care in rural areas
- Insurance reimbursement prevents transfer of high-risk neonates to appropriate hospital
- Lack of a donor breast milk program in the state

**Strengths and Needs**

Although there are no clear instances in the areas examined where Georgia's population is meeting or exceeding national averages or HP 2020 objectives, certain population sub-groups are. The infant mortality rate among White and Hispanic infants is a strength in Georgia. 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 stratum 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.

**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. 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, children in Georgia using public insurance are more likely to receive a developmental screening compared to children using private insurance (44.9% and 38.2% respectively). These disparities are not present at the national level.

## 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. 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 (74.82) and Hispanic (28.3) counterparts. A higher rate was seen among males compared to females.

## 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, children aged 6 to 11 were more likely to perform 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. The most notable disparity is between genders, with 36.3% of boys performing physical activity for 20 minutes daily compared to 24.4% of girls.

## Qualitative Findings

Table 5. Child Health Qualitative Findings

Focus Groups: School Readiness	
Individual-Level	<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>
Structural-Level	<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>
Key Informant Interviews	
Priority Needs	<ul style="list-style-type: none"><li>• Physical activity</li></ul>
Structural-Level	<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.

### 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. 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). In 2009 8.3% of high school and 7.9% of middle school students reported an attempted suicide. Suicide attempts increased in 2011 but returned to previously seen levels in 2013. Although the suicide death rate is highest among Non-Hispanic Whites, 16.0% of Hispanic high school students in Georgia attempted suicide in 2013 compared to 11.3% of Hispanic students nationally. Twice as many non-Hispanic Black high school students reported a suicide attempt as non-Hispanic Whites. In middle school, females reported more than twice as many suicide attempts as their male counterparts.

### 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%). Data on parent-reports of bullying show that the percentage of children being bullied in Georgia decreased from 17.0% to 16.4% from 2007 to 2011/12. In 2011/12, 14.2% of parents reported bullying nationally. Hispanic high school students reported experiencing electronic bullying most often (18.8%), compared to their non-Hispanic White (16.4%) and non-Hispanic Black (7.3%) peers. Female high school students also reported more instances of electronic bullying (17.5%) compared to male high school students (9.4%).

### 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. Students in grades 9 through 11 reported more physical activity than 12th grade students. Male students are the only group in Georgia currently achieving the HP 2020 objective and reported two times the physical activity as their female counterparts (34.5% compared to 15.1%).

## Non-Fatal Injury

The rate of hospitalization due to non-fatal injury among adolescents has decreased from 2008 to 2012. In 2008, the rate was 260.8, but it decreased to 191.0 in 2012. 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 271.71 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.

## 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%. 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) (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.

## Qualitative Findings

Table 6. Adolescent Health Qualitative Findings

Key Informant Interviews	
Priority Needs	<ul style="list-style-type: none"><li>• Physical activity</li><li>• Bullying</li><li>• Sexual and reproductive health</li></ul>
Structural-Level	<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

- Georgia Shape has successfully promoted physical activity in elementary and middle schools throughout the state.
- The Child Occupant Safety Program administers child safety seats to prevent injury during motor vehicle accidents

### 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.



## 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%). 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.

### Medical Home

In 2009/10, 45.7% of Georgia's CYSHCN received care within a medical home compared to 43.0% nationally. 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.

### Qualitative Findings

Table 7. CYSHCN Qualitative Findings

Focus Groups: CYSHCN	
Individual-Level	<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>
Structural-Level	<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	
Priority Needs	<ul style="list-style-type: none"><li>• Medical homes</li><li>• Access to primary and subspecialty care</li></ul>
Structural-Level	<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 2008 to 2012, the percentage of mothers who smoked during pregnancy remained steady at about 6.0%. In 2013, the percentage increased to 7.5% but remained lower than the national average of 8.5%. The percentage of non-Hispanic White mothers (12.2%) who smoke during pregnancy is 1.6 times higher than the state average. More women with at least some high school education but not a high school degree report smoking during pregnancy (18.1%) than all other educational levels.

### 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. Children of parents who did not graduate high school experience more second hand smoke exposure in the home than children of parents who received a college degree (36.5% compared to 12.2%).

### Dental Visits during Pregnancy

Although 38% 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.

### 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. Only 67.5% of low-income children ages 1 to 17 in Georgia had one or more preventive dental care visits in the last 12 months in Georgia compared to 86.3% of those in the highest income category.

## 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%).

## Qualitative Findings

Table 8. Cross-Cutting Qualitative Findings

Key Informant Interviews	
Priority Needs	<ul style="list-style-type: none"><li>• Oral health of adolescents</li><li>• Perinatal oral health</li><li>• Early childhood caries</li></ul>
Individual-Level	<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>
Structural-Level	<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><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><li>• Limited number of caregivers capable of taking care of oral health for CHSCN</li><li>• Dentist shortages</li><li>• Uninsured clients cannot pay for care</li></ul>

## Strengths and Needs

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

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

## Programmatic Efforts

### 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 Georgia Department of Public Health (DPH) administers the Title V Block Grant. DPH 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 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.

Title V provides funding to Brain Trust, Injury Prevention and Georgia SHAPE, which are located outside of MCH. The following is a list of Title V-funded programs

### Title V Funded Programs

Brain Trust seeks to encourage parents to speak to their young children to support brain development and reading proficiency.

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.

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

Universal Newborn Hearing Screening and Intervention (UNHSI) screens for hearing loss in the birthing hospital and links infants to appropriate intervention.

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

MCH currently has the capacity (structural resources, data systems, partnerships and competencies) to provide Title V services to the following domains: maternal/women's health, perinatal health, child health, CYSHCN and oral health. 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. Georgia's adolescent health program is located in Adolescent and School Health (ASH) to address and improve this area of concern. 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

### Description

There are currently 39 FTEs working on behalf of the Title V program in Georgia.

### MCH Leadership Staff

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. 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. 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.

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 on state Title V program staff.

## **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. Leaders of organizations targeting culturally diverse groups partner with our programs. 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 organizations. State Systems Development Initiative and D70 are MCHB investments provided directly to MCH.

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



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

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

Other programs within the State Department of Health: MCH partners with several other sections in DPH. MCH partners with Adolescent and School Health, 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 must 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 serve 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

We estimate 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 Parent as Partners project, parents are providing emotional support, linkages to community resources, transition to adult health care education and assistance with navigating the health care and special education systems. Families have been engaged with Child Health Screening in the last year on the addition of Critical Congenital Heart Disease Screening and Severe Combined Immunodeficiency, and expanding coverage for medical foods.

#### Impact of family/consumer partnership on programs and policies

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

### Selection Process

Georgia has used the following definition for a priority need: 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 of. 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 criterion were averaged, multiplied by their weight, and added together to determine the final rating score for each priority need.

Table 1. Priority Need Rating

Rank	Potential Need Rated by Stakeholders	Rating	Status
1	Reduce the number of infants born with a low or very low birth weight	63.44	Addressed by preventing maternal mortality, infant mortality and increasing access to family planning services
2	Decrease the maternal mortality ratio	62.63	Selected as a priority need
3	Increase physical activity among children	60.94	Selected as a priority need and NPM
4	Increase access to specialty care for CYSHCN	60.42	Addressed by improving systems of care for CYSHCN
5	Reduce the number of infants born preterm	59.84	Addressed by preventing maternal mortality, infant mortality and increasing access to family planning services

<b>6</b>	Decrease deaths related to motor vehicle accidents for children 0-19	59.26	Not selected: Programmatic efforts to prevent childhood deaths are in place in DPH and MCH has a low capacity to address the need
<b>7</b>	Reduce substance abuse during pregnancy	59.20	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
<b>8</b>	Increase the percentage of VLBW infants born in a Level III facility	59.04	Selected as an NPM
<b>9</b>	Reduce suicidal ideation, planning and attempts	58.71	Selected as a priority need
<b>10</b>	Decrease adverse childhood experiences among children	58.12	Not selected: MCH has low program capacity to properly address the need
<b>11</b>	Decrease the percent of mothers smoking during pregnancy	57.97	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
<b>12</b>	Decrease the percent of children, including those with special health care needs, exposed to second hand smoke at home	57.42	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
<b>13</b>	Increase physical activity among adolescents	57.23	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
<b>14</b>	Decrease tobacco use among adolescents	56.69	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
<b>15</b>	Reduce unplanned teen pregnancies	55.60	Addressed through increasing access to family planning services overall
<b>16</b>	Increase the number of women receiving well-woman visits	55.11	Selected as an NPM
<b>17</b>	Reduce the percent of adolescents who are bullied or who bully others	55.03	Selected as an NPM
<b>18</b>	Increase the percent of CYSHCN who received services necessary to make transitions to adult health care	54.62	Selected as an NPM

<b>19</b>	Increase the number of pregnancies that are planned	54.55	Selected as a priority need
<b>20</b>	Increase the percent of children and youth, including those with special health care needs, receiving a preventive dental visit	54.26	Selected as a priority need
<b>21</b>	Increase the proportion of women receiving prenatal care in the first trimester	54.19	Not selected: Community support for this need was lower than well-woman visits, which promote health before women enter pregnancy.
<b>22</b>	Increase the percent of CYSHCN having a medical home	54.11	Addressed by improving systems of care for CYSHCN
<b>23</b>	Decrease non-fatal injury among children	54.04	Not selected due to higher community support for other needs
<b>24</b>	Increase the number of CYSHCN that receive care coordination services	53.62	Addressed by improving systems of care for CYSHCN
<b>25</b>	Increase the percent of women receiving a dental visit during pregnancy	52.71	Selected as an NPM
<b>26</b>	Increase the percentage of children receiving a developmental screening	51.80	Selected as a priority need and NPM
<b>27</b>	Increase the number of infants placed to sleep on their back	51.57	Will be addressed by an SPM
<b>28</b>	Increase the percent of adolescents receiving a well-visit	50.72	Not selected due to higher community support for other needs
<b>29</b>	Increase the proportion of women receiving postpartum care	49.96	Not selected due to higher community support for other needs
<b>30</b>	Decrease cesarean sections among low-risk first births	49.31	Not selected due to higher community support for other needs
<b>31</b>	Increase the percent of families and emergency responders that feel prepared to assist CYSHCN during an emergency	48.97	Not selected due to higher community support for other needs
<b>32</b>	Reduce non-fatal injury among adolescents	48.10	Not selected due to higher community support for other needs
<b>33</b>	Increase the number of infants who are breastfed	46.08	Selected as an NPM

<b>34</b>	Increase the number of people drinking fluoridated water	41.42	Addressed through improving oral health among all populations
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### **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 the state with the highest maternal mortality ratio in the nation (cite). 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. Increase access to family planning services**

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

### **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 increased from 6.3 in 2010 to 7.2 in 2013. Strong racial disparities are present and should be addressed to achieve health equity. Although preventing infant mortality was not independently ranked at the Stakeholder Meetings, factors impacting infant mortality were considered. Low birth weight and preterm deliveries were among the highest ranked needs, displaying strong community support to address the overarching issue of infant mortality. Although breastfeeding, perinatal regionalization and safe sleep received lower ratings, quantitative analysis revealed that Georgia needs to make significant improvements to be comparable to national averages and achieve Healthy People 2020 goals. Strong community support to address breastfeeding was displayed 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 at the stakeholder meetings, 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
Increase access to family planning services	Reduce repeat adolescent pregnancy
Prevent infant mortality	Decrease infant mortality and injury
Promote physical activity	Decrease obesity among children and adolescents
Promote developmental screening	Increase developmental screening for children in need
Prevent suicide among adolescents	No similar need
Improve systems of care for CYSHCN	Increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs
Promote oral health among all populations	No similar need
No similar need	Reduce motor vehicle crash mortality

	among children ages 15-17 years
No similar need	Improve maternal and child health surveillance and evaluation infrastructure
No similar need	Improve childhood nutrition
No similar need	Increase awareness of the need for preconception health care among women of childbearing age

Promoting planned pregnancies was identified as a key priority in both assessments, although it was expanded to promote family planning across all ages in 2016-2020. Given the overall infant mortality rate for the state and the racial, income, and geographic disparities, preventing infant mortality was identified as a priority in both assessments. Decreasing obesity among children (2011-2015) 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 2012-2015 reporting cycle.

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

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. Increasing access to family planning services does not have an associated NPM and will be addressed by an SPM.

Table 3. Linkage Between Priority Needs and National Performance Measures

Domain	Priority Need	National Performance Measure
<b>Maternal/Women's Health</b>	Prevent maternal mortality	Well-woman visit
<b>Maternal/Women's Health</b>	Increase access to family planning services	None
<b>Perinatal Health</b>	Prevent infant mortality	Perinatal regionalization Breastfeeding
<b>Child Health</b>	Promote developmental screenings among children	Developmental screening
<b>Child Health</b>	Promote physical activity among children	Physical activity
<b>Adolescent Health</b>	Prevent suicide among adolescents	Bullying
<b>CYSHCN</b>	Improve systems of care for CYSHCN	Transition
<b>Cross-Cutting</b>	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 measure 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 ensure that mothers and infants are born 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 reduce disparities and promote it among all children, not just those receiving services from DPH. Increasing developmental screenings is intended to promote early identification of children that have social and emotional delays and linkage to services during critical periods of the child's development.

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

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

*Priority Need: Improve systems of care for CYSHCN*

Improving transitions to adulthood is intended to address the priority need of improving the overall system of care for CYSHCN by linking them 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 will impact the overall health status of Georgians.

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

*Priority Need: Promote oral health among all populations*

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

## II.F. Five Year State Action Plan

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

- Accomplishments: October 1, 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

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

#### Maternal/Women's Health

Maternal/Women's Health			
Priority Needs	Objectives	Strategies	National Performance Measure
1. Prevent maternal mortality	<b><u>1.1</u></b> Increase the number of data abstractors	<b><u>1.1.a</u></b> Collaborate with GOGS to identify and hire abstractors <b><u>1.1.b</u></b> Train abstractors	Well-woman visit
	<b><u>1.2</u></b> Develop 1 Maternal Mortality Report each year	<b><u>1.2.a</u></b> Write a Maternal Mortality Report each year with recommendations <b><u>1.2.b</u></b> Assess policies and procedures for the Maternal Mortality Review Committee and update as needed	
	<b><u>1.3</u></b>	<b><u>1.3.a</u></b>	

	<p>Increase the number of hospitals educated on mandated reporting requirements by 10% each year for 5 years</p> <p><b><u>1.4</u></b> Develop and implement 1 translational project based on findings</p> <p><b><u>1.5</u></b> Increase the number of well-woman visits occurring in family planning clinics by 10%</p>	<p>Develop strategic plan for training hospitals <b><u>1.3.b</u></b> Train hospitals on passive surveillance protocol</p> <p><b><u>1.4.a</u></b> Identify a data to action team <b><u>1.4.b</u></b> Develop a translational project with the data to action team and MMRC <b><u>1.4.c</u></b> Implement implementation plan</p> <p><b><u>1.5.a</u></b> Build partnership with district offices <b><u>1.5.b</u></b> Work with district offices to develop marketing strategies <b><u>1.5.c</u></b> Implement marketing strategies in counties <b><u>1.5.d</u></b> Provide training to district offices and local departments on well-woman visits and proper coding methods</p>	
2. Increase access to family planning services	<p><b><u>2.1</u></b> Increase the number of family planning clients in public health clinics by 10% every year for five years</p> <p><b><u>2.2</u></b> Increase the number of family</p>	<p><b><u>2.1.a</u></b> Build partnership with district offices and develop promotional campaign for family planning services <b><u>2.1.b</u></b> Implement promotional campaign</p> <p><b><u>2.2.c</u></b> Educate local providers on providing culturally competent care services for teens</p>	

	planning providers in public health clinics who have been trained to provide care to teens by 30%		
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## Reporting Year

### **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) continues to occur in the public health districts. Clients are referred to OB providers, WIC and Medicaid. Quarterly conference calls with stakeholders have been held to build capacity for expanding the Centering Pregnancy Model.

#### Current Activities

A Perinatal Nurse was hired to partner with March of Dimes to increase Centering Pregnancy sites. MCH participated in a Centering Pregnancy conference hosted by United Way of Greater Atlanta to raise awareness and generate interest in the program.

## Plan for Upcoming Year

### **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 identify 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 consistent messaging.

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.

## Family Planning

Increasing 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.

## Perinatal Health

Perinatal Health			
Priority Needs	Objectives	Strategies	National Performance Measure
3. Prevent infant mortality	<b><u>3.1</u></b> Increase the number of hospitals participating in the 5-STAR program by 20%	<b><u>3.1.a</u></b> Conduct presentations to recruit hospitals <b><u>3.1.b</u></b> Provide support to hospitals participating in the program	Breastfeeding Perinatal Regionalization
	<b><u>3.2</u></b> Partner with WIC to conduct 1 training per year for public health workers on breastfeeding for five years	<b><u>3.2.a</u></b> Using evaluation forms from previous trainings, identify a topic to educate public health workers on <b><u>3.2.b</u></b> Conduct VICS trainings for public health workers	
	<b><u>3.3</u></b> Increase the number of worksites with lactation policies by 20%	<b><u>3.3.a</u></b> Educate employers on the Business Case for Breastfeeding	
	<b><u>3.4</u></b> Ensure all birthing hospitals have been educated on the requirements for neonatal level of care	<b><u>3.4.a</u></b> Assess Perinatal Capacity Survey results <b><u>3.4.b</u></b> Develop strategic plan for RPCs	

## Reporting Year

### **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 Programs 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 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. Follow-up for abnormal results in contracted with Emory University, Georgia Regents University, 18 public health districts and now Children's Healthcare of Atlanta. 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. To communicate about progress and results, the Georgia Newborn Screening and Genetics Advisory Committee meets twice a year. The state also provides NBS info 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. 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. NBS also partners with the Georgia Hospital Association, and published information on the website and through social media, and through webinars. The state also 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 service 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.

#### Current Activities

CCHD screening is occurring in approximately 99% of birthing hospitals with 92% reporting results to DPH. Hearing screening is occurring in all birthing hospitals and reporting varied by hospital with most reporting all screens 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. A major activity is 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. This activity resulted in less than 31% of all hospitals with 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, and 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.

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

##### Last Year's Accomplishments

MCH has begun a strategic plan with WIC and Worksite Wellness colleagues focused on breastfeeding initiation. A draft plan was developed to increase breastfeeding-friendly hospitals in the state, but limited funding and staffing has impeded progress.

##### 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.

#### **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 loss 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 (exceed 5%) or extremely low referral rates (<1%). The UNHSI Program Coordinator presented at the Georgia



Association of Young Children (GAYC) Conference in October 2013. The UNHSI Stakeholders Committee Meetings continue to be held quarterly and health districts hold local stakeholder meetings bi-annually. The UNHSI 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 UNHSI Program is moving towards more efficient ways to document all 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

Some of the activities include providing educational materials and targeted, planned outreach about newborn hearing screening (UNHSI) and the importance of follow-up screening; reduction in the percentage of babies who are lost to follow-up/documentation; obtaining individualized hearing screening results on all newborns that have been screened for hearing; continued development of the UNHSI module in SendSS for accurate documentation of hearing screening results; diagnostic evaluations; intervention; follow-up activities and evaluation reports; training and technical assistance regarding UNHSI process/best practice to hospitals and other healthcare providers who provide newborn hearing screening and follow-up. A UNHSI 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 UNHSI 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.

### **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 facilitate data collection. 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.

## **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. We actively participated in all five Collaborative Improvement and Innovation Network (CIIN) 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 to 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.

## **Plan for Upcoming Year**

### **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.

MCH will continue the 5-STAR initiative to encourage hospitals to take steps toward becoming breastfeeding-friendly and achieving Baby-Friendly designation if desired. 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. 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 Perinatal Capacity Survey was disseminated in July 2014 to compare neonatal level of care designations and operational level of care. The data is currently being reviewed and will 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 to gain consensus on the purpose and benefits of the perinatal regionalization system and identify areas to be improved.

The Safe Sleep Coordinator will continue to make contact with as many partners as possible throughout the state. Educational materials will be distributed to ensure consistent messaging throughout Georgia regarding safe sleep practices. 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. The Safe Sleep Coordinator will additionally work 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.

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 less than 5% rate of early elective deliveries. Nearly twenty hospitals in Georgia have been awarded the banner and several more are in the application process. 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.

## Child Health

Child Health			
Priority Needs	Objectives	Strategies	National Performance Measure
4. Promote developmental screenings among children	<b><u>4.1</u></b> Increase the number of public health districts utilizing a standardized public health developmental screening tool to 18 PH districts by 2020	<b><u>4.1.a</u></b> Identify child health screenings strategic team <b><u>4.1.b</u></b> Conduct an evaluation of developmental screening tools being used by districts <b><u>4.1.c</u></b> Identify a standardized screening tool or tools that provide the best positive predictive value for Georgia's	Developmental Screening

	<p><b><u>4.2</u></b> Increase the number of public health districts documenting developmental screens to 18 by 2020</p> <p><b><u>4.3</u></b> Increase the percentage of children receiving a developmental screen by 2020</p>	<p>birth to three population <b><u>4.1.d</u></b> Train public health districts on standardized developmental screening tool</p> <p><b><u>4.2.a</u></b> Develop a standardized process for documenting and submitting developmental screening data to state office</p> <p><b><u>4.2.b</u></b> Develop evaluation plan to assess data quality (completeness, accuracy etc.)</p> <p><b><u>4.2.c</u></b> Implement the evaluation plan to assess data quality</p> <p><b><u>4.3a</u></b> Build partnership with DECAL and primary care providers</p> <p><b><u>4.3.b</u></b> Develop a community and provider outreach strategic plan to decrease the racial and insurance disparities</p> <p><b><u>4.3.c</u></b> Implement community and provider outreach strategic plan</p> <p><b><u>4.3.d</u></b> Collect developmental screening data from DECAL and primary care providers</p> <p><b><u>4.3.e</u></b> Provide training to primary care providers on using standardized screening tool and the referral process</p>	
5. Promote physical activity among children	<b><u>5.1</u></b> Complete Georgia Shape Evaluation	<p><b><u>5.1.a</u></b> Conduct evaluation using Power Up for 30 data</p> <p><b><u>5.1.b</u></b> Analyze policy work in elementary school settings</p> <p><b><u>5.1.c</u></b> Conduct Georgia Shape Public</p>	Physical Activity

		Health Reports Special Supplement Symposium	
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## Reporting Year

### **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.

### **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. One example is 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. The state recently completed 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.

### **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 grades 1-12 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.

### **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

During the CPS monthly classes, a total of 11,122 caregivers were trained and counties distributed 4,702 car seats in the classes. This number reflects existing inventory in months prior. In total, 67,595 pieces of PI&E were distributed, including 5,464 total child safety seats, 10 of which were for children with special needs. Possibly 486,629 total individuals were reached.

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

IP staff received 18 Teddy Bear Stickers to document the number of lives saved from injury and/or death due to program funded child safety seats.

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.

### **Plan for Coming Year**

#### **Physical Activity**

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.

### Developmental Screening

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 build 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.

## Adolescent Health

Adolescent Health			
Priority Needs	Objectives	Strategies	National Performance Measure
6. Prevent suicide among adolescents	<b>6.1</b> Increase the awareness of the "Step Up. Step In." Awareness Campaign	<b>6.1.a</b> Revise and improve the DPH Adolescent and School Health "Step Up. Step In." Awareness campaign website	Bullying
	<b>6.2</b> Increase the number of schools participating in the "Step Up. Step In." Awareness Campaign by 5	<b>6.2.a</b> DPH Adolescent and School Health will fund up to 20 schools and 13 public health district to participate in the "Step Up. Step In." Awareness Campaign. Schools will develop and implement innovative communication techniques for schools to address bullying in middle and high school (e.g. pep rally awareness, morning PSAs	



		etc.)	
		<b><u>6.2.b</u></b> Increase partnership with local schools to address bullying	

## Reporting Year

There were no activities conducted during FY2015 under the primary leadership of the Title V program. Activities where Title V had a partnership role will be discussed under Other Programmatic Activities.

## Plan for Upcoming Year

### Suicide

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.

## Children and Youth with Special Health Care Needs

Children and Youth with Special Health Care Needs			
Priority Needs	Objectives	Strategies	National Performance Measure
7. Improve systems of care for CYSHCN	<b><u>7.1</u></b> Increase by 5 the number of organizations at the state, local and community level that are active partners by 2020	<b><u>7.1.a</u></b> Identify hospitals with a "Family-centered care program" <b><u>7.1.b</u></b> Form a Systems of Care Advisory sub-committee that meets monthly to determine awareness related to medical homes, specialty care and transition etc. Each sub-committee must have at least 1 actively participating parent or caregiver <b><u>7.1.c</u></b> Build collaboration with 5 hospitals that have "Family-centered care programs" <b><u>7.1.d</u></b> Meet quarterly with Systems of Care Advisory sub-committee	Transition to adulthood

	<p><b><u>7.2</u></b> Increase the awareness of services provided to CYSHCN by 5% by 2020</p> <p><b><u>7.3</u></b> Increase awareness about medical homes, available supporting resources for CYSHCN, pediatric and adult specialty care among CYSHCN to Medical School, Dental School, Nursing School and Physician Assistant School students to 40% of schools</p> <p><b><u>7.4</u></b> Increase access to specialty care</p>	<p><b><u>7.2.a</u></b> Develop a mock revised DPH Child Health website to include educational and user-friendly about medical homes, transition, and available resources and FAQ by district.</p> <p><b><u>7.2.b</u></b> Make the DPH Child Health website Spanish &amp; English</p> <p><b><u>7.2.c</u></b> Build partnership with Georgia Tech to develop an app to discuss developing an app that provides families and providers with CYSHCN resources</p> <p><b><u>7.2.d</u></b> Have 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><b><u>7.2.e</u></b> Develop app for CYSHCN resources with Georgia Tech</p> <p><b><u>7.3.a</u></b> Build partnerships with academic institutions to develop ideas on developing and implementing a curriculum/lecture to educate students about treating and providing services to CYSHCN</p> <p><b><u>7.3.b</u></b> Develop and implement curriculum for participating schools on Pediatric and Adult specialty care</p> <p><b><u>7.4.a</u></b> Conduct an environmental scan of the state that shows the number of telehealth sites that provide specialty care.</p>	
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	<p><b><u>7.5</u></b> Increase the number of YSHCN enrolled in CMS who transition to an adult health care provider prior to being discharged from the program</p>	<p><b><u>7.5.a</u></b> Develop standardized transition plan protocol for CMS</p> <p><b><u>7.5.b</u></b> Implement transition plan protocol in all public health districts</p> <p><b><u>7.5.c</u></b> Monitor patient and family satisfaction of the development and strategies outlined in their transition plan</p> <p><b><u>7.5.d</u></b> Collaborate with state agencies to develop a resource portal of transition services and supports</p>	
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## Reporting Year

### **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.

### **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. Jeoffrey 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.

### **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% have CMS only. 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. For families without insurance during the time of enrollment, CMS Care Coordinators assess eligibility for the State's Medicaid and SCHIP programs and assist with the applications for CMS and BCW clients. 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 request 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.

**NPM 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily**

Last Year's Accomplishments

There were no accomplishments listed for these activities.

Current Activities

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

**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 81

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 GA-FP 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.

#### **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.

### **Plan for Upcoming Year**

#### **Improve systems of care for CYSHCN**

A Systems of Care Advisory Committee will be developed this year to provide input into plans related to improving care for CYSHCN both inside and outside of MCH CYSHCN programs. Sub-committees will be identified to provide input into specific areas.

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 host 2 educational events in 2 public health districts to personally educate families about resources and services that are available to them.

MCH will build 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.

## Cross-Cutting/Life Course

Cross-Cutting/Life Course			
Priority Needs	Objectives	Strategies	National Performance Measure
8. Promote oral health among all populations	<b><u>8.1</u></b> Increase awareness and education about perinatal oral health screenings	<b><u>8.1.1</u></b> 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.  <b><u>8.1.2</u></b> Educate and update district oral health staff on special considerations and treatment needs for special needs patients.  <b><u>8.1.3</u></b> Offer two comprehensive 2 hours educational webinars/presentations.	Dental visits during pregnancy  Dental preventive visits for children
	<b><u>8.2</u></b> Develop 1 database for dental providers serving CYSHCN	<b><u>8.2.1</u></b> Determine data sources and begin collecting data to develop a special needs dental access database with location of practices serving special needs children and adults/special services offered such as general anesthesia, orthodontics, insurance accepted and other specialties	

## Reporting Year

**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.



### **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.

### **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. Adedineswo 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.

## Plan for Upcoming Year

### **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 importance 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.

## Other Programmatic Activities

### Reporting Year

#### **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.

### **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 Quitline 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 Quitline 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 nine 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.

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.

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

### **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.

#### **SPM 04: Deaths to children ages 15 to 17 years caused by motor vehicle crashes per 100,000 children (Vital Records/OASIS)**

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

### **Plan for Upcoming 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.

UNHSI 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. UNHSI 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, UNHSI plans to improve individual reporting on the NBS bloodspot card.

### **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. Also, strategies for addressing ACEs are just emerging. Due to the large impact that ACEs can have on a child's health and wellbeing 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.”

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