

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

Georgia

**FY 2024 Application/
FY 2022 Annual Report**

Created on 7/31/2023
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I. General Requirements

I.A. Letter of Transmittal



Kathleen E. Toomey, M.D., M.P.H., Commissioner / Brian Kemp, Governor

200 Piedmont Avenue, SE
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July 31, 2023

Dr. Michael Warren
Associate Administrator
Maternal and Child Health
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane, Room 18-31
Rockville, MD 20857

Grantee Name: Georgia Department of Public Health
Grant Name: Maternal and Child Health Services Title V Block Grant
Funding Opportunity Number: HRSA-24-001

Dear Dr. Warren:

This is a letter of transmittal informing you that a grant application requesting funding for the Maternal and Child Health Services Title V Block Grant FY 2024 Application / FY 2023 Annual Report has been submitted from the Georgia Department of Public Health.

For questions related to the grant, please contact Diane Durrence, Director of the Division of Women, Children, and Nursing Services. Ms. Durrence can be reached at 404-205-3112 or Diane.Durrence@dph.ga.gov.

Sincerely,

Diane Durrence

Diane Durrence, APRN, MSN, MPH
Director
Division of Women, Children, and Nursing Services
Georgia Department of Public Health

William E. Bell

William E. Bell
Chief Financial Officer
Georgia Department of Public Health

We protect lives.

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Georgia's Title V program, in partnership with the Health Resources and Services Administration (HRSA), is responsible for promoting the health of all mothers and children, including children and youth with special health care needs, and their families. The Georgia Department of Public Health (DPH) Division of Women, Children, and Nursing Services administers the MCH Services Title V Block Grant. The division includes the Office of Women's Health, the Office of Child Health, and the Office of Nursing. The Title V Program serves as the backbone of maternal and child health policy and program administration, providing the core public health system for women, infants, children, children and youth with special health care needs (CYSHCN), and families in the state's 18 public health districts comprised of 159 counties.

Title V activities are driven by data to ensure activities address the needs of communities throughout the state. Data are used to track the impact and effectiveness of services, activities, and strategies. The Title V program relies on state and local partnerships with numerous organizations, including the local public health districts, to implement activities and create coordinated systems of care for MCH populations. Title V activities are coordinated across funding sources to maximize impact. Title V continues to address the goal of establishing a foundation of health early in life by investing in and fulfilling its commitment to improve the health of women, infants, and children, including those with special health care needs and addressing social determinants of health, creating strategies and practices to improve health equity and reduce disparities.

Family and community partners, as well as people with lived experience, are engaged in strategic planning, program development, quality improvement initiatives, and workforce development to assess and build capacity around family engagement. The Division of Women, Children, and Nursing Services hosts multiple committees and councils for which families, organizations, and partners participate throughout the health districts.

Assessing State Needs

The five-year needs assessment and needs assessment update during interim years drive Georgia's Title V programs. State priorities were selected through the needs assessment process and cover each of the five health domains. These priorities determined the National Performance Measures (NPMs) chosen for programmatic focus.

The five-year needs assessment process utilized a mixed methods approach relying on input from a diverse network of stakeholders, partners, and community members. The needs assessment identified two overarching principles to be applied across all priorities, performance measures, and strategies: (1) to ensure health equity for MCH populations and (2) to promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities. Across all MCH programs, implementation efforts include activities specific to health equity, community and family engagement, performance management, quality improvement and evaluation. The priority needs identified are:

1. Prevent maternal mortality
2. Prevent infant mortality
3. Promote developmental screening among children
4. Increase the number of children, both with and without special health care needs, who have a medical home
5. Improve systems of care for children and youth with special health care needs
6. Increase bullying and suicide prevention
7. Promote oral health among MCH populations
8. Increase father involvement among MCH populations

Nine NPMs and three State Performance Measures (SPMs) were chosen to align with the priority needs. Through the NPMs, Georgia focuses on reducing racial disparities and preventing maternal and infant mortality, increasing breastfeeding rates, promoting safe infant sleep practices, ensuring developmental screening, preventing bullying, increasing the number of all children with a medical home, planning transition for children with special health care needs, and promoting oral health care for MCH populations. The SPMs include preventing congenital syphilis, reducing the rate of infant mortality in Black infants, and improving father involvement.

Strategies, activities, and programming have evolved throughout the year and will continue to see enhancements in the coming years due to ongoing evaluation and needs assessments. Strengthening family partnerships, engaging communities, and improving health equity remain a focus of Title V programming and serve as the foundation for improving outcomes for MCH populations in Georgia.

The 2024 Application and 2022 Annual Report provides an overview of Title V's previous and recent successes and achievements as well as upcoming plans.

Women/Maternal Health

Title V continues its focus and efforts on improving maternal health and eliminating racial disparities in maternal mortality. Data shows that the pregnancy-related death rate for Black, non-Hispanic women in Georgia is twice that of White, non-Hispanic women. The Georgia Maternal Mortality Review Committee (MMRC) was established to understand the burden of pregnancy-related deaths in Georgia, the factors that contribute to deaths, and opportunities for prevention. The MMRC has made efforts to ensure the review identifies social determinants of health and drivers of disparities. Key Informant Interviews with family members or other key informants provide qualitative data and contextual information on the woman's life, pregnancy, and events surrounding her death to help the committee better identify contributing factors and recommendations for prevention. The MMRC also collaborates with stakeholders to ensure recommendations for prevention are implemented. The MMRC has reviewed deaths from 2012-2020 and is currently reviewing 2021 cases.

The Women's Health program builds infrastructure and capacity to promote well-women visits, health and wellness among women of childbearing age through the efforts of women's health programming including the Family Planning program, Regional Perinatal System, Perinatal Psychiatry Education and Community Engagement (PEACE) for Moms, Maternal Health ECHO, and the implementation of the Alliance for Innovation on Maternal Health (AIM) bundles to include implementation of the AIM Obstetric Hemorrhage Bundle and the AIM Severe Hypertension in Pregnancy Bundle and upcoming Cardiac Conditions in Obstetrical Care AIM Bundle. There are 58 of the 70 (83%) birthing hospitals participating in one or both initiatives.

Perinatal/Infant Health

Infant mortality is a leading indicator of the overall health and well-being of a population. In the 2020 needs assessment, stakeholders identified preventing infant mortality as a priority due to Georgia's infant mortality rate (IMR) with Black, non-Hispanic infants dying at twice the rate of White, non-Hispanic or Hispanic infants. The major evidence-based strategies recommended nationally for addressing infant mortality are regionalized perinatal care, designating levels of neonatal care, safe sleep initiatives, and improving breastfeeding rates. In 2018, DPH began an initiative to designate hospitals according to the appropriate level of maternal and neonatal care provided. DPH continues to strengthen the perinatal regionalization system by coordinating Regional Perinatal Centers (RPC) to help ensure access to risk-appropriate care in each perinatal region. Efforts to improve breastfeeding initiation and continuation and the Georgia Safe to Sleep initiative that provides birthing hospitals with safe infant sleep education to eliminate Sudden Unexplained Infant Deaths (SUID), are ongoing Title V initiatives that are integral parts of Georgia's strategic plan to reduce infant mortality.

Although Georgia has made progress in reducing infant mortality, data continues to show disparities between Black and White birth outcomes. Georgia developed a SPM to reduce the racial disparity in Black infant mortality by improving community engagement to promote awareness of and access to public health interventions in Georgia. As part of the Georgia Perinatal Quality Collaborative's (GaPQC's) focus on health equity, the maternal and neonatal committees continued the two phased approach to address racism and improve health equity. In partnership with the Institute for Perinatal Quality Improvement (IPQI), multiple sessions of the SPEAK UP Against Racism trainings were offered. The training allows participating clinicians to become Speak Up Champions and create and implement action plans to support their hospital specific equity projects.

Child Health

Promoting developmental screenings for children, including refugee children, and increasing the number of children who have a medical home were identified as Child Health priorities in the 2020 needs assessment. According to 2020/21 National Survey of Children's Health (NSCH), approximately 33.1 percent of children, ages 9 through 35 months, received a developmental screening using a parent-completed screening tool. The Children 1st program facilitates trainings for the Ages and Stages Questionnaire (ASQ) developmental screening tool, developmental milestones, and Child Health Referral System to hospitals, public health programs, community organizations, daycare centers, head start programs and primary care offices. Strategies prioritize the use of a patient-centered medical home to provide accessible, comprehensive, family-centered, coordinated, and culturally effective medical care.

Plans to improve access to a medical home include expanding the use of telehealth technology, facilitating efforts to

educate families about telehealth as an option for care, and providing ongoing evaluation of DPH's telehealth network to ensure pediatric services meet the needs of families and patients. The Office of Child Health focuses on activities to strengthen HMG® as a resource for ensuring a medical home for all children and expand the capacity of HMG® liaisons to increase capacity to help families navigate and access comprehensive services.

Adolescent Health

Title V addresses risk and protective factors for children, ages eight through 17, at the local, regional, and state levels and provides evidence-based interventions and evidence informed strategies. Bullying and suicide prevention was identified as a priority in the 2020 needs assessment due to suicide being the second-leading cause of death for children ages 10 through 17 behind unintentional injury. The Division of Women, Children, and Nursing Services expanded the partnership with the DPH Injury Prevention program to address the need in this area.

State suicide prevention partners were engaged to develop an Injury and Violence Prevention Strategic Plan using a Shared Risk and Protective Factors framework to identify the risk and protective factors shared across multiple forms of violence and injury to inform guidance and/or recommendations provided to partners regarding laws, policies, and evidence-based strategies to prevent bullying. While prevention efforts continue to focus on schools and youth, the program aims to help adult support systems provide safe, stable, and nurturing relationships and environments needed to support youth and help prevent bullying, death by suicide, and other forms of youth violence.

Children and Youth with Special Health Care Needs (CYSHCN)

Georgia's Children and Youth with Special Health Care Needs (CYSHCN) program, Children's Medical Services (CMS), works to strengthen the systems of care for families and their children with particular emphasis on medical home access and successful transition from pediatric to adult health care. The CMS program provides a statewide network of care coordination and pediatric specialty care programming, innovative opportunities to engage families and youth in decision making, service delivery improvements and program outreach, linkages to community resources and supports and workforce development opportunities for staff, health care providers and community stakeholders. CMS provides comprehensive, family centered, community based, and culturally competent services to more than 6,000 families on an annual basis. With many counties across the state without pediatric subspecialists, the CMS specialty clinics serves as the primary source of care for many children. Utilizing the Department's telemedicine and telehealth infrastructure is a strategy currently used to improve access to medical home for children with and without special health care needs.

The services provided by CMS help to prevent complications due to untreated condition(s), offer continuity of care, promote healthy growth and development as well as improved quality of life. CMS works closely with primary care providers, pediatric subspecialists, and healthcare vendors to facilitate timely access to early and continuous screenings, comprehensive care within a medical home, face to face and telemedicine specialty clinics, linkages to social services, financial assistance for medical expenditures and health care transition planning for youth/young adults moving from pediatric to adult health care.

Cross-Cutting/Life Course

Oral Health

Oral health is a priority for MCH and a strategic focus to improving health outcomes for women, infants, and children. The Oral Health program provides training to organizational stakeholders and services which include fluoride varnish, dental sealants, prevention education and comprehensive restorative treatment. School-based prevention programs targeting high-risk children, teledentistry, and tobacco prevention programs to pregnant women are also provided.

Oral Health conducts training and presentations on best practices and the importance of oral health in all MCH domains at the local, state, and national levels.

Fatherhood Involvement

Title V explores and develops targeted approaches to best engage fathers to improve maternal and birth outcomes and provide a valuable contribution in helping children and families thrive. The Fatherhood Initiative continues to engage community partners and strengthen programming and resources to support fathers. Strategies to increase father involvement throughout all MCH population domains are developed to positively impact birth outcomes.

To improve outcomes related to these initiatives, Georgia strives to maintain the infrastructure, capacity and engagement opportunities with families, people with lived experience, community, local and state agency and organization stakeholders and partners across all population domains.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

The Division of Women, Children, and Nursing Services provides services through federal Title V funds and state funds that reflect Georgia's commitment to improve the health and well-being of mothers, infants, children, adolescents, and children and youth with special health care needs (CYSHCN). Title V funds provide infrastructure and resources to complement and support state-led MCH efforts.

Direct services are provided for preventive and primary care services for pregnant women, mothers, and infants up to age one, children, and preventive and primary care services. For example, Children's Medical Services (CMS) is the payer of last resort for medical expenses for CYSHCN when Title V funds are used for patient benefits (i.e. diagnostic testing, medications, audiology, durable medical equipment). The Regional Perinatal Centers provide direct services to high-risk women and infants requiring tertiary care. Both programs use a combination of federal and state funds to deliver services. Direct services are also provided through the autism initiatives, BCW, and newborn screening programs.

Title V also provides enabling services for MCH populations. CMS provides enabling services for CYSHCN by providing travel assistance for specialty medical services and interpretation services. Children 1st, which serves as the single point of entry for infants and children into MCH programs, relies on a complementary relationship between Title V and state funding. Title V funds the Children 1st program and epidemiology staff at DPH, while state funds are provided to all 18 public health districts to support the local staff and infrastructure needed for program implementation.

Federal Title V funds are used to support public health services and systems, including the Maternal Mortality Review Committee, the Georgia Perinatal Quality Collaborative, and oral health initiatives to support community water fluoridation. Title V leadership and staff that support programs within the Division of Women, Children, and Nursing Services are funded by Title V. Epidemiology staff who provide data analysis for MCH population needs assessment and impact evaluation of interventions, are funded by Title V and state funds. Staff responsible for overseeing family engagement in Title V programs are funded by federal Title V funds.

Title V, other federal funds, and state funds complement one another to support MCH programs at the local level. DPH administers federal and state funds to the state's 18 public health districts through Grant-in-Aid to implement programs locally, including funds for Children's Medical Services, C1st, Babies Can't Wait, and Early Hearing Detection and Intervention.

III.A.3. MCH Success Story

Georgia's Maternal Mortality Review Committee (MMRC), led by the Office of Women's Health, has made significant efforts to conduct a thorough and timely review of all pregnancy-associated deaths. As a result of increased staff capacity and a concerted effort by the MMRC staff and committee members, the MMRC is currently reviewing all deaths within two years of the date of death. The review process was also revised to allow for more time to discuss each case.

Georgia has been a leader in conducting key informant interviews. A Licensed Clinical Social Worker conducts culturally sensitive interviews with family and other close contacts of the decedent to learn contextual information surrounding the death. Informant interviews have enhanced the ability of the MMRC to center the deceased person in the review and identify social determinants of health. The interview information is woven into the case narrative to create a comprehensive narrative that captures the decedent's story and experiences. The MMRC staff now incorporate descriptors of clinical information into the narratives to enhance the ability of non-clinical members to meaningfully engage in the review process and identify contributing factors and recommendations that address social determinants of health.

Women's Health has also made efforts to implement committee recommendations for prevention. The MMRC has collaborated with the Georgia Perinatal Quality Collaborative (GaPQC) to implement the AIM Severe Hypertension patient safety bundle and the AIM Cardiac Conditions in Obstetrical Care patient safety bundle. These two bundles address the leading causes of pregnancy-related deaths among Black women in Georgia and address the main drivers of disparity. The MMRC also collaborates with the Maternal Health ECHO, which provides monthly education sessions to clinicians and community stakeholders to address leading causes of pregnancy-related deaths and to facilitate the implementation of recommendations from the MMRC. The MMRC also collaborates with the Levels of Maternal Care Designation Program to ensure patients are transferred to risk-appropriate facilities when needed. PEACE for Moms through Emory University implements the MMRC recommendation to educate obstetric providers on treating mental health conditions during the perinatal period and to increase access to mental health treatment and skills groups.

The MMRC has been successful in providing information that resulted in legislative action. Senate Bill 338 passed in April 2022, extending the previous year's expansion of postpartum coverage under Medicaid from six months to one year following the end of the pregnancy. This bill also provides lactation care and services to pregnant and lactating women and children who are breastfeeding or receiving their mother's milk. House Bill 977 passed in April 2022, which provided \$500,000 to fund a comprehensive care management pilot for high-risk pregnancy populations. This bill also provides \$680,000 to fund a Cardio-Obstetrics pilot program to perform echocardiograms of pregnant and postpartum patients to address maternal mortality.

III.B. Overview of the State

Known as the “Peach State”, Georgia has a diverse and growing population, robust political landscape, and a slow growing health care environment. The distinct health care environments in rural Georgia and the urban metropolitan area are a unique challenge for the Title V program.

Geographic Description

Georgia is on the southeastern Atlantic coast and its terrain spans coastal beaches, farmland, and mountains. The state 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 main geographical features include mountains such as the Ridge-and-valley Appalachians in the northwest, the Blue Ridge Mountains in the northeast, the Piedmont plateau in the central portion of the state and Coastal Plain in the south. Georgia has fourteen barrier islands off its coast and include Saint Simons Island and Jekyll Island, both popular tourist destinations. Georgia is vulnerable to hurricanes, though the coast rarely experiences a direct hurricane strike due to its location and shorter coastline. With elevations ranging from sea level to more than 4,700 feet the ecology of Georgia is widely varied with a diverse geological base and many different soil types.¹ Georgia is ranked 24th in the nation in terms of land size and is the largest state geographically east of the Mississippi River.² Georgia has over nine million acres of prime farmland and both the agricultural areas and the waters of Georgia have created a thriving environment for hunting, fishing and game.^{3,4}

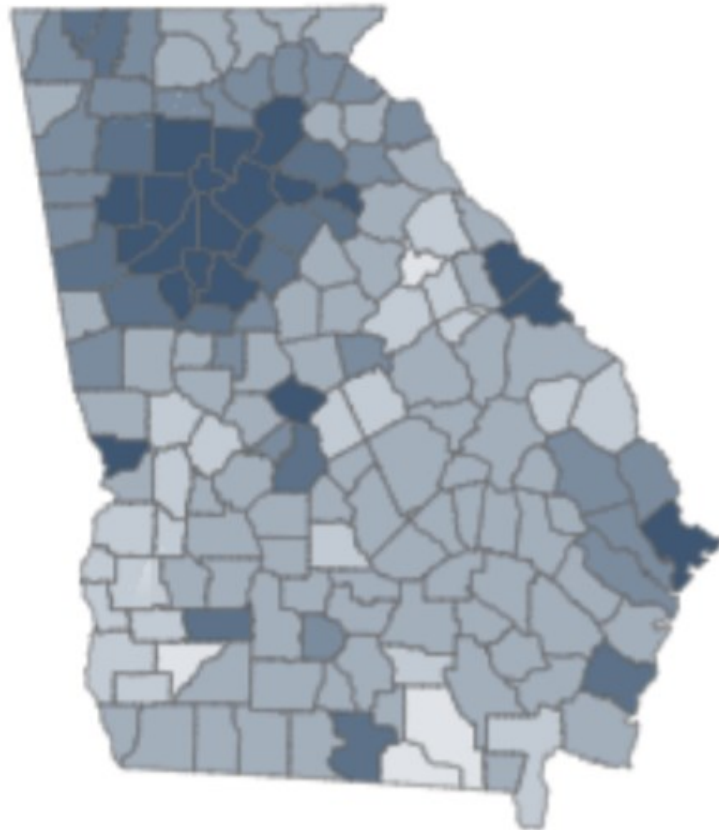
Urban and Rural Counties

Georgia has 535 incorporated municipalities in 159 counties with 13 congressional districts.⁵ Of Georgia’s 159 counties, there are both urban and rural counties located throughout the state. The Census Bureau defines two types of urban areas; urbanized areas of 50,000 people or more, and urban clusters between 2,500 people and 50,000 people. All other counties are considered rural. Of the 159 counties, 120 are designated as rural and 21% of the state’s population lives in a rural area as of the 2020 census, which is less than 25% from the 2010 census.⁶ Most of the state’s rural counties are in the southern half of the state. According to projections based on the 2020 census data, rural counties in the southern part of Georgia are expected to continue to decline in population, while rural counties in the northern part of Georgia are expected to increase in population.⁶ 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 is challenging, and as such it is essential for DPH to accommodate the needs of the rural population. DPH provides an alternative approach in meeting the needs of Georgia’s rural citizens through innovative strategies such as telehealth services in all 159 counties that increase access to health care providers and services.

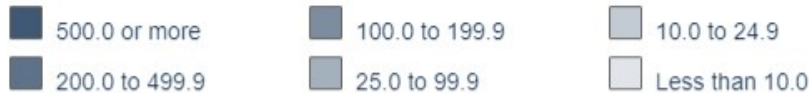
According to the 2020 census data, there are 14 Metropolitan Statistical Areas in Georgia: Atlanta-Sandy Springs-Roswell, Augusta (GA-SC), Savannah, Columbus (GA-AL), Macon, Athens, Gainesville, Warner Robins, Albany, Valdosta, Dalton, Brunswick, Rome, and Hinesville.⁵ Georgia’s population growth from 2010-2020 was primarily due to an increase in population in urban counties.⁶

The following map generated by the US Census Bureau based on population data for 2020 depicts the population density in Georgia.⁷

Figure 1: Population Density in Georgia Counties: 2020



People per square mile



Population

Georgia's population reached 10.7 million, gaining a million new residents from 2010 to 2020, up 10.6%, making Georgia the eighth most populous state in the nation.⁷ Georgia is the 12th fastest growing state in the country.⁸ This growth has resulted in a fundamental shift in Georgia's population changing the state from a largely rural area with urban centers to an urban state with rural areas. Rural Georgians have health experiences that contrast their urban counterparts including, travelling longer distances to seek medical care and higher rates of chronic health conditions. It is estimated that Georgia's population will increase to 11.8 million by 2030.⁹ As with any population growth, there are increasing demands on state and local governments to provide necessary services, including health and social services.

Georgia is growing more urban and diverse with 2020 Census figures showing a continued shift in population toward metro Atlanta and away from the rural areas that were once the backbone of the state. The state's fastest-growing areas remain in the suburbs of Atlanta, Savannah, and Augusta. Bryan County, just south of Savannah, grew by 48% over the decade, making it the sixth-fastest-growing county in the nation. Forsyth County, located north of Atlanta is the 13th-fastest-growing county nationally due to its 43% growth.¹⁰ Sixty-seven of Georgia's 159 counties, most of them smaller and rural, lost population, as part of a nationwide trend.⁷

Atlanta, the state capital, is the economic, cultural, and demographic center of Georgia. Located in DeKalb and

Fulton counties, Atlanta has a population 490,270.¹¹ It is the largest city in Georgia and the 39th largest city in the U.S according to 2023 population estimates.¹¹ Atlanta is currently growing at a rate of -1.86% annually as people migrate to the surrounding suburbs.¹¹ Spanning over 135 miles, Atlanta has a population density of 3,685 people per square mile.¹¹

The Atlanta metropolitan area includes 29 counties and is home to 5.6 million people, making it the ninth largest metropolitan area in the U.S.¹¹ Metro-Atlanta contains about 57 % of Georgia's entire population.¹² In Georgia, approximately 5% of residents are under age five, 17.4% are under the age of 18 and 11.6 % are over age 65.¹³ Atlanta has the 19th largest number of LGBTQ adults in a large metropolitan statistical area and is the second largest majority Black metro area in the country.¹¹

Diversity

The state's population is 51.9% White, 31% Black, 10.5% Hispanic or Latino, and 4.5% Asian.⁷ Close to 7% of the population identify as two or more races.⁷ Georgia grew substantially more diverse over the last ten years as its Black, Hispanic and Asian populations increased and its number of White residents slightly decreased.¹⁴ Statewide, the number of Black Georgians increased by 13%, while the White population dropped by 1%. The state's Asian population increased by 53% and its Hispanic population increased by 32%.¹⁴ The growth in diversity and population necessitates the availability of culturally competent health care, education, and human services.

Age

According to the 2020 US Census Bureau, 23% of the state's population is under 18 years of age.¹⁵ In 2020, the population of women ages 15-44 was 2,197,385.¹⁶ The median age in Georgia is 37.5 years according to 2021 estimates.¹⁷

Immigration

Georgia's population is continually evolving with the immigration of foreign-born individuals that add to the racially and ethnically diverse population of Georgia. According to 2019 data, approximately 1.1 million immigrants (foreign-born individuals) comprise 10.2% of the population.¹⁸ Among the foreign-born population, 5.5% are aged 0-15 and 83.3% are aged 16-64.¹⁸ There are 70,852 foreign-born children in Georgia.¹⁸ The top countries of origin for immigrants are Mexico (22 %), India (9 %), Vietnam (5%), Jamaica (4%), and Guatemala (3.8%).¹⁸ Among foreign-born immigrants, 25% have less than a high school education, 38.7% have high school and some college, 19.7% have a bachelor's degree, and 16.5% have a graduate degree.¹⁸

There are 352,643 undocumented immigrants in Georgia.¹⁸ Immigrants who are "qualified non-citizens" are generally eligible for coverage through Medicaid and the Children's Health Insurance Program (CHIP).¹⁹ Non-qualified adult immigrants or undocumented adult immigrants may be eligible for emergency medical services only that includes the cost of labor and delivery.¹⁹ Emergency medical assistance is not an ongoing coverage plan and applicants must apply for this service as a medical hardship is incurred.¹⁹

Language Proficiency

According to the US Census Bureau's American Community Survey, over 14% of Georgia residents, ages five years and older, speak a language other than English.¹⁵ Of the other languages spoken, Spanish is the most spoken language at approximately 7.9% of the state's population.⁹ According to Kids Count Data, 53% of children in immigrant families have resident parents who have difficult speaking English.²⁰ These factors can have implications on the services offered to residents and may necessitate investment in interpretation and culturally competent approaches to health care delivery.

Family Household Type

Children growing up in single-parent families typically do not have the same economic or human resources available

as those growing up in two-parent families. According to the 2021 Kids Count Data, 38% of Georgia's children lived in single-parent families.²¹ The percentage of children under age 18 who live in families with income below the federal poverty level decreased from 26.3% in 2014 to 19.5% in 2020.²²

Educational Attainment

Public schools are the primary source of education in Georgia. In 2021, 49.1% of four-year-old children were enrolled in a public pre-kindergarten program.²³ According to the Kids Count Data, 32% of fourth graders and 31% of eighth graders were at or above proficient in reading in 2022.²⁴ Additionally, 34% of fourth graders and 24% of eighth graders were at or above proficiency in math in 2022.²⁴ High school students not graduating on time reduced to 16% in 2019-2020 from 28% in 2013-2014.²⁵

Georgia's high school graduation rate continues to rise and has increased by 14.4% since 2012.²⁶ In 2022, Georgia's high school graduation rate rose to 84.1%, an all-time high since the state began using the adjusted cohort calculation now required by federal law.²⁶

The University System of Georgia awarded an all-time high of 74,446 degrees in fiscal year 2022 which was a 2.1% annual increase over fiscal year 2022.²⁷ The state has approximately 70 public institutions and specialized schools, and over 45 private universities for higher education which include 10 Historically Black Colleges and Universities. The flagship research institution, University of Georgia, is the oldest public school in the country.

In Georgia, 33% of adults aged 25 and over have a bachelor's degree or above.¹⁵ Eighty-eight percent have a high school graduate degree or higher.¹⁵

Household Income and Poverty

According to the 2022 American Community Survey of the U.S. Census Bureau, the median household income for Georgia is \$65,030.¹⁵ Compared to the median U.S. household income of \$70,784, Georgia's median household income is lower.²⁸

According to the 2021 American Community Survey of the U.S. Census Bureau, Georgia has the 14th highest poverty rate in the U.S. with 14% of Georgians living below the federal poverty line, compared with 11.6% for the United States overall.¹⁵ According to the 2021 Kids Count Data, 30% of children live below 150% of the federal poverty level and 41% live below 200% of the federal poverty level.²⁹ Poverty disproportionately affects race and ethnicity in Georgia.

Health Equity and Social Determinates of Health (SDOH) Disparities

According to the 2023 Kids Count Data Book, Georgia ranked 37th in overall child well-being.³⁰ The ranking is based on the state's wealth and other resources, policy choices and investments in the state in which the child is born and raised. The annual Kids Count Data Book uses 16 indicators to rank each state across four domains that include health, education, economic well-being, and family and community that represent what children need the most to thrive. Georgia ranked 35th in economic well-being, 31st in education, 43rd in health, and 29th in family and community.³⁰

There are consistent disparities by race/ethnicity in Georgia for health outcomes. Georgia's pregnancy-related mortality ratio shows that non-Hispanic Black women are over 2 times more likely to die of pregnancy-related causes than non-Hispanic White women, primarily driven by differences in outcomes related to cardiac conditions. In 2020, racial disparities were also seen in infant mortality rates with a rate of 9.6 in Black, non-Hispanic or Latino infant deaths compared to a rate of 5.1 in White, non-Hispanic or Latino infant deaths under one year of age.³¹ The

percentage for Black, non-Hispanic or Latino low birth weight infants was 14.5% compared to 7.2% for low-birth-weight White, non-Hispanic or Latino infants.³¹ Premature births in 2020 occurred at 14.4% in Black, non-Hispanic women compared to 10% in White, non-Hispanic women.³¹

Economy

Six U.S. interstates, with over 1,200 miles of highway, connect Georgia to neighboring states and the rest of the nation and help move workers from their homes to places of employment in the major cities. Three of the interstate highways converge in Atlanta, making it, along with Hartsfield-Jackson Atlanta International Airport, the transportation hub of the southeast. These advantages have led to 9 Fortune 500 companies on Fortune's 2023 list to be headquartered in Georgia. All but two of these are based in metro Atlanta.

According to the Georgia Department of Transportation's (GDOT) 2020 Statewide Airport Economic Impact Study, Hartsfield-Jackson Atlanta International contributes \$66.8 billion in annual economic benefits, which accounts for 90% of all economic activity among the state's 103 public airports.³² Together, the airports support 15% of Georgia's GDP and 13% of all statewide jobs.³²

The film and television industry are other industries elevating Georgia's economy. Georgia offers lucrative tax incentives for television and movies making the state a popular site for filming and production, stimulating further growth. The tax credit that allows productions to collect a credit of up to 30% of its budget, enabling studios to save money or increase their budgets. The amount of the annual credit doubled between 2013 and 2019. The state's generally lower prices compared with California or New York and the geographic diversity with cities such as Atlanta and many rural locations offer a variety of settings. In 2021, Georgia's film production exceeded its pre-pandemic pace, setting a record of \$4.4 billion in direct spend in production in the state in 2022.³³ Georgia has more than 3 million square feet in purpose-built space in 2022, and this is planned to more than double in the next two years.³³

Georgia has a rich, varied, and ongoing tradition of producing quality sports teams that enhance the economy. Atlanta is home to several professional sports franchises, including the Braves (Major League Baseball), Hawks (National Basketball Association), Falcons (National Football League), Dream (Women's National Basketball Association), and Atlanta United (Major League Soccer). In 2020, an additional professional sports league (Major League Rugby) was established in Georgia with the Rugby ATL. Atlanta was home to NFL Superbowl LIII with more than 500,000 attending and more than 150,000 out-of-state visitors. In addition to Atlanta's major league sports teams, minor league franchises are hosted by several Georgia cities. Augusta, Georgia is home to the Masters, professional golf's most famous and prestigious event. Atlanta Motor Speedway hosts NASCAR's Sprint Cup Series Race each Labor Day weekend. Sports provide an economic boost for the city and remain a key revenue-generator within the tourism industry.

The COVID-19 pandemic impacted several industries in Georgia. Not including agriculture, over 531,000 jobs were initially lost. The hospitality industry experienced the greatest impact, initially losing over 223,000 jobs. Hospitality workers are disproportionately represented by people of color and typically perform "essential jobs" which include frontline, close-contact tasks. Economic development has improved with the unemployment rate remaining stable at 3.1% in 2023.³⁴ In January 2023, Job numbers were up 3.4% over the previous year to 4,874,000, an all-time high.³⁴

Homelessness

According to the Annual Homeless Assessment Report to Congress (AHAR), a Housing and Urban Development (HUD) report that provides estimates of homelessness, the total homelessness number in Georgia for 2022 was 10,689, including 1,785 individuals under age 18.³⁵ The number of homeless individuals increased 4.4% from 2020.³⁶

Insurance

In 2020, 13.7% of the total population were uninsured with the largest part of the population insured through employers.³⁷ Approximately 36% of Georgians without health insurance are Black and 22% are Hispanic.³⁸ According to the 2023 Kids Count Data Book, 7% of Georgia's children, ages zero to 18, were uninsured, making it the 9th highest rate of uninsured children in the U.S in 2019.³⁹

Medicaid and PeachCare for Kids® provide access to affordable vital health services to nearly two million Georgians, including children, pregnant women, low-income seniors, and those with physical and developmental disabilities. Medicaid and PeachCare for Kids® covers 1.3 million Georgia children, which is nearly half of all children in Georgia. Private care management organizations (CMOs) operate in the state for families who do not meet Medicaid eligibility and allow families to select a health care plan at no cost to families for children under age six. Starting at age six, premiums are determined based on the federal poverty level and household size. CMOs operating in Georgia include Amerigroup Community Care, CareSource and Peach State Health Plan. In April 2022, the Georgia General Assembly passed Senate Bill 338, extending last postpartum coverage under Medicaid from six months to one year following the end of the pregnancy.

The Affordable Care Act, signed in 2010, went into effect in 2014. Georgia does not participate in Medicaid expansion. For 2023 coverage, 879,084 individuals enrolled in health insurance plans through the Georgia exchange. Beginning in the fall of 2023, Georgia plans to run its own exchange platform.⁴⁰

Department of Public Health Priorities

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 health perspective. In 2011, the General Assembly restored DPH to its own state agency after more than 30 years of consolidation with other departments. At the state level, DPH functions through numerous divisions, sections, programs, and offices. Locally, DPH funds and collaborates with Georgia's 159 county health departments and 18 public health districts. Through the changes, the mission to protect the lives of all Georgians has remained constant. Today, DPH's main functions include Women, Children, and Nursing Services, Infectious Disease and Immunization, Environmental Health, Epidemiology, Emergency Preparedness and Response, Emergency Medical Services, Pharmacy, Nursing, Volunteer Health Care, the Office of Health Equity, Vital Records, and the State Public Health Laboratory.

In 2019, DPH achieved national accreditation through the Public Health Accreditation Board. The national accreditation program works to improve and protect the health of the public by advancing and transforming the quality and performance of health departments. Under the leadership of DPH Commissioner Dr. Kathleen Toomey, DPH continues its mission to prevent disease, injury and disability, promote health and well-being, and prepare for and respond to disasters.

DPH's workforce is guided by the following core values in carrying out public health work:

People— We value our employees as professional colleagues. We treat our customers, clients, partners, and those we serve with respect by listening, understanding, and responding to needs.

Excellence— Commitment, accountability, and transparency for optimal efficient, effective, and responsive performance.

Partnership— Internal and external teamwork to solve problems, make decisions, and achieve common

goals.

Innovation– New approaches and progressive solutions to problems. Embracing change and accepting reasonable risk.

Science– The application of the best available research, data, and analysis leading to improved outcomes.

III.C. Needs Assessment

FY 2024 Application/FY 2022 Annual Report Update

Ongoing Needs Assessment Activities

Maternal Mortality Review Committee (MMRC)

The MMRC reviews all pregnancy-associated deaths occurring among Georgia residents to understand the causes of maternal mortality and identify actionable recommendations to prevent future deaths. The committee meets at least quarterly to review deaths and publishes data annually. A report on 2018-2020 data was released in 2023 and includes detailed information on pregnancy-related deaths.

Oral Health

The Basic Screening Survey (BSS) is used to obtain data on the oral health status, risk factors, and barriers to care and prevention services among kindergarten and third grade school children. The BSS was implemented during the 2022-2023 school year and the initial sample resulted in a total of 64 schools throughout Georgia in all geographic areas participating in the BSS. Results will be available within 6 to 8 months and will be used to update the 2016 3rd Grade BSS and Burden of Oral Health in Georgia Report.

Safe Sleep

To address the disconnect between prenatal intentions and actual safe infant sleep practices, the Safe Infant sleep program developed and tested a “booster session”, to be delivered three to five weeks after the infant is born. A safe sleep intervention that included coaching parents after the infant was born demonstrated feasibility and acceptability in helping to address challenges. The engagement of parents of newborns is a priority to assess information needs and determine what is most useful in helping parents and caregivers practice safe infant sleep.

Children’s Medical Services (CMS)

The CMS program developed and distributed a brief survey assessing the overall experience with services provided by the CMS program and to help determine what improvements in services and service delivery should be made. Survey responses were collected from parents/caregivers and young adults, 18 years of age and older, who have been enrolled in the CMS program for at least six months and who have engaged with their care coordinator for care coordination and/or specialty clinic services within the last six months.

Babies Can’t Wait (BCW)

Less than 15% of children eligible for Early Intervention (EI) services access intervention services and minority groups disproportionately enroll in EI. A University of Georgia interdisciplinary team has begun to implement an environmental scan of Georgia’s BCW system to better understand the patterns of usage across regions and demographics, barriers that interfere with enrollment, and supportive factors that facilitate enrollment. Currently, six focus groups, seven interviews, and 18 surveys have been completed.

Changes in the Health Status and Needs of the MCH Population

Maternal/Women’s Health

Maternal Mortality: The MMRC found that from 2018-2020, there were 48.6 pregnancy-related deaths per 100,000 live births among Non-Hispanic (NH) Black women compared to the 22.7 pregnancy-related deaths per 100,000 live births among NH White women. The MMRC determined all the pregnancy-related deaths attributed to hemorrhage, mental health conditions, cardiomyopathy, cardiovascular and coronary conditions, and preeclampsia and eclampsia to be preventable.

Well-Women Visits: The 2021 Behavioral Risk Factor Surveillance System (BRFSS) estimated approximately 72.5% of women, ages 18 to 44 years, reported visiting a doctor for a routine checkup in the past year. According to the 2017-2021 Pregnancy Risk Assessment Monitoring System (PRAMS), 59% of Georgian women of reproductive age (WRA) had seen a doctor in the past 12 months. The percentage of WRA reporting seeing a doctor in the past 12 months was greatest among NH White women and women with health insurance coverage.

Family Planning: From 2017-2021, PRAMS data show the percentage of women with a recent live birth who reported an unintended pregnancy has remained relatively constant around 7%. Among women who were not trying to get pregnant when they became pregnant, a plurality of women (47%) reported using low-efficacy birth control methods, followed by common methods. Use of high-efficacy birth control methods was least commonly reported among women who were trying not to get pregnant when they conceived.

Postpartum Care: Available PRAMS data from 2017-2021 show the percentage of women who received a postpartum visit with a health care provider remained relatively constant around 90%. Among women who did not receive a postpartum visit, the most reported topics discussed were birth control methods for use after birth (90%), mental health screening (86%), healthy habits (diet and exercise, 62%), and smoking cigarettes (64%).

Mental Health Evidence-Based Screenings: During the three months before pregnancy, 11% of women with a recent live birth from 2017-2021 reported having depression. Among women who reported having depression during the three months before pregnancy, 40% reported having a health care visit for depression or anxiety in the 12 months before getting pregnant. From 2017-2021, the percentage of women reported feeling down, depressed, or hopeless since their new baby was born increased by 13%. Among women whose baby was alive and living with them, 6.4% reported using counseling services for depression or anxiety since their new baby was born.

Perinatal/Infant Health

Infant Mortality: DPH's standardized health data repository, Online Analytical Statistical Information System (OASIS), indicates the infant mortality rate was 6.3 per 1,000 live births in 2022.

Breastfeeding: In the 2018 National Immunization Survey (NIS) approximately 80.9% of infants were reported by a parent to have ever been breastfed, while only 24.3% of infants were reported by a parent to have been breastfed exclusively through six months. The 2017-2021 PRAMS show that among women with a recent live birth, 82% ever reported breastfeeding or pumping breastmilk to feed their infant. At the time of the PRAMS survey (2-6 months after birth), approximately 42% of those women reported they were currently breastfeeding.

Safe Sleep Practices: According to the 2020 PRAMS data, 71.3% of mothers reported they most often place their baby to sleep on their back only. A quarter of the mothers (25.5%) reported that their baby always/often slept alone, usually in a crib, bassinet, or pack and play. Approximately 37.4% of women report their baby did not usually sleep with blankets, toys, cushions, pillows, or crib bumper pads.

Evidence-Based Home Visiting Programs: According to PRAMS, 7% of Georgia women with a recent live birth from 2017-2021 reported receiving a home visit from a health care worker since their infant was born to learn how to care for themselves and/or their new baby.

Congenital Syphilis: The Centers for Disease Control and Prevention's (CDC) 2021 Sexually Transmitted Disease (STD) Surveillance Report provided trends in STDs to describe current epidemiology of nationally notifiable STDs. In 2021, the number of reported congenital syphilis cases was 93, with a rate of 75.0 per 100,000. This rate is comparable to the national congenital syphilis rate of 77.9 cases per 100,000 live births (a 30.5% increase relative to 2020).

Child Health

Developmental Screenings: According to 2020/21 National Survey of Children's Health (NSCH), approximately 33.1% of children, ages 9 through 35 months, received a developmental screening using a parent-completed screening tool.

Medical Home: In 2020-2021, NSCH estimated half (49.2%) of children without special health care needs (non-CSHCN), ages zero through 17, received care that met the criteria for having a medical home. Non-Hispanic Black children (41.8%) were less likely to report having care that met the criteria for having a medical home than NH White children (61.8%).

Childhood Immunization Rates: The 2022 Georgia Immunization Report for Children, showed Georgia's immunization coverage for the complete 4:3:1:3:3:1:4 series was 75.5%. The 2021 Georgia Immunization Report for Adolescents aged 13 through 17 reported Georgia's overall immunization coverage for the complete 1:3:2:3:2:1 series was 28.3%. By individual vaccines, Hepatitis B had the highest coverage at 91.4% and Human papillomavirus (HPV) for all genders was lowest at 38.2%.

Physical Activity: The 2020/21 NSCH showed 42.8% of children, ages six to 11, were physically active at least 60 minutes per day for one to three days per week, 23.3% were physically active at least 60 minutes per day for four to six days per week, and 27.0% were physically active for 60 minutes every day.

Adolescent Health

Bullying: In the 2020/21 NSCH, 8.9% of adolescents, ages 12 to 17, were reported by a parent or guardian to have bullied others. The 2020/21 NSCH estimated approximately 26.5% of adolescents, ages 12 to 17, were reported by a parent or guardian to have bullied, picked on, or excluded by other children. According to the 2019 High School Youth Risk Behavior Survey (YRBS), 14.5% of students reported having been bullied on school property in the last 12 months before taking the survey. In the same survey, about one in ten (10.6%) of public high school students reported having been electronically bullied (i.e., through texting, Instagram, Facebook, other social media) during the 12 months before the survey.

Suicide: The 2019 High School YRBS reported 18.5% of Georgia high school students seriously considered attempting suicide during the 12 months before the survey. Over one in ten high school students reported that in the 12 months before the survey, they (1) planned about how they would attempt suicide, 12.4%, and (2) attempted suicide, 11.8%.

Transition to Adult Health Care: According to the 2020/21 NSCH, 14.2% of adolescents without special health care needs, ages 12 to 17, received services necessary to make transitions to adult health care. Parents and guardian of NH White adolescents (16.9%), ages 12 to 17, were more likely to report they received services necessary to make transitions to adult health care than NH Black adolescents (14.7%).

Physical Activity: The 2020/21 NSCH showed 39.4% of adolescents, ages 12 to 17, were physically active at least 60 minutes per day for one to three days per week, 26.1% were physically active at least 60 minutes per day for four to six days per week, and 16.8% were physically active for 60 minutes every day.

Children and Youth with Special Health Care Needs

Medical Home: In 2020-2021, NSCH estimated half (48.5%) of children special health care needs (CSHCN), ages zero through 17, received care that met the criteria for having a medical home. NH White CSHCN (50.7%) were

slightly more likely to report having care that met the criteria for having a medical home than NH Black CSHCN (48.0%).

Transition to Adult Health Care: According to the 2020/21 NSCH, approximately 14.9% of adolescents with special health care needs, ages 12 to 17, received services necessary to make transitions to adult health care. Parents and guardians of NH White adolescents with special health care needs (18.0%) were twice as likely to report they received services necessary to make transitions to adult health care than NH Black adolescents with special health care needs (8.3%).

Access to Specialty Care: The 2020/21 NSCH estimated 28.2% of CSHCN and 7.1% of non-CSHCN, ages zero to 17, received care from a specialist doctor (other than a mental health professional) during the past 12 months. Approximately 4.6% of CSHCN, ages zero to 17, needed to see a specialist doctor, but did not receive care. Over a quarter of CSHCN (27.2%), ages three to 17, received treatment or counseling from a mental health professional in the past 12 months.

Care Coordination Services: In 2020/21, NSCH reported CSHCN (50.2%) ages zero to 17, were more likely to receive needed health care coordination during the past 12 months compared to non-CSHCN (31.5%). The reported percentage of CSHCN (23.5%) who needed but did not receive care coordination was also higher when compared to non-CSHCN (10%).

Cross-Cutting

Dental Visits During Pregnancy: PRAMS showed approximately 34% of women with a recent live birth from 2017-2021 had their teeth cleaned by a dentist or dental hygienist in the 12 months before pregnancy. Thirty-six percent of women reported having their teeth cleaned during their pregnancy. About nine in ten women reported they knew it was important to care for their teeth and gums during pregnancy, while 75% reported having insurance to cover dental care during their pregnancy.

Childhood Dental Visits: According to the 2020/21 NSCH, 72.8% of non-CSHCN children ages one to 17, received a preventive dental visit in the past year and 80.4% of CSHCN children ages one to 17, received a preventive dental visit in the past year.

Smoking During Pregnancy: The 2017-2021 PRAMS indicated 4.5% of women reported smoking cigarettes and 1.5% reported using electronic nicotine delivery systems (ENDS) during the last three months of pregnancy. Among women who reported smoking during the three months before pregnancy, the most common reasons that make quitting difficult were cravings for a cigarette (60%), loss of a way to handle stress (53%), others smoking around them (53%), and worsening anxiety (38%). During pregnancy, women who smoked in the past two year were more likely to report allowing smoking inside their home than non-smokers.

Tobacco, or Nicotine, Use Among Children and Adolescents: The Youth Tobacco Survey (YTS) showed one in four Georgia high school students reported ever trying cigarette smoking. In 2017, 8% of high school students reported current tobacco use, 13% reported current electronic cigarette use, 8% reported use of smokeless tobacco products, and 14% reported cigar use.

Title V Program Capacity

Organizational Structure

DPH is the lead agency in preventing disease, injury and disability; promoting health and wellbeing; and preparing

for and responding to disasters from a public health perspective. The DPH Commissioner and State Health Officer reports directly to the Governor. The Director of the Division of Women, Children, and Nursing Services reports to the Commissioner and State Health Officer and is the Title V Director. The Division of Women, Children, and Nursing Services has primarily responsibility for the administration of the Title V Block Grant and includes the Office of Child Health, the Office of Women's Health, the Office of Nursing, Oral Health, Telemedicine, and the Title V Block Grant. The Office of Child Health contains Child Health Home Visiting, Babies Can't Wait, Child Health Referral and Screening Programs, and Children's Medical Services, the state's CYSHCN program. The Office of Women's Health includes the Maternal Mortality Review Committee, Maternal Mental Health, Levels of Maternal and Neonatal Care, Regional Perinatal System, Georgia Perinatal Quality Collaborative, Breastfeeding, Breast and Cervical Cancer Prevention, and Perinatal Case Management. The Title V program sets program policy and monitors compliance with state and federal laws and rules and offers technical assistance to staff in district public health departments regarding Title V programs. The Division of Women, Children, and Nursing Services partners with other DPH programs that have responsibilities for addressing Title V priorities, including Epidemiology, Injury Prevention Program, Chronic Disease, Immunization, Infectious Disease, Public Health Pharmacy, the Public Health Laboratory, and Refugee Health.

DPH began a review of its programs and services during FY 2023 to realign the department structure with agency priorities following several years when the focus of the agency had been largely on the COVID-19 pandemic. DPH Leadership implemented a plan to restructure the division for maternal and child health services to elevate those programs as priorities for the agency. The reorganization began in January 2023 and was completed at the end of March 2023 and resulted in the new Division of Women, Children, and Nursing Services. Child Health and Women's Health services were combined into one division to increase collaboration and partnerships between these programs. Child Health was realigned to equally support priority programs including CYSHCN, home visiting, infant and child screening and referral programs, and early intervention.

Agency Capacity

Maternal/ Women's Health

The Office of Women's Health implements a robust system of services for women of reproductive age. Women's Health staff oversee the implementation of family planning services, cancer screenings, and HPV vaccines that occur in local public health districts and counties. Women's Health staff also lead maternal mortality prevention programs, including the MMRC, Georgia Perinatal Quality Collaborative (GaPQC), Maternal Mental Health, Maternal Health ECHO, Levels of Maternal Care, and the Regional Perinatal System. Women's Health Epidemiology supports data analysis for these programs. Data sources used are the MMRC, GaPQC data, PRAMS, Vital Records, BRFSS, and Family Planning program data. MCH and Women's Health have active partnerships with hospitals, private practice physicians, academic institutes, cancer and HIV screening agencies, the Chronic Disease Prevention Section, Healthy Mothers Healthy Babies Coalition of Georgia (HMHGBA), Postpartum Support International (PSI), Georgia Obstetrical and Gynecological Society (GOGS), March of Dimes (MoD), the Alliance for Innovation on Maternal Health (AIM) Community Care Initiative, and the Maternal Health Innovation program to ensure a comprehensive system of services for women of reproductive age in Georgia.

Perinatal Health

Staff from multiple DPH sections support programs that aim to improve infant health and prevent infant mortality. Women's Health staff lead Levels of Neonatal Care, the Regional Perinatal System, GaPQC initiatives related to infant health, and breastfeeding initiatives. Child Health staff lead the Newborn Screening program. Title V also funds staff in the Injury Prevention Program that work on safe sleep initiatives and epidemiology staff to collect and analyze data on perinatal health. The primary data source used are PRAMS and Vital Records. Women's Health, Child Health, and the Injury Prevention Program have active partnerships with RPCs, birthing facilities, private practice

physicians, academic centers, Association of State and Territorial Health Officials (ASTHO), GOGS, HMHBGA, MoD, and WIC.

Child Health

The Title V program has established a coordinated system of services for children in Georgia. The Office of Child Health leads a system for developmental screenings and referrals that is implemented at the state, district, and local level. The Oral Health program promotes oral health among children. The Injury Prevention Program leads the Child Occupant Safety Project that aims to prevent motor vehicle crash deaths among children. Child Health utilizes the State Electronic Notifiable Disease Surveillance System (SendSS) and the Babies Information and Billing System (BIBS) to assess developmental screening data. To ensure comprehensive system of services among children, Child Health, Oral Health, and the Injury Prevention Program have active partnerships with the Chronic Disease Prevention Section, Department of Early Care and Learning (DECAL), Department of Education (DOE), academic institutions, Georgia Chapter of the American Academy of Pediatrics (GA-AAP), Georgia Academy of Family Physicians (GAFF), Marcus Autism, and Emory Autism Centers.

Adolescent Health

Title V funds the Injury Prevention Program to identify the prevalence, existing prevention programs, and legislation on bullying and facilitate improvements in bullying prevention efforts to schools that serve the target population. Data resources include the Georgia Student Health Survey and Preventing Adverse Childhood Experiences data map. Partners include the DPH Office of Whole Child Supports, Prevent Child Abuse Georgia, Essentials for Childhood, and Preventing Adverse Childhood Experiences Data to Action.

Children and Youth with Special Health Care Needs

Title V and other federal and state funds support several programs to provide services to Georgia's CYSHCN. Children 1st acts as the access point 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. CMS promotes access to specialty care, care coordination, transition to adulthood, and medical homes for CYSHCN. Epidemiologists support data collection for CMS and the primary data sources used are CMS quarterly reports, NSCH, and contractor monthly reports. The CYSHCN programs partner with academic centers, Parent to Parent of Georgia, GAFF, GA-AAP, health care providers, payers, and multiple community-based organizations.

Oral Health

Title V, CDC, state, and private-donated funds support Oral Health staff and oral health initiatives. The data sources used are PRAMS, NSCH, CMS, and the Third Grade and Head Start Basic Screening Surveys. MCH Epidemiology supports data analysis for Oral Health. To ensure a comprehensive oral health system of services, Oral Health has active partnerships with WIC, private practices, dental hygiene programs, academic institutes, schools, the Oral Health Coalition, and CDC.

Workforce Capacity

Title V has a robust workforce across all population domains. There are 35 FTE positions that are funded by Title V at the state-level. Other positions work in the Division of Women, Children, and Nursing Services and are funded by state or other federal funds.

Title V leadership is comprised of the following individuals:

Diane Durrence, APRN, MSN, MPH – Women, Children, and Nursing Services Division Director: The Division

Director provides oversight for all programs in the Division of Women, Children and Nursing Services. In this role, the Division Director provides leadership and guidance to support DPH priorities across the Offices of Women's Health, Child Health and Nursing including grant deliverables, budget actions, and reports.

Laura Layne, MSN, MPH, RN - Women's Health Director: The Women's Health Director is responsible for providing operational and programmatic support for Women's Health programs and initiatives.

Kimberly Ross, MA - Child Health Director: The Child Health Director is responsible for providing operational and programmatic support for Child Health programs and initiatives for children, including CYSHCN.

Ankit Sutaria, MBBS, MPH - Epidemiologist III: The Epidemiologist III oversees Child Health Epidemiology and is the Newborn Screening Team (NBST) lead within MCH EPI. This role performs surveillance and analytic activities for several programs related to child health and newborn screening.

Kristina Lam, MD, MPH – Women's Health Medical Epidemiologist: The Women's Health Medical Epidemiologist oversees WH Epi and provides scientific oversight, strategic planning, and coordination of women's health epidemiology activities.

The Family Support Coordinator, a CYSHCN parent, provides support and guidance to state and local district BCW and CMS staff by developing and promoting opportunities to engage families, establishing partnerships with community stakeholders, and facilitating resolutions to family concerns.

Prior to the reorganization that occurred in 2023, there were several vacancies in Child Health. Salary structure and position descriptions were revised to align with the responsibilities and skill sets needed for the positions. The Child Health organizational chart was revised to reflect a new support and reporting structure. As a result of the revision, responsibilities for all positions were streamlined resulting in fewer positions required to implement Title V funded programs and state-led initiatives. At the end of SFY 2023, there is only one vacancy still under recruitment in the Office of Child Health.

The Office of Women's Health had previously been organized to include positions posted at higher levels for both salary and responsibility and has been successful for several years in recruiting highly qualified staff. Fortunately, due to increased focus on maternal health and outcomes, recruitment has primarily been a result of new positions being posted when increased funding was added for program growth and expansion rather than a result of turnover. Women's Health has only had one resignation in the past two years and currently only has one vacancy. The current vacancy occurred because of an internal staff promotion during the creation of the new Women, Children, and Nursing Services Division.

Partnerships and Collaborations

Title V continues to focus on collaborative partnerships to expand the capacity of the Title V program to meet the needs of MCH populations.

MCHB Investments: Title V works collaboratively with other MCHB investments, including but not limited to: State System Development Initiative, Maternal, Infant, and Early Childhood Home Visiting, Healthy Start, the Alliance for Innovation on Maternal Health Community Care Initiative, and the Maternal Health Innovation program.

Other Federal Investments: Title V receives other federal investments through CDC funding which includes PRAMS, Oral Health, perinatal quality improvement, ERASE MM, and EHDI. The United States Department of Agriculture funds WIC and works closely with Individuals with Disabilities Education Act Services Part C.

Other Health Resources and Services Administration Programs: District coordinators partner with Federally Qualified Health Centers, Head Start, and Early Head Start.

State and Local MCH Programs: The Title V program coordinates regularly with the state's 18 public health districts and 159 local health departments to implement activities. The Title V program also partners with various local community-based organizations, including but not limited to HMHBGA, Postpartum Support International, Georgia Chapter, March of Dimes, and the Center for Black Women's Wellness.

Other programs within DPH: The Division of Women, Children, and Nursing Services partners with the Adolescent Health, Chronic Disease Prevention, Immunizations, Injury Prevention, STD, Refugee Health, Environmental Health, and Vital Records.

Other governmental agencies: Title V has strong relationships with the Georgia Department of Community Health, the Department of Behavioral Health and Developmental Disabilities, the Division of Family and Children Services, DOE, and DECAL.

Public health and health professional educational programs and universities: Title V frequently partners with Emory University, Georgia State, University of Georgia, Morehouse School of Medicine, Mercer University, Valdosta State University, and Augusta University.

MCH Advisory Council: The MCH Advisory Council serves in an advisory capacity to the Title V Program, monitors progress, and addresses specific MCH population needs. The Council is comprised of a multidisciplinary team of professionals with expertise in MCH and people with lived experience.

Operationalization of Five-Year Needs Assessment Process and Findings

Title V operationalized the Five-Year Needs Assessment process and findings by developing practices to better assess and monitor the status of process measures intended to advance the national and state performance measures. Quarterly ESM meetings with Title V program staff provide the opportunity to regularly assess the impact of developed strategies and activities contained in the State Action Plan. The Title V team held monthly meetings with Title V programs outside of the Division to review program activities and provide technical assistance. The budget representative is included in monthly meetings to ensure that the Title V budget is aligned with programming needs and activities. Through regular and continued assessment of strategies and practices, improvements in performance and improved outcomes are expected.

Emerging Public Health Issues

Creating health equity is a guiding priority and public health issue. DPH seeks to improve the health of all Georgians by integrating the promotion of health equity into all statewide public health programs and services and into the organizational culture of the department. Efforts to improve health equity, including those to reduce health disparities and improve minority health, is embedded across all divisions, sections, and programs. DPH continues to reduce the burden and impact of COVID-19 among vulnerable populations using the following approaches for ensuring health equity: Identify Vulnerable Populations, Community Engagement and Outreach, Utilize Data and Technology, and Identify and Engage Stakeholders.

Click on the links below to view the previous years' needs assessment narrative content:

[2023 Application/2021 Annual Report – Needs Assessment Update](#)

[2022 Application/2020 Annual Report – Needs Assessment Update](#)

[2021 Application/2019 Annual Report – Needs Assessment Summary](#)

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$17,412,396	\$17,133,550	\$19,811,036	\$17,124,972
State Funds	\$113,196,297	\$115,221,184	\$109,975,740	\$107,243,628
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$165,676,651	\$177,165,919	\$165,826,555	\$0
Program Funds	\$6,087,139	\$5,026,641	\$6,578,000	\$174,979,677
SubTotal	\$302,372,483	\$314,547,294	\$302,191,331	\$299,348,277
Other Federal Funds	\$35,139,766	\$35,696,702	\$35,533,337	\$34,250,051
Total	\$337,512,249	\$350,243,996	\$337,724,668	\$333,598,328
	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$19,613,858	\$17,133,015	\$17,274,806	
State Funds	\$108,962,207	\$98,436,370	\$111,210,201	
Local Funds	\$0	\$0	\$0	
Other Funds	\$193,945,994	\$0	\$0	
Program Funds	\$5,166,374	\$199,279,326	\$199,279,326	
SubTotal	\$327,688,433	\$314,848,711	\$327,764,333	
Other Federal Funds	\$32,799,832	\$23,745,088	\$35,730,450	
Total	\$360,488,265	\$338,593,799	\$363,494,783	

	2024	
	Budgeted	Expended
Federal Allocation	\$17,274,806	
State Funds	\$114,234,014	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$211,219,876	
SubTotal	\$342,728,696	
Other Federal Funds	\$49,649,743	
Total	\$392,378,439	

III.D.1. Expenditures

FY 2022 Annual Report

Georgia's Maternal and Child Health State and Federal funds are allocated based on priority needs identified through the Title V needs assessment process. This process includes reviewing health status and outcomes for MCH populations, determining program capacity/infrastructure, and assessing future needs. DPH's budgets are designed to reflect the needs of women, infants, children, adolescents, and children and youth with special health care needs.

The MCH Block Grant funding and expenditures for FY 2022 is based on actual expenditures and supported data. Expenditures are reported out of Oracle's PeopleSoft Financials and Uniform Accounting System (UAS). The following measures are in place to ensure compliance with federal, state, and other requirements:

- Program staff meet with contractors, vendors, and local public health districts virtually on Teams Outlook, to conduct regular meetings and site visits.
- Funds are allocated to the local public health districts based on performance measures, data and allocation formula methods to ensure compliance requirements are met.
- Local Public Health Districts are required to submit monthly and quarterly reports to state program managers to ensure oversight of expenditures.
- The Budget Manager generates monthly and quarterly reports to monitor expenditures.

FY 2022 Title V 30/30/10 requirement expended \$17,133,015. Of this amount as follows: (See Form 2 lines 1A-1C):

- Preventive and Primary Care for Children 30%: 5,801,492 (33.4%)
- Children with Special Health Care Needs 30%: 7,709,679 (44.4%)
- Title V Administrative Costs 10%: 1,323,615 (7.7%)

FY 2022 State MCH Funds expended \$98,436,370 exceeding the 75% State Match requirement of \$12,843,729 for FY 2022 MCH Federal Allocation of \$17,360,856. In addition to the required match for the MCH Block Grant, additional State Funds are used to support MCH programs and partnership activities in the MCH Population Domains: Women/Maternal Health, Child Health, Adolescent Health, Cross Cutting/Life Course, and Children with Special Health Care Needs. (See Form 2 line 3).

FY 2022 Program Income expended \$199,279,326; funds were used to support the following:

- Regional Perinatal Centers (RPC) providing information and education to delivering facilities, staff, and women to ensure they deliver at the appropriate facility in instances where mother and baby may require specialized care.
- Georgia's early intervention services program, Babies Can't Wait (BCW), expanded its scope of services in 2018 to include the provision of autism related services. This expansion was due to Medicaid's expansion of covered services to include adaptive behavioral services (ABS) for individuals under the age of 21 with autism spectrum disorders (ASD).
- Georgia added and successfully implemented Krabbe disease to the Georgia Newborn Screening panel. The implementation process included a public hearing and comment period; targeted communication to families via the NBS brochure; targeted information sent directly to hospitals, public health districts, Georgia Chapter of the American Academy of Pediatrics, Georgia Association of Family Physicians, and physicians who routinely submit NBS specimen; and general updates on the process shared during the Newborn

Screening Advisory Committee (NBSAC) stakeholder meetings. NBS and NBS follow-up was sustained during the COVID-19 pandemic. Adjustments were made to protocols to maintain the urgency of follow-up while minimizing risk of exposure to the virus.

- Partnership with Immunization Vaccines for Children (VFC) program, which is used to fund infants less than 1 and children 1-22.
- Children Elderly Trust Fund, Georgia provides for programs for home delivered meals, transportation services for the elderly, and preschool children with special needs, including but not limited to disabled children, troubled children, school readiness programs, and other similar needs for the benefit of the citizens of Georgia.
- Title V District Program Income is derived from Medicaid Perinatal Case Management, Medicaid DSPS earnings, Family Planning Fees, Private Insurance, Health Check earnings and Outpatient Client Fees, for services provided to Pregnant and Postpartum Women, Preventive and Primary Care for Children and Reproductive Health Services to Women. The expenditures are tracked and monitored through the Uniform Accounting System (UAS) monthly/quarterly. The UAS data reports are reviewed quarterly for annual reporting.

FY 2022 Other Federal Funds expended \$23,745,088; the amount represents the variation of federal funds managed under the Title V Administrator. These funds are used to support the need of preventing, promoting, and improving children and youth with special health care needs and pregnant women, mothers, and infants.

FY 2022 Federal-State Title V Block Grant Partnership Annual Report expended \$321,232,943 and the Georgia Maintenance of Effort (MOE) sustained the level of \$36,079,622. The FY 2022 State MCH Budget /Expenditure Grand total is \$ \$338,593,799. (See Form 2 line 11)

Priority Need/National Performance Measure (NPM) Annual Report:

Women's/Maternal Health:

- The priority needs for women/maternal health are to prevent maternal mortality and promote oral health among MCH populations.
- NPM 1 (Well-Woman Visit): Title V funded staff who provided nursing consultation for the 18 districts and five contract locations who implement the Breast and Cervical Cancer Program (BCCP). Title V also funded efforts to prevent maternal mortality by funding state staff that manage the Maternal Mortality Review Committee, PEACE for Moms, the Levels of Maternal Care Designation Program, and the Georgia Perinatal Quality Collaborative (GaPQC). State funding provided staff who manage BCCP and the Family Planning Program, as well as additional maternal GaPQC staff.
- NPM 13.1 (Preventive Dental Visit): Title V supported efforts to promote oral health among by the pregnant and postpartum population by funding two state Oral Health program staff and two dentists practicing in rural districts.
- Federal Title V funds were supported by other federal funds, including the State-Based Perinatal Quality Collaborative grant, Preventing Maternal Deaths grant, Temporary Assistance for Needy Families (TANF) contract with the Department of Human Services, and Georgia's State Actions to Improve Oral Health Outcomes grant. State funds support family planning services, breast and cervical cancer screenings, additional Maternal Mortality Review Committee staff, Women's Health epidemiology staff, and a contract with The Joint Commission to implement Levels of Maternal Care surveys. State funds are also used to support rural hospital participation in the Georgia Perinatal Quality Collaborative. Contracts with Emory University to implement the PEACE for Moms program and with HMHBGA to implement peer support groups are also funded by state funds.

Perinatal/Infant Health:

- The priority need for perinatal/infant health is to prevent infant mortality.
- NPM 3 (Risk-Appropriate Care): Title V funded staff that coordinate the Regional Perinatal Centers and oversee the Levels of Maternal and Neonatal Care Designation Program. It also funded contracts with the American Academy of Pediatrics (AAP) to implement the AAP NICU Verification in Georgia and the Georgia OB/GYN Society to promote maternal health messaging and quality improvement initiatives among obstetrical providers. State funding provided support for First Care for 13 districts to provide home visiting and care linkages for low-birth weight infants.
- NPM 4 (Breastfeeding): Title V funded Women's Health staff that supported statewide breastfeeding initiatives through contracts and hospital providers across the state. Title V funded a contract with the Georgia Chapter of the American Academy of Pediatrics (AAP) to provide the Educating Physicians in the Community (EPIC) Breastfeeding Program, a peer-to-peer breastfeeding education program for pediatric providers. Other federal funding supported hospital quality improvement efforts to improve their internal processes for successful breastfeeding.
- NPM 5 (Safe Sleep): Title V funded Injury Prevention Program staff that support the safe sleep initiative. In addition to staff, Title V funding also provided educational materials and supplies to promote safe sleeping practices.
- SPM 1 Congenital Syphilis: Title V funded staff distributed congenital syphilis information to OB providers during their annual conference. The OB/GYN Society contract funded by Title V shared prenatal screening awareness information to their members via newsletter and social media.
- SPM 2 (Infant Mortality in the Black Population): Title V funded Women's Health staff that support the health equity work implemented by GaPQC.
- Other federal funds were used to support perinatal/infant health, including the State-Based Perinatal Quality Collaboratives grant, the Maternal, Infant and Early Childhood Home Visiting Grant Program and the Healthy Start Initiative. State funds provide direct services through the Regional Perinatal Centers and newborn screening disorders follow-up services and education.

Child Health:

- The priority needs for child health are to promote developmental screenings among children, increase the number of children who have a medical home, and promote oral health among MCH populations.
- NPM 6 (Developmental Screenings): Title V funding provided the funding for the Children 1st Program Manager at DPH who serves as lead for the program as well as the lead for Ages and Stages Developmental Screenings that are conducted as part of program services. Title V funded a contract with Healthy Mothers, Healthy Babies Coalition of Georgia (HMHBGA) for a call center, HMHBGA Online Resource Database, to help families, providers, and communities locate needed services and resources. State funding was provided to all 18 districts to implement the Children 1st Program that provides developmental screening.
- NPM 11 (Medical Home): Title V funded state staff who lead C1st staff and Help Me Grow Georgia.
- NPM 13.2 (Preventive Dental Visit): Title V funded state Oral Health staff and two dentists in rural health districts that work to promote oral health among children. It also provides for a contract with the Georgia Rural Water Association to increase water Fluoridation across the state. State funding to 16 districts supported the provision of oral health care through a variety of services including school-based sealant programs, teledentistry, and exams and preventive treatment.
- Other federal funds provided funding to all 18 districts to implement Early Hearing Detection Intervention Services (EHDI). State funds provide services to public health districts to implement the Children 1st Program Services.

Children and Youth with Special Healthcare Needs:

- The priority needs for CYSHCN are to improve systems of care for CYSHCN and increase the number of CYSHCN who have a medical home.
- NPM 11 (Medical Home) and NPM 12 (Transition): Title V funded state staff and providing funding for all 18 health

districts to provide services for CYSHCNs and their families across the state. CMS is the payer of last resort for medical expenses when Title V funds are used for patient benefits (i.e. diagnostic testing, medications, audiology, durable medical equipment). Enabling services such as travel assistance for specialty medical appointments and interpretation services were also provided by the CMS program. Title V funds the contract with Parent to Parent of Georgia, Family to Family Health Information Center, to provide resources, trainings and support to families with children with special health care needs and disabilities from birth to 26 years of age. Contracts with health care providers offering services face to face or via telemedicine and contracts with physician member organizations to educate members were funded. Incentives for youth and family leaders were also supported with Title V funds.

- Other federal funds include BCW Part C, and EHDI. State funds provide services for Babies Can't Wait, CMS, Children 1st, contracts for early autism intervention, Telehealth Sickle Cell, a contract with the Sickle Cell Foundation, and Comprehensive Child Health newborn follow-up.

Adolescent Health:

- The priority need for adolescent health is to increase prevention efforts and resources for bullying and suicide.
- NPM 9 (Bullying): Title V funded Injury Prevention Program staff implemented strategies to prevent bullying.

Cross-Cutting:

- The priority need for the cross-cutting domain is to increase father involvement among MCH populations.
- SPM 3 (Fatherhood): Title V funded staff in the Division of Women, Children, and Nursing Services to support the inclusion of fatherhood involvement in Title V programming.

III.D.2. Budget

FY 2024 Application Budget

The MCH Title V Block Grant is administered in the Division of Women, Children, and Nursing Services of DPH. DPH has a system of accountability to monitor the allocation and expenditures of funds provided to the 18 public health districts. The division utilizes program systems including Oracle's PeopleSoft Financials a recognized Enterprise Solution for financials, HR records, transactions, and operations. The Uniform Accounting System (UAS) is utilized to track district financial activity and districts submit MIERSs reimbursement to the State Office for services provided monthly. The Division administers audits, monitors compliance by contractors and public health districts, and ensures compliance with legislative financial requirements, including the 30%-30%-10% requirements.

FY 2024 Federal Application Budget is \$17,274,806. The required 75% State Match for Georgia is \$12,956,104, which includes federal earmarked for Preventive and Primary Care for Children and Children with Special Health Care Needs.

FY 2024 Federal Allocation earmarked 30%-30%-10% requirement:

- Preventive and Primary Care for Children is budgeted for: \$6,057,185 (35.1%)
- Children with Special Health Care Needs is budgeted for: \$7,193,100 (41.6%)
- Title V Administrative Cost is budgeted for: \$1,597,962 (9.3%)

FY 2024 Federal-State Title V Block Grant Partnership subtotal is \$342,728,696. Of this this amount, the subtotal budget supports the following areas: Federal Allocation (5%), State MCH Funds (35%) and Program Income (60%). Georgia's total Maintenance of Effort (MOE) from 1989 is \$36,079,622. As shown on Form 2, MCH efforts far exceeds the State Match and MOE requirements. FY 2024 State MCH Budget/Expenditure Grand Total is \$392,378,439 (Including Other Federal Funds).

Title V Programs received additional state funds in the FY24 state budget in the following areas:

- Georgia's Cost-of-Living Adjustment: to address agency recruitment and retention needs.
- Women's Health Services:
 - Increase funds for Positive Alternatives for Pregnancy & Parenting Grant Program (\$250,000)
 - Provide funds for a pilot program for Perinatal Home Visiting project (\$1,689,000)
- Genetics Sickle Cell Services:
 - Increase funds for the Sickle Cell Foundation of Georgia (\$463,675)

FY 2024 Other Federal Funds received additional funds to support the following:

- State-Based Perinatal Quality Collaborative – Supplemental funding will be used to advance GaPQC's strategy for engaging patient and family partners.
- Preventing Maternal Deaths – Supplemental funding was awarded for FY24 to implement a Community Care Initiative to improve postpartum health.
- Increase in federal funding:
 - Increase in US Department of Education Part C Grant (\$1,237,730)
 - Increase in US Department of Health and Human Services EHDI Grant (\$6,000)
 - Increase in US Department of Health and Human Services MIECHV Grant (\$209,294)
- Decrease in federal funding:

- Funding ending for US Department of Education Part C ARP Grant 9/30/2023
- Funding ending for US Department of Health and Human Services MIECHV ARP Plan 1 Grant 9/30/2023

Women's/Maternal Health:

In the application year, the budget will be used to address the priority need to prevent maternal mortality. Title V will continue to fund staff who provide nursing consultation for BCCP and the five contract locations. Title V will also continue to fund staff who oversee the Maternal Mortality Review Committee, PEACE for Moms, the Levels of Maternal Care Designation Program, and the Georgia Perinatal Quality Collaborative (GaPQC). State funding will continue to support the manage BCCP and the Family Planning Program, as well as additional maternal GaPQC staff.

The Title V budget will also continue to be used to support efforts to promote oral health among MCH population, including pregnant and postpartum individuals. Title V will continue to fund two state Oral Health staff and two dentists practicing in local public health.

Other federal funds, including the State-Based Perinatal Quality Collaborative grant, Preventing Maternal Deaths grant, Temporary Assistance for Needy Families (TANF) contract with the Department of Human Services, and Georgia's State Actions to Improve Oral Health Outcomes grant will continue in FY 24. An increase in the Preventing Maternal Deaths grant will fund a new contract with the Center for Black Women's Wellness to implement a community care initiative. State funds will also continue to support family planning services, breast and cervical cancer screenings, additional Maternal Mortality Review Committee staff, the PEACE for Moms program, Women's Health epidemiology staff, and a contract with The Joint Commission to implement Levels of Maternal Care surveys. State funds will continue to be used to support rural hospital participation in the Georgia Perinatal Quality Collaborative.

Perinatal/Infant Health:

The FY2024 budget will continue to be used to prevent infant mortality. Title V will continue to fund staff that coordinate the Regional Perinatal Centers, the Levels of Maternal and Neonatal Care Designation Program, and contracts with the AAP and Georgia OBGYN Society.

Title V will also continue to fund Women's Health staff that support statewide breastfeeding initiatives and a contract with the Georgia Chapter of the American Academy of Pediatrics (AAP) to provide breastfeeding education. Other federal funding will be used for hospital quality improvement efforts to improve their internal processes for successful breastfeeding.

Federal Title V funds will continue to fund staff supporting the safe sleep initiative and educational materials and supplies promoting safe sleeping practices.

Title V funds will be used for staff that work to educate OBs on congenital syphilis and a contract with the OBGYN Society to promote awareness among members.

Title V will fund Women's Health staff that support the health equity work implemented by GaPQC.

The following other federal funds and state funds have been approved for FY24: the State-Based Perinatal Quality Collaboratives grant, the Maternal, Infant and Early Childhood Home Visiting Grant Program and the Health Start

Initiative, state funds for the Regional Perinatal Centers and newborn screening.

Child Health:

The Title V budget reflects the state's commitment to promoting developmental screenings among children, increasing the number of children who have a medical home, and promoting oral health among MCH populations.

Title V funds will be used for state staff who lead Children 1st and Help Me Grow Georgia as well as provide resources to all 18 public health districts. Title V will also fund the contract with HMHBGA for the HMHBGA Online Resource Database and call center. Other federal funds and state funds will fund all 18 districts to implement EHDI and support the C1st program.

Title V will continue to support state Oral Health staff, two dentists in rural health districts, and a contract with the Georgia Rural Water Association to increase water Fluoridation across the state. State funding will support 16 districts that provided oral health care through a variety of services including school-based sealant programs, teledentistry, and exams and preventive treatment.

Children and Youth with Special Healthcare Needs:

The priority needs for CYSHCN are to improve systems of care for CYSHCN and increase the number of CYSHCN who have a medical home. Title V will continue to fund state CMS staff and provide funding for all 18 health districts. CMS is the payer of last resort for medical expenses and Title V funds are used for patient benefits (i.e. diagnostic testing, medications, audiology, durable medical equipment). Title V will also continue to provide enabling services and develop public health services and systems through travel assistance, interpretation services, and contracts with Parent to Parent of Georgia, health care providers, physician member organizations, and incentives for youth and family leaders.

Other federal funds will include BCW Part C, and EHDI. State funds will provide services for BCW, CMS, Children 1st, contracts for early autism intervention, Telehealth Sickle Cell, a contract with the Sickle Cell Foundation, and Comprehensive Child Health newborn follow-up.

Adolescent Health:

The priority need for adolescent health is to increase prevention efforts and resources for bullying and suicide. Title V will continue to fund Injury Prevention Program staff to implement strategies to prevent bullying.

Cross-Cutting:

The priority need for the cross-cutting domain is to increase father involvement among MCH populations. Title V will support staff in the Division of Women, Children, and Nursing Services to support the inclusion of fatherhood involvement in all Title V population domains.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Georgia

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

The MCH Title V Block Grant is administered in the Division of Women, Children, and Nursing Services of DPH. The Division implements 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. The core public health functions of assessment, assurance, and policy development are integral to Title V's approach to programs in Georgia. This is accomplished through assessing health needs, assuring access to health services, strengthening partnerships, implementing evidence-based strategies, and utilizing program and surveillance data to support the mission.

To ensure that Title V MCH Block Grant funding is utilized with intention, effectiveness, and efficiency, MCH provides health promotion, education, and disease prevention programs in the community, educates health care providers about public health issues, helps ensure access to care, and implements quality improvement processes to achieve measurable improvements in outcomes and other indicators of quality in services, which contribute to increased health equity and improved community health.

Title V ensures that program development is data-informed and guided by needs assessments conducted with both qualitative and quantitative methodology. Georgia's MCH and Women's Health epidemiology and evaluation teams support programmatic efforts through the ability to analyze data, identify trends, and build and guide programmatic efforts. Title V provides a foundation for family and community health across the state by continuing to address health inequities and develop strategies specific to factors that contribute to the populations' higher health risks and poorer health outcomes. These efforts help to ensure access to the delivery of quality health care services for mothers, infants, and children, including CYSHCN.

To address national and state performance measures, Title V strategically coordinates activities and efforts with partners and stakeholders to improve health outcomes for Georgia's MCH population. This strategic alignment is imperative in assuring the greatest impact of improved MCH health outcomes statewide. Partnerships and collaborations are essential to working towards the goals and mission of the MCH Block Grant. Title V serves as a convener and a point of contact for MCH issues across the state and addresses public health issues facing the MCH population from a broad perspective across the life course. Title V program staff lead multiple stakeholder groups that address both internal and external MCH programming. The Title V MCH Advisory Council contributes to the development of Title V plans, assessment of needs, prioritization of services, and establishment of objectives for MCH programs. In addition to maintaining close relationships with public health districts, MCH partners with over 100 external stakeholders, including Georgia's Hospital Association, GA-AAP, GAFFP, and Georgia's Obstetrics and Gynecological Society (GOGS). These advisory councils, workgroups, and engagement opportunities with people with lived experience provide perspective on stakeholder policy issues and approaches for defining problems and possible solutions.

The Title V program seeks to understand the lived experiences of those served and understand the landscape of their health priorities and challenges. Family centered care is a priority as people with lived experience are valued partners in making significant change in performance measures. The Division of Women, Children, and Nursing Services strengthens the core principles of family centered care with an emphasis on engagement and leadership for families. Family engagement strategies are implemented throughout programs in each MCH population domain and family leaders and persons with lived experience are engaged at state and local levels. Title V aims to continually assess MCH programmatic support of family engagement activities at state and district levels to ensure engagement throughout each part of the family engagement framework.

Title V will continue developing partnerships, identifying new stakeholders, and working toward collective impact through new and existing partnerships that support the goals of the Title V Block Grant. Georgia Title V strives to improve the health of all MCH populations and meet the objectives outlined in the State Action Plan.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

The Division of Women, Children, and Nursing Services leadership is responsible for workforce development strategies that ensure recruitment and retention of qualified staff, training and professional development for employees, and strategic staffing to maximize funding resources.

The reorganization that occurred in 2023 provided an opportunity to enhance recruitment and retention of staff by revising salary structures for the Office of Child Health. Only one position is currently vacant. The Office of Women's Health had previously been organized to include positions posted at higher levels for both salary and responsibility and has been successful for several years in recruiting highly qualified staff. Women's Health has only had one resignation in the past two years and currently only has one vacancy. The current vacancy occurred because of an internal staff promotion during the creation of the new Women, Children, and Nursing Services Division.

Recruitment efforts leverage social media to help brand DPH as an employer of choice (i.e., advertising on LinkedIn and Handshake, upgrading the department website critical data dashboards, and an information bot). Job descriptions are routinely reviewed to ensure that core responsibilities are clearly communicated along with benefits such as remote working. Recruitment also utilizes sponsored jobs for postings intended to draw high-quality applicants. Title V Program position job descriptions include public health competency skills.

The Division of Women, Children, and Nursing Services has developed a strategic staffing management plan includes workforce development plans for Title V program workforce. The plan will be reviewed quarterly by the Division Director and Senior Leadership team and updated as needed. The plan establishes staffing requirements to meet current objectives, goals, and mission. Title V program capacity planning ensures sufficient staffing levels to accomplish work processes related to state performance measures.

Training needs are registered in the annual performance review as an individual development plan and successful completion is evaluated at the end of the fiscal year. Professional development opportunities are offered for all staff within the division. Staff can attend conferences and other training events to enhance competencies. DPH HR provides ongoing training and staff development opportunities through an online platform. Career development contributes to a well-skilled, diversified team, and well-rounded staff who have more insight into several different business units across an organization, greater opportunity to explore interests within the organization and across different departments and encourage employee retention across the organization. Staff competencies are evaluated as part of the annual performance review.

Ensuring equitable services for Georgia's MCH populations is a priority of the Title V program. The Division of Women, Children, and Nursing Services has made it a goal to have all staff complete a health equity training annually. Training completion is tracked by division leadership and trainings are offered regularly. Most recently, Women's Health provided a health equity training that was also offered to district and local staff, the Georgia Perinatal Quality Collaborative, and Maternal Mortality Review Committee members. Women's Health is also working with Morehouse School of Medicine to develop a health equity toolkit for programs.

The division has expanded partnerships to create innovative staff structures and grow pools of resources to enhance Title V program capacity through the following programs and activities:

- The Office of Child Health in partnership with CDC's Public Health Associate Program (PHAP), has a PHAP associate assigned to the CYSHCN/CMS program. The associate will serve as the CMS Youth Engagement Coordinator and is currently in year one of their two-year assignment. Responsibilities will include

coordinating and supporting various activities associated with the CMS program's youth advisory group, Health Care Transition Outreach and Engagement Campaign, partnership expansion with youth-led organizations and peer to peer transition education training modules. The associate will increase the number of youth/young adults contributing to the CMS program's health care transition campaign planning efforts, increase the number of community partners and stakeholders that are engaged in health care transition planning and implementation activities, produce a social media toolkit and training modules for youth-led organizations to use for health care transition promotion and education.

- The Office of Women's Health and Epidemiology are collaboratively working on a partnership with Rollins School of Public Health that will provide two Emory Epidemiology Fellows for two-year assignments beginning in July 2023. The Fellows will increase the capacity for evaluation of family planning and perinatal quality improvement.
- DPH University Relations initiates and maintains partnerships with colleges and universities to identify graduate public health students for agency internships. Among these schools are Georgia State University, Morehouse University, Emory University, and the University of Georgia.

III.E.2.b.ii. Family Partnership

Title V acknowledges the importance of engaging stakeholders that are representative of the MCH population. A “Culture of Family Engagement” is fostered throughout all aspects of program planning, implementation, and evaluation. The Multidimensional Framework for Patient and Family Engagement in Health and Health Care (Carmen et al., 2013) is currently used to measure, monitor, and evaluate Title V’s levels of family engagement across a continuum. Title V’s core value of engagement demonstrates a commitment to cultivating collaboration and trust with families and community partners to improve outcomes for all MCH populations.

Building a capacity of people with lived experience to include women, children, including children and youth with special health care needs, and their families to partner in decision-making with Title V programs at federal, state, and community levels is a critical strategy to achieve priorities. Families and consumers provide knowledge and insight to state programs and staff, as well as suggestions on how to make positive changes for MCH populations. The Title V program provides opportunities for meaningful family engagement at varying levels of involvement and intensity to meet the needs of consumers and families. Families, interns, and community partners are included alongside Title V staff in training, quality improvement initiatives, block grant development and review, workforce development, and policymaking.

Georgia’s Title V program has a 12-year history of integrating family engagement into programming and decision-making. Family engagement strategies were initially implemented in CYSHCN programs and are now included in all Title V programs. Through a partnership with the National MCH Workforce Development Center, Title V has been established and sustained a formidable Fatherhood Initiative for the past four years.

Title V currently has three full time staff serving in leadership roles for family engagement. The Title V Family Engagement Manager, Sherry Richardson, received services for her child through Title V programs. She also served as the Family-to-Family Health Information Center (F2FHIC) Director and Family Voices Director with Parent to Parent of Georgia. She now develops the Title V family engagement and health equity strategic direction and provides technical assistance for all Title V programs. The BCW SICC and Family Support Manager, Elizabeth Snarey, participated in Georgia State University’s GA Leadership Education in Neurodevelopmental and Related Disabilities (GA LEND) Program. The CMS Family Engagement Manager, Sheila Carter, worked with Title V through partnerships with local nonprofits and community-based organizations.

Title V has paid and volunteer family leaders at the state and local district levels through partnerships with colleges and universities, other state agencies, nonprofits and local CBOs, including fathers as leaders. Title V programs invite People with Lived Experience (PLE) to participate in special projects to increase engagement at the direct care, organizational design and governance, and policy-making levels of the Family Engagement Framework. Title V programs engage with families through the following activities:

Safe Sleep Initiatives: Safe Infant Sleep staff participate in the multi-disciplinary team for Healthy Mothers, Healthy Babies Coalition of Georgia research study utilizing a community-based participatory approach to better understand facilitators and barriers to practicing safe sleep as well as other maternal and infant health topics. The program also is working with a researcher to address the disconnect between prenatal intentions and actual safe infant sleep practices. Staff follow up with participants from a safe sleep education class, 3 to 5 weeks after the infant is born to hear directly from families what their needs are as parents of a newborn. The engagement of parents of newborns is a priority to assess information needs and determine what is most useful in helping parents and caregivers practice safe infant sleep.

Bullying Prevention: The Bullying prevention staff participate in the Essentials for Childhood Steering Committee. These meetings invite PLE to attend and have regional and statewide reach. Injury Prevention utilizes a shared risk and protective factor framework and strives to engage with families across the lifespan. The youth violence prevention team conducted focus group testing with youth on materials to promote the “Teen Text Line”. This is to encourage help seeking behaviors in youth around healthy relationships. These materials will also be utilized by the

Bullying Preventing and Youth Suicide Prevention teams.

Atlanta Healthy Start Initiative Community Action Network (CAN): Title V, Child Health, and Women's Health staff participate in the Atlanta Healthy Start Community Action Network (CAN) with Healthy Start program participants, community partners, and healthcare organizations. Healthy Start participants share their lived experience to provide insight and input for current and future activities of advocating for community well-being. Healthy Start participants are invited to participate in the Title V needs assessment through survey and focus group participation.

Babies Can't Wait (BCW), Early Intervention Services Program: The State Interagency Coordinating Council (SICC) advises Title V by providing an appropriate, family-centered, comprehensive service delivery system aimed at promoting optimal child development and family functioning. SICC recruits, trains, and engages diverse family leaders across the 18 public health districts to serve and participate in the SICC with collaboration from the SICC Parent Advisory Committee and the BCW SICC and Family Support Manager, Elizabeth Snarey. The SICC currently has four Governor appointed family leaders.

The current SICC chairperson, Karen Lewis, is a long-time Title V family leader whose child was a participant in the BCW program. Through continued engagement, training, and support, Mrs. Lewis has increased in leadership capacity and effectively serves in the highest leadership role for the SICC.

To increase family representation on the SICC, the *Family Voices Family Engagement in Systems Toolkit* was used to help inform the development of the SICC Parent Advisory Workgroup (PAW) in the summer of 2021. The PAW consists of four family leaders serving a minimum of two years. Family leaders serving on the workgroup will receive ongoing training and mentorship to become active participants on the Council. The SICC collaborates with Georgia's Family to Family Health Information Center to provide the "*Serving on Groups that Make Decisions*" training. Each family leader is compensated for attending trainings and SICC quarterly meetings. The PAW will provide an opportunity for continued family representation on the SICC and a model for family advisory workgroups within Child Health.

Georgia Autism Initiative: The Behavioral Health and Development Program facilitates the Autism Plan for Georgia Advisory Board in partnership with the Center for Leadership in Disabilities (CLD) at Georgia State University (GSU), which guides early intervention research priorities within the state with a goal to identify priorities for future early intervention research, including but not limited to, the implementation of evidence-based strategies that support children who may be on the autism spectrum and their families. Parents of children with autism and adult advocates living with autism participate as board members along with members from various backgrounds such as early intervention, early education, state agencies with early education/intervention programs, community professionals, medical professionals, and secondary and higher education professionals. Members of the board contribute feedback during quarterly meetings about organizational resources, quality indicators and areas of focus for the Autism Plan for Georgia.

CYSHCN: Children's Medical Services (CMS), Georgia's Children and Youth with Special Health Care Needs program, partners with families, youth and family-led organizations to gain feedback on service delivery, obtain recommendations on communication tools to promote awareness of services and CYSHCN-related initiatives, facilitate family training opportunities as well as identify challenges experienced while navigating Georgia's systems of care. The CMS program's goal is to create and maintain diverse access points for engagement across the state.

The local district CMS programs engage with families and young adults to understand their experiences with services, delivery of services and interactions with CMS staff through the distribution of annual satisfaction surveys. Responses from the annual satisfaction survey help determine statewide improvements for the CMS program. In addition to ongoing enhancements in service delivery, local district CMS staff receive ongoing guidance and training to strengthen the core principles of family centered care and family leadership. Funding and processes are in place to support the local district program's efforts to coordinate community outreach events and connect families to leadership opportunities. A quarterly newsletter, named the *F.E.E.D* (Family Engagement Experiences Defined), is developed and distributed to local district staff. The *F.E.E.D* offers practical ways to enhance engagement with

families, highlights local outreach activities and family engagement champions, promotes upcoming trainings, and includes helpful resources.

The CMS program also partners directly with youth to support planning activities associated with the Health Care Transition Outreach and Awareness Campaign. Youth are engaged through focus groups and workgroup activities to solicit recommendations on health messaging, communication platforms and marketing tools. In collaboration with Georgia HOSA, the program identified 10 youth to participate in the inaugural CMS 2023 GA Steps Up for Youth summer workgroup. This workgroup consists of eight weekly sessions in which youth will learn about health care transition concepts and are compensated for their participation and involvement with creating digital marketing content for the Campaign.

Through a contractual partnership with Parent to Parent of Georgia (P2PGA), families of children and youth with special health care needs have access to the special needs database and hotline, leadership and health care transition trainings, as well as opportunities to participate in focus groups geared towards systems of care issues. P2PGA also administers the Parents as Partners project which employs parents of a child or youth who has a special health care need. There are currently seven trained Parent Partners who support local district child health programs and pediatric specialty clinics. Parent Partners provide one-on-one assistance, information, guidance, and referrals on educational and health-related issues to families as well as maintain ongoing communication with staff at the designated site to share challenges and barriers experienced by families receiving services.

The CMS program is currently participating in the Family Voices Title V Community of Practice (CoP) in which the Family Engagement in Systems Assessment Tool (FESAT) is used to assess family engagement in systems level work. The FESAT process helped to spearhead the quality improvement initiative for the Parents as Partners project, identifying opportunities to improve in the areas of communication, training, leadership development and coordination of services.

To expand organizational support, the CMS program has a full-time dedicated Family Engagement Manager and Youth Engagement Coordinator. With additional staffing and partnerships with youth serving and family-led organizations, the CMS program is exploring the possibilities of coordinating a family and youth advisory council with representation from across the state. Extending the program's reach and connecting with families and youth in rural and underserved communities will place the program in a good place to support the upcoming Title V Block Grant Five Year Needs Assessment and CYSHCN Blueprint for Change planning activities.

Early Hearing Detection and Intervention (EHDI): The EHDI Program facilitates family engagement in partnership with Georgia Hands & Voices, offering family-to-family support and navigation services. The program also collaborates with the Georgia Parent Infant Network for Educational Services (Georgia PINES), which provides an initial transition-like meeting called the Early Hearing Orientation Specialist (EHOS) visit. This meeting, conducted by trained providers, assists families who have a child newly diagnosed with hearing loss in transitioning from diagnosis into early intervention. Additionally, Georgia PINES offers the Deaf Mentor program, which provides mentorship and coaching to assist families in acquiring visual language skills.

Furthermore, families of children who are deaf or hard of hearing (DHH) are included in all EHDI stakeholder meetings, Georgia's Newborn Screening Advisory Committee (NBSAC), EHDI Learning Communities, and the Georgia Commission for Deaf and Hard of Hearing (GaCDHH). Family members and individuals who are DHH represent 25% of the EHDI stakeholder group. Through these formal groups, families have a significant impact on the policies and processes implemented by agencies in support of early identification and early intervention for children with hearing loss.

Child Health Home Visiting: Child Health Home Visiting leads the Continuous Quality Improvement (CQI) project focused on maternal depression. A component of the CQI plan is to engage families in CQI efforts and facilitate the

provision of high-quality, evidence-based family support services to at-risk families and children, prenatally up to age five. The CQI explores the best methods of including families in continuous quality improvement efforts and intentionally including families in the implementation of the Mothers and Babies Curriculum. Home Visitors include families in testing the new curriculum and sharing feedback with other home visiting programs as they begin implementing the curriculum. The CQI encourages programs to include the parent voice in screening, referral facilitation and implementation of new initiatives.

Fatherhood Initiative: The Strong Fathers Strong Families Initiative improves maternal health outcomes through father involvement. The project equips Black fathers and their families with education to make healthier choices and provide fathers with practical ways to support mothers in breastfeeding initiation and duration.

Georgia Perinatal Quality Collaborative (GaPQC): The GaPQC team in the Office of Women's Health participated in the National Network of Perinatal Quality Collaboratives (PQCs) Demonstration Workgroup to increase patient and family engagement. This included participation in an eight-week Community of Learning (COL) led by MoMMA's Voices (Maternal Mortality and Morbidity Advocates), a maternal health patient advocacy coalition to amplify the voices of birthing persons who've experienced pregnancy and childbirth complications and loss, especially those who have been historically marginalized. During the COL, the team developed a 90-day action plan and formal evaluation plan to integrate individuals with lived experience, especially individuals from at-risk communities in Georgia who are most affected by adverse maternal and infant outcomes, into the Collaborative. Following the development of an orientation manual and toolkit for recruiting and onboarding individuals with lived experience, GaPQC launched the Lived Experience Integration Program in May 2023. Recruitment will begin in the fall 2023.

Newborn Screening (NBS): The NBS Family representatives attend the semi-annual Newborn Screening and Genetics Advisory Committee (NBSAC) meetings to present and testify the impact of newborn screening on saving lives and changing outcomes for children with heritable conditions. The NBSAC is composed of parent representative organizations including Parent to Parent of Georgia, Hands and Voices, PKU Alliance, and the Sickle Cell Foundation of Georgia. The current co-chair of the NBSAC is a family representative.

Oral Health: The Oral Health program partners with the community to provide oral health education and raise awareness of oral health services and outcomes. Oral Health continues to work with partners and stakeholders, including parent leaders, churches, Special Olympics, Head Start, Easter Seals, CYSHCN (BCW and CMS), daycares, and preschools to identify opportunities to reduce barriers to family engagement, as well as leverage surveillance data to develop targeted goals and activities. Oral Health will continue to encourage family and community participation on the policy level and evaluate activities for effectiveness.

MCH Advisory Council: The MCH Advisory Council includes a person with lived experience to ensure quality and useful evaluation of programs, services, and strategies. The family representative assures the needs of families and consumers are central to programming, initiatives, and special projects.

As Title V moves to the new Title V Block Grant Guidance and heads into the next 5-year needs assessment, the Title V team will be adapting and implementing the North Carolina Early Childhood Family Engagement and Leadership Framework. This framework most closely aligns with Georgia Title V's family engagement objectives and strategies to effectively impact system level changes for the MCH population. Title V will focus on the framework's four conditions of success and seven system components.

Four Conditions of Success:

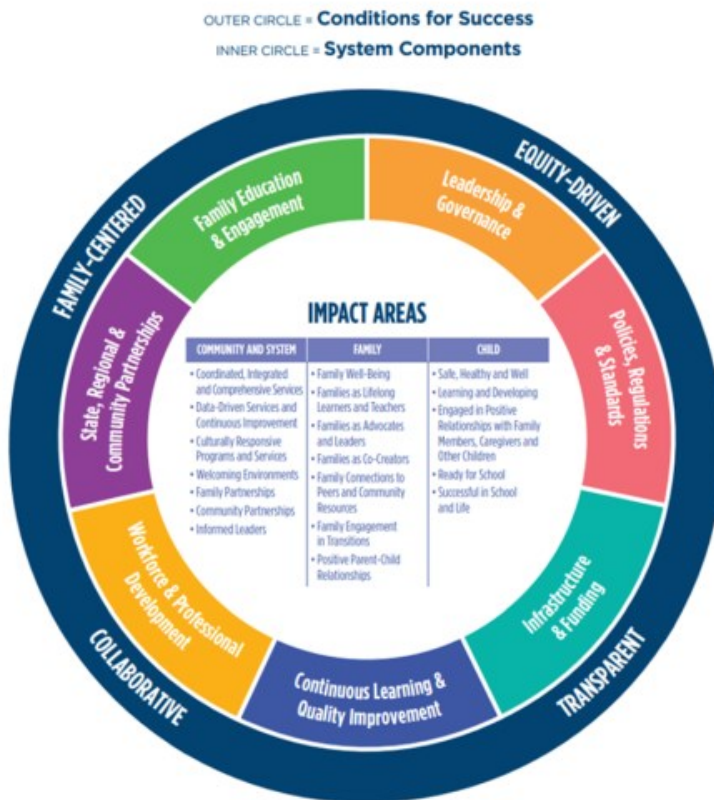
1. Family-centeredness
2. Health equity
3. Transparency

4. Collaboration

Seven System Components:

1. Leadership & Governance
2. Policies
3. Regulations & Standards
4. Infrastructure & Funding
5. Continuous Learning & Quality Improvement
6. Workforce & Professional Development
7. State, District & Community Partnerships
8. Family Education & Engagement

Family Engagement and Leadership: System-Level Implementation



Adapted From: Parent, Family, and Community Engagement Framework for Early Childhood Systems. National Center on Parent, Family and Community Engagement, 2018

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

The Maternal and Child Health Epidemiology Section (MCH EPI) is organizationally located within DPH's Epidemiology Division. MCH EPI performs ongoing surveillance, data collection, and analysis in support of several Title V funded programs within DPH. Tonia Ruddock, MPH (Supervisory Epidemiologist, funded by Maternal and Child Health Program (MCHP)) oversees MCH EPI and provides scientific oversight and coordination of maternal and child health epidemiology activities. Additionally, Ms. Ruddock leads most Title V-related analyses of vital records (e.g., birth certificates, death certificates, fetal death certificates, induced terminations of pregnancy) and completion of Title V Forms and related annual analyses. MCH EPI is comprised of three teams: (1) Newborn Surveillance (NS), (2) Newborn Screening (NBS), and (3) Health Surveys (HS). These three teams cover a variety of health topics, including infant morbidity and mortality, newborn screening, birth defects, oral health, and more general maternal and infant health surveillance via the implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS).

The Newborn Surveillance Team (NST) is led by Jerusha Barton, MPH (Epidemiologist III, funded by MCHP). Jerusha Barton has been with DPH in an expanding capacity for nearly eight years and is a subject matter expert on birth defects surveillance at DPH. Jerusha Barton and a former epidemiologist (A. Elise Barnes) have each previously won a best poster award for their work on validating Zika-associated birth defects surveillance at the annual Council of State and Territorial Epidemiologists (CSTE) conference. The NST is focused on birth outcomes surveillance, including the longitudinal health impact of *in utero* exposures during pregnancy.

Dr. Ankit Sutaria, MBBS, MPH (Epidemiologist III, funded by MCHP) is the Newborn Screening Team (NBST) lead within MCH EPI. Dr. Sutaria has had increasing responsibilities as an epidemiologist over the past eight years. The NBST performs surveillance and analytic activities for several programs, including pulse oximetry screening, genetic screening, early hearing screening, referral to health services, and early health services. Michael Lo, MSPH (Epidemiologist II, funded by MCHP) has served as the early hearing screening epidemiologist for the Early Hearing Detection and Intervention program for seven years.

Jenna Self, MPH (Epidemiologist III, Project Director) serves as the Team Lead for the Health Surveys Team (HST). The HST performs implementation, analysis, and/or dissemination activities for PRAMS and the Basic Screening Survey (BSS). The HST focuses on the collection of valid data using rigorous protocols. The person with primary responsibility for the daily implementation activities of PRAMS is Jamey Wagnon (Administrative Assistant II, MCHP funded). The HST also includes a bilingual interviewer (Erika Bonilla-Garcia, MCHP funded) who is responsible for performing Spanish and English interviews of PRAMS participants. Sabrina Johnston, MPH (Epidemiologist III, MCHP funded) is the primary analyst for the Oral Health Program and assists in the implementation, data collection, and analysis of the Basic Screening Survey, which is currently being implemented for 3rd grade and Kindergarten students. Ms. Johnston assists the Oral Health Program with meeting grant deliverables and documenting progress on key measures.

MCH EPI staff engage in professional development opportunities through a variety of avenues that include the Council of State and Territorial Epidemiologists (CSTE) and Association of Maternal and Child Health Programs (AMCHP). During these national conferences, there is targeted skills building training and peer to peer sharing, as well as opportunities to present on analyses done throughout the year through oral or poster presentations. In the past year, MCH EPI staff have participated in multiple training opportunities, including those focused on data visualization, Environmental Systems Research Institute (Esri) Aeronautical Reconnaissance Coverage Geographic Information System (ArcGIS). To stay abreast of the latest research in MCH, MCH EPI engaged in monthly virtual book clubs. As in recent years, MCH EPI will continue to transition into an enterprise environment that permits

greater use of data on the Esri ArcGIS platform and suite of products.

The Women's Health Epidemiology section (WH EPI) is organizationally located within DPH's Epidemiology Division and provides support for all women's health programs and initiatives within the Division of Women, Children, and Nursing Services. Kristina Lam, MD, MPH (Medical Epidemiologist, funded by Maternal Mortality Evaluation/State) has been a medical epidemiologist with DPH for the past seven years. Dr. Lam oversees WH Epi and provides scientific oversight, strategic planning, and coordination of women's health epidemiology activities. Elizabeth Burkhardt, MPH (Epidemiologist 3, funded by Maternal Mortality Evaluation/TANF) is the senior WH epidemiologist and has been an epidemiologist with DPH for the past seven years. Ms. Burkhardt is responsible for analysis, interpretation, and reporting of data for the Georgia Perinatal Quality Collaborative (GaPQC) and the Maternal Mortality Review Committee (MMRC). Jalpa Shah, MPH (Epidemiologist 1, funded by Maternal Mortality Evaluation/State) recently joined DPH from another state health department. Ms. Shah will be responsible for management and analysis of data for the Family Planning Program and the MMRC. In August, two Emory University Rollins School of Public Health Epidemiology Fellows will join WH EPI to provide additional support for GaPQC and the Family Planning Program.

The WH EPI section is newly developed and has taken over implementation of a new data collection system utilizing Aeronautical Reconnaissance Coverage Geographic Information System (ArcGIS) for GaPQC maternal initiatives. WH EPI will continue to explore training opportunities to build internal capacity for management of ArcGIS systems, as well as work with DPH developers to update current data collection systems in the State Electronic Notifiable Disease Surveillance System (SendSS).

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

MCH EPI has access to timely and linked MCH data systems. Except where otherwise indicated, MCH EPI has at least annual access to each data source via an electronic data source. Below is a summary of the status of the relevant data sources:

1. **Vital Records Birth:** MCH EPI maintains annual access to “final” vital records data and live access to the vital records data management system (Georgia Vital Events Registration System (GAVERS)). Except for Induced Termination of Pregnancy certificates, the “final” vital records data are internally linked, as are data sets derived from the live data on an *ad hoc* basis.
2. **Vital Records Death:** MCH EPI maintains annual access to “final” vital records data and live access to the vital records data management system (GAVERS). Except for Induced Termination of Pregnancy certificates, the “final” vital records data are internally linked, as are data sets derived from live data on an *ad hoc* basis.
3. **Medicaid:** MCH EPI maintains access to Medicaid data for some notifiable conditions. Maternal mortality data can be linked to the Medicaid data to identify if and when a woman had Medicaid coverage and, if so, services received.
4. **WIC:** Broadly, Title V Programs have access to WIC data in aggregate and as requested. WIC data that can be linked to other data sources (e.g., identifiable) is not available at this time.
5. **Newborn Bloodspot Screening:** All Newborn Screening data are available without lag, aside from the time spent to process and/or enter data. Genetic testing, performed by an external vendor, is available at least annually and by request. These data are linked to vital records’ birth certificates upon intake within the State Electronic Notifiable Disease Surveillance System (SendSS).
6. **Newborn Hearing Screening:** All Newborn Screening data are available without lag, aside from the time spent to process and/or enter data. Genetic testing, performed by an external vendor, is available at least annually and by request. These data are linked to vital records’ birth certificates upon intake within SendSS.
7. **Hospital Discharge:** MCH EPI obtains quarterly hospital discharge files from the Georgia Hospital Association. The lag in the receipt of these files is four to six months. A final hospital discharge file is available around nine or ten months after the end of a calendar year. As needed or requested, these data may be linked to birth certificate data using a unique identifier.
8. **PRAMS:** MCH EPI, the entity responsible for the implementation of PRAMS, has received data representative of women with a recent live birth each year since 2017 and anticipates receiving the most recent year (2022 birth cohort) in September 2023. PRAMS data are linked to birth certificates.
9. **Vital Records Fetal Death Certificate:** MCH EPI maintains annual access to “final” vital records data and live access to the vital records data management system (GAVERS). Except for Induced Termination of Pregnancy certificates, “final” vital records data are internally linked, as are data sets derived from live data.
10. **Vital Records Induced Termination of Pregnancy:** MCH EPI maintains annual access to “final” vital records data and live access to the vital records data management system (GAVERS). Except for Induced Termination of Pregnancy certificates, “final” vital records data are internally linked, as are data sets derived from live data.

Role of SSDI in Title V

MCH EPI worked closely with Title V-funded programs and staff. During the most recent Five-Year Needs Assessment and for the subsequent establishing of priorities and national and state outcome measures, MCH EPI was responsible for a large part of the quantitative component. SSDI funding allowed MCH EPI to maintain ongoing access to key metrics, including access to infant morbidity and mortality data. Specifically, the SSDI-funded epidemiologist was responsible for assisting in the calculation of vital records-related NOMs and State Performance Measures (SPMs). SSDI funds also supported requisite technical development for birth outcomes surveillance.

Key SSDI Program Activities

During the current budget year, SSDI funding supported several projects. First, SSDI funding supported the ongoing maintenance and modification of the Birth Defects Registry (BDR). Renewed focus on the BDR has centered around two areas: for patients with dates of birth starting in 2016, (1) connecting, validating, and updating a trial HL7 connection to the largest pediatric healthcare system in Georgia (CHOA); and (2) reviewing, validating, and ingesting missed files reported by birthing facilities (GBDRIS). Georgia is one of the few sites doing birth defects surveillance to have piloted, validated, and begun ingesting data using HL7 messages. To date, nearly 10,000 unique patients have been reported through this HL7 mechanism (N=9,924 unique patients with 12,388 reports, 32% of total patients in BDR). Review of GBDRIS files uncovered a vast number of duplicate reports across files, leading to a new business rule for the BDR for identifying and excluding duplicate patients. GBDRIS files have contributed over 8,000 unique patients (N=8,715 unique patients with 11,258 reports, 28% of total patients in BDR) to the BDR.

Second, SSDI funding supported an epidemiologist position to fill a critical gap in infant surveillance. This position, the Infant Epidemiologist (Infant EPI), drastically increases MCH EPI's capacity to perform surveillance of critical infant health outcomes. This position was vacant from May 6, 2022 until November 1, 2022, when Sarah Powell, MPH was hired for the role. The Infant EPI is undergoing training for birth outcomes surveillance and has already achieved several critical deliverables: creation of birth outcomes cohorts, linkages (probabilistic and deterministic) between surveillance and vital records data, created data visualizations to monitor the burden of infant outcomes, assisted in the modernization of MCH data, and performed analyses in support of maternal and child health programs.

With the support of the SSDI grant, we have achieved several improvements related to data capacity and still have several outcomes we would like to achieve during the project period. As previously indicated, the Infant EPI has performed ad hoc linkages using a combination of vital records, laboratory, and case report data. The Infant EPI completed the development of a web-based medical record abstraction tool using Survey123, Esri's data collection tool. This tool has expedited our capacity to perform data entry, while reducing duplication of efforts and enhancing our ability to track case review progress. The Infant EPI has begun creation of an infant surveillance dashboard to monitor the burden of infant health outcomes in Georgia. This project should be completed by the end of the upcoming fiscal year. The Infant EPI has also participated in the ongoing development of Georgia's Birth Defect Registry (BDR) and participated in biweekly meetings to discuss the technical development of the BDR. As has been documented previously, the BDR effectively brings together data from well over a dozen data sources ranging from the various vital records (birth, death, fetal death, induced termination of pregnancy) to single case reports by a healthcare provider. By the end of the current fiscal year, the Infant EPI will have helped get the BDR to a functional status as it was prior to COVID-19. When this technical development work reaches a pausing point, the Infant EPI will help lead Georgia's first statewide birth defects burden report in many years.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Title V data capacity efforts funded by sources other than SSDI support up to date MCH data and information systems and program activities such as the Title V Block Grant Five-Year Needs Assessment, annual MCH Block Grant performance measure reporting/monitoring, and data-driven programming.

Pregnancy Risk Assessment Monitoring System (PRAMS)

The Centers for Disease Control and Prevention (CDC) PRAMS is a core dataset being used to assess overall state MCH data capacity. Beginning with the 2017 birth cohort, Georgia PRAMS now meets CDC benchmarks for data collection. Prior to the 2017 birth cohort, the most recent Georgia PRAMS data currently available is the 2014 birth cohort, which did not meet the strict response rate cutoff. This means results from the 2014 data should be interpreted with caution and are not available in CDC analyses. Though Georgia submitted data to the CDC for the 2015 birth cohort, the response rate was not high enough to consider the results representative of all Georgia moms who recently gave birth. For the 2016 birth cohort, Georgia was unable to provide a data submission to the CDC for cleaning and weighting purposes as PRAMS operations ceased after pulling the first six batches. Thus, data are not available for the 2016 birth cohort either. A major shift in the responsibility for PRAMS occurred and was transferred to the Maternal and Child Health Epidemiology Section in the Epidemiology Division. Since this time (2017 to 2021 birth cohorts; with 2022 birth cohort nearing completion and 2023 birth cohort about to begin), Georgia PRAMS has had a response rate high enough to achieve results representative of all Georgia women with a recent live birth.

Georgia PRAMS Supplements

Emerging public health threats and issues of importance to maternal and child health may require the use of supplements to the PRAMS questionnaire. Georgia PRAMS has demonstrated the capacity to implement such new survey supplements. During the previous and current project period, Georgia PRAMS implemented the following supplements:

- April 2022-March 2023: A Social Determinants of Health supplement is currently being implemented to ascertain the prevalence and distribution of various determinants of health, like housing stability, food access, transportation mode, health literacy, mental health care access, and discrimination.
- April 2020-present: A Mental Health supplement continues to be implemented as part of a collaboration between Georgia PRAMS and the Office of Women's Health. Focusing on the time during and shortly after the end of the pregnancy, this supplement is collecting information on communication between health care providers and recent mothers, taking mental health medications, counseling, and depression and anxiety symptoms.
- April 2021-present: An Oral Health supplement continues to be implemented to better understand the oral health problems, treatment, and oral health care access during and shortly after the end of the pregnancy.
- April 2021-March 2022: A Covid-19 vaccination supplement was implemented to assess the sources of vaccination information, vaccination-related behaviors, and vaccination-related attitudes.
- January 2021-March 2021: A Covid-19 supplement was implemented to better understand the impact of Covid-19 on the behaviors and experiences of pregnant and recently postpartum women and their infants, including care-seeking during the pandemic.
- January 2019-April 2021: A Disability supplement was implemented to understand the prevalence of disabilities among women with recent live birth and explore disparities in the prevalence of negative maternal and child health outcomes among women with disabilities.

PRAMS for Dads

In collaboration with Northwestern University and CDC, GA-PRAMS designed and implemented PRAMS for Dads.

This pilot project, conducted from October 2018-December 2019 to collect data on the experiences, behaviors and needs of fathers after the birth of a new infant, was intended to assess the most effective method for contacting fathers shortly after the birth of a live infant and to fill a gap in knowledge regarding the experiences and behaviors of new fathers and their role in the health of their families. Sampled fathers were randomized into two groups to receive either: 1) direct outreach (“Direct to Dads”) or 2) outreach through the mother (“Mother as Gatekeeper”). Thus far, the results of the initial implementation have (1) led to a manuscript that examines the strengths of each mode of outreach and (2) multiple conference presentations, both oral and poster. A manuscript detailing this pilot study was published in PLOS One, “Pregnancy Risk Assessment Monitoring System for Dads: A piloted randomized trial of public health surveillance of recent fathers’ behaviors before and after infant birth”. Another manuscript has been accepted for publication in Pediatrics, “Breastfeeding and Infant Sleep Practices: Findings from the PRAMS for Dads Study”. Currently, Georgia PRAMS is preparing for implementing PRAMS for Dads starting in June 2023. This implementation will include methodology changes following the initial implementation, including moving the start date to sooner following the pregnancy, reducing the number of phone calls to each father, and only implementing a protocol similar to the previously implemented “Direct to Dads” approach.

Examples of PRAMS data used to increase the MCH knowledge base follow:

- 2017-2021 Georgia PRAMS data continue to be used to inform and monitor progress on the MCH Title V Block Grant. Georgia PRAMS provided data points ranging from safe sleep and breastfeeding to mental health and prenatal care. Additionally, to better inform programmatic efforts, Georgia PRAMS provided data on the information recent mothers received from healthcare providers; these indicators were previously not considered as part of the decision-making process.
- 2017 Georgia PRAMS data were used in Healthy Mothers, Healthy Babies Coalition of Georgia (HMHBGA) of Georgia’s “2019 State of the State of Maternal & Infant Health in Georgia” report (<https://hmbga.org/education/toolkits-reports/>).
- Provided Center for Oral Health Systems Integration and Improvement (COHSII) with Georgia PRAMS oral health data for inclusion in the “Identifying and Implementing Oral Health Quality Indicators for the Maternal and Child Health Population: 2018–2019” report (2019). Georgia was one of the initial COHSII participants.
- In collaboration with the DPH Chronic Disease, Health Behaviors, and Injury Epidemiology (CHIE) Section’s Occupational Health team, Georgia PRAMS 2017-2019 occupation data were analyzed and were recently disseminated through a presentation examining the relationship between industry and occupation and breastfeeding practices.
- Georgia PRAMS data on safe sleep informed the selection of educational support materials that were distributed to birthing hospitals for parents of newborns to help reinforce the safe infant sleep recommendations provided by the American Academy of Pediatrics. Use of PRAMS data allowed for identification of targeted interventions and guidance for the creation and provision of educational materials.
- As part of a collaboration between DPH’s Oral Health and Chronic Disease programs, PRAMS data were used in the Tobacco Cessation Resource Toolkit for Oral Health Providers (<https://www.gaohcoalition.org/resources/for-healthcare-providers/>) and publication of two PRAMS infographics on tobacco use and secondhand smoke exposure during pregnancy increasing the proportion of callers to the Georgia Tobacco Quitline referred by oral health providers by 20 percent. (<https://dph.georgia.gov/PRAMS>).

Birth Defects Registry (BDR)

The Zika pandemic highlighted the need for statewide rapid and ongoing population-level birth defects surveillance. However, Zika-associated birth defect case ascertainment was initially only available in a small catchment area under the purview of CDC's Metropolitan Atlanta Congenital Defects Program. To address this critical surveillance gap, DPH developed the electronic BDR for rapid, population-based surveillance of birth defects for the entirety of Georgia. The BDR was developed using surveillance guidelines established by the National Birth Defects Prevention Network (NBDPN), from variable selection to the case abstraction tool. The BDR leverages multiple data sources to get at the burden of birth defects among the Georgia population. The COVID-19 pandemic resulted in less resources being available to work on birth defects surveillance. Following the pandemic, MCH EPI has had a renewed focus on the BDR. This focus has centered around two areas: for patients with dates of birth starting in 2016, (1) connecting, validating, and updating a trial HL7 connection to the largest pediatric healthcare system in Georgia (CHOA); and (2) reviewing, validating, and ingesting missed files reported by birthing facilities (GBDRIS). To date, nearly 10,000 unique patients have been reported through this HL7 mechanism (N=9,924 unique patients with 12,388 reports, 32% of total patients in BDR). Currently, GBDRIS files have contributed over 8,000 unique patients to the BDR.

Sickle Cell Disease and Related Hemoglobinopathies

MCH EPI is partnering with the Georgia Health Policy Center on performing population-level surveillance of sickle cell disease and related hemoglobinopathies. This collaboration expands on existing capacity for newborn screening analyses and helps Georgia have a more accurate assessment of the burden of sickle cell disease on the population, including the distribution of cases and potential unmet need among persons with sickle cell disease. Through this collaboration, we worked on assessing COVID-19 infection Outcomes among children living with Sickle Cell Disease and Trait. This led to a manuscript published May 2023 in the Journal of Pediatric Hematology and Oncology entitled, "COVID-19 Infection and Outcomes in Newborn Screening Cohorts of Sickle Cell Trait and Sickle Cell Disease in Michigan and Georgia". Also, we are working to examine immunization adherence and opioid use among children living with Sickle Cell Disease and Trait.

Georgia Perinatal Quality Collaborative (GaPQC)

Hospital Discharge Data (HDD) is a critical data source for GaPQC programming. Under Georgia law, HDD is collected by the Georgia Hospital Association and transmitted to DPH through the Office of Health Indicators for Planning and DCH on a quarterly basis. The newly established Women's Health EPI team analyzes HDD to assess severe maternal morbidity for hospitals participating in the AIM Hemorrhage and Hypertension bundles. Preliminary analyses for hospitals participating in the AIM CCOC bundle have also been conducted. EPI's participation in GaPQC has provided the opportunity to create an initial "rapid cycle" surveillance system of severe maternal morbidity that allows participating facilities to have close to "real time" severe maternal morbidity metrics. To date, severe maternal morbidity outcome measures for the Hemorrhage and Hypertension bundles that use the HDD have been made available to all participating facilities by quarter dating back to Q1 2016. Women's Health EPI submits all measures (process, structure, and outcome) available on the AIM portal and multiple facility-specific reports that include each measure have been disseminated on a quarterly basis. In turn, the lag time for accessing HDD has decreased from the previous time to obtain annual HDD (18 to 24 months) to the lag time needed to obtain quarterly HDD, four to six months. All quarterly data points have been corrected in the AIM portal to reflect this change. As part of participation in the AIM bundles, Georgia received an award from AIM for data timeliness.

Maternal Mortality Review Committee (MMRC)

The Georgia Maternal Mortality Review Committee (MMRC) receives funding from Title V and the CDC ERASE MM program to increase capacity to complete timely review of pregnancy-associated deaths. During 2022, the MMRC achieved the CDC goal of reviewing all pregnancy-associated deaths within two years of the date of death.

Timeliness of data entry has also been improved. Data are abstracted and entered into the Maternal Mortality Review Information Application (MMRIA) database prior to review committee meetings and committee decisions are entered into the database within 30 days of the review meeting. The MMRC staff have also worked to improve timeliness of case confirmation and pregnancy is now confirmed within three months of death identification. Timely case identification has also led to more success with pregnancy checkbox corrections. When a death certificate has an indication of pregnancy within the past year on the pregnancy checkbox but confirmation of pregnancy cannot be found, the certifier is contacted to request a correction on the pregnancy checkbox. This effort improves the data quality of national maternal mortality data. The development of the Women's Health Epidemiology section (WH EPI) has increased the capacity to analyze and report maternal mortality data.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The Title V program understands the importance of emergency preparedness (EP) planning and response as it relates to MCH populations. Title V makes a conscious effort to develop a partnership with the Department of Public Health's Emergency Preparedness (PHEP) and Healthcare Preparedness Program (HPP) teams on the state and local levels to ensure that the needs of women of reproductive age, pregnant women, infants, children, adolescents, and children and youth with special health care needs were considered, especially during emergency response and recovery phases of tornadoes, floods, hurricanes, and pandemics.

The Division of Women, Children, and Nursing Services and WIC programs work closely to support EP operations during the mitigation, planning, response, and recovery phases of critical emergency incidents to mitigate adverse effects and promote better outcomes for public health populations.



The PHEP section is responsible for generating and maintaining the State's Emergency Operation Plan (EOP), which is an all-hazards plan that establishes a single, comprehensive framework for the management of local and statewide incidents of public health significance. The EOP is reviewed annually with internal and external partners by May 31st of each year, and then updated accordingly. Offices, sections, divisions, units and supporting agencies within DPH are responsible for developing and maintaining standard operating procedures (SOPs), standard operating guidelines (SOGs), and annexes and maintaining the parts of the base plan under their core professional area.

Georgia's EOP historically considered the needs of the MCH population within its normal population categories, and more specifically under Vulnerable Populations, which includes the elderly, nursing home residents, those with chronic conditions, neonates, those with intellectual disabilities, pregnant women, the homeless, etc. However, with the intentional creation of MCH EP Liaisons and in collaboration with Title V programs, including CYSHCN, Child Health Home Visiting, Women's Health, Communications, and WIC, much progress has been made in explicitly defining the MCH population and in enhancing Georgia's EOP to better support the MCH population.

The Division of Women, Children, and Nursing Services contains the Office of Nursing. The Office of Nursing is intricately involved in EP planning and activities and leads the coordination of division services in all phases of disaster planning, including providing staffing support to PHEP at the State EOC or virtually, as requested, maintaining a staff call list for the division, supporting recovery operations as needed, coordinating with district staff to provide support as needed, developing continuity of operations plans for services provided to division programs, coordination of the revision of response plans and actions as indicated based on changes needs of the response, staffing, and other logistics, and the coordination mitigation activities to include review of lessons learned and implementation of a quality improvement plan.

The Deputy Chief Nurse of Emergency Preparedness serves as the Office of Nursing Liaison to the PHEP section. In this role, the Deputy Chief Nurse serves on various committees to ensure MCH populations are considered and supported in the planning and response activities conducted by PHEP. The EP Functional Needs Support Services (FNSS), Underserved Populations (USP) Committee, and Emergency Preparedness Coalition for Individuals with Disabilities and Older Adults develop trainings and other resources to be presented and delivered to EP Directors, local emergency management agencies, state agencies, and federal partners. Other agency representation serving on these committees include the Georgia Division on Aging, Georgia Emergency Management and Homeland Security Agency (GEMA/HS), Georgia Institute of Technology, Georgia Department of Behavioral Health and Developmental Disabilities, Georgia's Americans with Disabilities Act (ADA) Coordinator's Office, Region IV Federal Emergency Management Agency (FEMA), and Georgia Healthcare Association. In addition to committees that develop training and resources, the Deputy Chief Nurse plans trainings for EP and other Division Staff on both the state and local levels about MCH population characteristics and needs. Many of these trainings occur virtually and are presented annually or as needed.

The Office of Nursing played a critical role in assisting the Emergency Preparedness Section and Immunization Program in COVID-19 response efforts, particularly for MCH populations, including CYSHCN. MCH was one of many partners that assisted DPH in developing a COVID-19 Vaccination Rollout Plan and a COVID-19 Health Equity Strategic Plan for vulnerable populations and communities of color.

Highlights for the current year include:

1. The Division of Women, Children, and Nursing Services helped to support the Statewide Mass MPOX vaccine events held at the Atlanta Freight Depot. Volunteers from the division assisted with registration, scheduling, and providing vaccines to clients.
2. The Office of Nursing provided clinical support at the State Operations Center during activation for both Hurricane Ian and the winter tornadoes affecting District 4.
3. The Office of Nursing and Office of Emergency Preparedness conducted the State of Georgia's first functional exercise of a sheltering mission for public health nurses to include training for vulnerable populations and those with functional and access needs and developmental disabilities
4. The Deputy Chief Nurse of Emergency Preparedness presented a paper at both the Georgia Public Health Association Annual Conference and the Preparedness Summit on "Mass Sheltering for Public Health Nurses".

Title V will continue to be proactive in EP planning and to coordinate with partners at the state and local levels to develop emergency preparedness and response plans that include the needs of the MCH population. Title V will continue to assess the adequacy of the EOP in responding to an emerging public health threat or disaster that impacts the MCH population.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Title V serves as a convener of partners and collaborates at the state and local levels to ensure coordination within the MCH health care delivery system. The program works collaboratively with state agencies, professional organizations, and community-based nonprofits to ensure access to quality health care and needed health services for women, children, children with special health care needs and families. Statewide efforts are coordinated to provide and promote quality driven, comprehensive, family-centered, and community-based systems of care for Georgia's diverse and growing populations. Title V prioritizes the intentional alignment of federal-state local initiatives, interaction with state advisory groups and regular communication with public and private local agencies and organizations such as health departments and hospitals. As a leader and partner, Title V provides expertise, gathers feedback, and makes connections to assure access to services to maximize the effectiveness of the health system, as well as other systems impacting overall health and well-being. Title V works with the MCH Advisory Council to review the development, implementation, and adoption of programs, policies, and strategies. The Council assist with identifying any concerns and gaps in services to ensure quality improvement within the MCH program. Title V offers education and outreach to health care providers, home visitors, community partners, families, and parents and caregivers of CYSHCN.

In the upcoming year, the MMRC and GaPQC are establishing a new partnership with the Alliance for Innovation on Maternal Health (AIM) Community Care Initiative (CCI). This partnership will help advance non-clinical recommendations of the MMRC, including efforts to improve care in the postpartum period. This community-led bundle will also support the goals of the GaPQC AIM Cardiac Conditions in Obstetrical Care bundle (CCOC), which seeks to make changes in the community. MMRC and GaPQC staff are also partnering with Georgia's State Maternal Health Taskforce, established by the Maternal Health Innovation HRSA grant, to implement more MMRC recommendations and establish new partnerships to advance the work of both the MMRC and GaPQC.

The Georgia General Assembly appropriated funding for DPH to pilot a perinatal home visiting program in underserved, rural counties beginning in FY2024. DPH worked collaboratively with DHS, DCH, DECAL, and DBHDD to develop the pilot model to comprehensively address the needs of families. The pilot will provide home visiting during pregnancy and postpartum with goals to improve birth outcomes, reduce preterm deliveries, and decrease infant and maternal mortality/morbidity. The addition of home visits to provide assessment and monitoring between provider visits will provide an opportunity for earlier detection and intervention of medical complications, especially for moms who face travel challenges. The pilot will work closely with local prenatal care providers to encourage program referrals for at risk moms. Additional outreach will be done with labor and delivery nurses, emergency rooms, primary care/FQHC providers, pediatricians, and DFCS. Maternal and infant referrals will also be encouraged when concerns are identified by WIC staff.

The Child Health Home Visiting program is establishing a new partnership with The Maternal Early Childhood Sustained Home-visiting (MECSH) program to support the implementation of their home visiting curriculum in two new public health district sites, reaching six additional counties through evidence-based home visiting. Child Health programs have partnered with Find Help Georgia, an organization that connects people to essentials resources in their community from financial assistance to food pantries, medical care, childcare, job training, and other free or reduced-cost services. Child Health programs partnered with Find Help Georgia on a webinar with home visiting and Healthy Start sites to share information and inform sites how to connect their families with the organization.

A new initiative that was created through a partnership with DFCS's State Office Safety Unit addresses the needs of mothers and/or infants who have tested positive for substance use or exposure at the time of delivery. This new initiative, Plan of Support and Care, connects these families with a public health nurse in their county who works

directly with the family to create a plan of support and care that addressed the health and substance use treatment needs of the infant and affected family or caregiver.

Title V staff continue to identify opportunities for new partnerships. Coordination meetings with leaders and experts take place on a regular basis to continue aligning and integrating the initiatives at the state and local levels. This commitment to continuously improve, create efficiencies, and add value has resulted in major shared efforts and systems change resulting from Title V led initiatives.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

The Title V program has a longstanding, collaborative relationship with Georgia Medicaid to ensure that all MCH populations have access to the resources and services needed to maintain a healthy life. Georgia's Medicaid, administered by DCH, is one of the largest insurers in the state serving nearly two million residents; 92% of whom are children, elderly or disabled. Medicaid covers one in 11 adults, three in eight children, and one in three individuals with disabilities. Seventeen percent of Georgian's, those who are identified as low-income (below the federal poverty level), are enrolled in Medicaid although 32% of the population is below the federal poverty level. Through Medicaid, parents of children with disabilities or complex healthcare needs are connected to early intervention services offered through our CYSHCN program and Early Intervention / Early and Periodic Screening and Diagnostic Treatment (EPSDT) program. Women are also able to receive breast and cervical cancer services as well family planning services.

To improve healthy pregnancies and preventative care for women as well as reduce the number of low-birth-weight babies, Title V administers the Perinatal Case Management program as well as promote the enrollment of women ages 18 to 44 in Medicaid's Planning for Healthy Babies (P4HB) demonstration waiver program. Title V and Medicaid also partner with supplemental funding to provide six RPCs for access to maternal and neonatal specialty care.

Improving access to adequate health insurance coverage for Georgia's children and youth with special health care needs is a priority for Title V. The CMS program's care coordination services ensure that families that meet eligibility criteria for Medicaid programs are enrolled, including the Health Insurance Premium Payment program, Children's Health Insurance Program Reauthorization Act, Katie Beckett, and Home and Community Based Waivers. Georgia has five home and community-based services waiver programs. Waiver program services include assistance with daily living activities, facilitating the arrangement of medical or support services and services to relieve family caregivers. Waiver programs serve people who are elderly, physically disabled, have developmental or intellectual disability, or are medically fragile children.

Close partnership between Medicaid and Title V also assists with providing timely access to EPSDT benefits for children and adolescents in areas where there are shortages in pediatricians. The Title V program collaborates with CMOs to meet program goals. Together MCH and Medicaid have the capacity to reduce morbidity and mortality among women, infants, children, and adolescents, as well as improve the health status of women and children in Georgia. Local health departments, including rural areas, provide EPSDT services to low-income children and adolescents. Many children birth to five with identified developmental delay and risk factors are connected to the Children 1st program for assessment, monitoring and linkages to the early intervention services.

Georgia's early intervention services program, BCW, expanded its scope of services in 2018 to include the provision of autism related services. This expansion was due to Medicaid's expansion of covered services to include adaptive behavioral services (ABS) for individuals under the age of 21 with Autism Spectrum Disorders (ASD). ASD coverage is provided for assessment and treatment services according to severity and is based on medical necessity. To ensure adequately trained professionals to provide quality diagnostic assessments, the Georgia Autism Assessment Collaborative (GAAC) was formed. GAAC is funded by Title V and implemented by the Emory Autism Center, with cooperation from the Georgia Psychological Association. BCW is enrolling board-certified behavioral analysts to provide ABS to eligible children as well as working with the Children 1st program to expand access to Modified Checklist for Autism in Toddlers screenings for infants and toddlers.

Title V palso works with professional organizations to strengthen the public/private partnership with physician members and dental providers to ensure access to quality medical services for women, children and CYSHCN.

Partners include the GA-AAP, GAFP, Georgia Perinatal Association, Georgia Dental Hygienists, Georgia Dental Society, Georgia Hospital Association, and GOGS. Working with professional organizations extends the reach of public health initiatives and strengthens access to pediatric medical home, developmental screenings, early intervention services, oral health care for pregnant women and CYSHCN, breastfeeding education and countless other initiatives. Title V works closely with GOGS to initiate and administer the GaPQC initiative to implement the use of AIM patient safety bundles in the state's birthing hospitals. Physicians also play an instrumental role in supporting the CMS program's specialty clinics. CMS partners with more than 30 medical providers to improve access to pediatric specialty care for children and their families living in rural counties across Georgia. The CMS program works closely with DPHs Office of Telehealth and Telemedicine to utilize telemedicine technology within seven specialty clinic sites.

HMHBGA partners with the Georgia Association for Primary Health Care to provide education to families on health insurance, Affordable Care Act (ACA) plans, eligibility and directly enroll families in ACA plans through the Federal Healthcare Marketplace and P4HB.

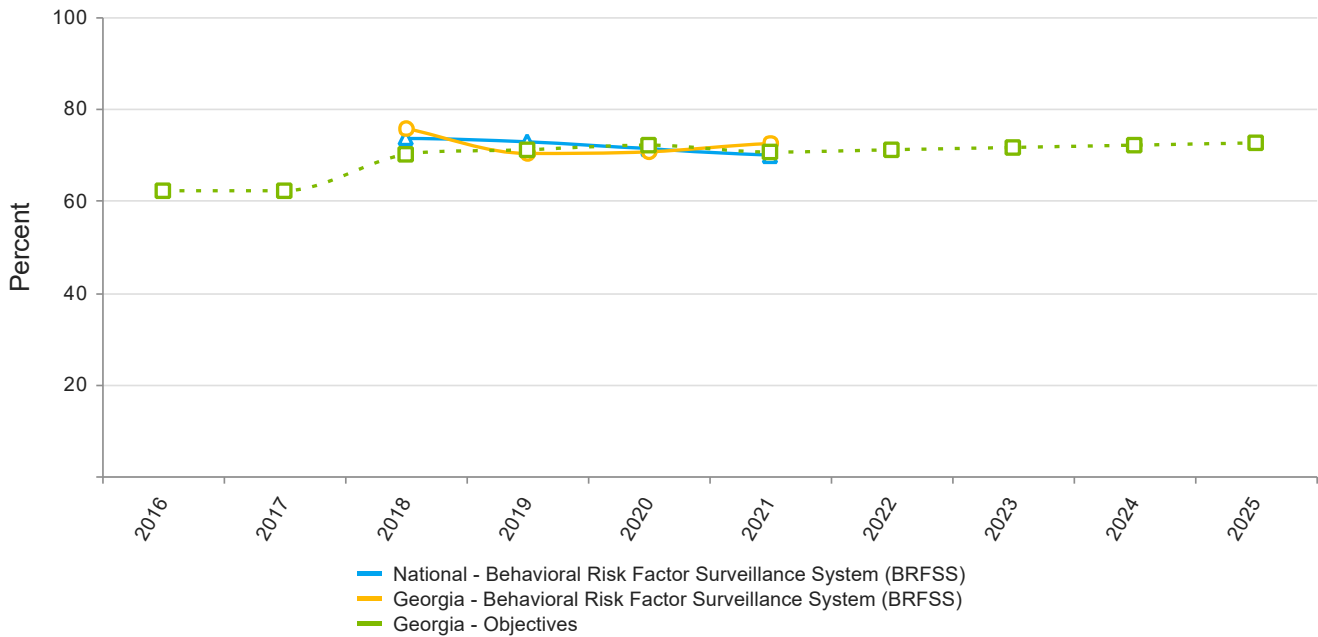
The work of Title V is collaborative and involves countless statewide partners to ensure that women, children and CYSHCN have access to quality health care. The partnerships with Medicaid, professional organizations and many community-based nonprofits continues to provide Title V opportunities to meet the needs of the MCH population.

III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2018	2019	2020	2021	2022
Annual Objective			72	70.5	71
Annual Indicator		75.5	70.1	70.6	72.5
Numerator		1,443,474	1,345,915	1,359,329	1,409,595
Denominator		1,912,418	1,918,848	1,926,441	1,944,801
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

i Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	2024	2025
Annual Objective	71.5	72.0	72.5

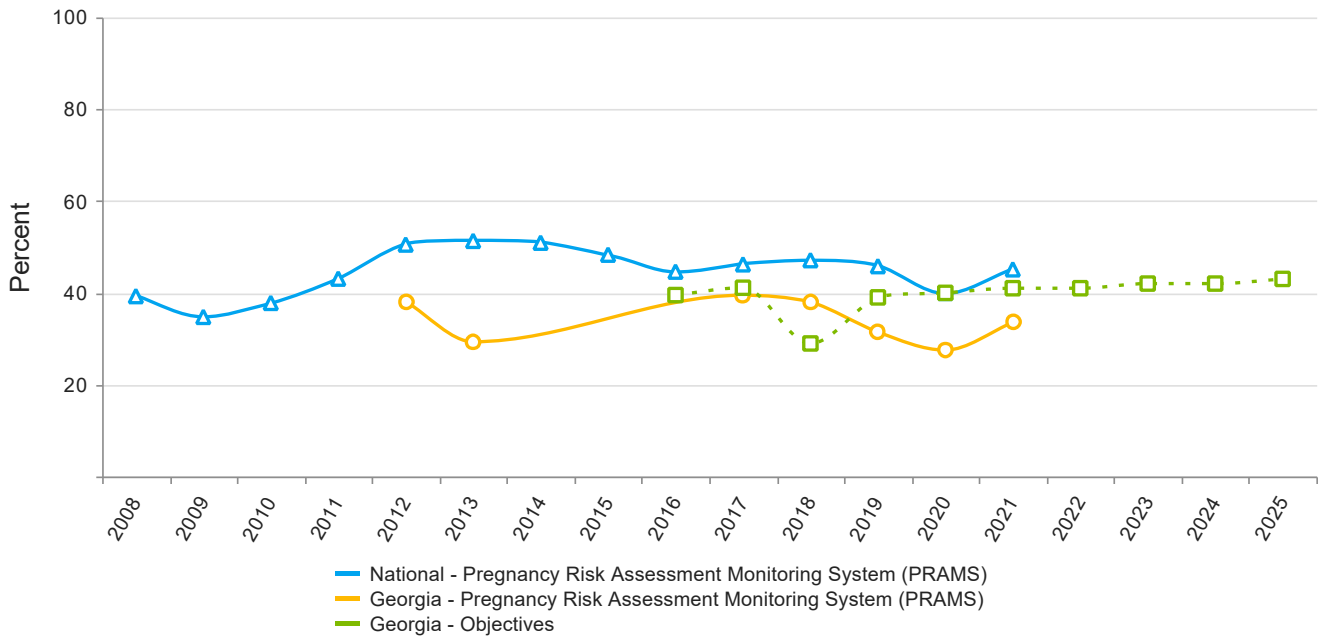
Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of women (30 years or older) who have never been screened or not screened within the last 10 years, who received an initial program cervical screening test

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			20	35
Annual Indicator			25.3	33.4
Numerator			564	961
Denominator			2,226	2,874
Data Source			BCCP Data	BBCP Data
Data Source Year			SFY 2021	SFY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	35.0	35.0	35.0

**NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
Indicators and Annual Objectives**



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	2019	2020	2021	2022
Annual Objective	29	39	40	41	41
Annual Indicator	39.3	37.9	31.5	27.7	33.6
Numerator	48,597	45,805	38,297	32,519	40,090
Denominator	123,575	120,710	121,626	117,577	119,458
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives			
	2023	2024	2025
Annual Objective	42.0	42.0	43.0

Evidence-Based or –Informed Strategy Measures

ESM 13.1.2 - Number of oral health resource bags distributed to pregnant women and caregivers of young children through internal and external partners

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			2,566	2,592
Annual Indicator		2,541	3,000	300
Numerator				
Denominator				
Data Source		Oral Health Program Data	Oral Health Program Data	Oral Health Program Data
Data Source Year		FFY 2020	FFY 2021	FFY 2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	2,617.0	2,643.0	2,668.0

State Action Plan Table

State Action Plan Table (Georgia) - Women/Maternal Health - Entry 1

Priority Need

Prevent Maternal Mortality

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

1.1a Annually provide $\geq 8,005$ federally funded breast cancer screening or diagnostic services to Breast and Cervical Cancer Program (BCCP) eligible women.

1.1b Annually meet or exceed the CDC guidelines of providing $\geq 35\%$ of initial program cervical cancer screening to women, aged 30 and older, who have never been screened or not screened with the last 10 years.

1.2 Complete a Levels of Maternal Center designation for at least 10 hospitals annually.

1.3 Conduct one site visit annually at each RPC to verify RPC compliance with Level III+ care.

1.4 Review 75% of pregnancy-associated deaths identified for Maternal Mortality Review Committee review within 2 years of the date of death.

1.5 Annually increase the number of providers registered with PEACE for Moms by 15%.

1.6 Enroll 28 of Georgia birthing facilities into the Cardiac Conditions in Obstetrical Care AIM patient safety bundle in the first two years after launch.

Strategies

1.1a Collaborate with Breast and Cervical Cancer Program (BCCP) providers (i.e., district and contracted providers) to improve preventative care for women by meeting or exceeding the CDC Guidelines for breast and cervical cancer prevention services annually.

1.1b BCCP implement at least two evidence-based interventions (EBIs) in each public health system (e.g., patient reminders, community-based group education, patient navigation, provider education, extended hours, reduction of structural barriers, provider assessment and feedback, one-on-one education, and small media).

1.2 Increase participation in the Levels of Maternal Care designation program by outreaching to hospitals and providing technical support in completing the application.

ESMs	Status
ESM 1.1 - Percent of women (30 years or older) who have never been screened or not screened within the last 10 years, who received an initial program cervical screening test	Active
ESM 1.2 - Percent of women (ages 15-44) served in Georgia Family Planning Program who use long-acting reversible contraceptives (LARCs)	Inactive

NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
NOM 5 - Percent of preterm births (<37 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Georgia) - Women/Maternal Health - Entry 2

Priority Need

Promote oral health among MCH populations

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

13.1 By 2025, increase the percent of women who had a preventive dental visit during pregnancy by 5% (Baseline: 31.5%, PRAMS, 2019).

Strategies

13.1a Support state supplemental PRAMS questions regarding pregnancy and oral health to create a more comprehensive understanding of oral health status and access to care in pregnant women in Georgia.

13.1b Partner with Georgia OBGYN Society (GOGS), Healthy Mothers Healthy Babies Coalition of Georgia (HMHBGA), and Georgia Academy of Family Physicians (GAFF) to coordinate trainings on oral health and the medical provider role.

13.1c Partner with the state Home Visiting program to provide resources and trainings on oral health and pregnant women.

13.1d Create a multi-tiered varied platform approach by developing a campaign that uses radio ads, physical resource bags, videos and social media clips to increase oral health literacy in pregnant women.

13.1e Provide trainings to local water plant operators on the value of community water fluoridation and technical assistance to improve monthly reporting from local community water systems.

ESMs

Status

ESM 13.1.1 - Percent of medical providers who reported an increase of oral health knowledge from trainings and presentations Inactive

ESM 13.1.2 - Number of oral health resource bags distributed to pregnant women and caregivers of young children through internal and external partners Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Priority Need: Prevent Maternal Mortality

The factors impacting women's health are complex and varied, ranging from social-emotional issues, environmental impact, health insurance status, access to health care, birth spacing, and any number of other factors, including the social determinants of health, or the conditions in which individuals are born, grow, live, work and age. Improving women's health throughout the lifespan is an essential component to bettering the health and wellness of Georgia's women. The Office of Women's Health promotes and supports a myriad of efforts to improve the health of all women. Over the past year, Women's Health continued to focus on improving access to health care, including access to the most effective forms of contraceptives and preconception health to promote women's health prior to pregnancy. The all-encompassing goal to promote health equity for all Georgians, which is emphasized throughout all domains, is reflected in the Women/Maternal Health section of the report.

Maternal mortality was identified as a priority need for Georgia in 2020 with a strategic focus on increasing the percentage of women who receive a preventive health care visit. Due to the critical need to reduce maternal mortality in Georgia, the Title V program focused on strategies that reduce maternal mortality. Understanding the factors associated with maternal mortality and morbidity is essential for improving maternal health outcomes.

NPM 1: Well-Women Visit

Preventive Medical Visit

Well-woman visits are important to a woman's overall health and well-being. One of the many benefits of these visits is the opportunity for women to discuss their health and to prevent and/or help identify serious health concerns before they become life-threatening. Programmatic activities and strategies undertaken during the reporting year promoted routine well-woman visits to support the health care needs of women.

The Breast and Cervical Cancer Program (BCCP) collaborated with district and partner providers to improve preventative care for women by meeting its CDC service goals and achieving core indicators for breast and cervical cancer prevention services. New CDC Guidelines were provided, and the annual objectives and measures were revised in the State Action Plan Table based on the updated guidance.

The Family Planning (FP) Program collaborated with public health district leaders to identify opportunities for increasing access to preventive health screenings that are part of FP. The number of women receiving FP and preventive screening services decreased during the COVID-19 pandemic as staff were redirected to pandemic related services. A plan for service expansion was developed including a plan to increase the number of staff available to provide FP services.

Current Year:

Women's Health continues to support activities to meet or exceed the CDC service goals and core indicators and to provide well-woman or preconception visits. The BCCP continues to provide breast and cervical cancer screening and diagnostic services to low income, uninsured, and underinsured women to reduce health disparities for priority population groups, including Black women who have higher rates of breast and cervical cancer incidence and mortality, Hispanic or Asian women at risk for cultural/language barriers, women aged 40 to 64 for breast cancer screening, women aged 21 to 64 for cervical cancer screening, and those who have never or rarely been screened.

The BCCP updated its program manual to reflect the latest guidance from the CDC and public health nurse protocols to improve preventative care. The program has also developed and distributed brochures and posters to the health districts to increase awareness of breast and cervical services, as well as educate the public of the importance of screenings. The BCCP will continue to engage its collaborative network of partners and utilize surveillance data to ensure Georgia women at risk for health disparities and inequitable cancer outcomes receive breast and cervical cancer screening services, diagnostic follow-up, and linkage to care.

The BCCP has installed a new, electronic case management module in eight of its health districts to improve the quality of electronic records associated with breast and cervical services and to help streamline the management of care.

The FP program has provided preventive health screenings to over 4,000 so far this year including screening for cervical cancer, sexually transmitted infections and HIV, and clinical breast exams.

Maternal Mortality Review Committee

The Georgia Maternal Mortality Review Committee (MMRC), led by Women's Health, is a multidisciplinary committee that reviews all pregnancy-associated deaths occurring among Georgia residents. Nurse abstractors obtain medical records, autopsies, and police reports to create a case narrative summarizing the events leading up to the death. A Licensed Clinical Social Worker interviews family members or other key informants to learn contextual information the decedent's social determinants of health, experiences with health care, and events surrounding the death, and includes this information in the case narrative. The MMRC meets quarterly and determines pregnancy-relatedness, cause of death, preventability, contributing factors, and recommendations for prevention on each death reviewed. Women's Health enters data on each case into the Maternal Mortality Review Information Application (MMRIA) hosted by CDC. Women's Health also creates reports, disseminates findings, and collaborates with partners to ensure recommendations from the MMRC are implemented.

During the reporting period, the MMRC completed the review of 2019 and 2020 cases and began reviewing 2021 cases, meeting the goal of reviewing all deaths within two years of the date of death. Data entry for 2018, 2019, and 2020 cases were completed. A fact sheet on data from 2015 to 2017 was published to the DPH website and disseminated to partners and stakeholders. The fact sheet also included key recommendations that supported the need to obtain more autopsies on pregnancy-associated deaths and extend Medicaid coverage up to one year postpartum, two key pieces of legislation passed by the Georgia General Assembly.

Key Informant Interviews continued as part of the review process. During the review of 2019 cases, 37 of the 66 cases (56%) outreached on had a completed interview. For 2020 cases, 45 out of 80 cases (56%) outreached on had a completed interview. Currently for 2021, the completion rate has been 65%. The primary reason interviews are not completed is due to lack of accurate contact information for the informant.

Efforts were made to provide support for MMRC members, including establishing a process to provide financial support for members who are unable to participate on the committee as part of their job duties. A self-care plan was created for MMRC staff and committee members which includes the development of a list of resources, such as meditations and breathing exercises that can be used before, during, and after MMRC meetings. A self-care training and vicarious trauma training was also provided for committee members.

The review process was revised to incorporate more discussion on each case. Members now meet in subcommittees to discuss approximately 2 cases in depth and complete the Committee Decisions Form prior to the MMRC meeting. At the MMRC meeting, all members review the case and provide input on the final determinations.

Current Year:

The MMRC is currently reviewing 2021 cases and identifying 2023 cases for review. Currently, all cases are being reviewed within two years of the date of death.

Women's Health has been working to incorporate more community-level and contextual information into case narratives to better understand the social determinants of health impacting maternal mortality. Abstractors began incorporating county-level health indicators from the Community Vital Signs Dashboard into case narratives. Informant interviews have continued, and the qualitative information is now integrated into the case narrative to tell a more comprehensive story of the decedent's experiences during health care encounters.

Quality improvement activities have been implemented based on findings from the MMRC Data Quality Report developed by CDC on a quarterly basis.

A report on 2018 to 2020 data was developed and includes qualitative and quantitative analysis on the pregnancy-related mortality ratio, causes of pregnancy-related deaths, qualitative descriptions of contributing factors, and recommendations to prevent deaths. The report will be disseminated during the current year to the community and diverse group of partners and stakeholders working to prevent pregnancy-related deaths. Women's Health has also been working with Emory University to develop a qualitative analysis report focused on mental health conditions among pregnancy-associated deaths.

The MMRC staff will coordinate with various programs, including GaPQC, Perinatal Psychiatry, Education and Community Engagement (PEACE) for Moms, Maternal and Child Health programs, and the ECHO to ensure programs are implementing recommendations from the MMRC.

Related Legislation:

Senate Bill 338 passed in April 2022, extending last year's expansion of postpartum coverage under Medicaid from six months to one year following the end of the pregnancy. This bill also provides lactation care and services to pregnant and lactating women and children who are breastfeeding or receiving their mother's milk.

House Bill 977 passed in April 2022, which will provide \$500,000 to fund a comprehensive care management pilot for high-risk pregnancy populations. This bill also provides \$680,000 to fund a pilot program to perform echocardiograms of pregnant and postpartum women to address maternal mortality.

Levels of Maternal Care

Women's Health implements the Levels of Maternal Care Designation Program. Through the program, hospitals may voluntarily apply for a designation to verify their level of care. To achieve a designation, hospitals must complete a site survey with The Joint Commission (TJC) based on standards developed by the American College of Gynecology and Obstetrics, and the Society for Maternal-Fetal Medicine. Women's Health contracts with TJC to provide funding to reduce the cost of the survey.

In the reporting year, DPH revised regulations to allow for a Level IV designation, which was previously not available to hospitals. The regulations were also revised to align standards with those set forth by the American College of Gynecology and Obstetrics and the Society for Maternal-Fetal Medicine.

Women's Health also established the contract with TJC to implement the Maternal Levels of Care Verification Program, which was announced in March 2022. All hospitals seeking a Level II and Level III designation in Georgia are required to use the TJC program. Level I hospitals have the option of using TJC or receiving a survey through DPH. One hospital completed the process was designated as a Level IV for maternal services in the fall of 2022.

Current Year:

Women's Health has continued to work with The Joint Commission (TJC) to designate hospitals according to their level of maternal care. Currently, ten hospitals are completing the application process with TJC and Women's Health has been meeting with hospitals to help promote the program and provide technical assistance on preparing for the application. Sharing information about the verification process has been a focus in the current year. Presentations to the RPC Medical Directors during their quarterly meeting and hospitals during the GaPQC annual conference were forums to promote the Levels of Maternal Care program.

Other Women/Maternal Health Programs

Georgia Perinatal Quality Collaborative (GaPQC) Maternal Initiatives

Led by Women's Health, the Georgia Perinatal Quality Collaborative (GaPQC) supports birthing hospitals in implementing the Alliance for Innovation on Maternal Health (AIM) patient safety bundles. Georgia was accepted as an AIM state in October 2017 to lead the implementation of the AIM Obstetric Hemorrhage (HMG) and Severe Hypertension (HTN) patient safety bundles in the state's birthing hospitals.

In the reporting year, 44 hospitals participated in the HMG initiative and 50 hospitals participate in HTN. GaPQC continued to support HMG hospital teams during the sustainability phase to promote ongoing quality improvement (QI). Three key sustainability strategies were implemented to help sustain the gains of our HMG facilities. The first is utilization of Regional Maternal Outreach Educators to provide ongoing training to hospital teams in Georgia's six public health regions. In collaboration with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), Women's Health supported an 'OB Emergencies' workshop and instructor training for the Maternal Outreach Educators to build knowledge and skills related to obstetric emergencies, including postpartum hemorrhage, hypertension disorders of pregnancy, and maternal sepsis. Two maternal educators became instructors and have provided this training to obstetric, emergency department, medical/surgical intensive care, and critical access clinicians in their regions. Additionally, GaPQC received supplemental AIM funding and recruited an Improvement Advisor (IA) to ensure focus on the AIM HMG and HTN bundles and to provide internal feedback on learning opportunities to help sustainability efforts. The IA began outreach to all AIM facilities in August 2022 offering improvement coaching and provided education on GaPQC's newest initiative, Cardiac Conditions in Obstetrical

Care (CCOC). Women's Health and the Maternal and Child Health Epidemiology team continued to provide HMG outcome data for facilities that were enrolled in the initiative to support ongoing QI.

The MMRC identified the leading causes of pregnancy-related maternal deaths between 2015-2017 to be cardiovascular and coronary conditions and cardiomyopathy with a large Black-White disparity gap. GaPQC launched the CCOC AIM bundle in 2022. An interest survey was disseminated to identify hospitals interested in joining the cardiac initiative with approximately 30 hospitals saying 'yes' or 'maybe' to enrollment. GaPQC decided to officially launch the CCOC initiative in June 2022. Extensive planning went into preparing for the launch of the CCOC bundle which included the formation of a multidisciplinary working group and subgroups focusing on creating products that address key bundle elements. The working group and four subgroups met monthly during the reporting period and are creating products to support hospital teams with bundle implementation. The four subgroups include Intentional Cardiac Screening, Clinician and Patient Education, Acute Management of the Cardiac Patient, and Consultation and Referral. Recruitment for the workgroups is ongoing to ensure multidisciplinary representation of specialties (e.g., Maternal and Fetal Medicine, Cardiology, Family Medicine, Emergency Medicine, Obstetrics and Gynecology, Midwifery, Anesthesiology, etc.). The CCOC bundle kick off webinar was held on March 1, 2022 with national AIM physicians and leads presenting about the importance of improving cardiac outcomes, especially in Black birthing patients. Recruitment and the official launch date was June 7, 2022. Georgia is the first state in the country to implement the CCOC AIM bundle and the GaPQC team presented on the National Network for Perinatal Quality Collaboratives (NNPQC) webinar on August 10, 2022 to share initial plans and learnings to support other PQC's with this bundle. The team also presented on the CCOC initiative at the Annual Georgia Perinatal Association meeting in September 2022.

To support perinatal QI efforts in rural hospitals, eight rural hospitals received an additional year of state funding. Rural facilities received a Rural Hospital Achievement Award in October 2021 at GaPQC's annual meeting to celebrate the collective impact on Severe Maternal Morbidity (SMM) for HMG and HTN. Rural facilities were encouraged to participate in IA sessions and to share their improvement efforts with the wider collaborative. In this reporting period, a partnership was formed with the Community Care Initiative (AIM CCI) to build on the existing quality improvement efforts underway at hospitals by focusing on using maternal safety bundles in nonclinical settings. This effort will enhance existing maternal quality improvement initiatives and maximize impact within the state. GaPQC participated on an exploratory call regarding metrics for the AMI CCI initiative and a connection to the Maternal and Child Health Epidemiology team was made for further data requests.

For Quarter 4 2021, 59% (33 out of 56) AIM hospitals submitted data for HTN structure/process measures. The submission percentage was 61% (34 out of 56) for Quarter 1 2022 and 46% (26 out of 56) for Quarter 2 2022. GaPQC initiated a data transformation project in Q2 2022 to improve user experience with maternal data submission and to create easier access to facility and collaborative wide data. Backend production for data submission via Survey 123 and the GaPQC data dashboard occurred throughout 2022 with potential launch in winter 2022. Due to several factors including GaPQC's data transformation project, AIM HTN metric updates, and staff transitions in the Maternal and Child Health Epidemiology department, there were delays in Q3 2022 data collection and subsequent provision of hospital reports. Communication with GaPQC facilities is ongoing regarding data transformation and submission expectations including the extended deadline for data submission.

GaPQC launched a two-phased approach to build capacity in health equity and translate strategies into action and meaningful change across the state. Phase I launched in August 2020 with the Health Equity and Implicit Bias Virtual Learning Series. In partnership with the Institute for Perinatal Quality Improvement, SPEAK UP Against Racism trainings for clinical teams and leadership were purchased and offered to health care providers to build knowledge around racial bias in healthcare, build a culture of equity, and develop specific action plans. Hospitals are currently in Phase II which focuses on translating knowledge into action. Implicit bias virtual training was provided using the March of Dimes online curriculum for 100 members of the GaPQC leadership team, Advisory Council, and maternal and neonatal committee members. Women's Health continues to work with partners and clinicians who completed implicit bias training to assess Race, Ethnicity and Language (REaL) data collection processes at their respective institutions and implement their action plans. Efforts to reduce disparities in severe maternal morbidities and adverse maternal and early child health outcomes in Georgia continued to be a priority in the reporting year with hospitals disaggregating their quarterly process measure data by Race/Ethnicity and reporting the number of providers and staff completing implicit bias training/education.

Women's Health is transitioning focus to the CCOC AIM bundle and incorporating Respectful and Equitable Care into all active initiatives. They are continuing to build capacity and create a culture of equity, including systems for

reporting, response, and learning through partnerships with organizations to support improving population level outcomes for mothers and infants. The March of Dimes partners with Women's Health in the health equity work and the partnership with Healthy Mothers, Healthy Babies Coalition of Georgia (HMHBGA) supports policy and clinical implementation workgroups. Building on the foundational work of AIM, Women's Health will participate in AIM Clinical Community Integration to address preventable maternal mortality and severe maternal morbidity among pregnant and postpartum women outside of hospital and birthing facility settings.

GaPQC hosted monthly webinars for current initiatives. The hypertension webinars focused on the process and structure measures for the AIM bundle. The hemorrhage initiative moved into sustainability in September 2021 and all webinars are archived in Microsoft Teams. The 2021 GaPQC Annual Meeting was held on October 14 and 15, 2021 to celebrate the tremendous efforts and impact hospitals have made, as well as to recommit to improving health outcomes and providing equitable care for all mothers and babies throughout Georgia.

Current Year:

GaPQC continues to support the AIM Patient Safety Bundles by providing technical assistance to birthing hospitals across the state to implement the HMG, HTN, and CCOC patient safety bundles. Currently, 83% (58 of the 70) birthing hospitals have participated in at least one initiative with 73% (51 of 70) birthing hospitals participating in the hypertension initiative and 17% (12 out of 70) in the cardiac initiative. The HMG initiative moved into sustainability in September 2021 and GaPQC continues to support hospitals around sustainability efforts through IA coaching sessions, regional education, and HMG outcome data.

GaPQC's newest initiative focusing on maternal cardiac conditions has moved out of the planning stage and is now in implementation. There are 12 hospitals actively enrolled in the CCOC initiative which include 8 healthcare systems. The multidisciplinary cardiac work group continues to meet monthly, providing strategic direction for GaPQC's cardiac initiative. The four subgroups also meet monthly and focus on creating products to address key bundle interventions. To support hospitals with the educational components of the CCOC bundle, a cardiac lecture series was developed starting in September 2021, and built out through June 2023. The goal for these lectures is to provide foundational education across disciplines on maternal cardiac conditions. Key takeaways and a connection to specific CCOC bundle elements have been built into the lectures. Presentations and webinar recordings are available on the GaPQC website for access by all teams and partners.

GaPQC continues to disaggregate HTN and Cardiac outcome data by Race/Ethnicity and hospitals will report Race/Ethnicity for process measure data. Analyses will be completed to measure the impact on absolute disparity reduction. The GaPQC Improvement Advisor is providing mentorship to hospitals on strategies to improve respectful and equitable care and will collect efforts underway in the state to share the bright spots. During the current year, GaPQC produced clinician and patient education resources which will be disseminated to AIM facilities focused on cardiac screening across all care settings, acute management of the cardiac patient, and maternal cardiac warning signs. GaPQC is also continuing to build on efforts to create a culture of patient and family engagement, share stories for improvement, and empower patients utilizing Speak Up Against Racism.

Data transformation is a priority for GaPQC. Data submissions that were postponed began again in March 2023. Survey platform assessment is planned for 2023 as feedback is received on the new data submission process. A Women's Health Epidemiology team, led by a Medical Epidemiologist, was developed to provide dedicated support to Women's Health and assist with continuous improvement around GaPQC data.

GaPQC is assessing sustainability readiness for HTN while encouraging birthing facilities to join the CCOC initiative. Educational needs assessments will be ongoing through different mediums including coaching sessions, webinar discussions, workgroup meetings, and surveys. GaPQC is assessing capacity and opportunities to synergize for greater impact including with other maternal health projects in the state and share learnings, locally and nationally, as the first perinatal quality collaborative in the country to implement the AIM CCOC patient safety bundle.

Minding the Gap (MTG) Advisory Group

The Minding the Gap (MTG) Advisory Group was developed by Emory University to reduce the racial gap in severe maternal morbidity (SMM) and adverse maternal and early child health outcomes and provide actionable evidence to policymakers, community organizations, and health systems. Title V staff served on the MTG Advisory Group in the reporting year, which was in its second year of a five-year study. The study has three aims: 1) Analyze birth and hospital discharge data to examine racial disparities in SMM during delivery and postpartum; 2) Analyze Medicaid data to evaluate impact of Planning for Healthy Babies (Georgia's Medicaid Inter-Pregnancy Care Program) on

severe maternal morbidity by race/ethnicity; and 3) Postpartum intervention at Grady Memorial Hospital for women who have cardiovascular risk for severe maternal morbidity. In the reporting year, 28 in-depth interviews were conducted with postpartum clients from Grady Hospital. The interviews addressed clients' postpartum care experiences, including reason for attendance or absence, their postpartum visit, and any facilitators or barriers to care. The findings are being used to inform decision making for reducing disparities in maternal morbidity and mortality.

Current Year:

The MTG Advisory Group continues meeting and the Women's Health Director and the Women's Health Medical Epidemiologist currently participate in the group. Progress continues to be made on the three aims. Quantitative analyses of birth and hospital discharge data (Aim 1) and Medicaid data from Planning for Healthy Babies (Aim 2) is currently being completed. Interviews with Planning for Healthy Babies clients (Aim 2) were completed this year and a report is being developed. Once finalized, the report will be shared with the state's Care Management Organizations. The postpartum intervention (Aim 3) has recruited over one hundred women into the randomized clinical trial. The intervention cohort receives enhanced postpartum care, and the control cohort receives standardized postpartum care. The clinical trial will continue for one more year. Qualitative work was completed with Grady patients to inform the development of the clinical trial and manuscripts on that work are currently being developed.

Maternal Mental Health

Women's Health contracts with the Emory Brain Health Center to implement the Perinatal Psychiatry, Education and Community Engagement (PEACE) for Moms. PEACE for Moms is a perinatal psychiatry access program that increases Georgia's capacity to provide mental health care during the perinatal period. The PEACE for Moms program aims to: 1) Consult with providers with prescriptive authority who are treating perinatal patients with mental health conditions and provide one-time evaluations with patients when needed; 2) Train providers to manage mental health conditions in the perinatal period; and 3) Increase access to skills groups to prevent perinatal depression.

PEACE for Moms continued to provide consultations to providers on mental health treatment and began offering face-to-face consultations with patients of enrolled providers who require further assessment. In January 2022, PEACE for Moms launched the first Mothers and Babies group to prevent perinatal depression.

The program presented at various meetings and conferences to promote the program and increase the number of providers and therapists enrolled. A new website was developed that includes resources and toolkits for providers.

The program consulted with Lifeline for Moms and participated in the Lifeline for Moms network to promote ongoing program improvement.

Women's Health also continued to partner with Healthy Mothers, Healthy Babies Coalition of Georgia (HMHBGA) to train peer support group facilitators on perinatal mental health and provide peer support groups virtually. HMHBGA developed and launched Maternal Mental Health online classes through Pickles & Ice Cream, a virtual education platform. Curriculum for a Maternal Substance Use class was also developed.

Women's Health also contracted with Postpartum Support International, Georgia Chapter (PSI GA) to provide trainings on perinatal mood and anxiety disorders for providers.

Current Year:

Women's Health continues to contract with the Emory Brain Health Center to implement the Perinatal Psychiatry, Education and Community Engagement (PEACE) for Moms. PEACE for Moms continues to provide consultations and face-to-face assessments with patients of registered providers. PEACE for Moms provides skills groups using the Mothers and Babies curriculum for pregnancy and postpartum patients. The program is also working with Mothers and Babies to become trainers to increase the availability of the program throughout the state. PEACE for Moms, in partnership with Women's Health, established a Reproductive Mental Health ECHO during the current year. The ECHO includes a curriculum that participants will complete in live ECHO sessions held monthly.

Women's Health also partners with Healthy Mothers, Healthy Babies Coalition of Georgia (HMHBGA) to train peer support group facilitators on perinatal mental health and provide peer support groups virtually. Maternal Mental Health and Maternal Substance Use classes are offered online. Women's Health is also contracting with Postpartum Support International, Georgia Chapter (PSI GA) to provide trainings on perinatal mood and anxiety disorders for

providers.

Maternal Health ECHO

The DPH Maternal Health ECHO project was created to provide clinical and community education on key findings and recommendations from the Georgia Maternal Mortality Review Committee (MMRC). Maternal Health ECHO project sessions are held virtually on the 3rd Wednesday of each month to increase the accessibility of information and tools for practice to clinicians and community advocates in underserved areas of our state. Each session is accredited to provide 1.0 AMA PRA Category 1 Credit or 1.0 ANCC contact hour. Alliance for Innovation on Maternal Health (AIM) bundles are used in each session to provide consistent evidence-based recommendations for action, including targets for health equity. Attendees consist of Physicians, APRNs, Social Workers, and a wide range of Community Advocates and Members. Typical attendance for sessions is approximately 50 attendees, with some specialty sessions (e.g., Cardiac Conditions, Reproductive Life-planning) attracting 70+ participants.

From October 2021 to September 30, 2022, the Georgia Department of Public Health held 7 Maternal Health ECHO project sessions. Sessions in July, August, and September of 2022 were cancelled or rescheduled due to speaker conflicts. Session topics from October 2021 to September 20, 2022 included: Hypertensive Complications of Pregnancy (October 2021); Community Coordination and Models for Optimal Care for Cardiac Complications of the Perinatal Period (November 2021); Screening, Referral, and Consultation to build a Cardio-Obstetric Network in Georgia (January 2022); Prevention of Primary Cesarean Section in Women of Size (February 2022); Community-focused Postpartum Cardiac Care (April 2022); Connections between Preeclampsia and Future Cardiac Outcomes (May 2022); Key Recommendations for Action from the Georgia MMRC (June 2022).

Current Year:

From October 2022 to May 2023 the Georgia Department of Public health held 6 Maternal Health ECHO project sessions. The April 2023 session was cancelled due to staff attendance at the CDC MMRIA User Meeting Conference.

Session topics from October 2022 to May 2023 included: Reproductive Life-Planning and Contraceptive Access for Women with Chronic Health Conditions (October 2022); Clinical Pearls for Screening and Treatment of Mental Health Conditions (November 2022); Community Resources for Perinatal Services and Support (January 2023); Health Information Exchanges for Continuity of Care Between Hospitals (February 2023); Medication Assisted Therapy for Opioid Use Disorders in Pregnancy (March 2023), Lived Experiences of Rural Prenatal Care Systems (May 2023).

Planned session topics from July to September 2023 include: Nursing and Public Health Care Coordination for High-Risk Pregnancies (July 2023); Culture of Safety and Team building for Response to Obstetric Hemorrhage (August 2023); Metabolic Complications of Pregnancy and Postpartum Health (September 2023).

Family Planning

Georgia's Family Planning program provides leadership, guidance, and resources to Georgia's 18 public health districts in the development and provision of resources that increase the access of family planning services to women. The Family Planning program offers patient-centered, comprehensive health care services designed to provide women support to plan the birth of their children, reduce unintended pregnancies, determine effective birth control methods, and improve the well-being of families statewide.

Women's Health continued to promote and increase access to family planning services by launching Phase III of its marketing campaign to increase awareness of family planning services in the health departments. Site visits with public health districts began in November 2021 to garner insight on district level implementation of family planning. A total of nine hybrid site visits were completed both virtually and in-person. Information gathered from the site visits were used to improve the delivery of family planning services and inform the content of the quarterly Women's Health Coordinators meetings.

In early 2022, a comprehensive family planning preceptor program started in three public health districts with sites located in Valdosta, Augusta, and Macon. An eight-week series of women's health courses for new nurses is also being provided. One of the challenges in FP service provision has been in providing equal access to long-acting reversible contraceptive methods (LARCs) in all locations. Rural counties often only had the midlevel providers needed for LARC services available onsite a few days each month. It was determined that the Georgia public health nurse protocol legislation would allow RNs to provide the most demanded LARC method, the contraceptive implant.

In collaboration with the manufacturer, the first RN insertion training was completed in August for 13 RNs with plans for additional trainings over the next reporting cycle. Georgia is the first state in the country to train and utilize RNs to insert contraceptive implants.

Current Year:

Hybrid site visits continue to be conducted in the public health districts virtually and in-person. Best practices, successes, challenges, and lessons learned continue to be shared during the site visits. Women's Health District Coordinator quarterly meetings continue to provide Family Planning staff with updates on best practices, as well as opportunities for shared learning. A family planning campaign was developed to educate the public about family planning services. A total of 123 nurses completed DPH's Women's Health Exam Training through December 2022. These trainings include an overview of the Family Planning program to help increase nurses' knowledge of Family Planning services. Training will continue throughout the remainder of the current year. The Family Planning Manual was also updated to include tools for family planning education. A virtual Family Planning conference was held in March of 2023 for Georgia's public health Family Planning nurses in collaboration with OB/GYNs from Emory University who special in complex family planning care. Over 400 nurses and nurse practitioners participated in the training.

Women's Health continues to promote family planning services and increase access to contraception, particularly LARCs, by increasing the available inventory in local health departments and increasing the workforce available to provide family planning services. The program set a goal of increasing the unduplicated number of women served in family planning by 25% from the previous year's baseline (39,000) and is currently on target to achieve its goal. All districts continue to maintain staff who precept new staff. Regional family planning preceptor programs have been implemented in Valdosta, Augusta, Macon, and Dalton which provide districts additional opportunities to refer new nurses for comprehensive preceptorship.

The program continues to provide nurses with the skills they need to be successful as the first state in the country where RNs provide insertions of contraceptive implants. The FP program has completed three contraceptive implant insertion trainings and one removal training and scheduled one more of each type of training before the end of the the current year. 63 RNs have completed insertion training and 18 have completed removal training so far this year.

Perinatal Case Management

Perinatal Case Management (PCM) is a voluntary program that is implemented in the public health departments. PCM allows for a case manager to assist a pregnant woman with identifying special needs and facilitates access to medical, nutritional, social, psychosocial, educational, and other services to improve health outcomes of mother and baby.

Plans were underway to increase the number of county health departments providing PCM services from 112 to 115 by the end of 2022. Marketing materials (i.e., post cards and brochures) used to promote PCM benefits have been distributed to all public health districts for use by the PCM Case Managers and the pregnant women enrolling in PCM. The PCM program was collaborating with the Child Occupant Safety Program (COSP) to increase participation in the car seat program in all counties and providing education to pregnant mothers on safely transporting their child. DPH continued providing technical assistance on the PCM module, education, training, and updates of the PCM program to all district PCM Case Managers on the health outcomes for at risk women. PCM continued collaborating with Oral Health to distribute dental kits to pregnant women in the public health districts that enroll in the PCM program to promote good oral health during pregnancy.

Current Year:

In the current year, the goal of 115 county health departments providing Perinatal Case Management (PCM) services was achieved.

Women's Health continues to collaborate with internal and external partners to improve communication and PCM workflow. Remote trainings are provided on the Visual Health Net PCM Module process and assistance is provided to districts with any technical concerns with the PCM module. Virtual meetings are conducted with Care Management Organizations and the Department of Community Health representatives to resolve issues with data files. Women's Health also completes virtual annual site visits that include PCM enrollment performance.

The Office of Women's Health is maximizing the synergy between PCM services and breastfeeding education. PCM services integrate educational materials, webinars, and social media platforms to increase staff breastfeeding

knowledge. Information is also provided on perinatal mental health during PCM training to increase staff knowledge.

Maternal and Child Health Information and Resource Center

DPH continued to work with the existing Maternal and Child Health Information and Resource Center that operates the MCH resource hotline and website to include resources and referrals that identify and treat chronic illnesses such as hypertension, heart disease, obesity, and diabetes.

Current Year:

DPH has maintained the partnership with the existing Maternal and Child Health Information and Resource Center that operates the MCH resource hotline and website to provide resources and referrals.

Priority Need: Promote Oral Health to All Populations

NPM 13: Preventive Dental Visit

Oral Health

The Office of Oral Health continued to promote oral health among all populations, with a special emphasis on promoting oral health care services among pregnant women. Oral Health staff served on advisory boards and work groups for external partners including HMHBGA, Georgia Department of Early Care and Learning (DECAL), Georgia Cancer Control Consortium Human Papilloma Virus (HPV) workgroup, and the Georgia Bureau of Investigations (GBI), among other stakeholders. The Georgia Academy of Family Physicians and the Georgia OBGYN Society Oral Health program continued to create a more robust state oral health surveillance system by identifying gaps in data, researching data sources to fill gaps, and dedicating resources to incorporating sources. The Office of Oral Health partnered with Augusta University as subject matter experts to enhance the 100 Million Mouths Campaign which specialized in enhancing the curriculum at medical schools with the goal of increasing oral health knowledge among newly trained physicians and other allied health professional.

Oral Health continued to collaborate with both internal and external partners to provide oral health resources to pregnant women and caregivers of young children. District program staff were continuously provided updates and resources that help empower them to provide care, services, and education for MCH populations, including but not limited to, free continuing education opportunities, toolkits, guidelines, best practices, and recommendations from national oral health and MCH organizations.

In the reporting year, approximately 600 oral health resources bags were distributed throughout the state. The resource bags contain an adult toothbrush, two types of infant toothbrushes, floss, toothpaste, intraoral wipes for cleaning after nursing or bottle feeding, a brochure on health oral habits/behaviors, and a baby book on oral health. Public health district oral health program staff, district public health nurses, perinatal coordinators, home visitation workers, and external partners such as HMHBGA distributed the resource bags.

Oral Health funded the addition of four state supplemental oral health questions to the Georgia PRAMS survey, in addition to the two standard core oral health questions. With a combination of six questions related to oral health in PRAMS, future data will give a more complete picture of burden of disease, specific challenges and barriers, and information to help strategize on best solutions. Data from the additional questions are expected to be available in the upcoming year. The PRAMS oral health fact sheet continues to be shared with external partners. The Oral Health Epidemiology role transitioned to the MCH Epidemiology Section.

Oral Health disseminated the message of the importance of drinking fluoridated water at all ages to pregnant and parenting women through HMHBGA and the Home Visiting program. Eleven virtual fluoride training presentations were provided to community water plant operators across the state to ensure Georgia remains one of the top states in the country in terms of access to fluoridated water. Currently, approximately 96% of Georgia residents on community water have access to fluoridated water through the Community Water Fluoridation Program. The Fluoridation Administrator attended numerous meetings with fluoridation persons across the country and other CDC grantee states to foster collaboration and shared learning.

Current Year:

Oral Health continues to promote oral health among all populations, with a special emphasis on promoting oral health care services among pregnant women. Oral Health staff continue to serve on advisory boards and work groups for external partners. The Georgia Academy of Family Physicians and the Georgia OBGYN Society Oral Health

program continues to create a more robust state oral health surveillance system by identifying gaps in data, researching data sources to fill gaps, and dedicating resources to incorporating sources.

Oral Health plans to continue to collaborate with both internal and external partners to provide oral health resources to pregnant women and caregivers of young children. District program staff are continuously provided updates and resources that help empower them to provide care, services, and education for MCH populations, including but not limited to, free continuing education opportunities, toolkits, guidelines, best practices, and recommendations from national oral health and MCH organizations.

Oral Health continues to promote an oral health awareness campaign and provide Pregnancy Oral Health Resource Bags that contain an adult toothbrush, two types of infant toothbrushes, floss, toothpaste, intraoral wipes for cleaning after nursing or bottle feeding, a brochure on health oral habits/behaviors, and a baby book on oral health. Resource bags are distributed through district oral health program staff, district public health nurses, perinatal coordinators, and external partners such as HMHBGA. Approximately 800 resource bags have already been distributed.

Oral health social media videos are shared with key partners and outside stakeholders. Partners and stakeholder are encouraged to share videos with their organizational networks and post on their respective websites.

Women/Maternal Health - Application Year

Application Year: October 1, 2023 – September 30, 2024

Priority Need: Prevent Maternal Mortality

NPM 1: Well-Women Visit

Percent of women, ages 18 through 44, with a preventive medical visit in the past year

NPM 1 Strategies:

- 1.1a Collaborate with Breast and Cervical Cancer Program (BCCP) providers (i.e., district and contracted providers) to improve preventative care for women by meeting or exceeding the CDC Guidelines for breast and cervical cancer prevention services annually.
- 1.1b BCCP implement at least two evidence-based interventions (EBIs) in each public health system (e.g., patient reminders, community-based group education, patient navigation, provider education, extended hours, reduction of structural barriers, provider assessment and feedback, one-on-one education, and small media).
- 1.2 Increase participation in the Levels of Maternal Care designation program by outreaching to hospitals and providing technical support in completing the application.

Preventive Medical Visit

In the upcoming year, Women's Health will support activities to meet or exceed the CDC's service goals and core indicators for breast and cervical screenings and increase opportunities to provide well-woman or preconception visits. The BCCP will continue to provide breast and cervical cancer screening and diagnostic services to low income, uninsured, and underinsured women to reduce health disparities for priority population groups, including Black women who have higher rates of breast and cervical cancer incidence and mortality, Hispanic or Asian women at risk for cultural/language barriers, women aged 40 to 64 for breast cancer screening, women aged 21 to 64 for cervical cancer screening, and those who have never or rarely been screened.

The BCCP will continue to maintain and nurture its collaborative network of partners to ensure Georgia women at risk for health disparities and inequitable cancer outcomes receive breast and cervical cancer screening services, diagnostic follow-up, and linkage to care. The BCCP aims to increase its services among populations of focus and reduce screening and care disparities by continuing to leverage existing partnerships. The program will also provide districts with educational opportunities regarding the utilization of evidence-based interventions to increase reduce barriers to care and improve service delivery.

The BCCP plans to install its new, electronic case management module in another 7 health districts to improve the quality of electronic records associated with breast and cervical services and to help streamline the management of care.

Maternal Mortality Review Committee

In the application year, the MMRC will review 2022 deaths and ensure all pregnancy-associated deaths are reviewed within two years of the date of death. The MMRC will also continue to identify deaths on a monthly basis and confirm pregnancy within three months of identification.

The MMRC will develop an annual report and continue to disseminate data to stakeholders, including communities most affected by pregnancy-related deaths. Women's Health will work with Emory University on a qualitative analysis

of how COVID impacted pregnancy-related deaths.

Women's Health will also establish a new contract with the Center for Black Women's Wellness, which coordinates the AIM Community Care Initiative (AIM CCI) in Atlanta, a community-led effort which seeks to create a more responsive, respectful, and high-quality maternity care system. This effort will include facilitating community meetings to gather insights and solutions from community members on maternal mortality, collaborating with local community members to ensure MMRC recommendations align with community needs and priorities, and completing a test of feasibility on AIM CCI Community Care for the Management of Chronic Conditions maternal safety bundle.

Levels of Maternal Care

Women's Health will continue to implement the levels of maternal care verification program by outreaching to hospitals to facilitate participation, providing technical assistance during the application process and with any deficiencies noted, and providing funding to reduce the cost of the survey for hospitals.

Other Women/Maternal Health Programs

Georgia Perinatal Quality Collaborative (GaPQC) Maternal Initiatives

GaPQC plans to evaluate Cardiac Conditions in Obstetrical Care (CCOC) data to assess shifts and trends in process, structure and outcome measures, as well identify other data sets to measure quality of maternal cardiac care.

Additional learning events will be created to align with the identified needs of hospital teams and the Maternal Health ECHO program. GaPQC will focus on Patient Engagement in partnership with MoMMA's Voices and other patient empowerment organizations to continue GaPQC's focus on respectful care and equitable care.

GaPQC will continue recruiting birthing facilities to participate in the CCOC initiative and provide technical assistance to hospital teams. The Wave 1 CCOC facilities will be encouraged to serve as mentors to ongoing cohorts and to spread best practices in maternal cardiac care throughout the state including with rural hospitals.

Minding the Gap (MTG) Advisory Group

The MTG Advisory Group will be in the last year of the study in the upcoming year and the Women's Health Director and the Women's Health Medical Epidemiologist will continue to participate in the group. The analyses on racial disparities in severe maternal morbidity and the Planning for Healthy Babies program will be published and shared with the state's Care Management Organizations. The postpartum intervention randomized clinical trial will be complete and results will be published.

Maternal Mental Health

In the application year, Women's Health will continue to work with PEACE for Moms to provide consultations, provider education, and Mothers and Babies skills groups to prevent perinatal depression. PEACE for Moms will become Mothers and Babies trainers and begin to train providers throughout the state to implement the Mothers and Babies program.

Women's Health will also continue to work with HMHBGA to provide community support around maternal mental health. HMHBGA will continue to offer peer support groups and community education on mental health and substance use disorders. In partnership with the Georgia Chapter of Postpartum Support International (PSI GA), obstetric providers and other maternal health workers will receive training on perinatal mood and anxiety disorders.

Maternal Health ECHO

The Maternal Health ECHO will continue to hold regular sessions on topics aligned with findings from the Maternal Mortality Review Committee. Maternal Health ECHO sessions currently planned for the application year include: Response to Severe Hypertensive Crisis (October 2023) and Contraceptive Access (November 2023). The next curriculum meeting for the Maternal Health ECHO project will occur in Fall 2023.

Family Planning

Women's Health will continue to promote and increase access to family planning services through promoting awareness, education and training, expanding the family planning workforce, and increasing options for contraceptive methods with a goal of increasing the number of unduplicated women served in family planning. Women's Health will conduct site visits with a minimum of seven public health districts. A marketing campaign to increase awareness of family planning services in health departments will be launched. Women's Health will provide education and shared learning opportunities as part of the quarterly Women's Health Coordinator meetings and provide trainings to family planning staff regarding available contraceptive methods in the DPH formulary. Women's Health will also collaborate with the Formulary Committee and other stakeholders to assess new and emerging contraception to expand options for contraception methods. The program will maintain regional family planning preceptor programs in public health districts and work to increase the number of staff who provide family planning services. The program will continue to train RNs on contraceptive implant insertion and removal and evaluate the impact of this national initiative late in calendar year 2023.

Perinatal Case Management (PCM)

In the application year, the PCM program will focus on strengthening the provision services in 115 county health departments. This will include synergy with home visiting pilot program and incorporating breastfeeding education. The Office of Women's Health PCM program will continue to collaborate with internal and external partners to improve communication and PCM workflow. Virtual trainings and technical assistance will be provided on the Visual Health Net PCM Module process for districts. During the trainings, districts that excel in service delivery will be recognized and best practices will be shared across all districts. Virtual meetings will be conducted with Care Management Organizations and the Department of Community Health representatives to resolve issues with data files. Women's Health will complete annual site visits focusing on performance improvement.

An internal evaluation of the PCM and breastfeeding service integration will be conducted with the goal of improving service delivery and increasing staff knowledge of breastfeeding and perinatal mental health during PCM training. Results will guide program structure and process improvement.

In the application year, DPH plans to implement a home visiting pilot program. As part of this pilot, it's valuable to assess the role PCM services and the added benefit of involving Public Health Nurses in the pilot for PCM and breastfeeding education.

Maternal and Child Health Information and Resource Center

DPH will continue to work with the existing Maternal and Child Health Information and Resource Center that operates the MCH resource hotline and website to include resources and referrals to resources that identify and treat chronic illnesses such as hypertension, heart disease, obesity, and diabetes.

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

Percent of women who had a preventive dental visit during pregnancy

NPM 13.1 Strategies

- 13.1a Support state supplemental PRAMS questions regarding pregnancy and oral health to create a more comprehensive understanding of oral health status and access to care in pregnant women in Georgia.
- 13.1b Partner with Georgia OBGYN Society (GOGS), Healthy Mothers Healthy Babies Coalition of Georgia (HMHBGA), and Georgia Academy of Family Physicians (GAFF) to coordinate trainings on oral health and the medical provider role.
- 13.1c Partner with the state Home Visiting program to provide resources and trainings on oral health and pregnant women.
- 13.1d Create a multi-tiered platform approach by developing a campaign that uses radio ads, physical resource bags, videos and social media clips to increase oral health literacy in pregnant women.
- 13.1e Provide trainings to local water plant operators on the value of community water fluoridation and technical assistance to improve monthly reporting from local community water systems.

Oral Health

Oral Health will continue to promote oral health among all populations, with a special emphasis on promoting oral health care services among pregnant women. Oral Health staff will also continue to serve on advisory boards and partner with stakeholders to create a more robust state oral health surveillance system by identifying and addressing gaps in data, with a goal of expanding its reach to promote oral health among pregnant women and low-income children.

Oral Health plans to continue to collaborate with both internal and external partners to provide oral health resources to pregnant women and caregivers of young children. District program staff are continuously provided updates and resources that help empower them to provide care, services, and education for MCH populations, including but not limited to, free continuing education opportunities, toolkits, guidelines, best practices, and recommendations from national oral health and MCH organizations.

Oral Health will continue to promote an oral health awareness campaign and provide Pregnancy Oral Health Resource Bags that contain an adult toothbrush, two types of infant toothbrushes, floss, toothpaste, intraoral wipes for cleaning after nursing or bottle feeding, a brochure on health oral habits/behaviors, and a baby book on oral health. Resource bags will be distributed through district oral health program staff, district public health nurses, perinatal coordinators, and external partners such as HMHBGA.

District program staff and MCH organizations staff will be provided with resources to help sustain preventive dental activities, including free continuing education opportunities, toolkits, guidelines, best practices for developing cross sector partnerships, social media tools, and recommendations from national oral health and MCH organizations.

Perinatal/Infant Health

National Performance Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	83	84	85	87.5	88
Annual Indicator	85.8	87.5	85.9	85.6	86.2
Numerator	1,875	1,934	1,754	1,863	1,790
Denominator	2,186	2,211	2,042	2,176	2,077
Data Source	State Statistical File	State Statistical File	State Statistical File	State Statistical File	State Statistical File
Data Source Year	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	88.5	89.0	89.5

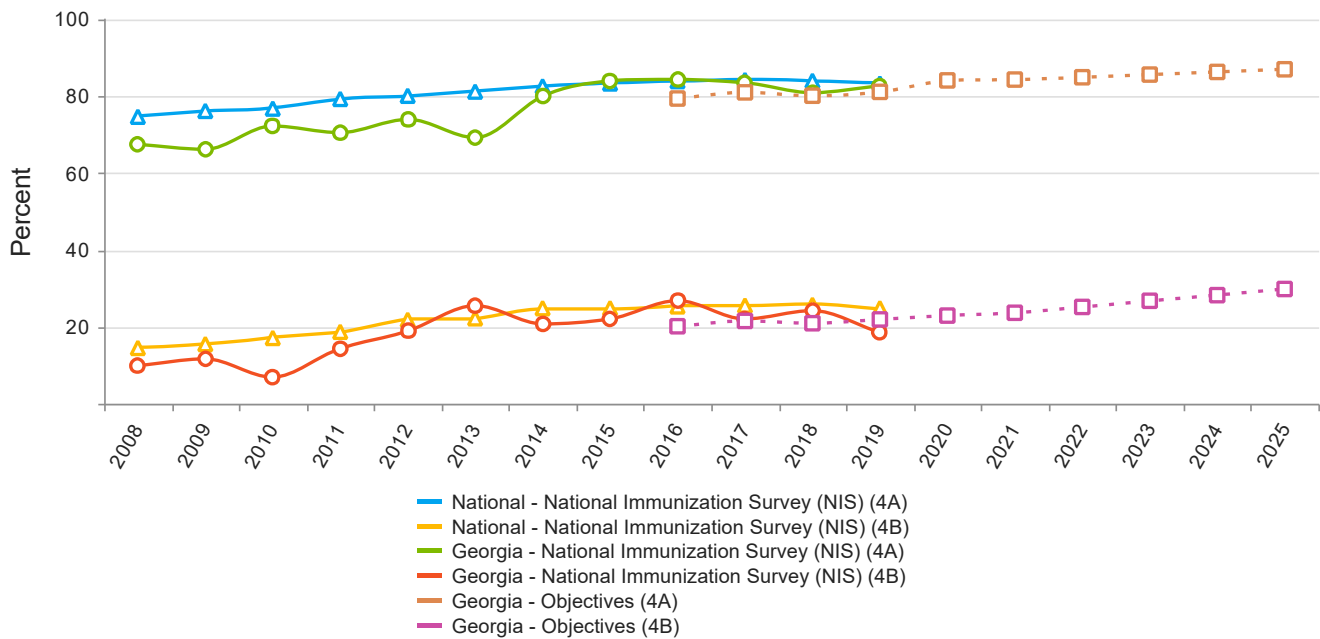
Evidence-Based or –Informed Strategy Measures

ESM 3.1 - Number of hospitals verified annually through the Levels of Neonatal Care Designation Program

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	10
Annual Indicator			0	1
Numerator				
Denominator				
Data Source			Levels of Neonatal Care Designation Program Data	Levels of Neonatal Care Designation Program Data
Data Source Year			FFY 2021	FFY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	10.0	10.0	10.0

**NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives**



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	2019	2020	2021	2022
Annual Objective	80	81	84	84.2	84.8
Annual Indicator	84.0	84.1	83.5	80.9	82.6
Numerator	106,087	109,903	98,519	98,232	90,076
Denominator	126,348	130,643	117,976	121,472	109,007
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	2024	2025
Annual Objective	85.5	86.2	86.9

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	2019	2020	2021	2022
Annual Objective	21	22	23	23.7	25.2
Annual Indicator	22.1	27.0	22.1	24.3	18.7
Numerator	26,140	33,943	25,731	29,042	19,941
Denominator	118,097	125,804	116,332	119,505	106,373
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	2024	2025
Annual Objective	26.8	28.3	29.9

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of the 10-Steps to Successful Breastfeeding training slots utilized by staff and providers from the state's birthing hospitals

Measure Status:		Inactive - Replaced		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	21
Annual Indicator			19.1	19.1
Numerator			64	64
Denominator			335	335
Data Source			Womens Health 5 STAR Initiative Program Data	Womens Health 5 STAR Initiative Program Data
Data Source Year			FFY 2021	FFY 2022
Provisional or Final ?			Final	Final

ESM 4.2 - Number of home visitors who report increased knowledge of breastfeeding best practices

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	0
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			Loving Support Training	AAP Breastfeeding Pre-/Post- Test
Data Source Year			CY 2021	CY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	0.0	0.0	0.0

ESM 4.3 - Number of MIECHV and Healthy Start women who are referred to WIC services

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			65	201
Annual Indicator			191	307
Numerator				
Denominator				
Data Source			GHVP Program Data	GHVP Program Data
Data Source Year			CY 2021	CY 2022
Provisional or Final ?			Final	Final

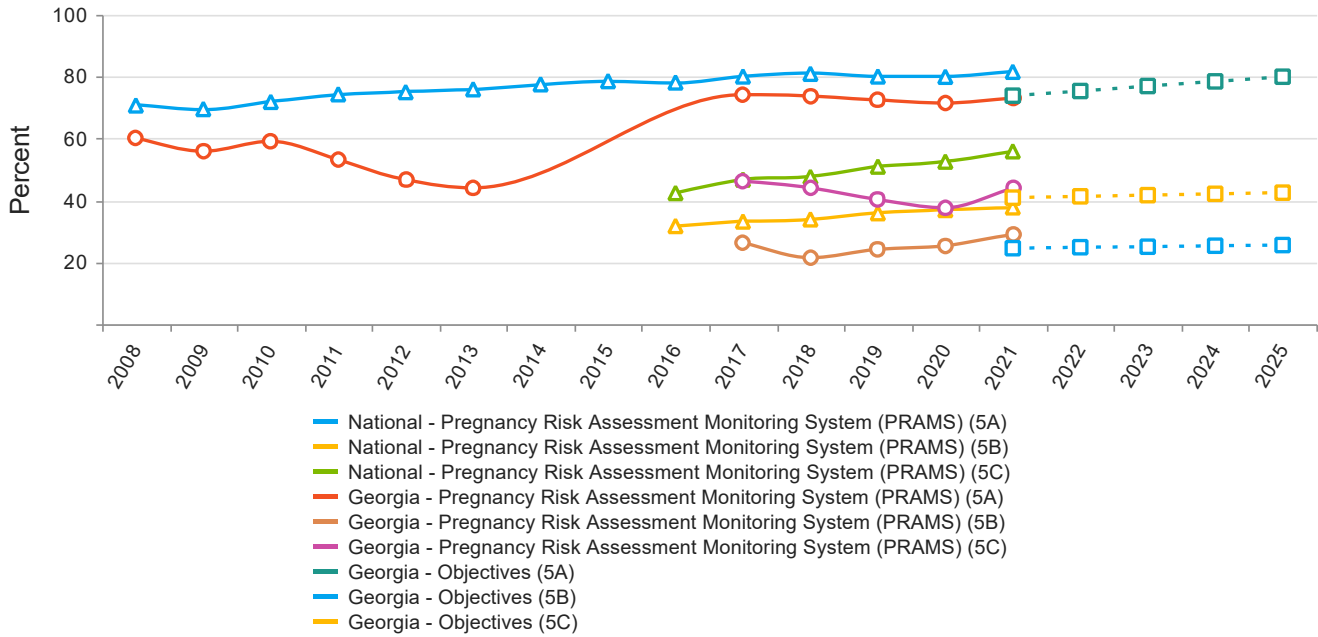
Annual Objectives			
	2023	2024	2025
Annual Objective	322.0	338.0	353.0

ESM 4.4 - Percent of Georgia hospitals actively implementing the Optimizing Nutrition for Georgia Newborns

Measure Status:		Active
State Provided Data		
	2022	
Annual Objective		
Annual Indicator	37.5	
Numerator	27	
Denominator	72	
Data Source	GaPQC Enrollment Data	
Data Source Year	CY 2022	
Provisional or Final ?	Final	

Annual Objectives		
	2024	2025
Annual Objective	41.7	45.8

**NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Indicators and Annual Objectives**



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	2020	2021	2022
Annual Objective			73.7	75.2
Annual Indicator	73.7	72.2	71.3	73.1
Numerator	87,074	85,632	82,301	85,380
Denominator	118,209	118,648	115,447	116,850
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

Annual Objectives			
	2023	2024	2025
Annual Objective	76.8	78.3	79.8

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	2020	2021	2022
Annual Objective			24.6	24.9
Annual Indicator	21.7	24.4	25.5	29.2
Numerator	25,317	28,716	29,201	33,719
Denominator	116,405	117,523	114,325	115,536
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

Annual Objectives			
	2023	2024	2025
Annual Objective	25.1	25.4	25.6

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	2020	2021	2022
Annual Objective			40.9	41.3
Annual Indicator	44.0	40.5	37.4	44.0
Numerator	50,752	47,803	43,071	51,145
Denominator	115,426	117,894	115,015	116,279
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

Annual Objectives			
	2023	2024	2025
Annual Objective	41.7	42.1	42.5

Evidence-Based or –Informed Strategy Measures

ESM 5.2 - Number of professionals trained to education on, identify, and model safe infant sleep environments

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			390	397
Annual Indicator		382	402	406
Numerator				
Denominator				
Data Source		Georgia Safe to Sleep Program Data	Georgia Safe to Sleep Program Data	Georgia Safe to Sleep Program Data
Data Source Year		FFY 2020	FFY 2021	FFY 2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	405.0	413.0	420.0

ESM 5.3 - Number of safe infant sleep educational materials distributed by the Program

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	115,473	
Numerator		
Denominator		
Data Source	Georgia Safe to Sleep Program Data	
Data Source Year	FFY 2021	
Provisional or Final ?	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	90,028.0	90,911.0	91,794.0

State Performance Measures

SPM 1 - Percent of congenital syphilis cases averted

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			81	81.6
Annual Indicator	79.2	71.6	54.2	60.3
Numerator	118	136	97	141
Denominator	149	190	179	234
Data Source	SendSS	SendSS	SendSS	SendSS
Data Source Year	CY 2018	CY 2019	CY 2020	CY 2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	82.3	83.0	83.7

SPM 2 - Rate of infant mortality (per 1,000 live births) in the Black Population

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			10.6	9.5
Annual Indicator	10.7	10.7	9.6	9.6
Numerator	468	468	406	400
Denominator	43,657	43,657	42,351	41,752
Data Source	OASIS	OASIS	OASIS	OASIS
Data Source Year	CY 2019	CY 2019	CY 2020	CY 2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	9.4	9.3	9.2

State Action Plan Table

State Action Plan Table (Georgia) - Perinatal/Infant Health - Entry 1

Priority Need

Prevent Infant Mortality

NPM

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objectives

3.1 Complete a Levels of Neonatal Center designation for at least 10 hospitals annually.

3.2 Conduct one site visit annually at each RPC to verify RPC compliance with Level III+ care.

Strategies

3.1 Increase participation in the Levels of Neonatal Care designation program by outreaching to hospitals and providing technical support in completing the application.

ESMs

Status

ESM 3.1 - Number of hospitals verified annually through the Levels of Neonatal Care Designation Program

Active

NOMs

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

State Action Plan Table (Georgia) - Perinatal/Infant Health - Entry 2

Priority Need

Prevent Infant Mortality

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

4.2 Annually increase the number of home visitors that take a breastfeeding best practice course.

4.3 By 2025, increase the number of referrals made from MIECHV and Healthy Start women to the Georgia WIC Special Supplemental Nutrition Program by 25%.

4.4a By the end of 2025, 50% of Georgia hospitals will be actively implementing the Optimizing Nutrition for Georgia Newborns.

4.4b Enroll 28 of Georgia hospitals into the Optimizing Nutrition for Georgia Newborns quality improvement initiative in the first two years after launch (GaPQC).

Strategies

4.2a Provide training and coaching to MIECHV and Healthy Start Home Visiting Staff to promote breastfeeding best practices.

4.2b Educate Home Visitors about PACIFY, a 24/7 perinatal and infant feeding support virtual platform, that can be utilized by clients who are new/expectant parents.

4.2c In partnership with Georgia AAP, will make breastfeeding recommendations and share nutrition education materials with Home Visitors and other programs.

4.3a Develop a one-pager on how to successfully collaborate between Georgia Home Visiting and Georgia WIC.

4.3b Develop and implement a referral process between Georgia Home Visiting and WIC Peer Counseling Program.

4.3c Increase the awareness of eligibility processes (i.e., Gateway Program).

4.4 Develop an active recruitment plan to enroll Georgia hospitals in the Optimizing Nutrition for Georgia Newborns initiative.

ESMs	Status
ESM 4.1 - Percent of the 10-Steps to Successful Breastfeeding training slots utilized by staff and providers from the state's birthing hospitals	Inactive
ESM 4.2 - Number of home visitors who report increased knowledge of breastfeeding best practices	Active
ESM 4.3 - Number of MIECHV and Healthy Start women who are referred to WIC services	Active
ESM 4.4 - Percent of Georgia hospitals actively implementing the Optimizing Nutrition for Georgia Newborns	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Georgia) - Perinatal/Infant Health - Entry 3

Priority Need

Prevent Infant Mortality

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

5.1 Implement a multicomponent strategy that engages childcare providers, health care providers (i.e., pediatricians and obstetricians), hospital systems, public health programs, faith-based organizations, and others to increase parental education of safe infant sleep and reduce Sudden Unexpected Infant Death (SUID) by 2025.

Strategies

5.1a Facilitate safe infant sleep trainings to assist healthcare professionals and those who interact with expecting families and caregivers (including home visitors, first responders, shelters) with providing accurate and up-to-date information on the AAP recommendations on safe infant sleep.

5.1b Collaborate with hospitals (i.e., well-baby, NICU, Pediatric Units) to provide consistent and accurate parent/caregiver education, conduct crib audits, update policy as needed and actively endorse, and model safe infant sleep practices.

5.1c Work with multi-sector organizations to reach all families, including those at higher risk for SUID, to specifically address disparities in the rates of infant mortality due to SUID.

5.1d Promote safe and healthy infant sleep behaviors and environments including access to smoking cessation programs and improving support systems that address Social Determinants of Health for populations/areas of greatest risk of SUID.

ESMs

Status

ESM 5.1 - Percent of hospitals and birthing facilities providing education and modeling safe infant sleep to parents with newborns or infants Inactive

ESM 5.2 - Number of professionals trained to education on, identify, and model safe infant sleep environments Active

ESM 5.3 - Number of safe infant sleep educational materials distributed by the Program Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Georgia) - Perinatal/Infant Health - Entry 4

Priority Need

Prevent Infant Mortality

SPM

SPM 1 - Percent of congenital syphilis cases averted

Objectives

1.1 By 2025, increase the percentage of congenital syphilis cases averted from 80.3% to 85%.

Strategies

1.1a Ensure investigations prioritized for females of reproductive age 15-45 and reactive serology, including provider follow-up to confirm age, treatment and pregnancy status.

1.1b Ensure timely and adequate treatment (30 days prior to delivery) for pregnant females with syphilis.

1.1c Ensure interviews are conducted on all syphilis cases for females of reproductive age 15-45.

1.1d Ensure treatment for partners of syphilis positive pregnant females.

1.1e Identify pregnancy status of all females identified as a new syphilis case.

1.1f Review & disseminate data on congenital syphilis cases with missed opportunities to all health districts.

1.1g Educate providers and general public on the law regarding 1st prenatal visit and 3rd trimester testing for Syphilis and HIV.

State Action Plan Table (Georgia) - Perinatal/Infant Health - Entry 5

Priority Need

Prevent Infant Mortality

SPM

SPM 2 - Rate of infant mortality (per 1,000 live births) in the Black Population

Objectives

2.1 By 2030, reduce the rate of infant mortality (per 1,000 live births) in the Black population by 10% (Baseline: 9.6, OASIS, 2020).

Strategies

2.1 Work with birthing hospitals individually to support the development and/or implementation of a hospital specific health equity action plan.

Perinatal/Infant Health - Annual Report

Perinatal/Infant Health – Annual Report, October 1, 2021 – September 30, 2022

Priority Need: Prevent Infant Mortality

Perinatal services are focused on the health of women and infants before, during, and after birth. DPH aims to assure pregnant women in Georgia have every opportunity to access comprehensive perinatal health care services appropriate to meet their individual needs. DPH is committed to improving the quality of perinatal care provided throughout the state.

Disorders related to preterm and low birth weight is the number one cause of infant mortality in Georgia. In 2020, the Infant Mortality Rate for Georgia was 6.3 per 1,000 live births, with a 9.6 infant mortality rate among Black, non-Hispanic infants. This rate is two times higher than White, non-Hispanic (5.1) or Hispanic infants (4.1). Research indicates that maternal and infant morbidity and mortality can be reduced if high-risk pregnant women and newborns receive risk-appropriate care.

Infant mortality is a priority for DPH, stakeholders, and partners. As a priority for many agencies and partners, it is important for DPH staff to create synergy around strategies to reduce maternal and infant mortality.

NPM 3: Risk Appropriate Perinatal Care

Regional Perinatal System

The Regional Perinatal System is a collaborative system of hospitals and providers working to ensure risk appropriate care for pregnant and postpartum patients and infants to improve birth outcomes. Georgia has six Regional Perinatal Centers (RPCs) located in Albany, Atlanta, Augusta, Columbus, Macon, and Savannah. The RPCs provide the most advanced care for high-risk mothers and infants in their perinatal region. Each RPC has a Maternal and Neonatal Medical Director and a Maternal and Neonatal Outreach Educator that work to provide consultations and coordinate transfers to ensure care is provided at a risk-appropriate hospital. Outreach Educators also work with regional hospitals to implement quality improvement activities.

During the reporting period, Women's Health continued to strengthen the system of regionalization by facilitating communication among the RPCs. Women's Health staff hosted and attended quarterly meetings with the RPC Medical Directors and quarterly meetings with the RPC Outreach Educators. Finance and data coordinator meetings were scheduled as needed. An annual site visit was held virtually with each RPC.

Women's Health also partnered with the RPCs and Outreach Educators to implement statewide quality improvement initiatives throughout their respective regions.

Current Year:

Women's Health continues to coordinate and align maternal and neonatal work with the RPCs across the state. Women's Health is holding regular meetings with RPC Medical Directors, Outreach Educators, finance staff, data coordinators and stakeholders. Each RPC rotates hosting the quarterly meetings and the Women's Health team attends and is responsible for a meeting summary. Staff are currently planning for the Medical Director's annual meeting that will occur in August 2023 in-person. The annual meeting will provide an opportunity to discuss trends identified across the state, best practices, and areas of improvement. These regular meetings facilitate communication and provide opportunities for collaboration.

Site visits for this year were conducted with each RPC and three were held virtually and three in-person. Next year,

Women's Health plans to alternate the in-person site visits and travel to the other three centers. Following each site visit, Women's Health developed a summary and shared that with each center.

The RPCs are continuing campaigns and developing interventions to effectively reduce infant mortality. Neonatal Outreach Educators and Medical Directors from each RPC are working collaboratively with Women's Health staff on planning for a statewide quality improvement project, implementation of the Hammersmith Infant Neurological Examination (HINE) Tool. When implemented, utilization of HINE can identify neurological disorders sooner, allowing for increased potential for early intervention.

Levels of Neonatal Care

Women's Health implements the levels of neonatal care program. Through the program, hospitals may voluntarily apply for a designation to verify that they are operating at their level of care authorized through their Certificate of Need to provide perinatal services. To achieve a designation, hospitals must complete a site survey with the American Academy of Pediatrics (AAP) based on the AAP national standards for levels of neonatal care. Women's Health contracts with AAP to provide funding to reduce the cost of the survey.

In the reporting year, DPH revised regulations to allow for a Level IV designation, which was previously not available to hospitals. The regulations were also revised to align standards with those set forth by the AAP.

The Women's Health program continued to contract with the AAP to implement the AAP NICU Verification Program. One hospital completed the process during the reporting year and was designated as a Level III NICU in the spring of 2022. Further applications were put on hold until the release of the AAP national standards.

Current Year:

Women's Health has continued to work with AAP to designate hospitals according to their level of neonatal care. Applications with AAP were on hold until the publication of the national standards, which occurred in May 2023. Currently, eight hospitals are completing the application process with the AAP. Women's Health hosted webinars for hospital staff to promote the program. Women's Health works closely with hospital staff to facilitate participation, enable hospitals to become ready to apply, and provide technical assistance throughout the application process.

NPM 4: Breastfeeding

Breastfeeding

Georgia 5-STAR aims to promote breastfeeding as the community norm for infant feeding in Georgia exclusively for six months and up to at least the first year of life, ensure that hospitals and health care facilities implement an infant feeding policy; and make lactation accommodation a reality for working women. In the reporting year, a contract with the Georgia Chapter of the American Academy of Pediatrics (GA-AAP) expanded capacity to provide practical assistance, support, and clinical training to participating Georgia 5-STAR hospitals. Many Georgia hospitals have expressed renewed interest in achieving Georgia 5-STAR status following the various challenges experienced during the COVID-19 pandemic. Education and training opportunities on the Ten Steps to Successful Breastfeeding, the broad framework of the Baby-Friendly Hospital Initiative, are provided through the First Latch-Breast Feeding Hospital Initiative (BFHI) online training module with practical assistance through the GA-AAP. During this period, GA-AAP provided 59 hours of technical assistance and subject matter expertise to participating birthing hospitals that are working towards completing the Ten Steps to Successful Breastfeeding. Practical assistance includes monthly phone and email support and policy reviews as requested by the birthing hospitals. Through these efforts, 19 hospitals have been awarded 5 Stars and 10 hospitals are in process of earning stars. Hospitals are recognized for completing steps towards the implementation of the Ten Steps to Successful Breastfeeding. A commemorating plaque is presented to hospitals that successfully complete a minimum of six

steps.

Women's Health worked with GA-AAP to deliver the Educating Physicians in their Communities (EPIC) breastfeeding program and distribute information to hospital staff on accessing lactation support services in the community to further patient education. Seventy EPIC trainings are provided annually.

In collaboration with the Georgia Perinatal Quality Collaborative (GaPQC), Women's Health provided opportunities for hospital teams to join educational webinars to increase the breastfeeding knowledge base of participating hospital staff. The series included topics to promote breastfeeding initiation within the first hour after birth and promote lactation support in the community for continuation and exclusivity through six months. These educational webinars aligned with the implementation of the GaPQC Optimizing Nutrition for Georgia Newborn statewide quality improvement initiative.

Working through the lens of health equity, Women's Health continued to explore opportunities to support hospitals in incorporating aspects of health equity into their policies and procedures to support breastfeeding and to assess facilitators and barriers to improve breastfeeding practices and outcomes. Birthing hospitals were invited to participate in the Institute for Perinatal Quality Improvement SPEAK UP trainings offered twice a year in 2021 and 2022.

Current Year:

The Georgia 5-STAR Hospital Initiative aims to promote breastfeeding as the community norm for infant feeding in Georgia exclusively for six months and up to at least the first year of life, ensure that hospitals and health care facilities implement an infant feeding policy, and make lactation accommodation a reality for working women. In the current year, Women's Health is continuing the Georgia 5-STAR Hospital Initiative to address the need to support in-hospital breastfeeding education and increase breastfeeding initiation rates. Women's Health continues to contract with GA-AAP to provide practical assistance, support, and clinical training to participating hospitals to increase the number of hospital staff and providers trained on the Ten Steps to Successful Breastfeeding. From the start of the period through May 30, 2023, GA-AAP provided 41 hours of practical assistance. The EPIC breastfeeding program is being delivered by GA-AAP as part of the ongoing collaboration and contract has been successful to reach clinical teams and distribute information on how to access lactation support services in the community for patient education. Seventy EPIC trainings are provided annually with a focus on reaching under resourced counties in Georgia. The EPIC program offers a pre-and post-presentation survey to assess changes in knowledge, planned practice changes, and program content. Results are compiled quarterly and reviewed for continuous quality improvement.

Women's Health supports the Athens and Waycross public health districts in implementing their breastfeeding support and continuation plan. The nationwide infant formula shortage highlighted the critical importance of these programs to promote breastfeeding to ensure better health for infants and children and reduce low food security. Breastfeeding promotion and support programs provide education about breastfeeding and necessary support to women and linkages to care such as family planning and WIC throughout pre-and post-natal care.

Georgia Perinatal Quality Collaborative (GaPQC) Neonatal Initiative

Optimizing Newborn Nutrition (ONN) is a two-year hospital-based quality improvement initiative focused on increasing the percent of newborns with human milk (maternal or donor) as the first feeding, decreasing the provision of formula, and mother breastfeeding or expression within six hours of birth. All hospitals in Georgia with Mother/Baby units or NICUs are eligible and encouraged to join the initiative. Educational webinars and self-paced microlessons started June 2022 and will continue through the two-year initiative. Each month featured an hour-long webinar with four associated foundational micro-lessons. The webinars provided opportunities to translate education

into practice and feature expert faculty. The webinars and microlessons began with supporting the normal course of lactation for the healthy, term dyad and then expanded into NICU-specific education. Webinars focused on quality improvement topics will also be offered quarterly.

Current Year:

GaPQC successfully launched the ONN Initiative in June 2022 and has been providing Mother/Baby units and Neonatal Intensive Care Units (NICUs) with educational webinars and self-paced microlessons featuring an hour-long webinar with associated foundational micro-lessons each month. Starting in July 2022, hospitals enrolled in active improvement submit minimal hospital data monthly for a random sample of ten infants. Quarterly, GaPQC provides active improvement hospital teams with quarterly reports that show how they are doing in the three main indicators (human milk as first feeding, provision of formula, and mother pumping or expressing in the first 6 hours after birth) in the unit and compared to the collaborative. Hospital teams use these reports to determine a SMART aim specific to their units' needs and build a driver diagram to guide their improvement work.

Related legislation: House Bill 825 passed in April 2022, which provides Medicaid coverage for donor human milk prescribed for an infant when ordered as medically necessary by a physician or physician assistant; the infant is younger than six months of age; the infant is medically or physically unable to receive maternal breast milk or participate in breastfeeding; the infant's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities; is unable to participate in breastfeeding despite optimal lactation support or has a contraindication to breastfeeding.

NPM 5: Safe Sleep

Safe Infant Sleep Program

The Safe Infant Sleep program leads the Georgia Safe to Sleep Campaign and implements evidence-based interventions to reduce the number of preventable cases of sudden unexpected infant deaths (SUID). Efforts are focused on ensuring accurate and consistent education provided to both professionals and caregivers, researching ways to address health inequities, and providing tools for families to practice Safe Infant Sleep.

In the reporting year, hospitals provided education and safe sleep education materials. However, the ability to initiate new work with hospitals on safe sleep stalled due to capacity issues. The program prepared a training for NICU nurses based off the 2021 Technical Report issued by the American Academy of Pediatrics to reinvigorate participation. The second cohort for the guided rapid-cycle continuous quality improvement initiative was offered to assist participants with assessing their hospital-based safe sleep programs and to make changes where needed. These two projects were placed on hold temporarily due to the release of the 2022 American Academy of Pediatrics recommendations on safe infant sleep. The program focused on updated training materials, provider aides and parent education.

The Safe Infant Sleep program manager joined the national Anti-racism and Health Equity working group offered through Safe States Alliance, a non-profit organization and professional association whose mission is to strengthen the practice of injury and violence prevention. The program also re-joined their second Children's Safety Learning Collaborative and partnered with DPH Chronic Disease's Tobacco Cessation program to focus on tobacco cessation for expectant mothers.

The program hosted monthly "Train the Trainer" sessions to build local capacity to teach safe sleep education within communities and ensure that safe sleep education remains accessible, accurate, and consistent. The first session had 129 participants with interest for additional sessions. The recruitment for booster sessions occurred with the assistance of Safe Kids Columbus, a community coalition providing car-seat checkups and safety workshops to help

parents and caregivers prevent childhood injuries.

Georgia State University provided Geographic Information System Mapping (GIS) for SUID data from the Georgia Child Fatality Review. Results showed interesting overlays, such as the number of SUID that occur in families with multiple people living in the home, resulting in overcrowding. The number of SUID where the infant or other siblings have been removed from the family home at some point prior to the infant death will also be investigated.

The Safe Infant Sleep program had its seventh article accepted for publication. "Incident and Racial Discrepancies in News Media Reporting of Sudden Unexpected Infant Death" was a collaboration between Children's Healthcare of Atlanta's, Dr. Sarah Lazarus, DPH Injury Prevention, and the Safe Infant Sleep program. The article was published in Injury Epidemiology.

The program's contract for portable cribs had an unexpected 77 percent increase in cost per item. This increase will undoubtedly impact the ability to provide safe sleep environments to families in need by both the Safe Infant Sleep program and others within the community.

Current Year:

In the current year, hospitals continue to provide education and safe sleep education materials. However, the ability to initiate new work with hospitals on safe sleep has stalled due to capacity issues at the hospitals.

The program continues to offer "Sleep Baby Safe & Snug" books and has engaged with the hospitals to offer a training on the 2022 American Academy of Pediatrics updates on safe infant sleep which has 1.25 CEU's available for nurses. This training includes expanded education around tobacco cessation which was the goal of participating in the Children's Safety Learning Collaborative and partnering with DPH Chronic Disease's Tobacco Cessation program. Previous education did not include information on the Georgia Quit Line and how professionals can refer clients to receive free assistance in tobacco cessation. Evaluation showed that over 93% of participants (N=173) felt confident discussing tobacco cessation options after the training.

The program also updated educational materials to reflect the 2022 American Academy of Pediatrics updates on safe infant sleep. These materials include the "What is Safe Sleep for Babies" educational flipbook which has been offered to sites around the state.

The program continues to evaluate safe sleep education and is exploring what information is helpful for families to support safe infant sleep after baby is born. The program follows up with willing participants when their infant is 3 to 5 weeks old and provides a brief educational session. Participants are also interviewed to elucidate what is easy or difficult when it comes to following safe sleep recommendation. The recruitment for booster sessions is on-going with the assistance of Safe Kids Columbus, a community coalition providing car-seat checkups and safety workshops to help parents and caregivers prevent childhood injuries as well as a local birthing hospital.

The program assisted in the development of a grant application which was awarded to a local non-profit. The program is a part of the multi-disciplinary team tasked with guiding the research meant to address racial disparities in SUID.

The program also launched the "Shelter Program" which works with shelters for unhoused or underhoused families as well as survivors of interpersonal violence. The program currently has 42 participating programs and recently expanded to include a program that works with substance exposed infants and their parents after release from the NICU. Families with infants under 6 months of age are eligible to receive a portable crib and a care package that

includes a wearable blanket and a “this side up” onesie and other educational materials. The shelters could also apply to receive portable cribs to use in their facility to ensure that room sharing without bed sharing could be practiced and encouraged.

SPM 1: Percent of Congenital Syphilis Averted

Congenital Syphilis

The Sexually Transmitted Diseases (STD) Office’s mission is to prevent STDs by providing quality intervention strategies, programmatic support, and education. With a focus on Congenital Syphilis, the STD team works to promote first and third trimester testing for Human Immunodeficiency Virus (HIV) and Syphilis, as well as improve the data quality of Congenital Syphilis cases. The STD Office works to improve the identification of pregnant females with Syphilis to ensure timely and appropriate treatment. The promotion of first and third trimester testing for HIV and Syphilis continued and efforts to provide education through trainings, community outreach, provider outreach, and district STD staff continued to be a priority.

The STD Office continued to work to prevent STDs by providing quality intervention strategies, programmatic support, and education throughout the state. To increase awareness, the STD office worked collaboratively with internal and external partners, which included Division of Women, Children and Nursing Services, to plan and develop a Congenital Syphilis Screening and Treatment Awareness Campaign and provider groups to promote congenital syphilis prevention messaging. Campaign channels included newsletter publications, provider presentations, social media messaging, and conference presentations. The STD Office worked collaboratively with the Office of Quality, Performance and Accreditation to identify Congenital Syphilis outcome measures for the DPH Strategic Plan. The STD office expanded its program staff specifically to support Congenital Syphilis prevention efforts. A Congenital Syphilis specialist was hired in January 2022. The STD Office worked closely with the health districts to prioritize investigations for females with syphilis for timely treatment. STD Office website enhancement efforts included Congenital Syphilis messaging during STD Awareness Week in April 2022, infographics, and data release. To help improve data quality, district and state Congenital Syphilis monthly reports and technical assistance were provided to each health district to ensure improvements in data collection through data matching and medical record extraction. The STD Office also held a Congenital Syphilis Prevention Training in August 2022 for district staff.

Current Year:

The STD Office is continuing to promote first and third trimester testing for Human Immunodeficiency Virus (HIV) and Syphilis, as well as improve the data quality of Congenital Syphilis cases. The STD Office is working to improve the identification of pregnant females with Syphilis to ensure timely and appropriate treatment. The program produces district and state Congenital Syphilis monthly reports and provide technical assistance to each health district to ensure improvements in data collection through data matching and medical record extraction. The Office of Women’s Health, Office of Nursing, and Office of STD are collaborating to address the increase in congenital syphilis cases in Georgia. An ECHO session targeting OB providers was held during November to increase awareness about the importance of screening early in the third trimester of pregnancy to provide adequate time for treatment before delivery. The program was promoted collaboratively with the GA Ob/Gyn Society and 99 participants, including physicians and midlevel providers, joined the session. A recording of the session is available on the agency website. Efforts are underway to leverage OB partners and communication channels to increase knowledge about testing, interpretation of test results, and treatment guidance and resources.

SPM 2: Reduce Infant Mortality in the Black Population

The Infant Mortality Community Toolkit was developed to empower community members, leaders, and organizations

with the information and resources necessary to promote infant health and reduce infant mortality in their communities. The Toolkit slide deck was presented to the Georgia Family Connections Regional Managers for external review and feedback.

As part of the Georgia Perinatal Quality Collaborative's (GaPQC's) focus on health equity, the maternal and neonatal committees continued the two phased approach to address racism and improve health equity. Phase one was to build capacity among hospital teams from Georgia's birthing hospitals. This remained a focus through the reporting period and beyond as turnover at the hospital level highlighted the need for ongoing training. A strong partnership with the Institute for Perinatal Quality Improvement (IPQI) allowed multiple offerings of the SPEAK UP Against Racism training during this period. During the training, participating clinicians became Speak Up Champions and created an action plans to support their hospital specific equity projects.

Current Year:

During the current year, GaPQC offered additional SPEAK UP health equity trainings in partnership with IPQI and moved into phase two of the health equity work. Phase two involves supporting hospital teams to implement their hospital specific action plans to strengthen their initiatives with a focus on equity. Sixty five percent (65%) of GaPQC hospitals attended the SPEAK UP training and are in various stages of working to improve their hospitals' quality improvement initiatives. GaPQC is supporting the SPEAK UP Champions in partnership with the Georgia OBGyn Society by hosting an 'office hours' type meeting for Champions to have a space to discuss their equity QI initiatives and how the implementation is going.

Other Perinatal/Infant Health Programs

Neonatal Abstinence Syndrome

Neonatal Abstinence Syndrome (NAS) is a notifiable condition in Georgia as of January 1, 2016. DPH requires notice and reporting of incidents of NAS by a health care provider, coroner, medical examiner, or any other person who has knowledge of diagnosis or health outcomes related, directly or indirectly, to NAS. GaPQC led the statewide QI initiative to reduce length of stay among newborns diagnosed with NAS with forty-six participating birthing hospitals. Through the QI initiative, 17 GaPQC hospitals had a greater than 10 percent reduction in length of stay from 16.3 days to 14.7 days. Sixteen hospitals achieved Center of Excellence status. A total of 16,063 lessons were completed with 1,971 participating staff members. The NAS initiative moved into sustainability in September of 2021. In the sustainability phase, GaPQC continued to provide support to hospitals enrolled in the initiative to embed their progress into the day-to-day functions of their hospital. Hospitals are still statutorily required to report incidents of NAS.

Current Year:

Hospitals continue to report cases of NAS for ongoing surveillance. GaPQC continues to support hospitals in sustaining the improvements made through the NAS Quality Improvement initiative.

Newborn Screening

Newborn Screening (NBS) is a life-saving public health service offered universally to infants born in Georgia. At the federal level, the Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) conducts thorough evidence reviews to determine if a condition should be added to the Federally Recommended Uniform Screening Panel (RUSP). Georgia's condition review process is similar to that at the federal level and Georgia typically adheres to RUSP.

In the current year, NBS continues to identify and provide early treatment for 35 selected inherited disorders that

otherwise would cause significant morbidity or death. The team provides education for parents and health care providers, universal testing of all newborns, follow-up including rapid retrieval and referral of the screen-positive newborns, confirmation of a normal or abnormal screening test result by a private physician or tertiary treatment center, rapid implementation and long-term planning of therapy, and validation of testing procedures. NBS facilitates communication between practitioners, birth hospitals, the laboratory personnel, and the follow-up teams to provide ongoing education for practitioners.

The Medical Nutrition Therapy for Prevention (MNT4P) program provided ongoing services to individuals with conditions identified through NBS. The MNT4P continues working to improve health outcomes and the quality of life for individuals with IMDs by increasing access to medical nutrition therapies necessary for treatment and maintenance of these metabolic disorders.

NBS and NBS follow-up continue to adhere to protocols established due to COVID-19. NBS follow-up teams continue to conduct conference calls with subspecialists to whom they typically refer infants that require further testing or are diagnosed with an NBS condition. Teams discuss the effectiveness of processes to keep children safe during appointments. Specialists maintain 24/7 call lines to support pediatricians who provide services to infants and children with an NBS condition.

The NBS team developed an unsatisfactory specimen process improvement map and action plan. The poster, "Prioritizing Newborn Screening Education: Engaging Hospitals to Improve NBS Quality and Reduce Unsatisfactory Rates in Newborn Screen Blood Specimens" was presented during a virtual panel at the Association of Public Health Laboratories (APHL) Continuous Quality Improvement annual national meeting in October 2021.

Current Year:

The NBS program is continuing efforts to ensure that every newborn is screened for heritable disorders with prompt identification and treatment. The NBS program continues to be responsible for the administration of the NBS system, which includes educating families and practitioners about NBS, overseeing the follow up process for infants that screen positive for conditions identified via NBS, monitoring and evaluating the NBS system, and reporting to state and federal officials and to the public. Contracts with Emory University, Augusta University, and Children's Healthcare of Atlanta continue to conduct short-term follow-up on abnormal NBS results. NBS short-term follow-up encompasses the time between receiving an abnormal result to the confirmation of a diagnosis. This helps ensure that all diagnosed cases are referred to Children 1st, leading to an assessment to determine the newborn's eligibility for Individuals with Disabilities Education Act (IDEA) Part C, Babies Can't Wait (BCW), children and youth with special health care needs (CYSHCN), and Children's Medical Services (CMS).

The NBS program provides education to parents and providers. The program partners with organizations that engage providers, such as the GA-AAP and the Georgia Academy of Family Physicians, to participate in webinars, blast fax communications, professional development conferences, and grand rounds. On-site and telephone technical assistance to birthing hospitals will continue as needed.

DPH and the NBS program continue to collaborate to improve electronic transmission of results to providers to increase access to electronic results and reduce the number of paper NBS results that are mailed to providers. This allows providers that were not listed as the provider of record on the NBS card easier access patients' NBS results. The NBS program continues to make improvements to the NBS database through SendSS by having frequent meetings with internal SendSS informational technology and epidemiology staff to discuss needed enhancements, build new requirements, and monitor the progress of any changes.

Child Health Home Visiting Program

The Child Health Home Visiting Program was established to strengthen Georgia's capacity for addressing the overall health, safety, and wellbeing of families and children through the implementation of Evidence-Based Home Visiting (EBHV) services and the enhanced coordination of services for at-risk families. The program is guided by a state-level infrastructure designed to support project implementation and evaluation via the provision of technical assistance and trainings. Data collection allows for performance monitoring and continuous quality improvement. The MIECHV program is the primary funding stream for home visiting. Other funding streams include Title V, Child Abuse and Neglect Prevention (CANP), Healthy Start, and other state dollars. Child Health Home Visiting provides EBHV program models as they are proven to improve outcomes in several domains including (1) maternal and child health, (2) positive parenting practices, (3) child development and school readiness, (4) reductions in child maltreatment, (5) family economic self-sufficiency, and (6) linkages and referrals to community resources and supports.

In the reporting year, the program continued the commitment to implement evidence-based, comprehensive, and community-based maternal and early childhood programs, including Healthy Families Georgia, Nurse Family Partnership, Parents as Teachers, and Maternal and Early Childhood Sustained Home Visiting. In-home, face-to-face home visiting services resumed on March 1, 2022, with required use of face masks. Each of the local implementing agencies (LIAs) received the 2022 Continuity of Operations Plan (COOP) that provides COVID-19 State of Georgia Guidelines for Re-Initiation of In-Home Home Visits. The COOP included guidance on social distancing, increased health practices and a decision tree originated by Washington State University to assist individuals and sites with safely returning to in-person visits. Clients enrolled in the home visiting program could choose to receive in-person home visits or continue with virtual visits.

Child Health Home Visiting continued to facilitate the Georgia Healthy Start Collaborative for the six Georgia Healthy State grantees and the Healthy Start National Project Officer to foster collaboration and team building and identified opportunities to leverage resources for successful partnerships. The collaborative continued to work together to meet the Healthy Start benchmarks and Title V performance measures.

Child Health Home Visiting provided monthly check-in calls with LIAs to provide support and guidance and allow sites to share strengths, challenges, and ideas regarding the impact of COVID-19 on service delivery, staff and families served. As a result of the monthly calls, the program successfully met its goal to have most of its sites maintain program capacity of at least 85 percent during the reporting period.

The Georgia Strong Families Program (GSFP) successfully recruited, enrolled, and retained families. Virtual visits were completed using DPH telehealth platforms Cisco WebEx and Cisco Telepresence. Virtual visits allowed Child Health Home Visiting to meet the goals to optimize child development through screening, early detection, and connection to appropriated services, enhance parenting skills and resilience through delivering approved EBHV models with fidelity, and safeguard maternal and infant health through education and linkage to community resources.

Healthy Start Professional Development Staff training opportunities aimed to increase their knowledge in family and community engagement included:

Connections Matter - This training provided participants knowledge about ACEs and provided a better understanding of the connection between trauma, brain development, resilience, and health.

Becoming Grief-Informed: Helping Parents Cope with the Loss of a Child - This training introduced the five stages of grief model and the three techniques used throughout the grief process. The session also provided practical

strategies for supporting grieving parents.

Executive Function Skills: Leading from the Inside Out - This training introduced the importance of executive function skills and how they are used in everyday life. Participants completed a self-assessment to develop a plan of action to increase their executive function skills.

GSFP Retreat - The University of Georgia Fanning Institute for Leadership Development conducted a professional development retreat for GSFP team and Community Action Network (CAN) partners.

Meeting of the Minds: Emergenetics - Emergenetics is an assessment based in the concept that one's personality is the emergence of behavior, genetic makeup, and life experiences. The assessment provides an in-depth insight into understanding one's individual identity. This assessment was conducted and used to equip GSFP staff with strategies and resources to enhance their personal effectiveness in communication and collaboration.

Leadership Practices and Principles - This session provided GSFP staff with an understanding of effective leadership principles that can be applied in their daily interactions with team members, community partners, and families.

Selfcare during COVID-19 for helping professionals - This session provided GSFP team tools to improve selfcare and reduce stress and provided instructions on how to avoid burnout and compassion fatigue while managing the needs of the families they serve.

Child Abuse and Neglect: Reporting and Responding while Strengthening Families - This session increased participants' knowledge, awareness and attitudes about child protective behaviors. Participants learned to define and recognize the four types of abuse and neglect, identify physical and behavioral indicators of legally recognized types of abuse and neglect, and provided knowledge on their role as mandated reporters.

Community Action Network Retreat - These interactive working sessions included a detailed overview of the collective impact process. The UGA Fanning team assisted the Valdosta and Columbus teams in developing their collective action plans and developing shared measurement strategies.

Current Year:

The Child Health Home Visiting program continues to strengthen its services and maintain its proven track record to positively impact the wellbeing of families, communities, and the state. The program continues to focus on diversifying funding to sustain and expand home visiting throughout the state, strengthening the workforce through assessment, and training and improving maternal mental health. The program has made maternal mental health a priority, as approximately ten percent of pregnant women worldwide and 13 percent of women who have recently given birth experience a mental disorder, primarily depression. Child Health Home Visiting is training staff and identifying community partners for direct linkage.

The Healthy Start Georgia Strong Families Program (GSFP), managed by DPH, is providing healthcare coordination, home visitation, and case management services to 700 participants in the reporting year including pregnant women, new mothers, infants, and fathers. Child Health Home Visiting program staff facilitate the coordination of community service delivery systems, as well as the promotion and improvement of health equity.

Perinatal/Infant Health - Application Year

Application Year: October 1, 2023 – September 30, 2024

Priority Need: Prevent Infant Mortality

NPM 3: Risk Appropriate Perinatal Care

Percent of very low birth weight (VLBW) infants born in a hospital with a level III+ Neonatal Intensive Care Unit (NICU)

NPM 3 Strategies

- 3.1 Complete a Levels of Neonatal Care designation for at least 10 hospitals annually.
- 3.2 Conduct one site visit annually at each RPC to verify RPC compliance with Level III+ care

Regional Perinatal System

To strengthen the system of regionalization in Georgia, Women's Health will focus on communication with Regional Perinatal Center (RPC) Medical Directors, Outreach Educators, Finance, and Data Coordinators during annual RPC site visits and change to an in-person/virtual rotation with each RPC. The RPCs will promote and support the hospitals in their region to implement the Georgia Perinatal Quality Collaborative quality improvement initiatives, specifically the most recent Optimizing Newborn Nutrition and the Cardiac Conditions in Obstetrical Care initiatives. The RPC Outreach Educators will also support the Levels of Maternal and Neonatal Care designation program by promoting the program among regional hospitals.

Levels of Neonatal Care

The Women's Health program will continue to implement the levels of neonatal care verification program by outreaching to hospitals to facilitate participation, providing technical assistance during the application process and with any deficiencies noted, and providing funding to reduce the cost of the survey for hospitals.

NPM 4: Breastfeeding

- A) Percent of infants who are ever breastfed
- B) Percent of infants breastfed exclusively through 6 months

NPM 4 Strategies:

- 4.2a Provide training and coaching to MIECHV and Healthy Start Home Visiting Staff to promote breastfeeding best practices.
- 4.2b Educate Home Visitors about PACIFY, a 24/7 perinatal and infant feeding support virtual platform, that can be utilized by clients who are new/expectant parents.
- 4.2c In partnership with Georgia AAP, will make breastfeeding recommendations and share nutrition education materials with Home Visitors and other programs.
- 4.3a Develop a one-pager on how to successfully collaborate between Georgia Home Visiting and Georgia WIC.
- 4.3b Develop and implement a referral process between Georgia Home Visiting and WIC Peer Counseling Program.
- 4.3c Increase the awareness of eligibility processes (i.e., Gateway Program).
- 4.4 Develop an active recruitment plan to enroll Georgia hospitals in the Optimizing Nutrition for Georgia Newborns initiative.

Breastfeeding

In the application year, Women's Health will work closely with GA-AAP and the Georgia Breastfeeding Coalition to form a stakeholder workgroup to begin to develop a Breastfeeding Strategic Plan for Georgia. This will provide a

road map for Women's Health to support breastfeeding initiation and continuation and offer strategic direction to align with partners for a stronger collective impact across the state.

DPH will continue to fund two DPH district pilot breastfeeding continuation support programs to assist postpartum mothers with their breastfeeding journey. Districts offer in-person and virtual education, support, and assistance to WIC and non-WIC eligible mothers. In the application year, beginning October 1, 2023, DPH will fund an additional district to expand the breastfeeding support programs in the state.

DPH will partner with GA-AAP to address the lactation knowledge and skills gap found among healthcare providers by implementing a Breastfeeding-Friendly Provider designation program.

Health equity will remain a top priority and Women's Health will offer educational trainings to build capacity among partners, districts, and hospital teams. This will ensure a health equity lens and approach is used when drafting the Breastfeeding Strategic Plan and working across the state to promote successful initiation and continuation.

Georgia Perinatal Quality Collaborative (GaPQC) Neonatal Initiative

GaPQC will continue to support the ONN initiative through September 2024. Monthly webinars and microlessons will continue and GaPQC will begin to conduct site visits and provide individual technical assistance to hospitals in the fall of 2023. In the spring of 2024, at the annual meeting for GaPQC, hospitals who have achieved specific milestones through the initiative will be recognized as a GaPQC Center of Excellence.

NPM 5: Safe Sleep

- A) Percent of infants placed to sleep on their backs
- B) Percent of infants placed to sleep on a separate approved sleep surface
- C) Percent of infants placed to sleep without soft objects or loose bedding

NPM 5 Strategies:

- 5.1a Facilitate safe infant sleep trainings to assist healthcare professionals and those who interact with expecting families and caregivers (including home visitors, first responders, shelters) with providing accurate and up-to-date information on the AAP recommendations on safe infant sleep.
- 5.1b Collaborate with hospitals (i.e., well-baby, NICU, Pediatric Units) to provide consistent and accurate parent/caregiver education, conduct crib audits, update policy as needed and actively endorse, and model safe infant sleep practices.
- 5.1c Work with multi-sector organizations to reach all families, including those at higher risk for SUID, to specifically address disparities in the rates of infant mortality due to SUID.
- 5.1d Promote safe and healthy infant sleep behaviors and environments including access to smoking cessation programs and improving support systems that address Social Determinants of Health for populations/areas of greatest risk of SUID.

Safe Infant Sleep Program

In the upcoming year, the Georgia Safe to Sleep Campaign will work with participating birthing hospitals, NICUs, and Pediatric Units to meet the goals of the program. Training and provision of education materials will continue for hospital staff, home visitors, local health departments, WIC offices, first responders, social workers, and other professionals, as requested. The program will improve local capacity to provide safe infant sleep training by hosting train the trainer sessions. Representatives of the program will continue to conduct research and participate in multidisciplinary team meetings to address infant mortality and improve birth outcomes. Additionally, the program manager will participate on the statewide Infant Mortality Working Group collaboration with DPH, Healthy Mothers Healthy Babies Coalition of Georgia, and the Georgia Bureau of Investigation (GBI), and participate on the GBI Child

Fatality Review committee.

SPM 1: Percent of Congenital Syphilis Averted

SPM Goal: Increase the percentage of Congenital Syphilis cases averted.

SPM 1 Strategies

- 1.1a Ensure investigations prioritized for females of reproductive age 15-45 and reactive serology, including provider follow-up to confirm age, treatment and pregnancy status.
- 1.1b Ensure timely and adequate treatment (30 days prior to delivery) for pregnant females with syphilis.
- 1.1c Ensure interviews are conducted on all syphilis cases for females of reproductive age 15-45.
- 1.1d Ensure treatment for partners of syphilis positive pregnant females.
- 1.1e Identify pregnancy status of all females identified as a new syphilis case.
- 1.1f Review & disseminate data on congenital syphilis cases with missed opportunities to all health districts.
- 1.1g Educate providers and general public on the law regarding 1st prenatal visit and 3rd trimester testing for Syphilis and HIV.

Congenital Syphilis

In the upcoming year, the STD Office will continue to work to prevent STDs by providing quality intervention strategies, programmatic support, and education throughout the state. To increase awareness, the STD office works collaboratively with internal and external partners. The STD Office will continue to work with the Office of Quality, Performance and Accreditation to quarterly report congenital syphilis outcomes to support strategic planning through 2025 and Division of Women, Children and Nursing Services to promote congenital syphilis prevention messaging. The STD Office will continue website enhancement efforts to include Congenital Syphilis messaging infographics, and data releases. To help improve data quality, district and state Congenital Syphilis monthly reports and technical assistance will be provided to each health district to ensure improvements in data collection through data matching and medical record extraction. The STD Office will continue to work closely with the health districts to prioritize investigations for female with syphilis for timely treatment. Additionally, the office will conduct a congenital syphilis prevention training as well as congenital syphilis review board meetings with district staff.

SPM 2: Reduce Infant Mortality in the Black Population

SPM Goal: Reduce the disparities in Black infant mortality compared with other populations.

SPM 2 Strategies:

- 2.1 Work with birthing hospitals individually to support the development and/or implementation of a hospital specific health equity action plan.

Improving Birth Outcomes

In the application year, the neonatal committee and the GaPQC leadership team plan to recruit and hire an Improvement Advisor (IA) to work directly with participating Mother/Baby and NICU units in birthing hospitals on their initiatives. All neonatal quality improvement initiatives have a health equity focus and the goal for the IA is to work one on one with hospitals to tailor their QI work to the population they serve focusing on those most impacted by adverse neonatal outcomes. With a health equity lens, the IA will support hospitals in looking at their data disaggregated by race/ethnicity to tailor approaches and continually improve practices.

Other Perinatal Infant Health Programs

Neonatal Abstinence Syndrome

GaPQC will continue to support hospitals in sustaining the improvements made through the NAS QI initiative. Education and trainings for providers and the public will be available and updated as necessary. Hospitals will continue to report cases of NAS for ongoing surveillance.

Newborn Screening (NBS)

The NBS program will propose adding guanidinoacetate N-methyltransferase (GAMT) and Mucopolysaccharidosis type II (MPS II) to Georgia's screening panel based on the recommendation of Georgia's Newborn Screening Advisory Committee. Implementation is planned for 2024 if approved. Additionally, the NBS program plans to increase the dried blood spot card from five to six spots to accommodate current and future screening tests.

To ensure comprehensive screening for heritable disorders, the NBS program will engage with birthing facilities, targeting those with high rates of unsatisfactory results. Facilities will receive training on appropriate specimen collection methods as Georgia transitions to the six-spot dried blood spot card. An electronic process will be implemented for facilities to complete the demographic section of the dried spot card, reducing errors, and improving documentation. This electronic process will enhance efficiency in obtaining and accessing screening results, facilitating prompt identification and re-screening when necessary.

Continuing commitment to education and patient follow-up, the NBS program will collaborate with Emory University, Grady Health System, Augusta University, Children's Healthcare of Atlanta, Hemophilia of Georgia, and the Sickle Cell Foundation of Georgia.

Child Health Home Visiting

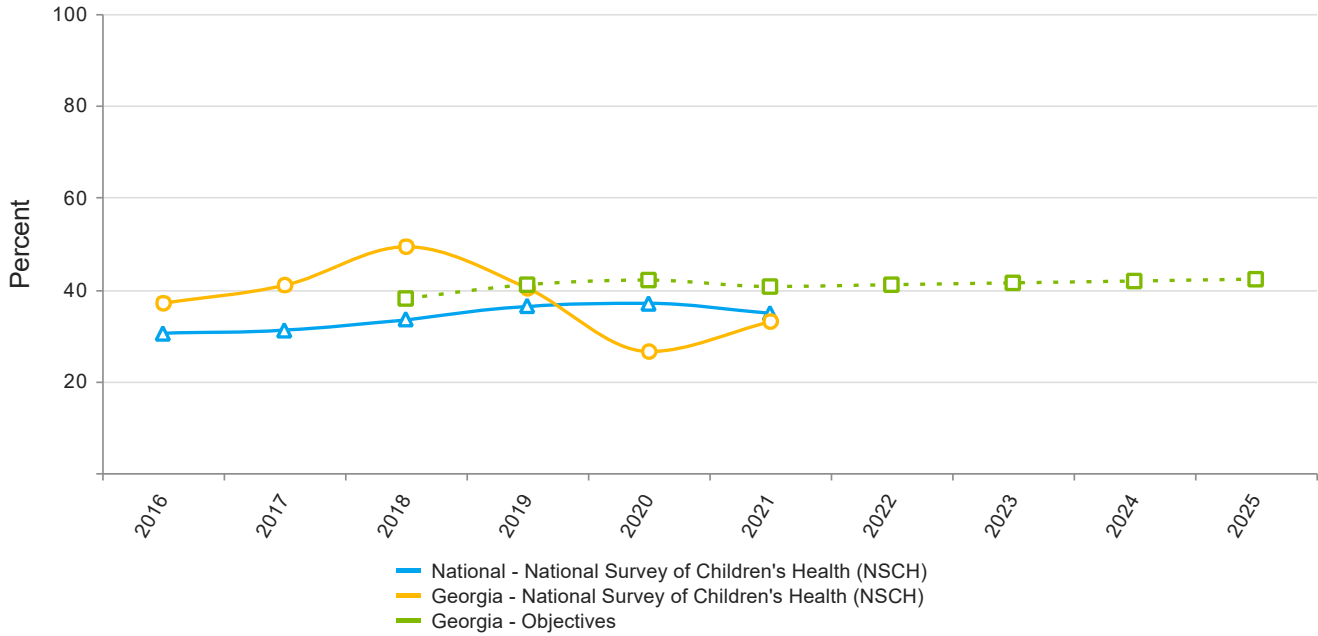
The Child Health Home Visiting program will add an additional six counties to its service area in the upcoming year, bringing the total number of counties served through evidence-based home visiting to twenty-nine. The Waycross health district will implement EBHV in three of its counties and has identified adolescent/teen pregnancy as a significant issue across their district. The health district has strong ties with their school systems and community organizations to help identify and serve this subpopulation.

In addition, Georgia will continue to explore opportunities to encourage and increase parent voice in local continuous quality improvement (CQI) efforts and activities and early childhood systems. While Georgia lost traction in this effort due to the COVID-19 public health emergency, the Child Health team took advantage of professional development opportunities to learn more about how to support this effort. The Georgia team is taking advantage of professional development to learn more about how to develop and sustain effective parent advisory committees and are using the new tools and resources to support LIAs in this process. The program will use CQI initiatives to continue to scale and spread innovative strategies for including home visiting clients in rapid cycle testing that have proven successful in HV CollIN participating LIAs. The goal will be to encourage local teams to start small and build momentum throughout the upcoming year. At several LIAs, parents and caregivers who either are active participants in home visiting or who have graduated from a home visiting program are serving as active members on LIAs' community advisory boards to provide a unique perspective to local leaders and stakeholders about the power of home visiting and how to market programming and increase awareness in innovative ways.

Child Health

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data

Data Source: National Survey of Children's Health (NSCH)

	2018	2019	2020	2021	2022
Annual Objective	38	41	42	40.6	41
Annual Indicator	40.8	49.4	40.2	26.4	33.1
Numerator	107,598	135,738	118,669	68,664	85,293
Denominator	263,952	274,649	295,208	260,348	257,448
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives

	2023	2024	2025
Annual Objective	41.4	41.8	42.2

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Number of providers that receive developmental screening education and training who report promoting developmental screenings with parents in their practices

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	3
Annual Indicator			0	54
Numerator				
Denominator				
Data Source			Children 1st Quarterly Report submissions	Children 1st Quarterly Report submissions
Data Source Year			SFY 2021	SFY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	57.0	59.0	62.0

ESM 6.2 - Percent of children that screen with concern that are referred to appropriate intervention services by providers

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			12	13
Annual Indicator	11.8	11	13	15.5
Numerator	951	855	767	855
Denominator	8,038	7,792	5,900	5,503
Data Source	SendSS	SendSS-NB	SendSS-NB	SendSS-NB
Data Source Year	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	14.0	15.0	16.0

ESM 6.3 - Number of community partners who promote developmental screenings and make referrals to their local public health district

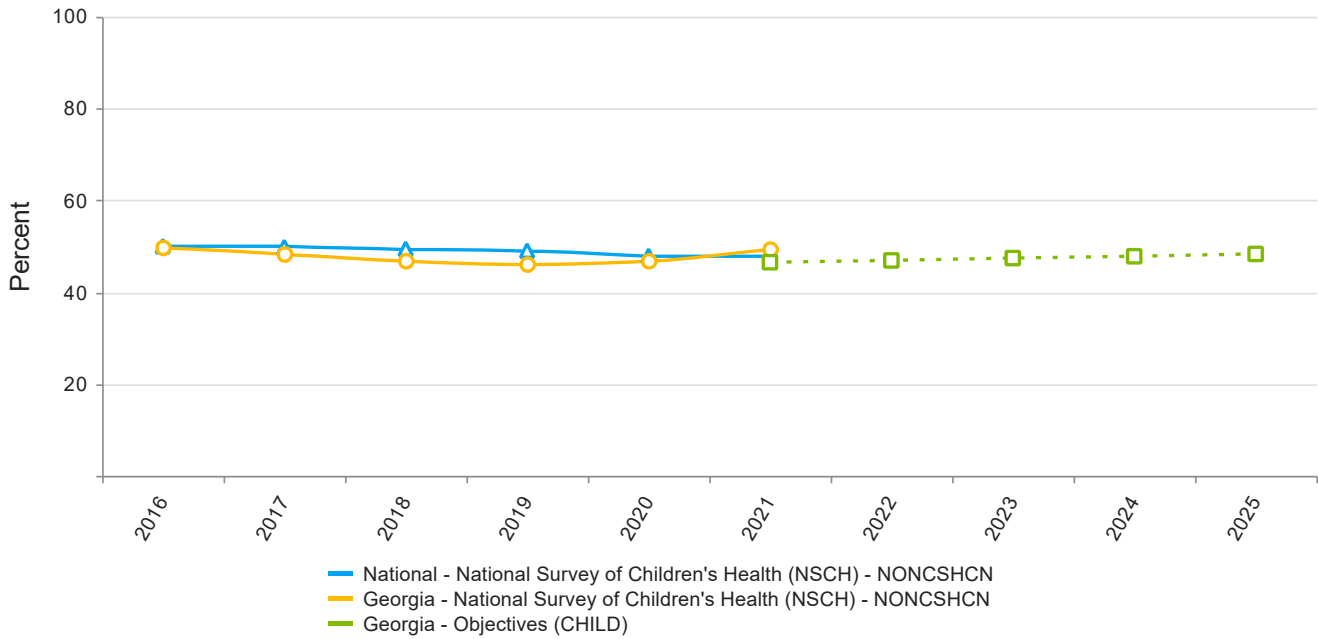
Measure Status:		Inactive - Replaced		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	5
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			Children 1st Quarterly Report Data	Children 1st Quarterly Report Data
Data Source Year			FFY 2021	FFY 2021
Provisional or Final ?			Final	Final

ESM 6.5 - Percent of children participating in Home Visiting with at least one developmental screening using a validated instrument.

Measure Status:		Active
State Provided Data		
	2022	
Annual Objective		
Annual Indicator	79.5	
Numerator	1,446	
Denominator	1,820	
Data Source	GEOHVIS	
Data Source Year	SFY 2022	
Provisional or Final ?	Final	

Annual Objectives		
	2024	2025
Annual Objective	80.0	80.0

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Indicators and Annual Objectives



NPM 11 - Child Health - NONCSHCN

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN				
	2019	2020	2021	2022
Annual Objective			46.5	46.9
Annual Indicator	46.8	46.0	46.7	49.2
Numerator	948,129	927,933	916,888	971,433
Denominator	2,024,578	2,016,279	1,964,051	1,972,586
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	47.4	47.8	48.3

Evidence-Based or –Informed Strategy Measures

ESM 11.2 - Number of telehealth/telemedicine providers in the network

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			14	18
Annual Indicator	10	15	15	12
Numerator				
Denominator				
Data Source	CYSHCN program/ DPH Office of Telehealth and Telem	CYSHCN program/ DPH Office of Telehealth and Telem	CYSHCN program/ DPH Office of Telehealth/Telemedic	CYSHCN program/ DPH Office of Telehealth/Telemedic
Data Source Year	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	22.0	26.0	30.0

ESM 11.3 - Number of callers connected to resources through Help Me Grow (HMG)

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			3,809	4,000
Annual Indicator	3,809	3,218	4,499	4,499
Numerator				
Denominator				
Data Source	Help Me Grow Data	Help Me Grow Data	Help Me Grow Data	Help Me Grow Data
Data Source Year	SFY 2020	SFY 2021	SFY 2022	SFY 2022
Provisional or Final ?	Final	Final	Final	Final

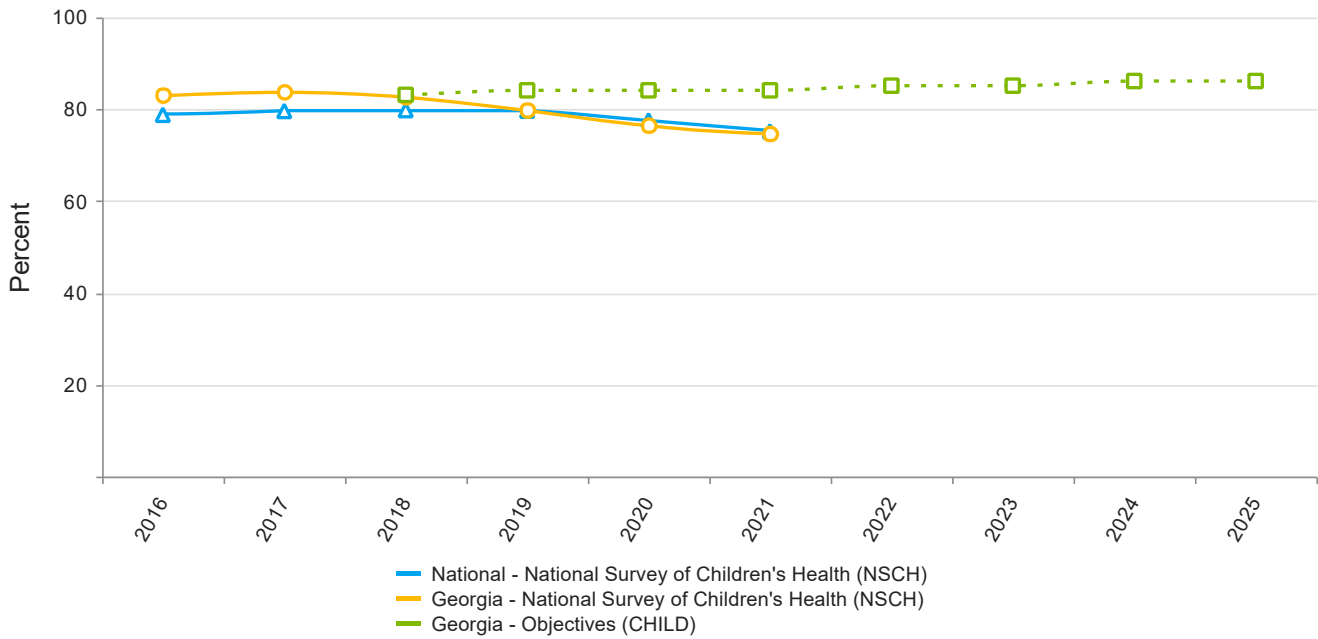
Annual Objectives			
	2023	2024	2025
Annual Objective	4,190.0	4,381.0	4,571.0

ESM 11.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	0
Annual Indicator			0	0
Numerator			0	0
Denominator			180	180
Data Source			Help Me Grow Data	Help Me Grow Data
Data Source Year			SFY 2022	SFY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	0.0	0.0	0.0

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Indicators and Annual Objectives



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	2019	2020	2021	2022
Annual Objective	83	84	84	84	85
Annual Indicator	83.5	82.4	79.7	76.2	74.4
Numerator	1,992,442	1,971,820	1,890,764	1,783,309	1,742,723
Denominator	2,384,889	2,393,072	2,372,140	2,340,717	2,341,165
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	85.0	86.0	86.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Number of children screened at school-based/ school-linked programs

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			2,500	2,500
Annual Indicator			119	552
Numerator				
Denominator				
Data Source			Oral Health Program Database	Oral Health Program Database
Data Source Year			2020-2021	2021-2022
Provisional or Final ?			Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	600.0	700.0	800.0

State Action Plan Table

State Action Plan Table (Georgia) - Child Health - Entry 1

Priority Need

Promote developmental screenings among children

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

6.1 By 2025, engage 15 physician practices to promote developmental screenings and submit referrals to public health.

6.2 By 2025, identify and collaborate with 25 community-based organizations to initiate or increase developmental screenings.

Strategies

6.1a Develop a Physician Outreach campaign to increase the number of providers utilizing standardized developmental screenings and supportive services available through Public Health (e.g., BCW, C1st, CMS, EHDI, Home Visiting, Help Me Grow).

6.1b Provide feedback on referrals to all referral sources to encourage care coordination and future referrals.

6.2a Provide 10 total trainings annually via the state office to community partners and provider practices through collaborative partnerships with medical and maternal and child health agencies.

6.2b Make the ASQs available to parents online.

6.2c Work with the Home Visiting program to produce a protocol to increase the number of de-duplicated developmental screenings.

ESMs	Status
ESM 6.1 - Number of providers that receive developmental screening education and training who report promoting developmental screenings with parents in their practices	Active
ESM 6.2 - Percent of children that screen with concern that are referred to appropriate intervention services by providers	Active
ESM 6.3 - Number of community partners who promote developmental screenings and make referrals to their local public health district	Inactive
ESM 6.4 - Percent of children, ages 0 through 5, who receive a developmental screening from DeKalb Board of Health Refugee Clinic	Inactive
ESM 6.5 - Percent of children participating in Home Visiting with at least one developmental screening using a validated instrument.	Active

NOMs

- NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
- NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Georgia) - Child Health - Entry 2

Priority Need

Increase the number of children, both with and without special health care needs, who have a medical home

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

11.1 By 2025, increase the number of families who receive linkage to appropriate care through a cross-agency referral system, Help Me Grow (HMG).

Strategies

11.1a Expand the use of telehealth technology to improve access to audiological and early intervention services for children and youth with special health care needs.

11.1b Facilitate efforts to educate families about telehealth as an option for care.

11.1c Provide ongoing evaluation of the Department's telehealth network to ensure pediatric specialty services meet the needs of families and patients.

11.1d Develop and implement a quality improvement plan for Title V's Children and Youth with Special Health Care Needs program to identify opportunities in which telehealth technology may be used to improve medical home access.

11.1e Expand the capacity of HMG liaisons to help families navigate/ access comprehensive services.

11.1f Improve access to information and resources for CYSHCN.

11.1g Develop an outreach plan to engage partners, providers, and families in the utilization of HMG, a shared resource to assist families to navigate the early childhood system.

ESMs

Status

ESM 11.1 - Number of telehealth/telemedicine patient encounters Inactive

ESM 11.2 - Number of telehealth/telemedicine providers in the network Active

ESM 11.3 - Number of callers connected to resources through Help Me Grow (HMG) Active

ESM 11.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Georgia) - Child Health - Entry 3

Priority Need

Promote oral health among MCH populations

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

13.2 By 2025, increase the percent of children, ages 1 through 17, who had a preventive dental visit in the past year by 5% (Baseline: 79.7%, NSCH, 2018-2019).

Strategies

13.2a Create and update a State Oral Health Surveillance Plan that functions to identify data sources, collection strategies, collection timeframes, and dissemination approaches.

13.2b Coordinate and provide district coordinator meetings periodically where resources are shared, updates are provided from states and district programs, continuing education or presentations are offered, and technical assistance is offered as needed.

13.2c Work with Healthy Mothers Healthy Babies (HMHB) and other external partners by providing subject matter expertise and strategic feedback.

13.2d Support district programs partnering with local schools to promote school-based/school-linked sealant and oral health prevention programs that target schools where 50% or more of the student population are eligible for free and reduced lunch.

13.2e Support district program staff going to local schools and providing oral health education programs.

13.2f Provide trainings to local water plant operators on the value of community water fluoridation and technical assistance to improve monthly reporting from local community water systems.

ESMs

Status

ESM 13.2.1 - Number of children screened at school-based/ school-linked programs

Active

ESM 13.2.2 - Number of Hispanic children who are provided with oral health education

Inactive

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Child Health - Annual Report

Child Health – Annual Report, October 1, 2021 – September 30, 2022

Priority Need: Promote Developmental Screenings Among Children

NPM 6: Developmental Screenings for Children

Children 1st

Children 1st serves as the single point of entry to child health services through DPH for children ages birth to five who are at risk for poor health and development. Children 1st connects children and families with public health and other prevention-based programs and services in all 159 counties in Georgia. The Children 1st program partners with the Department of Community Health (DCH), Department of Education (DOE), Department of Early Care and Learning (DECAL), Department of Family and Children Services (DFCS), primary care and specialty physicians, and DPH home visiting programs. Children 1st Coordinators are in each public health district and are the lead point of coordination for program referrals to ensure children birth to five years of age with social, environmental, behavioral, or biologic risk factors that may result in poor health or development outcomes, are identified and linked to appropriate public health, private, and community-based programs.

The Children 1st program functions within five core components to establish a baseline level of consistency and efficient service to all families referred regardless of location in the state. The five core components are identification, screening, assessment, referral/linkage and monitoring. Birth certificates for children born in Georgia are screened for risk factors identified during the perinatal period. The Children 1st program has longstanding relationships with the state's birthing facilities which send referrals for infants and their families before hospital discharge. Assessment and triage of referrals is provided to determine appropriate follow up including program enrollment or referral to early intervention or CMS. The Children 1st program provides a comprehensive assessment of the needs of the child and family to make appropriate linkages to public health, private, and community-based resources to best support the healthy growth and development of the child. Children enrolled in Children 1st receive case management and age-appropriate developmental screening.

All eighteen public health districts utilize Ages and Stages Questionnaires (ASQ) developmental screening tools to provide age-appropriate developmental screening for program participants. The Ages & Stages Questionnaires, Third Edition, ("ASQ-3") and the Ages & Stages Questionnaires: Social-Emotional, Second Edition, ("ASQ: SE-2") are the preferred developmental screening tools for the Children 1st and home visiting programs. The ASQ-3 is used to monitor and identify issues in general infant development in the communication, gross motor, fine motor, problem-solving, and personal-social domains for children between the ages of one through 66 months. The ASQ: SE-2 is used to monitor and identify issues in infant development in the social-emotional domain for children between the ages of one through 72 months.

To provide additional access to ASQ materials, the Children 1st program contracted with Paul H. Brookes Publishing Co., Inc. to provide ASQ Online accessibility to all district Children 1st programs. ASQ Online is a web-based screening, monitoring, and reporting system designed to track, report on, facilitate, and otherwise monitor the developmental progress of children using the Ages & Stages Questionnaires.

The ASQ Family Access Portal was established for district staff to access the resource. The resource launched during September 2022 and is available in English and Spanish. The Children 1st program created protocols and short how-to videos that included guidance on successful launch of ASQ Online.

In summer 2022, the Department of Early Care and Learning (DECAL) connected Children 1st with Learning Spaces, sponsored by United Way of Greater Atlanta to facilitate developmental screening and referrals to early intervention services. Learning Spaces is an early learning initiative for 0-5, developed to be a preschool program in a non-traditional space in the Metro Atlanta area. A process was developed to provide developmental screening on site at the Learning Spaces events and identify partners who to collaborate with to make this successful. Georgia State University (GSU) College of Education and Human Development Urban Child Study Center was identified to provide developmental screenings and make referrals to Children 1st for children identified at risk for delays. In September 2022, education and training was provided to Learning Spaces Facilitators and GSU screeners on developmental screening and referring to Children 1st.

Current Year:

Children 1st is working collaboratively to streamline internal opportunities to increase developmental screening of young children and establish a process to reduce duplicate and redundant screening and referrals. Children 1st program staff continue to work with the Child Health Home Visiting programs, MIECHV and Healthy Start, to improve the coordination of services and screenings provided to families.

Children 1st partnered with United Way of Greater Atlanta and Georgia State University to provide developmental screenings to children participating in Learning Spaces, a non-traditional preschool program in Metro Atlanta (Clayton, Cobb, Douglas, DeKalb, and Fulton counties) in 2022. As of March 2023, 22 children received developmental screening and 10 were referred to Children 1st for further screening and assessment. Children 1st is proud to be a part of this cross-agency collaboration to fulfill United Way's goal of "creating strong learners." Other resource partners working with Learning Spaces are Ferst Readers, Alliance Theatre, and The Rollins Center for Language & Literacy.

Children 1st staff were provided Learn the Signs. Act Early. training by the CDC Act Early Ambassador on March 1, 2023 to improve knowledge and understanding of the revised milestones and increase capacity to provide developmental milestones education to families to increase and improve screening and connection to early intervention services. Contract partner, Healthy Mothers, Healthy Babies Coalition of Georgia, was included to increase their capacity and knowledge as they assist Children 1st with monitoring, intake, and follow up for children who present with risk factors.

Child Health provided train-the-trainer ASQ training in May 2023 to increase capacity for training partners and providers and increase access to developmental screening. Staff from 17 districts completed the 3-day training to serve as trainers for staff in their district. Since the launch of ASQ online in September 2022, over 800 children have received developmental screening through the system.

Refugee Health

The State Refugee Health Program (SRHP) promotes the physical, mental, and social well-being of all newly arriving refugees in the state of Georgia. The program helps to ensure that refugees receive adequate healthcare and screening services. Refugee health screening has four purposes: (1) to reduce health-related obstacles to successful resettlement, (2) to protect the health of local, state, and national populations, (3) to identify health issues that may need continued care that public health departments cannot provide, and (4) to educate refugees about the U.S. healthcare system and participate in making decisions about their health.

The SRHP works in partnership and collaborates with the various stakeholders involved in refugee resettlement that include resettlement agencies, county health departments, community health centers, community-based organizations, mainstream social service providers, schools, members of charitable organizations, and church and

community leaders. The SRHP works with county health departments to screen all newly arriving refugees for communicable and chronic diseases, and to administer immunizations. The SRHP works with partners such as the Refugee Resettlement Agency, county health departments, schools, community-based organizations, and community service providers to provide maternal and child health program education. Outreach and educational materials have been translated into refugee languages to increase access to BCW and WIC.

To increase access to maternal and child health programs and developmental screening for children, SRHP recognizes the importance of working with partners to reach and educate the most vulnerable and hard to reach refugees and immigrant communities.

In the reporting year, the Department of Homeland Security resettled 76,000 Afghan evacuees, the majority of whom are women and children. SHRP is working with state and local governments, resettlement organizations, federally qualified health centers, community and faith-based organizations to meet the medical and mental health needs of this community. SHRP is in the process of filling a new Arabic, Pashto, and Dari/ Farsi interpreter position to ensure that cultural and linguistic needs are met in the health departments. In addition to these positions, a Public Health Educator and social worker have been hired to meet the increasing needs within this community.

Current Year:

The SRHP continues to collaborate with Child Health staff to promote and implement developmental screenings for children who have resettled in Georgia from the following countries: Afghanistan, Burma, Congo, Dominican Republic, Congo, Eritrea, El Salvador, Guatemala, Sudan, Syria, Tanzania, Ukraine. The Refugee Pediatric Center will continue to provide referrals to the DeKalb Board of Health Refugee Clinic at Kaiser Permanente. SRHP will monitor referrals and provide developmental screening outreach materials including the Children 1st program, BCW, CMS, EHDI, Autism, and Learn the Signs. Act Early.

Interpreters will continue to be available at the Refugee Pediatric Center for Arabic, Somali, and Swahili speaking refugees. The SRHP hired a Public Health Interpreter, Public Health Educator, Refugee Mental Health Specialist. The Public Health Interpreter works with new arrival refugees (Afghans) that speak Pashto/ Dari and Farsi to meet their language needs and assist them to have access to their healthcare needs in linguistically and culturally appropriate manner. The Public Health Educator to assist the new arrival refugees by providing health literacy on health and mental health within the refugee community. The position will focus on the physical and emotional wellness as a foundation for successful resettlement and integration of newly arrived refugees. The Refugee Mental Health Specialist will address mental health within the refugee community. In addition, there will be a focus on capacity building within the communities, which includes overcoming stigmas associated with mental health care and create opportunities for social engagement to reduce isolation by collaborating with ethnic-based organizations and/or local resettlement agencies. There will additionally be a focus on client-centered, trauma-informed, strength-based, and culturally and linguistically appropriate activities.

Priority Need: Increase the Number of Children, Both With and Without Special Health Care Needs, Who Have a Medical Home

NPM 11: Medical Home

In the reporting year, Child Health facilitated efforts to educate families about the importance of having a medical home and increasing families' access to a medical home through education and expanding telehealth capacity. Young children with access to consistent preventative health services, early and periodic screening, and coordination of care across a broad range of other specialty, ancillary and related services, are more likely to grow to become healthy and thriving adults. A medical home extends beyond the four walls of a clinical practice and provides care

that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

Medical Home

HMG Georgia is a strategy to help ensure that all children have a comprehensive, family-centered, coordinated care within a medical home. HMG Georgia continued to partner with Healthy Mothers, Healthy Babies Coalition of Georgia (HMHBGA) to provide information, healthcare referrals and follow-up services. Liaisons worked to help link children and families to developmental screening, day care, early learning resources, and behavioral services by coordinating with child focused programs within the local community. In the current year, 4,149 callers have been served through HMG Georgia.

Resources and referrals were provided to empower families to overcome barriers to services for children birth to age 8 and to improve the overall health and wellbeing of the family. Families were connected to resources that supported optimal health such as dental, vision and medical care providers, mental health, and substance use support. Referrals for food, clothing, housing, and medication assistance were also provided.

To foster a culture of respect, improved understanding, and enhanced communication skills and to ensure staff are engaging successfully with all callers, HMG Georgia Liaisons participate in annual cultural competency training, including topics such as serving lesbian, gay, bisexual, or transgender, queer/questioning, intersex, asexual, pansexual, and allies (LGBTQIA+) families and aging populations.

Birth certificates for children born in Georgia are screened for risk factors identified in the perinatal period. When risk factors are identified, families are contacted within 5 days of birth. During the initial contact families are provided education on Learn the Signs. Act Early. developmental milestones tracker app and linked to a medical home for their infant if needed. Mothers are also encouraged to schedule and complete their postpartum appointment.

Children 1st utilizes a program screening tool to determine risks for poor health outcomes and developmental delays. District Children 1st staff use this information to make appropriate linkages to public health, private, and community-based resources to meet the needs of the family and support healthy growth and development.

Current Year:

HMG Georgia continues to partner with HMHBGA to provide information, healthcare referrals and follow-up services. This partnership enables the network of resources and providers to grow as they provide outreach and education in the community, in addition to providing parenting classes and supports through their virtual education program, Pickles and Ice Cream. Promotional materials were created in partnership with HMHBGA and were utilized in outreach events across the state of Georgia to educate families on the HMG Georgia (1-888-HLP-GROW) free statewide resource and referral line to connect families to health care providers, state, and community resources.

HMG Georgia Liaisons facilitate referrals to Children 1st for children 0-5 years of age when families do not have a medical home. Children 1st provides developmental screening and referrals to pediatricians, primary care providers, and any additional medical services or immunization needs for the child and their family members.

HMG Georgia Liaisons participated in the annual cultural competency training and the Learn the Signs. Act Early. education session facilitated by the Georgia CDC Act Early Ambassador to better understand developmental milestones, recent revisions to the milestones, and to become well versed in promoting and describing this essential resource in connecting families to a medical home and early intervention services.

Children 1st continues to provide education, support and resources to families concerning the importance and benefits of a medical home for all children.

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

Oral Health

Oral diseases are a health concern in Georgia. Dental caries and periodontal diseases have economic and social cost, and can result in serious systemic problems, pain, and suffering. Most oral diseases are preventable, and the Oral Health program makes every effort to promote and implement preventive measures for all of Georgia's citizens.

In the reporting year, Oral Health served 16,840 children in district public health dental clinics, 21,909 children received dental screenings in any setting, 33,523 students received oral health education in school settings by district oral health staff, 4,710 dental sealants were placed on children's teeth, 10,484 fluoride varnish applications were provided to children, and six school sealant programs were carried out on-site at local elementary schools. Oral Health continued to distribute toothbrushes to school children through partnerships with local schools.

Current Year:

Oral Health continues to implement the American Academy of Pediatrics (AAP) "Book, Brush, Bed" program, which strives to build nighttime routines for children around brushing teeth for two minutes with fluoridated toothpaste.

Oral Health continues to serve on advisory boards and work groups on oral health for external partners, which includes HMHBGA, DECAL, Georgia Cancer Control Consortium Human Papillomavirus (HPV) workgroup, among other stakeholders.

Oral Health continues to promote school sealant programs, an evidence-based dental decay prevention measure of placing dental sealants on molar teeth in the school setting. This service occurs at a location where children congregate and does not require parents to be present, which helps eliminate barriers such as scheduling around the parents' workday and finding childcare for other children in the home. Dental screenings, fluoride varnish application, and oral health education are also components of the school-based program. Efforts to make referrals to dental providers and find dental homes for these children will continue so other dental needs can be addressed. Oral Health partners with district staff and external partners to increase the presence of school sealant programs within Georgia.

Other Child Health Programs

Help Me Grow

HMG Georgia provides a free statewide resource and referral line (1-888-HLP-GROW) that connects families, health care providers, and professionals to a database of over 3,000 state and community resources. HMG Georgia works to reach communities by engaging state and local agencies and promoting HMG Georgia as a resource that front-line staff may share when interacting with families. The HMG Georgia referral system includes partnerships with Department of Community Health (DCH), Department of Education (DOE), GA Department of Early Care and Learning (DECAL), and Division of Family and Child Services, (DFCS), and a host of maternal and child primary care providers.

In partnership with the Georgia Academy of Family Physicians, Dr. Paul Dworkin, Founding Director of Help Me Grow National, provided a virtual training for pediatricians and family physicians. Thirty-six providers attended the live session and learned about Help Me Grow Georgia. Providers were educated on the multitude of benefits for

families when they refer families in need to the Help Me Grow resource and referral line. The recording was made available for those that could not attend to listen in later.

HMG Georgia assisted families in supporting young children's healthy development and ensures access to community resources during times of need. HMG Georgia was essential during the infant formula shortage crisis during Spring 2022. HMG Georgia liaisons provided education and connected families to available resources during the formula shortage. Working closely with families and collaborating with GA Chapter of the American Academy of Pediatrics (GA AAP), Georgia WIC, and community partners, HMG Georgia provided support, resources, and referrals for families during the crisis. HMG Georgia continued to provide COVID-19 resource information, in addition to referrals to healthcare providers, as the pandemic was ongoing, and families returned to in person learning environments and caught up on well child appointments and immunizations that were postponed at the height of COVID-19.

Help Me Grow, Children 1st, and other child health programs along with partners from GA AAP and Georgia Early Education Alliance for Ready Students (GEARS) presented at the 2022 Association of Maternal & Child Health Programs (AMCHP) Conference, "Addressing Mental and Behavioral Health Needs: Collaboration is Key". The session covered best practices in developing and sustaining cross agency partnerships in communities to improve developmental screening, increase referrals to early intervention program rates, and to expand access to healthcare and a medical home.

An example of this partnership in Georgia to improve developmental screening, increase referrals to early intervention program rates, and to expand access to healthcare and a medical home is the collaborative partnership with DECAL. HMG staff trained DECAL Family Peer Ambassadors, including fathers, mothers, custodial grandparents, foster parents, stepparents or guardians of young children in licensed childcare or early intervention programs, on the HMG Georgia resource and referral line (1-888-HLP-GROW) and how families can access early intervention services. DECAL Family Peer Ambassadors share information learned on accessing healthcare, developmental milestones, developmental screening and early intervention services with families they engage with in the peer-to-peer support program.

Current Year:

HMG Georgia continues to provide the free statewide resource and referral line (1-888-HLP-GROW), promote HMG Georgia as a resource with state and local agencies, and maintain partnerships involved in the referral system.

Help Me Grow Georgia was identified as an essential entry point for families by the Act Early GA Team, a project aimed to improve systems of support for children birth to five in the state of Georgia by developing and coordinating Learn the Signs. Act Early education and outreach. The Act Early GA Team developed and distributed communication tools, including the Acting Early in Georgia infographics, Training Toolkit and Acting Early in Georgia website: <https://development.decal.ga.gov/#/actearly>. The Act Early GA Team project was led by Georgia State University Center for Leadership, DECAL, and the current GA Act Early Ambassador working in collaboration with DPH, DFCS, GA-AAP, Parent to Parent of GA, and the Georgia Advocacy Office.

To increase awareness about Help Me Grow Georgia, Act Early GA materials were made available to providers, community partners, and infant and early childhood stakeholders who attended the The Georgia Association for Infant Mental Health (GA-AIMH) kickoff event at GSU in fall 2023.

Vision Screening

Vision screening is an important way to identify vision problems. All children are required to have vision screening completed and documented on the Georgia state form 3300 prior to their initial entry into the Georgia school system.

DPH, in cooperation with the DOE, provided and monitored vision screening training and certification for local health department staff who perform vision screening on children three years of age and older. All staff within local health departments who administer vision screenings require certification prior to screening children and must complete recertification every three years. The vision certification process includes a didactic component as well as a demonstration of skills. The didactic portion of the vision screening training is available electronically through the DPH statewide training platform. Following the didactic instructions, those seeking recertification must pass a post-test, and accurately demonstrate key screening competencies to a certified screener. Vision screeners are recertified when they have passed the post-test and have competencies documented on a procedure's validation form.

Current Year:

In Georgia, Form 3300 includes documentation of vision screening results and must be on file for every student attending school. DPH will be working with DOE to determine if it might be possible to pilot a quality assurance process for Form #3300 to assess whether a form is on file for every student and whether follow up of abnormal findings has been completed.

Immunizations

The Georgia Immunization Program (GIP) seeks to increase immunization rates for all Georgians and decrease the incidence of vaccine-preventable diseases (VPD). GIP educates public and private medical providers through partnerships and collaborations about the importance of protecting their patient population from vaccine preventable diseases, in accordance with the Advisory Committee for Immunization Practices (ACIP) recommended immunization schedule. In addition, GIP works to educate medical providers and laboratories about the importance of disease reporting for all reportable VPDs, placing an emphasis on targeting prenatal care providers to increase the number of hepatitis B virus (HBV)-positive pregnant women identified annually.

The Georgia Perinatal Hepatitis B Prevention Program (PHBPP) worked with DPH's Assistant Commissioner for Policy to update the Rules of the Department of Public Health – Serologic Tests for Pregnant Women – Chapter 511-5-4 to include maternal hepatitis B surface antigen (HBsAg) testing each pregnancy. In May 2021, stakeholder calls were held with the Medical Association of Georgia, Georgia Obstetrical and Gynecology (OB/Gyn) Society, the Georgia Chapter of the American Academy of Pediatrics (GA-AAP), Georgia Academy of Family Physicians, Georgia Hospital Association, and the DCH to explain the need for the rule change and to obtain feedback from each organization. Comments received from the organization were incorporated into the revised version of the rule change language that was presented to DPH's Health Commissioner for consideration of adoption. On August 31, 2022, the new regulation became effective requiring Hepatitis B Virus (HBV) and Hepatitis C serologic testing for every pregnant woman in Georgia.

GIP continues to collaborate with Child Health and provide communication such as the Vaccines for Children (VFC) Programmatic Newsletters and the Immunize Georgia Newsletter. GIP includes Child Health as an attendee for quarterly immunization meetings and the annual statewide Immunize Georgia Conference, providing a platform for both programs to share and receive the most up-to-date immunization updates.

Related legislation: All Georgia physicians, laboratories, and other health care providers are required by law (OCGA 31-12-2) to report patients with the conditions listed under Notifiable Disease Reporting Requirements. Both laboratory confirmed and clinical diagnoses are reportable within the specified time interval.

Current Year:

In the current year, GIP has continued communication efforts with Child Health to strengthen coordination and collaboration.

The PHBPP has continued to provide state staffing support to public health districts and assist with case management activities. The PHBPP submitted the program's 2023 annual report to CDC for birth cohort 2021 in March 2023. The program increased their case completion percentage for post-vaccination serologic testing from 83 percent to 84 percent.

The PHBPP will continue to work with Georgia health organizations to promote the new regulation that requires Hepatitis B Virus (HBV) and Hepatitis C serologic testing for every pregnant woman in Georgia. An article promoting the new testing regulation was included in the GA-AAP's Spring 2023 newsletter, *The Georgia Pediatrician*.

In the remainder of the year, the PHBPP will collaborate with DPH's Epidemiology Program to add hepatitis B surface antigen (HBsAg) and hepatitis B surface antibody (anti-HBs) (positive, negative, indeterminate) laboratory reporting for infants and children less than two years of age to identify HBV-exposed infants that completed recommended testing.

Child Occupant Safety Program (COSP)

Motor vehicle related injuries continue to be a leading cause of death for children under 14 years of age. The Injury Prevention Program (IPP) used the CDC and Prevention's Guide to Community Preventive Services method of child passenger safety intervention through education, equipment distribution, enforcement, and policy change works to increase child safety seat use.

The Child Occupant Safety Project (COSP), utilizing local partners, conducts monthly education classes to train caregivers on proper use and installation of child safety seats. After participating in the classroom education, caregivers are provided an appropriate child safety seat (either a convertible or a booster). The caregivers then demonstrate proper installation technique before leaving the event. This education and distribution program is known as the Mini-Grant program. In 2022, 143 counties either directly participated in or were covered by the Mini-Grant program. The Mini-Grant provided 1,411 monthly classes, trained 4,950 caregivers, and distributed 2,514 seats during the reporting year.

In addition to the conventional seats distributed, COSP worked with families of children with special healthcare needs to evaluate transportation needs and issues. Evaluations were provided to 65 children. COSP staff previously developed a flow chart for use by Children's Medical Services and other field referrers to assist families through the process. Based on information received in the flow chart, many families have been able to receive seats through Medicaid funding, allowing COSP to transition to a funder of last resort.

Teddy Bear Stickers are placed on all car seats distributed to document the number of lives saved from injury/and or death due to program funded child safety seats. If a grant provided seat is involved in a crash, the caregiver may receive a replacement seat from the original issuing agency. That agency submits a report, along with the crash report, to IP staff. In 2022, IPP staff received 9 Teddy Bear Sticker forms and replaced 9 seats, bringing the total (potential) lives saved to over 440 children.

Other trainings and presentations offered by IPP staff in the reporting year include:

- "You have the Power in Your Pen" – 6 classes, training 160 law enforcement officers
- Child Passenger Safety Technician course – 34 classes, training 253 attendees
- CPST recertification class for current CPSTs – 24 classes with 124 attendees

- CPST Renewal course – 4 class with 11 students
- “Transporting Children with Special Health Care Needs Training” – 1 class with 11 attendees
- Keeping Kids Safe – 11 classes at 5 hospitals with 107 nurses trained

Current Year:

In the current year, IPP continues to distribute child safety seats to children, including specialized child safety restraint systems for children with special health care needs. The number of lives saved continues to be documented through Teddy Bear Stickers (TBS) placed on the child safety seats that are distributed.

IPP provides outreach and child passenger safety trainings to internal and external stakeholders utilizing Zoom and Microsoft Teams virtual platforms. The program is offering the following training opportunities during the current year:

- 16-hour Special Needs transportation program - “Safe Travel for All Children: Transporting Children with Special Health Care Needs”
- 30-hour Child Passenger Safety Technician certification
- 8-hour Child Passenger Safety Technician Renewal
- 6-hour Child Passenger Safety Technician recertification classes
- Power in your Pen for law enforcement
- Keeping Kids Safe for hospital personnel
- Transporting Children Safely in Ambulances for EMS and fire personnel
- Basic Child Passenger Safety Awareness for parents, caregivers, and other professionals

IPP continues to work with DFCS staff and contractors to provide training on proper transportation of children, state law and best practice recommendations. Similar training is offered to Head Start and other daycare agencies staff upon request.

Child Health - Application Year

Application Year: October 1, 2023 – September 30, 2024

Priority Need: Promote Developmental Screenings Among Children

NPM 6: Developmental Screening for Children

Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

NPM 6 Strategies:

- 6.1a Develop a Physician Outreach campaign to increase the number of providers utilizing standardized developmental screenings and supportive services available through Public Health (e.g., BCW, C1st, CMS, EHDI, Home Visiting, Help Me Grow).
- 6.1b Provide feedback on referrals to all referral sources to encourage care coordination and future referrals.
- 6.2a Provide 10 total trainings annually via the state office to community partners and provider practices through collaborative partnerships with medical and maternal and child health agencies.
- 6.2b Make the ASQs available to parents online.
- 6.2c Work with the Home Visiting program to produce a protocol to increase the number of de-duplicated developmental screenings.

Children 1st

In FY2024, Children 1st districts are encouraged to engage annually with at minimum one physician/health care provider, one community-based organization, and complete one community outreach activity to initiate or increase developmental screening and referral to early intervention services to improve the health and developmental outcomes of Georgia's children in their local health district.

Children 1st will collaborate with Children's Medical Services and Babies Can't Wait to provide education to Emory School of Nursing Students to promote developmental screening and educate on the referral system for early intervention in Georgia.

Children 1st is planning to revise the Screening and Referral form to improve the referral relationship with community partners, early care and learning centers, and DFCS by developing a user-friendly form. Children 1st will continue to explore opportunities to provide feedback on referrals to partners agencies that provide a release of information signed by the child's parent or legal guardian.

Children 1st will continue to offer ASQ train-the-trainer and other support for district staff as needed based on staff turnover or other training needs.

Children 1st will continue to provide ASQ online to parents of children who were referred for developmental concerns. Districts will explore how to best incorporate ASQ online outreach to best serve the needs of their area.

Refugee Health

In the upcoming year, the State Refugee Health Program (SRHP) will continue to promote the physical, mental, and social well-being of all newly arriving refugees in the state of Georgia. The SRHP will work in partnership and collaborate with the various stakeholders involved in refugee resettlement that include resettlement agencies, county health departments, community health centers, community-based organizations, mainstream social service

providers, schools, members of charitable organizations, and church and community leaders. The SRHP will work with county health departments to screen all newly arriving refugees for communicable and chronic diseases, and to administer immunizations. The Refugee Pediatric Center will continue to provide referrals to the DeKalb Board of Health Refugee Clinic at Kaiser Permanente. SRHP will monitor referrals and provide developmental screening outreach materials including the Children 1st program, BCW, CMS, EHDI, Autism, and Learn the Signs. Act Early.

Priority Need: Increase the Number of Children, Both With and Without Special Health Care Needs, Who Have a Medical Home

NPM 11: Medical Home

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

NPM 11 Strategies:

- 11.1a Expand the use of telehealth technology to improve access to audiological and early intervention services for children and youth with special health care needs.
- 11.1b Facilitate efforts to educate families about telehealth as an option for care.
- 11.1c Provide ongoing evaluation of the Department's telehealth network to ensure pediatric specialty services meet the needs of families and patients.
- 11.1d Develop and implement a quality improvement plan for Title V's Children and Youth with Special Health Care Needs program to identify opportunities in which telehealth technology may be used to improve medical home access.
- 11.1e Expand the capacity of HMG liaisons to help families navigate/ access comprehensive services.
- 11.1f Improve access to information and resources for CYSHCN.
- 11.1g Develop an outreach plan to engage partners, providers, and families in the utilization of HMG, a shared resource to assist families to navigate the early childhood system.

Medical Home

HMG Georgia will continue to partner with Healthy Mothers, Healthy Babies Coalition of Georgia (HMHBGA) to provide information, healthcare referrals and follow-up services. Trained liaison staff will increase to provide additional support on the HMG Georgia resource and referral line. A bi-lingual call center staff member will be trained as an HMG Georgia liaison to provide Spanish support for the HMG Georgia line.

HMG Georgia will continue to work to help link children and families to developmental screening, day care, early learning resources, and behavioral services by identifying and coordinating with child focused programs within the local community to add to the resource database. The resource database will be updated, and additional referrals will be added to empower families to overcome barriers to services for children birth to age 8 and to improve the overall health and wellbeing of the family.

HMG Georgia will strengthen the relationship with HMG national by attending the HMG conference, learning best practices from other states, and identifying opportunities for improvement in our HMG Georgia system of care.

Children 1st will continue to provide education, support and resources to families concerning the importance and benefits of a medical home for all children.

Priority Need: Promote Oral Health to All Populations

NPM 13.2: Preventive Dental Visit

Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

NPM 13.2 Strategies:

- 13.2a Create and update a State Oral Health Surveillance Plan that functions to identify data sources, collection strategies, collection timeframes, and dissemination approaches.
- 13.2b Coordinate and provide district coordinator meetings periodically where resources are shared, updates are provided from states and district programs, continuing education or presentations are offered, and technical assistance is offered as needed.
- 13.2c Work with Healthy Mothers Healthy Babies Coalition of Georgia (HMHBGA) and other external partners by providing subject matter expertise and strategic feedback.
- 13.2d Support district programs partnering with local schools to promote school-based/school-linked sealant and oral health prevention programs that target schools where 50% or more of the student population are eligible for free and reduced lunch.
- 13.2e Support district program staff going to local schools and providing oral health education programs.
- 13.2f Provide trainings to local water plant operators on the value of community water fluoridation and technical assistance to improve monthly reporting from local community water systems.

Oral Health

Oral Health will continue to implement the American Academy of Pediatrics (AAP) “Book, Brush, Bed” program, which strives to build nighttime routines for children around brushing teeth for two minutes with fluoridated toothpaste.

The Oral Health program staff will continue to serve on advisory boards and work groups on oral health for external partners.

The Oral Health program will also promote school sealant programs, an evidence-based dental decay prevention measure of placing dental sealants on molar teeth in the school setting. The program will also continue to support the health districts in sustaining their sealant programs by providing the necessary training and supplies. This service occurs at a location where children congregate and does not require parents to be present, which helps eliminate barriers such as scheduling around the parents’ workday and finding childcare for other children in the home. Dental screenings, fluoride varnish application, and oral health education are also components of the school-based program. Efforts to make referrals to dental providers and find dental homes for these children will continue so other dental needs can be addressed. The Oral Health program will continue to partner with district staff and external partners to increase the presence of school sealant programs within Georgia. BRFSS and PRAMS data will be used to identify gaps and barriers to oral care among school-aged children, as well as inform program planning.

Other Child Health Programs

Help Me Grow

DPH 1st Care program will promote the HMG Georgia resource and referral line (1-888-HLP-GROW) to connect families with infants born with substance exposure to a health and resource line that can be used for all household members. A similar process will be established to identify and engage child-serving community partners with HMG Georgia materials to promote the line across the state. Through partnership with key programs, child serving stakeholders will receive education about HMG Georgia, developmental screening, and develop strategies to incorporate HMG Georgia education into their work with families.

Child Health will identify ways to promote HMG Georgia across by collaborating with best practice HMG Georgia

programs in other states.

Vision Screening

DPH will continue to assist in the completion, compilation, and assessment of the Certificate of Vision, Hearing, Dental, and Nutrition Screening form required for the school admittance in Georgia.

Immunizations

The Georgia Perinatal Hepatitis B Prevention Program (PHBPP) will collaborate with DPH's Viral Hepatitis Program to develop strategies to increase the detection of pregnant persons who test HBsAg-positive and identify HBV-exposed infants as outlined in DPH's Viral Hepatitis Elimination Plan.

In this time period, District Case Managers and DPH PHBPP staff will contact HBsAg-pregnant women by phone to provide education about perinatal HBV transmission, newborn prophylaxis, hepatitis B vaccination, and post-vaccination serologic testing in an effort increase the percentage of cases interviewed prior to delivery.

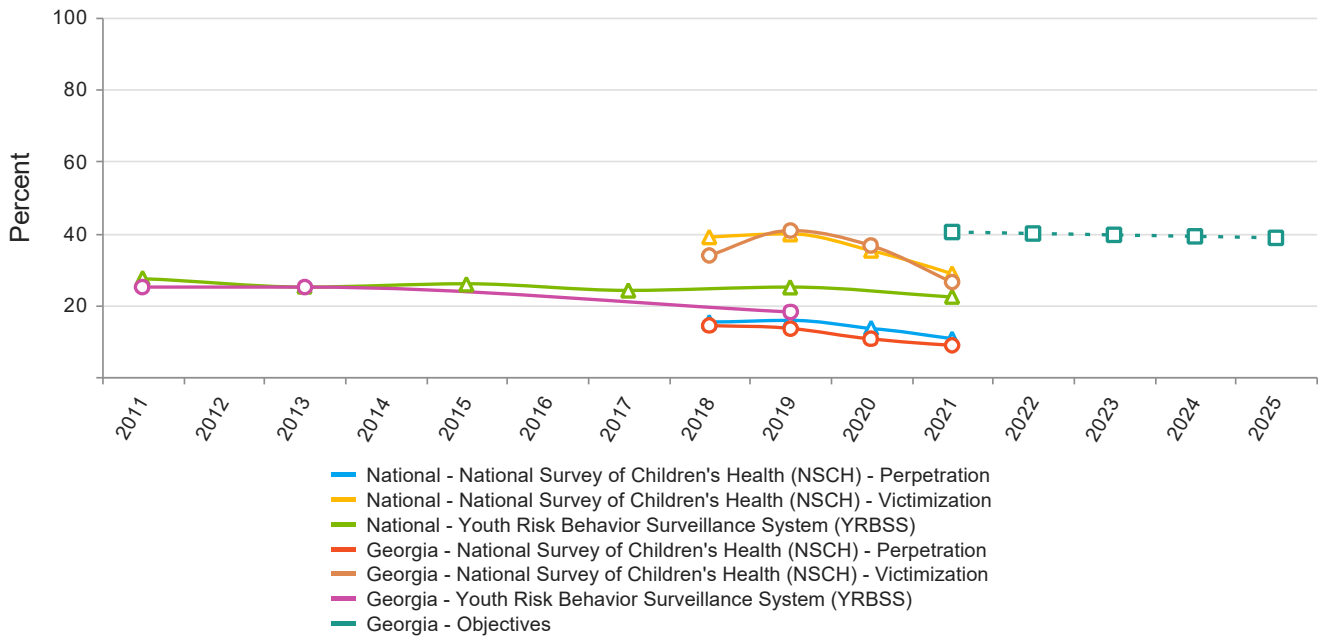
Child Occupant Safety Program (COSP)

The Injury Prevention program (IPP) will continue to distribute child safety seats to children, including specialized child safety restraint systems for CYSHCN. The number of lives saved will continue to be documented through Teddy Bear Stickers (TBS) placed on the child safety seats that are distributed. Child passenger safety trainings to internal and external stakeholders will continue. Staff will provide online modular trainings and will continue utilizing non-traditional methods to conduct outreach with agencies. Online platforms, such as Zoom and Microsoft Teams, are being utilized for training and outreach. The program will continue to offer a 16-hour special needs transportation program- "Safe Travel for All Children: Transporting Children with Special Health Care Needs" at least twice per year. Staff will continue to conduct transportation evaluations for CYSHCN during certain clinic days, in conjunction with CMS.

Adolescent Health

National Performance Measures

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



Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2019	2020	2021	2022
Annual Objective			40.3	39.9
Annual Indicator	25.1	18.3	18.3	18.3
Numerator	110,846	98,922	98,922	98,922
Denominator	442,284	540,678	540,678	540,678
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2013	2019	2019	2019

Federally Available Data

Data Source: National Survey of Children's Health (NSCH) - Perpetration

	2019	2020	2021	2022
Annual Objective			40.3	39.9
Annual Indicator	14.2	13.6	10.5	8.9
Numerator	106,312	108,009	89,060	77,416
Denominator	750,443	796,760	852,021	865,391
Data Source	NSCHP	NSCHP	NSCHP	NSCHP
Data Source Year	2018	2018_2019	2019_2020	2020_2021

Federally Available Data

Data Source: National Survey of Children's Health (NSCH) - Victimization

	2019	2020	2021	2022
Annual Objective			40.3	39.9
Annual Indicator	33.7	40.7	36.6	26.5
Numerator	257,779	327,333	311,850	229,248
Denominator	765,064	804,071	851,494	865,841
Data Source	NSCHV	NSCHV	NSCHV	NSCHV
Data Source Year	2018	2018_2019	2019_2020	2020_2021

Annual Objectives

	2023	2024	2025
Annual Objective	39.5	39.1	38.7

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - Number of schools, individuals, and organizations that receive guidance on evidence-based strategies to prevent bullying

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	0
Annual Indicator			0	125
Numerator				
Denominator				
Data Source			Injury Prevention Program Data	Injury Prevention Program Data
Data Source Year			FFY 2021	FFY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	131.0	138.0	144.0

State Action Plan Table

State Action Plan Table (Georgia) - Adolescent Health - Entry 1

Priority Need

Increase bullying and suicide prevention

NPM

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

Objectives

9.1 By September 2021, identify the prevalence and existing prevention programs and GA State policy and legislation on bullying.

9.2 By 2025, observe improvements in bullying prevention efforts by schools that service the target population (ages 12-17).

9.3 By 2025, increase use in clear and consistent use of language across organizations working on bullying and suicide prevention and other relevant stakeholder groups.

Strategies

9.1 Conduct an environmental scan and needs assessment to determine the status of bullying in Georgia.

9.2 Provide guidance and/or recommendations to DOE and individuals schools on evidence-based strategies to prevent bullying.

9.3 DPH IPP will engage in events hosted by agencies or organizations that include bullying prevention in their strategic plans and that align overall activities and policy contributions within a framework of shared risk and protective factors and/or social determinants of health, in order to support efforts to display and encourage the use of consistent language and communications around the public health issue of bullying.

9.4 Increase awareness of shared risk and protective factors between violence and suicide among partners, including those working on ACEs prevention, bullying prevention, child abuse and neglect, and interpersonal violence prevention.

ESMs

Status

ESM 9.1 - Number of schools, individuals, and organizations that receive guidance on evidence-based strategies to prevent bullying

Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Priority Need: Increase Bullying and Suicide Prevention

NPM 9: Bullying

Bullying and Suicide Prevention

Bullying is a community issue and must be addressed by students, parents, schools, and the entire community. Adolescents who bully others tend to exhibit other defiant and delinquent behaviors, have poor school performance, are more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation, as well as have poor school performance, suicidal ideation, and suicide attempts. Emotional and behavioral problems experienced by victims, bullies, and bully-victims may continue into adulthood and produce long-term negative outcomes, including low self-esteem and self-worth, depression, antisocial behavior, vandalism, drug use and abuse, criminal behavior, gang membership, and suicidal ideation.

In the reporting year, the Sources of Strength program continued to have a positive impact on student relationships in the Dawson County School System. The program continued training Adult Advisors in the train the trainer curriculum to help ensure that the Sources of Strength program is self-sustaining in the Dawson County School System. The program supported the establishment of a Suicide Prevention Coalition in Dawson County to provide an awareness event for students to present the Sources of Strength program information to parents and other community members.

The Suicide Programs Assessment Survey was re-disseminated across the state to gather additional data about the scope of work and activities for agencies working on ACEs, suicide, and bullying prevention and related areas. Focus groups were conducted, and data were analyzed to gather more in-depth information of desired needs and resources following the Georgia school administrator's assessment, which was conducted to assess opportunities for mental health support and resources. The focus for this project shifted during the current year and a core partner developed their own resource.

The Injury Prevention Program (IPP) also conducted an environmental scan and community needs assessment around existing prevention programs, policy, and legislation on bullying prevention and suicide prevention activities. The purpose was to identify resources as well as gaps in resources to address bullying through a primary prevention lens. IPP will continue to use the results of the environmental scan and the Suicide Programs Assessment Survey to inform guidance and/or recommendations provided to the Department of Education, the Department of Family and Children Services (DFCS), non-governmental organizations, and individual schools regarding laws, policies, and evidence-based strategies to prevent bullying, especially as a risk factor for and related to suicide.

The environmental scan revealed that while both bullying and suicide prevention are positively impacted through positive youth interactions with caregivers and non-caregiver adults, there were few prevention resources that included the adult caregivers. IPP is partnering with Prevent Child Abuse Georgia (PCA) to implement evidence-based parenting seminars for adolescents and their caregivers to fill existing gaps in services. PCA will work with IPP to solicit and vet organizations to become trained in the "Teen Triple P" program within identified regions of high bullying and suicide rates among youth. Teen Triple P is an evidence-based parenting program for parents of teens to guide parents in raising competent, responsible, and connected teens.

PCA staff conducted four half-day virtual Parent Café facilitator trainings with approved facilitators with the goal of training 25 facilitators per training. A total of 100 facilitators were trained in identified high risk regions. PCA also hosted a two-day virtual training with approved facilitators and Triple P accredited trainers to provide technical assistance and support to facilitators as they schedule and host their required seminar series to receive their Triple P accreditation. The program will help ensure that more individuals are trained as trainers in the “Triple P” parenting program and community organizations are equipped to provide this meaningful program to families. Implemented prevention efforts around bullying have focused heavily on the schools and the youth themselves and this program aims to help adult support systems provide the safe, stable, and nurturing relationship and environments needed to support youth and help prevent bullying, death by suicide, and other forms of youth violence.

IPP's efforts align with other grant funded activities such as, Preventing Adverse Childhood Experiences: Data to Action (PACE: D2A), Preventing Violence Affecting Young Lives (PREVAYL), and Core State Injury Prevention Program (CORE SIPP), which are funded by the CDC. Additionally, this work aligns with the Statewide Child Abuse and Neglect Prevention Plan that has been implemented regionally through DFCS.

Current Year:

In the current year, the Injury Prevention program (IPP) has continued to develop resources to assess needs and develop strategies to combat bullying among school-age children, as well as support youth suicide prevention.

IPP has continued to use the results of the environmental scan and the Suicide Programs Assessment Survey to provide guidance and recommendations to the Department of Education (DOE), Department of Family and Children Services (DFCS), non-governmental organizations, and individual schools regarding evidence-based strategies to prevent bullying, especially as a risk factor for and related to suicide. IPP has also utilized the data to work with the Department of Behavioral Health and Developmental Disabilities (DBHDD) and their work related to youth suicide prevention. IPP has done this by having regular meetings with the Department of Behavioral Health and Developmental Disabilities youth suicide prevention team to ensure timely resource and data sharing.

IPP has continued to partner with Prevent Child Abuse Georgia (PCA) to implement evidence-based parenting seminars for adolescents and their caregivers to increase prevention resources that include adult caregivers. IPP has supported these efforts by providing facilitator cards to be used during the seminars to support caregiver knowledge.

IPP has met with DOE to discuss what evidence-based prevention methods would be useful to compile into a resource packet that schools can reference. DOE has agreed to post the resource packet when complete on their website for ease of access by schools.

IPP will continue to align the efforts of other grant funded activities such as Preventing Adverse Childhood Experiences: Data to Action (PACE: D2A), Preventing Violence Affecting Young Lives (PREVAYL), and Core State Injury Prevention Program (CORE SIPP), which are funded by the CDC to support and enhance Title V program activities.

Adolescent Health - Application Year

Application Year: October 1, 2023 – September 30, 2024

Priority Need: Increase Bullying and Suicide Prevention

NPM 9: Bullying

Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Objectives

NPM 9 Strategies

Strategies

- 9.1 Conduct an environmental scan and needs assessment to determine the status of bullying in Georgia.
- 9.2 Provide guidance and/or recommendations to DOE and individual schools on evidence-based strategies to prevent bullying.
- 9.3 DPH IPP will engage in events hosted by agencies or organizations that include bullying prevention in their strategic plans and that align overall activities and policy contributions within a framework of shared risk and protective factors and/or social determinants of health, in order to support efforts to display and encourage the use of consistent language and communications around the public health issue of bullying.
- 9.4 Increase awareness of shared risk and protective factors between violence and suicide among partners, including those working on ACEs prevention, bullying prevention, child abuse and neglect, and interpersonal violence prevention.

IPP will use the results of the environmental scan and the Suicide Programs Assessment Survey's to provide guidance and recommendations to the Department of Education (DOE), Department of Family and Children Services (DECAL), non-governmental organizations, and individual schools regarding evidence-based strategies to prevent bullying, especially as a risk factor for and related to suicide. IPP will also use the data to work with the Department of Behavioral Health and Developmental Disabilities (DBHDD) and their work related to youth suicide prevention. IPP will continue regular meetings with the Department of Behavioral Health and Developmental Disabilities youth suicide prevention team to ensure timely resource and data sharing.

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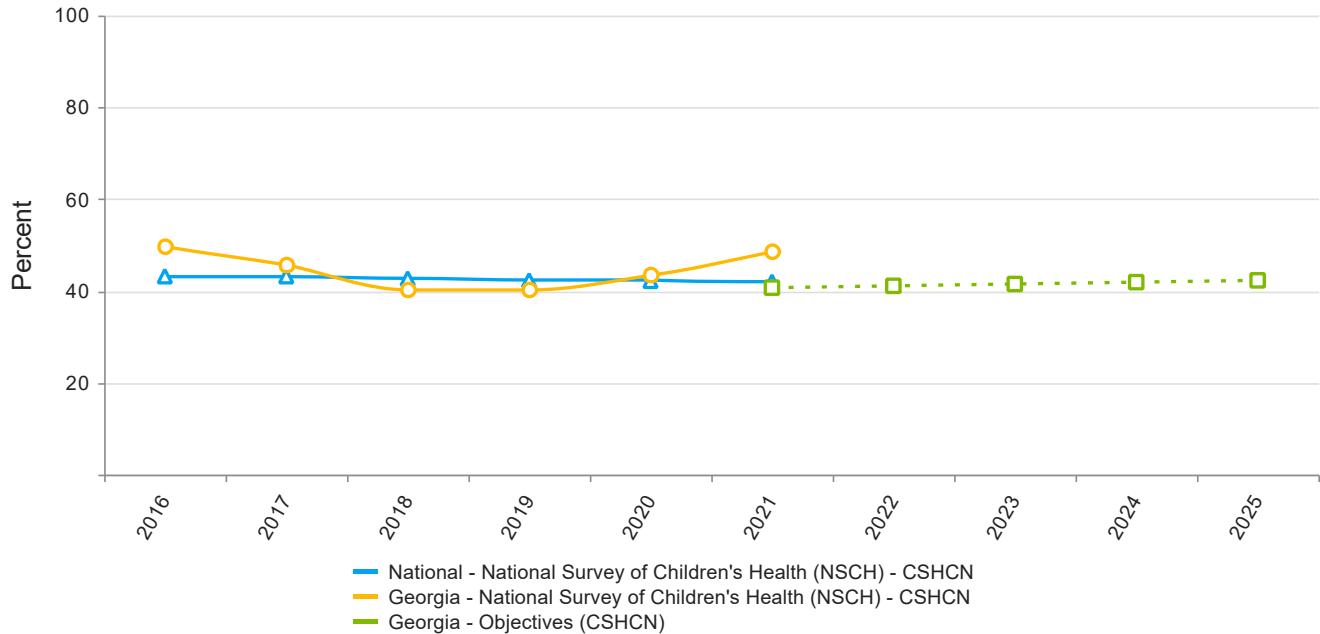
IPP will continue to align the efforts of other grant funded activities such as Preventing Adverse Childhood Experiences: Data to Action (PACE: D2A), Preventing Violence Affecting Young Lives (PREVAYL), and Core State Injury Prevention Program (CORE SIPP), which are funded by the CDC to support and enhance Title V program activities.

Children with Special Health Care Needs

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2019	2020	2021	2022
Annual Objective			40.7	41.1
Annual Indicator	40.3	40.3	43.3	48.5
Numerator	195,620	196,063	230,304	254,036
Denominator	485,463	486,615	531,719	523,657
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	41.5	41.9	42.3

Evidence-Based or –Informed Strategy Measures

ESM 11.2 - Number of telehealth/telemedicine providers in the network

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			14	18
Annual Indicator	10	15	15	12
Numerator				
Denominator				
Data Source	CYSHCN program/ DPH Office of Telehealth and Telem	CYSHCN program/ DPH Office of Telehealth and Telem	CYSHCN program/ DPH Office of Telehealth/Telemedic	CYSHCN program/ DPH Office of Telehealth/Telemedic
Data Source Year	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	22.0	26.0	30.0

ESM 11.3 - Number of callers connected to resources through Help Me Grow (HMG)

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			3,809	4,000
Annual Indicator	3,809	3,218	4,499	4,499
Numerator				
Denominator				
Data Source	Help Me Grow Data	Help Me Grow Data	Help Me Grow Data	Help Me Grow Data
Data Source Year	SFY 2020	SFY 2021	SFY 2022	SFY 2022
Provisional or Final ?	Final	Final	Final	Final

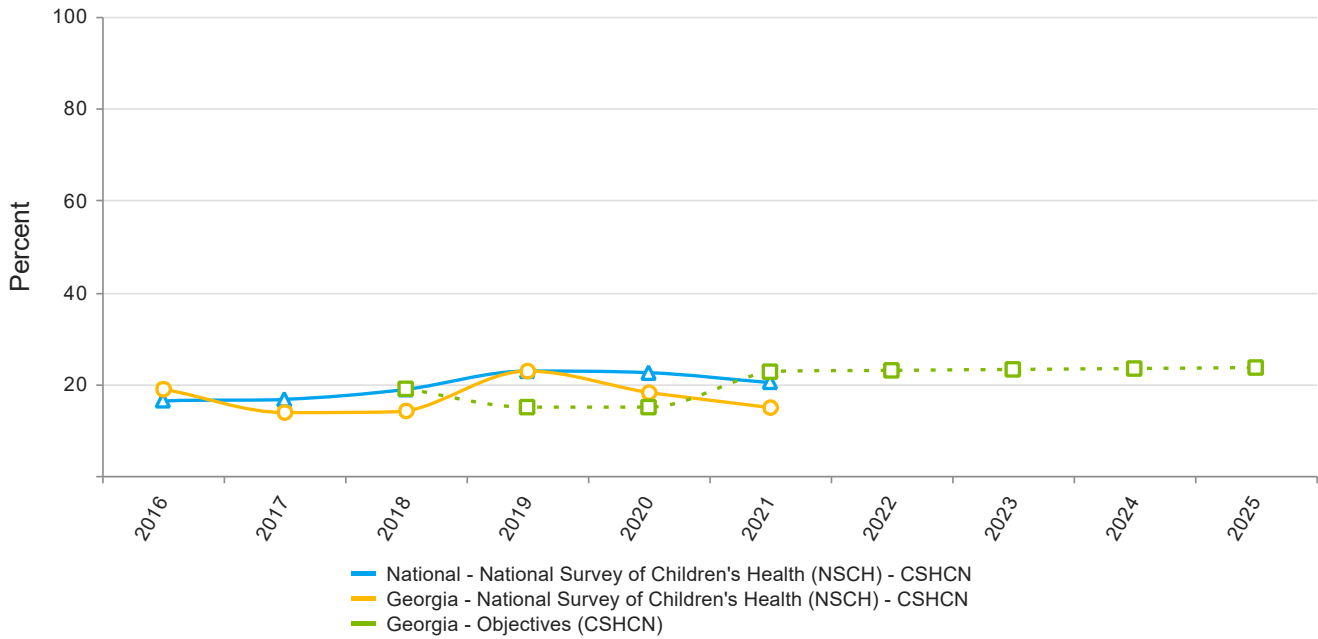
Annual Objectives			
	2023	2024	2025
Annual Objective	4,190.0	4,381.0	4,571.0

ESM 11.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	0
Annual Indicator			0	0
Numerator			0	0
Denominator			180	180
Data Source			Help Me Grow Data	Help Me Grow Data
Data Source Year			SFY 2022	SFY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	0.0	0.0	0.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	2019	2020	2021	2022
Annual Objective	19	15	15	22.7	23
Annual Indicator	14.0	14.2	22.7	18.2	14.9
Numerator	32,898	27,235	43,153	42,606	31,411
Denominator	234,571	192,079	190,472	234,140	211,314
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	23.2	23.4	23.6

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of youth/young adults enrolled in the Department's Title V program for Children and Youth with Special Health Care Needs (CYSHCN) that transfer to an adult provider.

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			23	49
Annual Indicator		25.6	49.1	42.5
Numerator		141	274	232
Denominator		551	558	546
Data Source		CMS Quarterly Report	CMS Quarterly Report	CMS Quarterly Report
Data Source Year		SFY 2020	SFY 2021	SFY 2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	54.0	59.0	64.0

ESM 12.2 - Number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs.

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			15	20
Annual Indicator		10	15	22
Numerator				
Denominator				
Data Source		CYSHCN Annual Assessment Survey	CYSHCN Annual Assessment Survey	CYSHCN Annual Assessment Survey
Data Source Year		SFY 2020	SFY 2021	SFY 2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	25.0	30.0	35.0

State Action Plan Table

State Action Plan Table (Georgia) - Children with Special Health Care Needs - Entry 1

Priority Need

Improve systems of care for CYSHCN

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

12.1 By 2025, increase the percentage of youth/young adults enrolled in the state's Title V Children and Youth with Special Health Care Needs program that report successful transfer to an adult provider by 40%

12.2 By 2025, increase the number of community stakeholders that partner with the state's Title V Children and Youth with Special Health Care Needs program to implement health care transition processes and procedures for youth/young adults with or without special health care needs by 25.

Strategies

12.1a Develop and implement a health care transition quality improvement and evaluation plan to assess the effectiveness and efficiencies of the Department's health care transition program activities that impact youth and families.

12.1b Provide technical assistance and guidance on health care transition planning for care coordinators supporting the Title V Children and Youth with Special Health Care Needs program.

12.1c Implement condition specific transition planning protocols for adolescents enrolled in the Title V Children and Youth with Special Health Care Needs program.

12.1d Provide educational opportunities for youth and families to increase their knowledge on health care transition planning services and resources.

12.2a Establish an advisory group to include youth, families, and providers to support practice improvement efforts for health care transition.

12.2b Partner with adolescent health programs within the Department to implement best practices that support health care transition planning for youth and young adults with or without special health care needs.

12.2c Develop and implement a health care transition communication plan to share targeted messaging for transitioning youth/young adults with and without special health care needs from pediatric to adult care for audiences to include youth/young adults, families, health plans, medical providers, state agencies and community partners.

12.2d Provide continuing education opportunities on the six core elements of health care transition for medical and nursing students, pediatric and adult providers.

ESMs Status

ESM 12.1 - Percent of youth/young adults enrolled in the Department's Title V program for Children and Youth with Special Health Care Needs (CYSHCN) that transfer to an adult provider. Active

ESM 12.2 - Number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs. Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Georgia) - Children with Special Health Care Needs - Entry 2

Priority Need

Increase the number of children, both with and without special health care needs, who have a medical home

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

11.1 By 2025, increase the number of families who receive linkage to appropriate care through a cross-agency referral system, Help Me Grow (HMG).

Strategies

11.1a Expand the use of telehealth technology to improve access to audiological and early intervention services for children and youth with special health care needs.

11.1b Facilitate efforts to educate families about telehealth as an option for care.

11.1c Provide ongoing evaluation of the Department's telehealth network to ensure pediatric specialty services meet the needs of families and patients.

11.1d Develop and implement a quality improvement plan for Title V's Children and Youth with Special Health Care Needs program to identify opportunities in which telehealth technology may be used to improve medical home access.

11.1e Expand the capacity of HMG liaisons to help families navigate/ access comprehensive services.

11.1f Improve access to information and resources for CYSHCN.

11.1g Develop an outreach plan to engage partners, providers, and families in the utilization of HMG, a shared resource to assist families to navigate the early childhood system.

ESMs

Status

ESM 11.1 - Number of telehealth/telemedicine patient encounters Inactive

ESM 11.2 - Number of telehealth/telemedicine providers in the network Active

ESM 11.3 - Number of callers connected to resources through Help Me Grow (HMG) Active

ESM 11.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Priority Need: Increase the Number of Children, Both With and Without Special Health Care Needs, Who Have a Medical Home

NPM 11: Medical Home

There are many challenges to providing comprehensive health and social services to children, youth, and families living in Georgia including the rurality of the state, a fast-growing population that outpaces the growth of the health care system and having approximately one in four children under the age of 18 who are living in poverty. According to the 2020 - 2021 National Survey of Children's Health, 21% of Georgia children and youth, ages zero to 17, have a special health care need but only 16.6% of those children and youth receive care in a well-functioning system. Among children with special health care needs ages 0-17, only 48.5% of children with special health care needs, have a medical home.

The Office of Child Health includes autism services, children and youth with special health care needs, developmental screening and monitoring, early intervention, evidence-based home visiting, high risk infant follow-up, and newborn screening programs. These programs provide critical services and support for children from infancy to young adulthood and their families. Working collaboratively across programs provides enhanced opportunities to leverage resources including subject matter expertise, funding, and trainings. Programs also provide leadership and guidance in health policy development and implementation, needs assessments, workforce development, strengthening family engagement, enhancing community partnerships, expanding telehealth services, and addressing social determinants of health.

Increasing the number of children with and without a medical home was identified as a priority need in the 2020 five-year needs assessment. Child health services are offered statewide and administered through local child health programs available in Georgia's 18 public health districts. Nurses, social workers, care coordinators, service coordinators, developmental specialists, early intervention specialists, therapists, and medical providers are responsible for providing direct services to children and youth with special needs and their families. Timely and ongoing screening and access to a continuum of health care services is critical to achieving optimal outcomes for children including children and youth with special health care needs.

Children's Medical Services

Children's Medical Services (CMS), Georgia's CYSHCN program, provides services to families caring for children and youth, birth to 21 years of age, through a statewide network of 18 public health district who implement CMS services. The CMS program partners with primary care providers, pediatric subspecialists, health care vendors, state agencies, and community-based organizations to coordinate timely access to health care services and supports for eligible CYSHCN and their families. Services include physical evaluations, diagnostic tests, inpatient/outpatient hospitalization, medications and other medical treatments, post-op therapy, durable medical equipment, hearing aids for eligible conditions, as well as genetic counseling. 97% of children and youth enrolled in CMS services receive care within a medical home.

Pediatric specialty care clinics were offered for children and youth living in rural counties where there is limited pediatric subspecialists. The CMS program offered pediatric specialty clinics in nine public health districts and coordinated services with more than 30 specialty providers for face to face as well as telemedicine clinic visits. During 2022, approximately 364 clinics were scheduled. Of those, 140 were provided via telemedicine, and 3,011

children and youth were served via the specialty clinics. Specialty clinic types included endocrinology, nephrology, cardiac, chronic lung, genetics, hematology/sickle cell, orthopedic, hearing, neurology, and cystic fibrosis.

The CMS telemedicine clinics received an upgrade during this reporting period when migration was completed to a web-based platform, Pathways. Prior to this upgrade, telemedicine clinics depended on the utilization of telemedicine carts which required a designated location, space for the cart and ongoing maintenance. Pathways can be accessed with only a laptop with internet connectivity and therefore offers more flexibility as to the location of the telemedicine visit. Pathways is also more cost-effective since it eliminates the need to purchase a cart or provide a dedicated circuit.

Telemedicine clinic satisfaction surveys are completed by patients and families after each clinic visit. The survey assesses individual experiences with scheduling the visit, connecting to the visit and communicating with the care coordinator and medical provider during the telemedicine visit. Overall, survey results indicate satisfaction with the telemedicine visit and most patients and families would schedule their next visit using telemedicine.

CMS serves as the payer of last resort for health care and medical expenses for families that do not qualify for Medicaid, SCHIP programs, or those who are without insurance during CMS program enrollment. In addition to filling in the health care coverage gap, CMS supported CYSHCN and their families by coordinating appointments, identifying resources, and assisting with social supports such as transportation and support groups. Helping CYSHCN and their families gain confidence in managing their health care needs and navigating complex social needs is an important goal for the CMS program.

During this reporting period, families enrolled in CMS received care coordination services by public health nurses and social workers and the program continued to implement its continuity of operations plan to ensure families had access to essential services. Annual and six-month care planning was primarily conducted via the phone following verbal consent. Home visits were not provided but health departments began offering office hours for families and care coordinators to address care plans and other care coordination needs. The primary focus of care planning addressed current and immediate medical and family support needs, promotion of well child visits and immunizations, transition planning and preparation, and assistance with medications and medical supplies.

During the latter part of 2020, the CMS program expanded telemedicine services to include care planning and eligibility determination for families. Cisco WebEx, the Department's secure videoconferencing platform, was utilized to assist with improved engagement and coordination of services. DPH also received funds from the Association of Maternal and Child Health Programs to support telemedicine expansion. The funding provided equipment for families and staff to access and utilize the Cisco WebEx platform.

Funding for Georgia's Family to Family Health Information Center, Parent to Parent of Georgia (P2PGA), is provided by CMS and the early intervention program. P2PGA maintains the Special Needs database that provides resources for children and youth, birth to 26 years, with developmental delays, disabilities and chronic health care conditions. The database houses more than 6,000 resources to assist families with navigating the health care and special education systems. The Special Needs database offers users the opportunity to search for information and referral resources online or receive one on one assistance from bilingual staff over the phone.

Increasing the number of children with and without a medical home was identified as a priority need in the 2020 five-year needs assessment. The American Academy of Pediatrics specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective care. In Georgia, only 40.3% of children and youth with a special health care need met the medical home criteria when accessing care. For children and youth, aged zero to 17, a greater percentage of non-Hispanic White (46.9%)

reported access to care within a medical home than the same aged non-Hispanic Black (38%) children and youth. Furthermore, according to the National Survey of Children's Health only 12.4% of children and youth with special health care needs in Georgia received care in a well-functioning system compared to 14.1% percent of children and youth with special health care needs nationwide.

Current Year:

The CMS program partners with primary care providers, pediatric subspecialists, health care vendors, state agencies, and community-based organizations to coordinate timely access to health care services and supports for eligible CYSHCN and their families. CMS also provides a statewide network of genetic services that include evaluation, treatment, and disease management for children diagnosed with heritable disorders. The CMS program's care coordination services support patient/family access to health care financing, linkage to community-based services and resources, health care transition planning, and linkage to pediatric specialty care in addition to reduction in service duplication, service gaps, and access to care and services barriers.

The CMS program provides specialty clinics in nine public health districts and coordinates services with more than 30 specialty providers for face to face and telemedicine clinic visits. Telemedicine clinic services are offered in seven of those locations and as the presenting site, are eligible for Medicaid reimbursement. All families accessing telemedicine have access to free language assistance services. Specialty clinic types included endocrinology, nephrology, cardiac, chronic lung, genetics, hematology/sickle cell, orthopedic, hearing, neurology, and cystic fibrosis.

An annual satisfaction survey is distributed by local public health CMS programs to families and patients over 18 years to learn what's working well and where improvements should be considered. Responses are collected from 5-10% of active caseloads and are available in English, Spanish, Burmese and Nepali. The survey asks whether families received the help they needed with finding and getting medical services and supports for their child. The survey asks respondents to rate service provision and staff responsiveness as well as experience accessing providers and resources. Overall, survey results indicate that participants are satisfied with their care coordinator and the services provided to them.

Eighty percent of children enrolled in the CMS program have fee for service Medicaid. Since the fall of 2022, the program provided monthly updates on the proposed Medicaid redetermination process to the local public health district CMS program leads. During the spring of 2023 in preparation for the redetermination process, local care coordinators cross-referenced contact information for families against Georgia Medicaid Management Information Systems. Any discrepancies in contact information warranted a follow-up with families. Many families expressed appreciation of the follow-up and being made aware of what to expect for their upcoming redetermination. Georgia Medicaid created and distributed an impressive campaign named, Stay Informed Stay Covered. There is a dedicated website for the campaign that provides communication materials in several languages for Medicaid recipients, providers, and the public. Local public health care coordinators utilized the materials to increase awareness among program participants and families through newsletters, flyers, social media messaging, website postings, and clinic area postings.

The Medicaid redetermination process is expected to take 12 -14 months. Redeterminations will take place on the Medicaid member's anniversary date and those potentially eligible for the Pathways to Coverage 1115 Waiver, will be redetermined last. Families have 90 days to provide information for their redetermination. CMS care coordinators will verify Medicaid eligibility status and discuss redetermination at six-month and annual reviews as well as at specialty clinics visits. For families experiencing challenges with coverage, the CMS program serves as the payor of last resort for health care and medical expenses for families that do not qualify for the state's Medicaid, SCHIP

programs, or those who are without insurance during the time of CMS program enrollment.

The Georgia Autism Initiative implemented the Board-Certified Behavioral Analyst (BCBS) Training and Supervision Program which allows children with autism spectrum disorder to receive behavioral support services from supervised trainees completing their filed hours required to become BCBA's. This initiative has provided field experience for approximately 12 professionals pursuing national certification and approximately 200 children have received behavioral support services through this initiative.

The Parents as Partners project is funded jointly by the CMS and BCW programs and administered by Parent to Parent of Georgia (P2PGA), Georgia's Family to Family Health Information Center. Parents as Partners are parents of a child or youth who has a special health care need who provide support to other parents of children with special health care needs. The partnership with the Department's Refugee Health program presented an opportunity to collaborate with a community-based organization (CBO) supporting the refugee/immigrant population in the city of Clarkston. The Parent Partner for the CBO supports families with accessing public health services and linkages to early intervention and CMS services. The program's participation in this year's Family Voices Community of Practice identified several strategies for improved engagement with the refugee population. This includes plans to create a seamless transfer from the CBO to the public health district CMS program in DeKalb County.

Early Hearing Detection and Intervention (EHDI)

The EHDI program continued to make progress in several key areas that included increasing collaborations and engagement with key stakeholders, completing modifications to the SendSS database used for surveillance and tracking of new data elements, and expansion of the state's capacity to provide teleaudiology services.

Stakeholder collaboration and engagement flourished, in part as a result of the passage of a legislatively mandated framework for collaborations. The Official Code of Georgia Annotated (O.C.G.A) § 30-1-5, the Language and Literacy Initiative, requires that DPH work with DECAL and DOE to improve educational outcomes of children who are deaf or hard of hearing (DHH); developing an actionable individualized birth to literacy plan for every child who is DHH in the state from birth through the third grade. The goal of OCGA 30-1-5 as amended by Act 462 is to create an individualized, child-focused system that supports a seamless provision of services for children and families as they move through the seven key transactions necessary for age-appropriate language and literacy outcomes. Seven key transaction points were identified based on best practices that provide guidance for families on their journey from birth to literacy. Georgia children who are DHH will be able to achieve proficient language and literacy skills in significantly greater numbers when every DHH child can complete these transactions in a timely and coordinated manner.

Key transaction points include:

1. Newborn hearing screening
2. Diagnostic evaluation
3. Early Hearing Orientation Specialist (EHOS) visit
4. Early Intervention
5. Transition
6. Preschool services
7. School-based services

Data from the EHDI program are reported in the first three transaction points and positions. Since August 1, 2018, for every infant identified as DHH, the EHDI program requests a Georgia Testing Identification (GTID) number from DOE to facilitate monitoring progress of children once they transition from infancy and early childhood into DOE services. DOE assigns every child enrolled in the Georgia public school system a GTID that remains with the student

through high school. This number allows educators and evaluators to identify and map the progress of every child identified as DHH enrolled in public school. Through the Language and Literacy initiative, DOE is now able to assign GTIDs at the time hearing loss is diagnosed (several years before school entry). To date, 1,191 children who are DHH have received a GTID through EHDI program requests. Each year, a report is submitted to the Governor and the Georgia Commission for the Deaf and Hard of Hearing. The 2021 report focused on Georgia's "Diagnostic Dilemma" regarding the lost to follow-up and loss to documentation from the newborn hearing screening to the diagnostic evaluation. In the Official Code of Georgia Annotated (OCGA) § 30-1-5 Year 1 Report, authors identified the need to break down specific risk factors, or health determinants, that may contribute to lower outcomes for children who are DHH. The Year 3 Report (2021) addressed these risk factors. Demographic data including race and ethnicity were also analyzed to understand their impact on diagnostic outcomes.

Collaborations with the newly developed Georgia Mobile Audiology (GMA) program progressed well during the first year of the program. Georgia's Legislature and DOE recently funded GMA, which launched with limited services in 2020. GMA includes a fully outfitted mobile audiology unit that will travel to rural areas to provide screening, audiological care, early intervention, and hearing aids to children who are DHH. Two pediatric/educational audiologists and a patient care coordinator plan to establish a routine schedule in underserved areas in Georgia. The focus of GMA is to provide gap-services in audiology to infants and school children in underserved areas throughout the state. GMA is working with the EHDI program to provide outpatient follow up services for infants referred from newborn hearing screening, infant hearing assessments, and assistance with professional development, training, and in-services for providers. Services expanded from collaborations for follow up audiology services in four health districts, Fulton, Valdosta, Rome, and Gainesville, to eight health districts and include Macon, Waycross, Albany, and LaGrange.

Webinars, grand rounds, presentations, and virtual meetings were conducted with stakeholders to engage, educate, and inform them about the EHDI system and their role in ensuring that infants and families receive timely and appropriate services. The EHDI program has two Ear, Nose, and Throat Physicians engaged as Chapter Champions, Dr. Paula Harmon for the GA-AAP and Dr. Nandini Govil for the GAFFP. Webinars were conducted for audiologists to address reporting requirements and updates to the audiology portal within the EHDI program data base. The webinars also included information and guidance on using the audiology portal in SendSS. Monthly teleconferences are being conducted with district EHDI coordinators to provide technical assistance and learn district updates on EHDI activities.

The EHDI program obtained a roster of audiologists licensed in Georgia from the Board of Examiners for Speech-Language Pathology and Audiology. The Audiology Roster was used as the foundation for developing a statewide email distribution list for audiologists. The roster listed 642 active audiologists in the state, with 498 of those on the list holding a Georgia address (Audiology Portal users of the state EHDI database must be providing services in Georgia). As the list does not include email addresses, the program worked to identify audiologists and facilities serving infants and young children to develop the email distribution list. Emails were located for 257 of the 498 licensed audiologists (52%) in the state, accounting for all known reporting facilities (100%) plus other audiologists not reporting to the EHDI program. Dr. Kathleen Toomey, DPH Commissioner and State Health Officer, distributed a letter reminding audiologists of the importance of reporting follow-up results and all newly identified children with Permanent Childhood Hearing Loss (PCHL) through age five, per Georgia law within seven days of testing (hearing loss is a notifiable condition in Georgia). The letter was distributed to 257 licensed audiologists on September 27, 2021. At that time, a baseline of 120 Audiology Portal accounts was measured (103 audiologists and 17 additional reporters). As of October 21, 2021, there was an increase of 18 audiology portal accounts in the SendSS database (16 audiologists and two additional reporters) for a total of 138 users. A dramatic increase in the number of infants reported with hearing loss was reported in the months after the letter was distributed, with 52 children through age

five reported with hearing loss in October 2021 and 34 in November 2021 compared to a monthly average of 26.

Over the last year of the project, the EHDI program worked with DPH IT to make numerous updates and modifications to the EHDI program module within the SendSS database. The changes made facilitate reporting and tracking, performing follow up activities, and promote progress towards meeting the 1-3-6 EHDI benchmarks. In addition, the modifications provide a means of documenting program progress towards referring families of infants with confirmed hearing loss for family-to-family support and for deaf adult to family support. During the reporting year, the EHDI program worked in collaboration with the Georgia Chapter of Hands and Voices (H&V) on a data elements group called Families and EHDI (FEHDI). Georgia, Illinois, Oregon, and Utah FEHDI participated along with state coordinators, and a family-based organization representative involved with EHDI. FEHDI developed and defined a data set that can be used as a tool for other states for reporting and data sharing between programs in response to HRSA's aim for the EHDI program to increase the number of families enrolled in DHH adult-to-family support services by 10 percent by no later than nine months of age. Data elements, definitions, and a model database were shared with state EHDI staff, federal partners, and Family Leadership in Language and Learning (FL3) members. CDC EHDI program adopted several of the data elements and definitions from the FEHDI workgroup for inclusion in the annual Hearing Screening Follow-Up Survey.

The impact of the COVID-19 pandemic was a concern for follow up for infants not passing the initial hearing screening prior to hospital discharge. While initial hearing screening was minimally impacted, outpatient services were interrupted, particularly in non-metropolitan regions of the state. District EHDI coordinators worked to educate families on the importance of newborn hearing screening and are exploring outpatient options to refer families for testing but some families are electing not to pursue follow up for their infants. The EHDI program presented on the receipt and timeliness of newborn hearing screening and follow-up services before and during the COVID-19 pandemic at the 2022 EHDI Annual Conference in March 2022. Findings of the study suggest while most infants continue to receive their initial hearing screening, referral rates decreased overall during the pandemic. In addition, receipt of diagnostic evaluations was delayed in time, and families were less likely to complete diagnostic evaluations as an overall decrease in the number of infants receiving follow up evaluations was reported.

House Bill 1186 was passed during the 2022 Georgia Legislative session to allow persons who are not licensed audiologists to use otoacoustic emissions (OAE) or auditory brainstem response technology as part of a screening process for the initial identification of communication disorders in individuals up to age 22, subject to certain conditions. Individuals using OAE for hearing screening must be under the oversight of audiology and must be trained by an audiologist. Training opportunities for use of OAE screening will be available for school nurses, public health nurses, speech language pathologists and associated early childhood care providers.

Increasing availability of providers that are permitted to use OAE as a screening tool should provide positive outcomes such as decreasing the demand on pediatric audiologists, increasing the availability of providers for hearing screening in early childhood, decreasing wait times for hearing screenings for speech/ language services, and increasing identification of early onset hearing loss in young children. Providers using OAE for screening will still be required to report all follow up results from newborn hearing screening, all newly identified suspected and confirmed permanent childhood hearing loss through age five, sensorineural and permanent conductive mixed auditory neuropathy to EHDI.

Several persistent challenges remain for EHDI as the program works to meet the 1-3-6 benchmarks for all infants who are DHH and their families. Loss to documentation/loss to follow up, staff turnover, and lack of institutional memory are challenges. COVID-19 continues to impact the Georgia EHDI program. To address these challenges, three new district EHDI coordinators have been hired and ongoing provider engagement and education is provided to address loss to follow-up and loss to documentation. State and district stakeholder meetings have resumed to

promote engagement, as well as postings on the Georgia Pediatric Audiology Network (GPAN), and outreach to individual practices to discuss Georgia EHDI policies and procedures.

Current Year:

In the current year, the EHDI program has worked to improve the system of care through strategies to decrease loss to follow-up and documentation, maintain and document hearing screenings for 95% or more of Georgia's occurrent births, increase timeliness and receipt of diagnostic evaluations for infants who do not pass the newborn hearing screening, improve data sharing between EHDI, family support and Early Intervention providers, improve change management, and improve stakeholder and family engagement.

The EHDI program has continued the work that was enhanced by Legislative Act 462, which brings into focus the academic landscape for DHH children. EHDI and Part C programs are working more collaboratively with DECAL and the DOE to monitor and strengthen the systems that support early identification, intervention, language development academic achievement for DHH children across the continuum of service they receive from birth to third grade.

EHDI has been collaborating with key stakeholders to enhance the quality and timeliness of the EHDI system and continue to promote activities that result in access to needed resources and interventions to promote language acquisition and optimal social, emotional, and cognitive development for children who are deaf or hard of hearing. EHDI has engaged two family support programs through Georgia H & V: Guide By Your Side and Advocacy Support and Training. Collaborations with GMA, Children's Health Care of Atlanta, and audiologists throughout the state will also expand this year to focus on surveillance of hearing status throughout early childhood.

The EHDI program also supports the Georgia PINES Deaf Mentor program to provide families who have children with hearing loss with family-centered, home-based, and curriculum-led early education, focusing on visual communication, American Sign Language, and Deaf Culture.

The EHDI program implemented two learning communities within the Augusta and Athens health districts to educate providers about the importance of meeting the 1-3-6 EHDI benchmarks (screen for hearing loss before one month of age, diagnose hearing loss before three months of age and enroll in early intervention programs before six months of age) and promoting care coordination in their district. Learning community members include DPH staff, audiologists, family members of children who are deaf or hard of hearing, hospitals, early intervention providers, and medical home providers. Learning Communities are targeting areas for improvement of service provision specific to their district based on the feedback received from the members and from performance measures shared by the state EHDI program.

Babies Can't Wait (BCW)

BCW is committed to increasing the percentage of infants and toddlers who are nearer to, or meet age expectations, for positive social-emotional skills including social relationships. For the past several years, BCW continued to provide service coordinators and special instructors with training and coaching to implement evidence-based practices for providing positive behavior supports to children identified with behavioral concerns.

In collaboration with the Georgia Department of Education (DOE) and the Department of Early Care and Learning (DECAL), the 2022 Annual Report on Language and Literacy Outcomes for Children who are Deaf and Hard of Hearing (DHH) was completed. The Report highlighted the progress made on critical measures to promote better outcomes for Georgia's children who are DHH. The collaboration started with the passage of 2018 legislation, Official Code of Georgia Annotated (O.C.G.A) § 30-1-5, Birth to Literacy Collaborative. A multi-agency task force

was created consisting of DPH, DECAL, and DOE to carry out the goal of the legislation as amended by Act 462 to create an individualized, child-focused system that supports a seamless provision of services for children and families as they move through the seven key transactions necessary for age-appropriate language and literacy outcomes. The seven key transactions are: 1) newborn hearing screening; 2) diagnostic evaluation; 3) Early Hearing Orientation Specialist (EHOS) visit; 4) Early Intervention; 5) transition; 6) preschool services; and 7) school-based services. In September 2022, Georgia Mobile Audiology was added to the task force to collaborate on this report and to further inform strategies.

As a result of this collaboration, the BCW/Part C and EHDI programs are working more collaboratively with DECAL and DOE to monitor and strengthen the systems that support early identification, intervention, language development, academic achievement for DHH children across the service continuum from birth to third grade.

Due to COVID-19, concentrated efforts were made to ensure that families continued to receive Early Intervention services through enhancing remote services via telemedicine. On March 1, 2022, families had the choice to receive in-person visits or continue with remote services. Many providers and families elected for a hybrid model of both in-person and remote visits. Early intervention services that occur within the family's natural environment (i.e., family home, childcare center) are prioritized when possible while making remote services available when needed. By continuing to provide remote services, the program can provide services to families in areas of the state who do not have access to certain providers for in person services. The continued utilization of remote service delivery has resulted in an increase of referrals to the program.

Current Year:

The BCW program is Georgia's Part C early intervention program that serves children birth to three with a diagnosed medical condition that places the child at risk for developmental delays or a significant developmental delay in at least one area of development or two moderate delays.

The program realized an increase in referrals after the implementation of remote service options and continues to make concentrated efforts to address the state's provider network shortage by focusing on increasing the number of providers and addressing the strengths and challenges within the program. The BCW Provider Relations Manager has formed partnerships with colleges and universities across the state to recruit contract providers. In addition, the program has ongoing job postings listed on the agency website and on the nationwide collegiate job board, HandShake. The program is working with DPH Communications to incorporate provider recruitment into the program's upcoming marketing campaign.

To ensure that BCW policies and procedures are streamlined across the state, the program has implemented a policy workgroup that consists of both agency and district staff. The purpose of the workgroup is to review and clarify program policies and procedures related to consistent implementation of the BCW/Part C program. As policies are updated, related training is developed and provided to district staff and contract providers to ensure understanding of program requirements and expectations. Some of the recent training offered by the program include Individualized Family Service Plan, outcome writing, child interest activity plan, Infant Early Childhood Mental Health endorsement, and billable documentation training. The BCW Regional Manager and Program Consultant has developed a data monitoring plan across all 18 district BCW programs to ensure that all local programs are maintaining compliance and improving outcomes for children and families. Quarterly data monitoring reviews are conducted by the DPH BCW staff to monitor and promote regular program data reviews so that the Annual Performance Report (APR) of required federal program compliance and performance indicators will increase in efficiency and accuracy. Along with the new data monitoring plan, the program has recruited members from the State Interagency Coordinating Council (SICC) to aid and support in the form of reviewing processes and providing feedback prior to the implementation of data monitoring plans.

The BCW program continues to collaborate with other state agencies, stakeholders, and community organizations who provide services and support to similar populations (Birth – 36 months). The collaboration between the Department of Public Health (DPH), the Department of Education (DOE), and the Department of Early Care and Learning (DECAL), to strengthen the transition process between state agency programs. The BCW program works with the 619/Part B Lead Agency (DOE) and the Early Head Start/Head Start Director (DECAL) to ensure a consistent understanding of the federal transition requirements/regulations between programs. BCW, 619/Part B, and Head Start programs are planning to relaunch transition forums across the state, allowing opportunities for BCW local program coordinators, Local Education Agencies (LEAs), and Head Start programs to come together to discuss transition expectations and local implementation plans. Regular meetings will be held to discuss challenges and next steps to ensure effective and compliant transitions. These transition forums will take place across the state in different districts to ensure that representatives from each state program agency (in the area) are able to attend the forum.

Recently, BCW has partnered with Georgia Infant and Early Childhood Mental Health (IECMH) and the Georgia Association of Infant Mental Health (GA-AIMH) to address the growing issue of childhood trauma in the state of Georgia. Recent studies have shown that approximately 3 out of 5 children in Georgia experience at least one adverse childhood event (ACE), such as witnessing or experiencing abuse, living with a caregiver who uses substances, or having a parent who is incarcerated. Georgia Infant and Early Childhood Mental Health (IECMH) focuses on the earliest experiences of a child's life from the prenatal period through age 5. The promotion of IECMH supports the nurturing of relationships and environments that can help prevent ACEs and mitigate the negative impacts when a child does experience trauma. Evidence-based, relational treatments, such as Child-Parent Psychotherapy (CPP), promote IECMH and support families and communities in creating nurturing and safe environments. Knowing this, BCW has partnered with GA-AIMH to identify opportunities to support infants and toddlers' mental health. Georgia State University (GSU) and the Department of Early Childcare and Learning (DECAL) has also joined this partnership to pilot BCW's ability to provide CPP services to eligible families.

Child-Parent Psychotherapy (CPP) is an evidence-based, relational treatment approach for young children from birth to 5 years of age who are currently or are at an increased risk of experiencing behavioral and mental health concerns because of exposure to traumatic events, environments, or relationships. The CPP approach is designed to promote physical and emotional safety for the family and support attachment between young children and the caregivers in their lives. Treatment focuses on the dyadic parent-child relationship and family factors as well as contextual factors such as cultural norms and the social-political environment. The CPP service approach is being piloted in three local health districts which are Athens, Macon, and DeKalb. Supporting the implementation of the CPP pilot are Licensed Clinical Social Workers (LCSW) who have completed 18 months of training and supervision to become certified to provide CPP to BCW families. These licensed clinicians are partnered with the local BCW program to incorporate CPP on the Individualized Family Support Plan (IFSP) for children who have experienced trauma. Evaluation and assessment of the CPP pilot initiative is assessed, the clinician's ability to successfully complete the required training is monitored, and the family's satisfaction in participating in the pilot is assessed and the results are shared with the program.

In addition, BCW is collaborating with the University of Georgia (UGA) to conduct an Environmental Scan of Georgia's BCW System with input from stakeholders including families and providers to provide an understanding of patterns of usage across regions and demographics, information about barriers interfering with enrollment, and supportive factors that facilitate enrollment. Nationally, research shows that less than 15 percent of children eligible for Early Intervention services access intervention and that minority groups disproportionately enroll in early intervention programs. Data gathered from the Environmental Scan will inform the development of a health equity plan to increase access to services in communities with low referrals and high needs. Data will also be used to create a provider engagement plan to increase BCW program awareness among colleges and universities. Data from the environmental scan will be shared with all members of the BCW program including local program leaders, the SICC, and other stakeholders.

Priority Need: Improve Systems of Care for CYSHCN

NPM 12: Transition to Adult Care for Children with and without special health care needs

Children's Medical Services

Children's Medical Services (CMS), Georgia's CYSHCN program, provides access to a comprehensive system of health care services, linkages to community-based resources and supports, financing for medical expenditures and health care transition planning for youth/young adults and their families moving from pediatric to an adult model of care. Services also include pediatric specialty clinical care, where patients are seen by a provider face to face or via telemedicine, in rural areas of the state as well as periodic home visiting for families caring for children and youth with special health care needs.

Through a statewide network of 18 local public health district CMS programs, public health nurses and social workers provide care coordination services for more than 6,000 families annually. The care coordination provided to families is patient- and family-centered, assessment-driven, team-based and meets the needs of children and youth with special health care needs while enhancing the caregiving capabilities of families. Care coordination services address and incorporate health care transition planning.

The CMS program implements the Six Core Elements of Health Care Transition, an evidence-driven approach to successfully transition youth and young adults from a pediatric to adult model of health care. The CMS program supports youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care. On an annual basis, more than 1,200 youth/young adults are engaged in the CMS transition planning process.

Due to the Covid 19 pandemic, transition planning was limited to over the phone vs. in-person, readiness assessments were sent and returned via mail and many young adults were not able to attend the annual review visit to develop health care goals. There were four (4) local public health district CMS programs that utilized videoconferencing for care coordination services.

The Title V State Action Plan for CYSHCN outlined the following key strategies to improve the services necessary for children with and without special health care needs to successfully transition from pediatric to adult health care; transition planning quality improvement, implementation of condition specific transition protocols, transition education for youth and families, transition advisory group, transition outreach and awareness and Six Core Elements of Health Care Transition education for health care providers.

Current Year:

To improve organizational support, the CMS program onboarded a full-time dedicated Family Engagement Manager in June 2023 and Youth Engagement Coordinator in October 2022. With additional program support, the program is exploring various opportunities to enhance youth and family engagement practices especially in rural and underserved communities across the State. The Family Engagement Manager position will focus on quality improvement activities for the Parents as Partners project, develop community resource navigation trainings and tools, identify and coordinate parent leadership training opportunities and convene family advisory groups for CYSHCN-related issues.

The Youth Engagement Coordinator is a CDC Public Health Associate and will remain with CMS until early 2025. This position will coordinate and support various activities associated with the Health Care Transition Outreach and Engagement Campaign including planning, development, implementation and evaluation. Responsibilities will also include coordinating the youth advisory group, expanding partnerships with youth-led organizations and developing peer to peer transition education training modules. The goals of the HCT Campaign are to increase the number of youth/young adults that receive health care transition information and the number of community partners and stakeholders that are engaged in health care transition planning and implementation activities.

Health Care Transition Planning Quality Improvement

The CMS program quality improvement efforts focused on transition to adult care data collection and community resource navigation. A revised data collection process for health care transition performance measures was developed and implemented to ensure a streamlined process across all 18 local public health district CMS programs. The process resulted in revised program data collection tools, updated guidance on patient record documentation and training for CMS coordinators. CMS also conducted quarterly transition case review audits to ensure health care transition planning procedures and documentation were being met. Technical assistance included sharing strategies on engaging and partnering with adult providers, parent mentors, and education transition specialists as well as presentations and program materials on community transition resources. To assist young adults with continuity of care as they age out of public benefits, resources were provided on community safety net clinics, federally qualified health centers, Medicaid services for adults, prescription assistance programs, and adult services available in the health departments.

The CMS program provided funding for transition services to the Adult Disability Medical Healthcare (ADMH), a non-profit organization that provides medical care to youth and young adults with intellectual and developmental disabilities. ADMH services are based on the patient centered medical home model and is supported by a multi-disciplinary team. ADMH provides transition planning and counseling, utilizes an age based and developmentally appropriate transition readiness assessment and planning tool and discusses emergency preparedness planning with families. The contractual partnership with ADMH began in 2016. The number of funded transition clinics increased from three to seventeen. More than one hundred individuals are served annually. The number of physicians supporting the transition clinic grew from two to four physicians, which made an impact in the ability for the clinic to serve more patients.

CMS worked closely with ADMH to incorporate telehealth services in their standard of care. DPH provided telehealth technology and training to ADMH. The program used the technology for program planning and connecting with the behavioral analysts for consultation services. With the impact of COVID-19, ADMH provided their comprehensive transition clinic visit remotely with patients in their home. ADMH's capacity to serve the community and individuals with developmental disabilities has grown considerably over the years and their model of care proves to be effective, compassionate, and supportive.

Leveraging Preventative Health Block Grant funding, Child Health partners with the Emory Autism Center (EAC) Education and Transition Services program on an initiative entitled Individualized Transition to Adulthood Plan (ITAP). This initiative supports the iterative development of a model of transition planning best practices for students with autism spectrum disorder (ASD). This model is strongly aligned with the Taxonomy for Transition Planning, developed by Kohler and colleagues (1996). The person-centered approach combines individualized Transition Assessment, educator training and technical assistance, parent engagement, collaboration with State agencies and schools, and infrastructure development. Emory Autism developed materials and resources for health care providers to offer services aimed at helping young people with autism spectrum disorder adopt a more independent and empowered lifestyle as they transitioned into adulthood. In collaboration with the CMS program, education was provided to pediatricians and family physicians on supporting young adults in transitioning to adult healthcare services through various training modalities; which included webinars, lectures presentations, and grand rounds for medical residents.

Current Year:

The CMS program quality improvement efforts focused on revising the health care policies and procedures as well as documentation to ensure care coordinators have the tools necessary to better support young adults with medical complexities and their families. The revisions will help to streamline the transition planning workflow and offer more

guidance on required documentation and linkages to community supports. The transition policy statement, progress tracking form, readiness assessments, emergency care plan, medical summary and transition resource sheets were all updated. The transition feedback survey is now included with the readiness assessment and easy to complete via survey link or QR code. The transition feedback survey will assess the family's experience and offer opportunity to provide feedback on the support and education received from the program. Young adults and parents/caregivers will receive copies of the readiness assessment which includes the jointly developed transition goals as well as QR codes and hyperlinks to community resources and supports.

Got Transition's annual self-assessment profile documents Georgia's progress with incorporating the Six Core Elements of Health Care Transition™ over the past five years. In 2022, Georgia's total score is 23 out of 28, a 64% increase from a score of 14 at baseline. Results collected at baseline was completed in 2017. The assessment is self-reported and includes the following benchmarks, levels ranging from 1 (basic) to 4 (comprehensive), with a total possible score of 28. The CMS program transition efforts earned Level 4 for Transition Policy, Tracking & Monitoring, Readiness, and Planning. Level 2 was achieved for Transition Transfer of Care and Transfer Completion. To improve level 2 status for Transition Transfer of Care, the CMS program will work on adult provider outreach and engagement to ensure care coordinators can refer and share transition plans with patient's new provider(s). Currently, 46% of CMS young adult program participants ages 18 to 21 have transferred to an adult provider or adult model of care. Level 3 was achieved for Youth & Family Engagement and will continue to improve to level 4 with additional staff support and transition campaign activities.

Adult Disability Medical Healthcare (ADMH) received continued funding to provide transition services for youth and young adults with intellectual and developmental disabilities. ADMH provides transition planning and counseling, utilizes an age based and developmentally appropriate transition readiness assessment and planning tool and discusses emergency preparedness planning with families. The number of funded transition clinics increased from 17 to 24. With the increase in the number of clinics provided, more than 160 individuals are served annually. ADMH became a member of the National Association of Free & Charitable Clinics (NAFC) whose mission is focused on the issues and needs of the medically underserved. This partnership leverages medication access and discounted supplies for patients, training as well as opportunities for grant funding.

The Behavioral Health and Development program continues to conduct Transition Assessments with students across two pilot sites of the Individualized Transition to Adulthood Plan program. Tapestry Public Charter School (Tapestry) is an inclusive charter school within the Atlanta metro area (i.e., DeKalb County School System); the second pilot site is Tift County Schools. The ITAP team completed 10 comprehensive Transition Assessments with students enrolled at pilot sites. Of these individuals, seven students and families have participated in Transition Assessment feedback meetings led by the ITAP team. The program expects to complete the remaining feedback meetings early in the FY24 ITAP Project year.

The ITAP assessment model includes multi-source interviews, behavioral observations, behavioral rating scales, and a review of available records/reports (e.g., student IEP, psychological evaluations). As project operations continue to transition from COVID-19 related public health policies, all Transition Assessments were conducted virtually and in-vivo student observation did not occur. Each student who participates in an ITAP Transition Assessment receives a personalized report with goal and activity targets in all available areas of the IEP Transition Plan (i.e., Education/Training, Development of Employment, Community Participation, Adult Living Skills and Post-School Options, Related Services, and Daily Living Skills).

The ITAP team conducted several trainings for educators at two pilot sites, in conjunction with Georgia Learning Resources System, and by request from partners and colleagues. Each training focused on general transition planning for students with ASD and on specific strategies for writing meaningful, individualized transition plans.

When possible, the program included opportunities for guided practice (e.g., writing workshops, small group learning activities, and low stakes knowledge checks).

Family Partnerships and Youth Engagement

There are 7 Parent Partners available in local district child health programs and pediatric specialty clinics ready to support other parents that are going through the process of supporting their youth with the move from pediatric to adult care. The Parents as Partners project is funded by the CMS program and administered by Parent to Parent of Georgia (P2PGA), Georgia's Family to Family Health Information Center. Parents as Partners are parents of a child or youth who has a special health care need and provide support to other parents who have children with special health care needs. The Parents as Partners are paid as part-time employees of P2PGA. Parent Partners provide one-on-one assistance, information, guidance, and referrals on educational and health-related issues to families as well as maintain ongoing communication with staff at the designated site to share challenges and barriers experienced by families receiving services. Parent partners organize transition related trainings for families across the 7 sites they support. On an annual basis, more than 4,000 families of children and youth with special health care needs ages birth to 26 access to P2PGA's special needs database and hotline which provide information and resources including transition to adult care.

The CMS program increased the number of community partners to include Georgia HOSA- Future Health Professionals (HOSA), Georgia Advocacy Office (GAO), Amerigroup 360, Georgia Campaign for Adolescent Power & Potential (GCAPP), Department of Family and Children Services (DFCS), and Georgia Family Connections. These partnerships allowed the program to expand engagement with youth through educational activities and provide opportunities for youth feedback on health care transition topics. The CMS program facilitated five virtual focus groups with 48 youth between the ages of 14-23. The focus groups gathered information from youth on their understanding of health care transition, general health and wellness topics, transition messaging, and marketing strategies. The information provided was instrumental in developing the communication and dissemination plan for increasing the number of youth/young adults that access health care transition information and resources.

Current Year:

Since the initiation of the Parent as Partners project, there have been 17 parent leaders trained and providing support to families receiving BCW and CMS services. Parent Partners provide one on one assistance to more than 700 families on an annual basis and coordinate more than 70 trainings in the areas of early intervention, transition planning, special education services, and Medicaid Waivers. Parent Partners received Six Core Element training to help improve one on one assistance with families in the areas of health care transition planning and provided feedback on the program's revised transition policies. Parent Partners are also participating in the Family Voices Title V Community of Practice (CoP) and provided several recommendations to improve communication, trainings, leadership development and partnering with program staff at their designated sites.

The CMS program also partners directly with youth to support planning activities associated with the Health Care Transition Outreach and Awareness Campaign. In collaboration with Georgia HOSA, the program received more than 50 applications from interested youth to participate in the CMS Steps Up for Youth summer workgroup. After careful consideration, 10 youth were selected for the workgroup to participate in the inaugural CMS 2023 summer workgroup. This workgroup consists of 8 weekly sessions in which youth will learn about health care transition concepts and are compensated for their participation and involvement with creating digital marketing content for the Campaign.

Health Care Transition Planning and Six Core Elements Training

Through contractual partnership with the Georgia Academy of Family Physicians (GAFF) and the Georgia Chapter of the American Academy of Pediatrics (GA-AAP), the CMS program provided continuing education on the Six Core Elements of Health Care Transition to pediatricians, family physicians, pediatric nurses, as well as medical students. Trainings were offered via webinar as well as face-to-face at the member organization's annual Fall and Summer Conferences. There were 281 medical providers that received training on health care transition and the Six Core Elements framework. Both GAFF and GA-AAP also included health care transition related articles and resources on their webpages and newsletters for physician members to access.

In partnership with Parent to Parent of Georgia (P2PGA), parent/caregivers had access to annual workshops on Preparing Your Adolescent for the Transition from Pediatric to Adult Health Care. Parent leaders facilitated the workshops and utilized the curriculum adapted from the Waisman Center and had accompanying workbooks for families to document their transition goals as well as activities to help their youth practice independent health care skills such as setting appointments, scheduling transportation, and filling prescriptions. Six workshops in English and Spanish were funded through the contract with P2PGA and 182 parent/caregivers participated in the trainings. Due to COVID-19, workshops were provided to families virtually. Workshops also included subject matter experts from the Marcus Autism Center and the Georgia Advocacy Center to focus on supporting individuals with intellectual and developmental disabilities and promoting self-determination skills.

ADMH provided trainings to families on how to support the transition needs for youth and young adults with intellectual and developmental disabilities. Trainings were offered on community and independent living, as well as person-centered planning. ADMH also developed and piloted a Developmental Disability Sensitivity Training: Guidelines for Professionals and Health Care Practices. The training addressed the challenges to providing primary medical care for adults with ID/DD before, during and after the visit, integrating health care transition planning and preparation with the patient and family and shared tips and resources to improve care for patients with ID/DD within a practice. ADMH provided trainings to 163 families and health care professionals.

Additional training opportunities were provided for youth through partnership with Georgia HOSA's Annual Spring Conference. More than 175 middle school, high school and college students learned about health care transition. Georgia HOSA has state and local chapters that provides opportunities for knowledge, skill and leadership development of health science education students.

Current Year:

Through contractual partnership with the GAFF and the GA-AAP, the CMS program provided continuing education on the Six Core Elements of Health Care Transition to pediatricians, family physicians, pediatric nurses, as well as medical students in the current year. Trainings were offered via webinar as well as face-to-face at the member organization's annual Fall and Summer Conferences. There were 184 medical providers that received training on health care transition and the Six Core Elements framework. Both GAFF and GA AAP also included health care transition related articles and resources on their webpages and newsletters for physician members to access.

In partnership with Parent to Parent of Georgia (P2PGA), parent/caregivers had access to annual workshops on Preparing Your Adolescent for the Transition from Pediatric to Adult Health Care. Seven workshops in English and Spanish were funded through the contract with P2PGA and 349 parent/caregivers participated in the trainings. Workshops were provided face to face as well as virtually and all were facilitated by a parent leader. Families also participated in the Life Skills Training series hosted by ADMH. Information on SSI & Medicaid, Guardianship, Medicaid Waivers and Family Support were provided to more than 100 families.

Community Outreach and Awareness

To assist with efforts to educate families, youth/young adults, and professionals on health care transition, the CMS

program revamped the DPH transition from pediatric to adult care webpage. The webpage has questionnaires and links to feedback surveys incorporated throughout to assess transition readiness and satisfaction with the transition information presented on the site. There is also the collection of transition materials specifically developed for families and youth. These materials are marketed at annual outreach events such as health fairs, expos, school transition fairs, and conferences and are now hosted on the revamped webpage.

The health care transition communication and dissemination plans were developed to help inform youth/young adults, families, health plans, medical providers, state agencies, and community partners on health care transition Six Core Elements framework, services, resources, and tools. The plan has four phases: The Phase I: Youth Health Care Transition and Health Care Coverage. Marketing and communications tools developed for youth/young adults to understand the importance of taking charge of their health care, knowing their health insurance status, how to access health care coverage, and how to access health care if uninsured. Phase II: Health Care Transition Linkages to Resources and Services for Families. Marketing and communication tools developed for parent/caregivers to increase their awareness of the services and resources available to assist in their long-term planning and supports for their youth/young adult. Phase III: Health Care Transition Practice Tools for Physicians. Marketing and communications tools developed for pediatric and adult medical providers to begin operationalizing transition protocols for the adolescent well child visit. Also, tools to help collect, assess, and disseminate information on providers that are implementing transition protocols, require technical assistance, and resources for their patients. Phase IV: Health Care Transition Tools for Health Plans and Care Management Organizations. Marketing and communications strategies and recommendations for health plans to utilize for youth engagement for maintaining coverage through 26 years of age, promote youth independence, and appropriate linkages for adult providers and health care resources. The communication plan will be used to drive the Health Care Transition Outreach and Engagement Campaign.

Current Year:

School districts began hosting face to face transition fairs this year and the CMS program developed materials for local public health district CMS programs to distribute. The materials included the transition timeline and QR codes for the CMS transition webpage, health care transition quiz and planning for adult care workbook. CMS staff provided information to more than 980 high school students across four public health districts.

The Health Care Transition Outreach and Awareness Campaign is underway. The campaign will address the four phases outlined in the communication plan. The CMS STEPS Up for Youth summer workgroup will help to inform Phase I activities within the next few months.

CMS provides health care transition education, resources and planning for program participants 12 years of age and older and their families. The Six Core Elements of Health Care Transition framework is used for developing and implementing program policies and procedures, communication tools and training materials for youth, families, community stakeholders and health care providers. The CMS health care transition policies and procedures creates a roadmap for care coordinators to effectively support youth/young adults and their parent/caregivers with the move from pediatric to adult care. CMS care coordinators receive ongoing training, technical assistance, quality assurance monitoring as well as access to transition resources and community supports.

Children with Special Health Care Needs - Application Year

Application Year: October 1, 2023 – September 30, 2024

Priority Need: Increase the Number of Children, Both With and Without Special Health Care Needs, Who Have a Medical Home

NPM 11- Medical Home

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

NPM 11 Strategies

- 11.1a Expand the use of telehealth technology to improve access to audiological and early intervention services for children and youth with special health care needs.
- 11.1b Facilitate efforts to educate families about telehealth as an option for care.
- 11.1c Provide ongoing evaluation of the Department's telehealth network to ensure pediatric specialty services meet the needs of families and patients.
- 11.1d Develop and implement a quality improvement plan for Title V's Children and Youth with Special Health Care Needs program to identify opportunities in which telehealth technology may be used to improve medical home access.
- 11.1e Expand the capacity of Help Me Grow (HMG) liaisons to help families navigate/ access comprehensive services.
- 11.1f Improve access to information and resources for CYSHCN.
- 11.1g Develop an outreach plan to engage partners, providers, and families in the utilization of HMG, a shared resource to assist families to navigate the early childhood system.

Children's Medical Services

Children's Medical Services (CMS), Georgia's CYSHCN program, will continue to ensure that children with chronic and complex medical needs have access to affordable, family-centered, continuous, and coordinated health care. In counties which are considered rural with limited access to pediatric specialty care, the CMS program will partner with pediatric subspecialists to provide services to more than 3,000 children and youth across nine rural public health districts. Services are provided face to face or via the Department's robust telehealth/telemedicine infrastructure. For more than a decade, the CMS program has partnered with pediatric healthcare systems, university systems, and private specialty providers for the expansion of telemedicine services. Telemedicine specialty care types include genetic testing, diagnostics and counseling, sickle cell follow up care, and endocrine, pulmonology, pediatric neurosurgery, and nephrology services. The program will continue to identify opportunities to utilize telehealth technology to engage with families and adolescents across the State. The CMS program will also utilize existing partnerships with community-based organizations and physician groups to promote education and awareness of telehealth opportunities with families as well as continue to monitor and evaluate the satisfaction of telemedicine services provided to families across child serving programs.

Medicaid redetermination will continue through 2024 and CMS care coordinators will work diligently with families to ensure continued access to health coverage. CMS will also promote Medicaid's new eligibility program, Pathways to Coverage, to ensure eligible young adults have continued health plan benefits. The program will also expand efforts to outreach and engage adult providers so that transition aged youth have access to a medical home as they age out of the CMS program. Early Hearing Detection and Intervention (EHDI) and BCW programs will continue to work more collaboratively with DECAL and the DOE to monitor and strengthen the systems that support early identification, intervention, language development academic achievement for DHH children across the continuum of service they receive from birth to third grade.

Babies Can't Wait (BCW)

Babies Can't Wait will continue to work collaboratively with Part B programs to ensure children remain connected to appropriate services when they transition from the Part C program. BCW will launch a communication campaign in the Fall of 2023 that will run through the winter. Targeting parents and caregivers of infants and young children, the campaign will highlight the importance of early identification and intervention and direct people to DPH resources that will connect them with appropriate programs and resources.

Priority Need: Improve Systems of Care for Children and Youth with Special Health Care Needs

NPM 12: Transition to Adult Care for Children with and without special health care needs

Percent of adolescents with and without health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Strategies

- 12.1a Develop and implement a health care transition quality improvement and evaluation plan to assess the effectiveness and efficiencies of the Department's health care transition program activities that impact youth and families.
- 12.1b Provide technical assistance and guidance on health care transition planning for care coordinators supporting the Title V Children and Youth with Special Health Care Needs program.
- 12.1c Implement condition specific transition planning protocols for adolescents enrolled in the Title V Children and Youth with Special Health Care Needs program.
- 12.1d Provide educational opportunities for youth and families to increase their knowledge on health care transition planning services and resources.
- 12.2a Establish an advisory group to include youth, families, and providers to support practice improvement efforts for health care transition.
- 12.2b Partner with adolescent health programs within the Department to implement best practices that support health care transition planning for youth and young adults with or without special health care needs.
- 12.2c Develop and implement a health care transition communication plan to share targeted messaging for transitioning youth/young adults with and without special health care needs from pediatric to adult care for audiences to include youth/young adults, families, health plans, medical providers, state agencies and community partners.
- 12.2d Provide continuing education opportunities on the six core elements of health care transition for medical and nursing students, pediatric and adult providers.

Health Care Transition Planning Quality Improvement

Georgia's CYSHCN program, Children's Medical Services (CMS), will work to increase the number of youth and young adults enrolled for services that transition to an adult model of care by increasing adult provider outreach and engagement and connecting eligible program participants to Georgia's new Medicaid eligibility pathway for adults. CMS will also begin using the results from the transition feedback surveys to identify future quality improvement activities as well as include in Title V Block grant reporting.

CMS will also focus on designing and implementing a process to collect and disseminate information on the various statewide health care transition initiatives that occur across health systems, academic spaces, state agency partners, and community-based organizations to ensure youth, families, and health care providers have access to current information as it relates to health care transition services and resources.

Continued partnership with the Georgia Mental Health Access in Pediatrics (GMAP) project for trainings and technical assistance to help address mental health screenings and community referral linkages, will be another quality improvement focus area for CMS health care transition planning.

Family Partnerships and Youth Engagement

The CMS program will increase statewide opportunities for youth and family engagement. With additional program staff and access to technology, the CMS program will explore coordinating youth and family advisory groups to help strategize in the areas of program eligibility, service delivery, communications, outreach and awareness, training and Blueprint for CYSHCN planning.

Due to the COVID-19 pandemic, local public health district CMS program staff began providing care coordination services for existing and newly enrolled families via DPHs secure videoconferencing platform. The telehealth technology available to local public health district CMS programs will continue to be used to explore additional opportunities to engage with youth and young adults during their transition planning activities. Activities may include transition goal setting, feedback sessions, and educational opportunities with medical providers. The opportunities are vast, and the program looks forward to engaging with youth to solidify some of these ideas.

The Parent as Partners project will continue working on the quality improvement plan developed during this year's Community of Practice with Family Voices. Also exploring the possibilities of an additional Parent Partner position to support family engagement in South Georgia via a collaboration with a local hospital system.

Health Care Transition Planning and Six Core Elements Training

Partner with physician member organizations (ie. GA AAP and GAFFP) on adult provider engagement and outreach strategies. Also, develop a report to summarize the physician annual transition assessments results shared by GA AAP and GAFFP.

An interactive Youth Awareness Workshop will be developed and launched in collaboration with the youth and community partners to educate youth and young adults on the importance of taking charge of their health care, attending important doctor's appointments, how to see and ask for help with their physical and mental health, knowing their insurance status and how to access health care services as an adult. Preparing Your Adolescent for the Transition from Pediatric to Adult Health Care training hosted by P2PGA, will be revamped with parent leader recommendations.

Community Outreach and Awareness

The CMS program will continue to forge partnerships with family-led and youth-led organizations to reach more families and youth. Efforts will continue with implementing the Health Care Transition Communication Campaign. The Campaign will focus on developing effective marketing strategies to help inform youth, families, state agencies, community partners, health care systems and health care providers on HCT education and awareness, policies, services, resources and tools. The campaign will also be used to drive the public to the DPH Transition webpage. Focus groups representing families, youth, health care providers and health plan representatives will continue and provide valuable recommendations to develop tools, electronic and print media that will best support transition efforts.

Cross-Cutting/Systems Building

State Performance Measures

SPM 3 - Percent of fathers (ages 18-55) whose knowledge increased using a Father Involvement curriculum in Georgia Healthy Start sites.

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	45.5
Annual Indicator			45.5	55.6
Numerator			5	10
Denominator			11	18
Data Source			Father Involvement Curriculum Pre-/Post-Test	Father Involvement Curriculum Pre-/Post-Test
Data Source Year			CY 2021	CY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	50.0	54.5	59.1

State Action Plan Table

State Action Plan Table (Georgia) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Increase father involvement among MCH populations

SPM

SPM 3 - Percent of fathers (ages 18-55) whose knowledge increased using a Father Involvement curriculum in Georgia Healthy Start sites.

Objectives

3.1 By 2025, increase the number of fathers that are recruited and enrolled into Georgia Healthy Start sites fatherhood programs by 5% annually.

3.2 By 2025, increase the number of fathers that are retained and complete the fatherhood programs using a Father Involvement curriculum by 5% annually.

Strategies

3.1 Educate Georgia Healthy Start sites on evidence-based and best practice models to recruit and retain fathers in fatherhood programming.

3.2 Increase Georgia Healthy Start sites access to training on Fatherhood Involvement.

3.3 Increase fatherhood collective impact activities that include meetings, trainings, and other events among the Georgia Healthy Start sites.

3.4 Provide fatherhood curriculum tools and resources to the Georgia Healthy Start sites (i.e. marketing materials, needs assessments, forms and templates, etc.).

3.5 Establish a media campaign to increase agency and community awareness of fatherhood programming available through the Fatherhood Initiative.

Priority Need: Increase Father Involvement in All MCH Populations

SPM 3: Father Involvement

Fatherhood Initiative

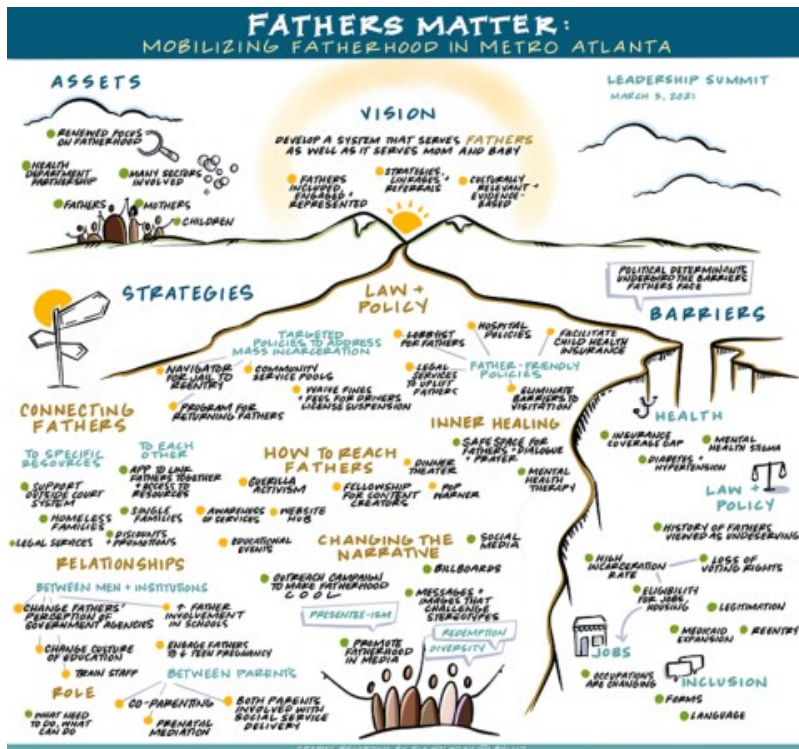
The DPH Strong Fathers Strong Families Georgia (SFSF GA) Coalition supports father involvement that leads to positive outcomes for children and families including improved social emotional development, academic achievement, and improved physical health for children. The SFSF GA Coalition interdisciplinary team is comprised of father and family-serving agencies and organizations, including state health and human services agencies, academic partners, local public health departments, as well as community-based and non-traditional partnerships including fathers, Georgia Healthy Start sites, Center for Black Women’s Wellness, TIME-ER Consulting Firm, LLC., Medicaid Care Management Organizations, fraternities, and sororities.

The mission of the SFSF GA Coalition is to connect family-serving agencies and organizations committed to coordinating strategies that address linking initiatives to existing programs and services into an accessible “father-friendly” network. The goal of the SFSF GA Coalition is to develop a system that supports fathers as well as mothers and babies. The major objectives of the coalition include: 1) Increase the number of evidence-based interventions available to fathers, 2) Provide resources and linkages to agency program partners, fathers, and their families, and 3) Facilitate projects and partnerships across traditional and non-traditional partners.

The SFSF GA Coalition stands upon the four pillars of Communication, Evaluation, Implementation, and Sustainability to connect and engage fathers throughout Georgia with an emphasis on serving fathers in the extended Metro Atlanta Area. The Coalition also partners with interstate and national agencies to provide multifaceted training and support to fathers and their families.

The SFSF GA Coalition uses a 3-Tiered Approach to engage and support fathers as follows:

- Tier 1: SFSF GA Core Coalition - Members provide strategic guidance, training, and support to the larger partner network. The coalition also provides evaluation and assessment activities for the coalition.
- Tier 2: Local Health District Healthy Start Sites – Healthy Start Programs in local districts provide evidence-based/informed fatherhood curriculums, such as 24/7 Dads. These programs also lead local community action teams to connect fathers to local resources and support within their communities.
- Tier 3: Fathers Matter Collective Action Network (CAN) - Through a partnership between DPH and the National Fatherhood Initiative (NFI), Morehouse School of Medicine was selected to serve as the community lead to conduct all Collective Action Network activities using the Community Mobilization Approach (CMA). Strategies for the CAN include 1) Connecting Fathers, 2) Reaching Fathers, 3) Improving Relationships, 4) Supporting Inner Healing, 5) Reclaiming the Narrative, 6) Addressing Mass Incarceration, and 7) Implementing Father-friendly Policies.



Link to Fathers Matter Community Mobilization Report (2021) <https://www.fathersmatteratl.com/community-mobilization-approach>

The SFSF GA Coalition continued to actively support the state’s efforts to develop a “father-friendly” linkage and referral network to serve fathers.

Local Health District Healthy Start Sites conducted monthly Fatherhood CAN meetings, conducted 24 father-specific training sessions via the 24/7 Dads curriculum, as well as a host of community events including resource fairs, fatherhood connection groups, barbershop talks, dad play groups, daddy bootcamps, etc. Fathers were also trained on reproductive health, healthy relationships, and completed Patient Health Questionnaires (PHQ-9s) to determine their need for mental health support. Local CANs have subcommittees that focus on breastfeeding, safe sleep, car seat safety and early literacy.

The Fathers Matter Initiative provided fundamental trainings to prepare partner sites to intentionally engage and include fathers in services. The trainings expanded knowledge of existing fatherhood staff and provide newly onboarded staff, new agency partners and Community Action Network (CAN) member organizations and collaborative partners a working knowledge of the importance of engaging fathers in programs and services.

Current Year:

Having implemented the original mission of the SFSF GA Coalition to connect family-serving agencies and organizations committed to coordinating strategies that address linking initiatives to existing programs and services into an accessible “father-friendly” network, and due to program reorganization, The SFSF GA Coalition relinquished its control of Tier 1 activities into the newly created Fathers Matter Community Action Network (Tier 2) Group. All partners of the original SFSF GA Coalition serve as leaders and committee members of the local level Fathers Matter CAN. This allows coalition members and partner agencies to work in a group setting, and/or directly with individual agencies and community-based organizations (CBOs) to develop creative programming and sustainable

impact for fatherhood programs. Title V contracts directly with Morehouse School of Medicine, Department of Community and Preventive Medicine, Community Research Center, the National Fatherhood Initiative, and other CBOs to provide sustainable fatherhood programming for the state of Georgia.

The Fatherhood Initiative has continued to increase father engagement and involvement in MCH programs through capacity building, collaboration, coordination, and providing resources to encourage father inclusion. The Fatherhood Initiative is continuing to focus on intentionally engaging fathers throughout maternal and child health programs and services. Driven by the three main objectives, the Fatherhood Initiative will advance partnerships across Maternal, Infant, Early Child Home Visiting program (MIECHV), Healthy Start, and other traditional and non-traditional partners to impact research, policy, and practice. Continuing to serve as a Fathers Matter CAN member, leading agency and convener for Fatherhood development in the state, the Fatherhood Initiative will continue its efforts to build capacity through hosting meetings, trainings, and events across state, local, and community entities.

Activities in current year include the following:

- Through the Fathers Matter CAN, continue implementing the Fatherhood action plan for the state using the Community Mobilization Approach (CMA) as a model in other parts of the state.
- Establish additional Fatherhood Program Sites across MIECHV and other Title V Programs.

During the current year, the Father Matters CAN partners hosted numerous fatherhood events of which one quarter is highlighted below:

April 6th – Caring Dads – Best Practices in Fatherhood

April 15th, 22nd, 29th – Dreams-4U – 16 Hours of Healthy Relationship Workshops for Singles

April 22nd – Live B4U Die Summit – Addressing Healthy Youth Behaviors

April 22nd – Roosevelt Muhammad Community Action Day (300 Computer Giveaway)

April 23rd – I AM DAD! Podcast Jessie L. Adolph, Ph.D., Assistant Professor of English Georgia State University

April 30th – Art & Jazz Gala

May 19th – Heart of the Community Award Ceremony (Three Fathers Matter CAN Agencies were honored)

May 27th – 3-on-3 Basketball Tournament

June 1st – Whole Healthy Man Webinar

June 7th - National Responsible Fatherhood Clearinghouse Event – Behavioral and Mental Health Support

June 8th – The National African American Child and Family Research Center (NAACFRC) Annual Community Engaged Research Conference

June 15th Men's Mental Health Symposium

June 17th Houston County Father's Day Resource Fair

Elevate: Date Night – Eight-90 Minute Sessions on Healthy Relationships

3rd Friday of Every Month – Wear blue for men's mental health awareness

Cross-Cutting/Systems Building - Application Year

Application Year: October 1, 2023 – September 30, 2024

Priority Need: Increase Father Involvement in All MCH Populations

SPM 3: Father Involvement

Percent of fathers (ages 18-55) whose knowledge increased using a Father Involvement curriculum in Georgia Healthy Start sites.

SPM 3 Strategies:

- 3.1 Educate Georgia Healthy Start sites on evidence-based and best practice models to recruit and retain fathers in fatherhood programming.
- 3.2 Increase Georgia Healthy Start sites access to training on Fatherhood Involvement.
- 3.3 Increase fatherhood collective impact activities that include meetings, trainings, and other events among the Georgia Healthy Start sites.
- 3.4 Provide fatherhood curriculum tools and resources to the Georgia Healthy Start sites (i.e., marketing materials, needs assessments, forms and templates, etc.).
- 3.5 Establish a media campaign to increase agency and community awareness of fatherhood programming available through the Fatherhood Initiative.

Fatherhood Initiative

In the coming year Title V will continue to provide guidance, training, and support to Home Visiting and Healthy Start sites, and will develop new tools to support and evaluate project programming for additional Title V programs seeking to implement new fatherhood strategies. The Fatherhood Initiative will also focus on increasing referrals that will provide 360-degree/Whole Family Support for fathers and their families by focusing on the social determinants of health affecting fathers most often.

Education	Parenting Skills Classes, GED Classes, Life Skills Classes, Relationship Classes
Hunger	Farm/Food Program, Food Distribution, Cooking Classes, Nutrition Classes
Housing	Permanent Housing, Rental Housing, Rental Assistance Programs
Environment & Safety	Child Abuse Prevention, Home Visiting, Parental Stress, Safety Planning, Domestic Violence
Income and Jobs	Community Supports, Job Skills Training, Access to Computers, Money Management
Access to Care	Access to Health/Dental Screening and Care, Community Referrals, Health Insurance
Transportation	Car Buying Classes, Gas Cards, Bus/Metro Passes
Isolation	Incarceration/Re-entry, Father Support/Talking Groups, Father/Family Events
Mental Health	Stress Reduction, Access to Mental Health Services, Trauma-Informed Care

III.F. Public Input

The Georgia Title V Program strives to solicit public input to guide program development, implementation, and evaluation. Title V staff seek opportunities to invite stakeholders, people with lived experience and the public to offer valuable input into policy and program development to ensure they are meeting the unique cultural needs of Georgia's diverse population and communities.

Title V is committed to collecting input throughout the year. Following the annual block grant review with HRSA staff, DPH will post the full Annual Report and Application to the Title V webpage. A public input survey will be posted on the DPH Title V webpage, via SurveyMonkey, to collect information on the Application and Annual Report from consumers and partners across the state that are concerned about the needs of MCH populations. The Division of Women, Children, and Nursing Services maintains a specific Title V email account which is listed on the website to facilitate comments or input on the Georgia Title V program and its efforts.

The MCH Advisory Council was created to provide support and guidance and to provide input on Title V priorities, strategies and outcome measures. The Council brings together several organizations and state agencies with a broad range of expertise to address and improve health outcomes for women, infants, children, and families. During the year, the Title V program presents program activities and updates and seek input from Council members. The Council serves as a conduit for the exchange of information and advises on progress, facilitates private and public sector support for improving health outcomes and helps focus efforts among partners, recommends collaborative initiatives, and reviews existing and proposed Title V projects. Council members include people with lived experience, representatives from state, local, non-profit, academic, health care, and professional organizations who have expertise in areas related to MCH.

The Title V program priorities and strategies are presented to various partners and stakeholders throughout the year and feedback is requested. The MCH Block Grant Annual Report and Application planning and reporting processes are routinely discussed with the MCH Advisory Council, committees and stakeholders such as the GA-AAP, the GAFFP, Georgia Interagency Directors for the Center for Excellence for Children's Behavioral Health, Georgia Healthy Start Grantees, and the State Maternal Health Innovation grantee.

Public input is solicited at public forums such as committee and grantee meetings, conferences, and advisory committees and boards. BCW SICC receives public comment during quarterly council meetings. The Oral Health program's Fluoride Advisory Committee promotes communication and input through quarterly meetings between multiple stakeholders and seeks public input through conducting surveys to solicit input from stakeholders and program participants. The NBSAC, a select review team with oversight and advisory responsibility for the Newborn Screening program, conducts bi-annual public meetings to determine selection of new conditions to the Georgia Newborn Screening panel. Individuals and organizations are invited to submit nominations to add new conditions for consideration. Title V staff regularly convenes and attends formal and informal advisory workgroups, steering committees, councils, task forces, and other groups to address emerging issues and work on collaborative initiatives related to MCH populations throughout the year.

As part of the 2020 Five-year Needs Assessment, DPH sought public input via surveys, focus groups, stakeholder meetings and advisory groups. MCH took deliberate steps to incorporate public involvement early in the process leading up to the Application/Annual Report. A communication plan was developed to include presentations to the Georgia Public Health Association, DPH Board of Public Health, MCH Advisory Council, and various other partner meetings throughout the state.

Title V partners, including family representatives and people with lived experience, will continue to be engaged as plans are developed and implemented. Title V will continue to create communication that increases visibility and strengthens outreach and utilization of MCH programs to the community.

III.G. Technical Assistance

Georgia Title V participates in multiple opportunities for technical assistance throughout the year from federal stakeholders such as CDC, HRSA, AMCHP, Maternal and Child Health Bureau (MCHB), National MCH Workforce Development Center, and the Child Safety Network Collaborative.

Title V provides technical assistance to programs and partners through various trainings, webinars and conferences. Meetings with Title V programs occur regularly to assess activities, ESM progress and to identify resources that may be needed to help ensure positive outcomes.

Title V staff will request technical assistance from MCHB if needs are identified in the future.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [IV. Title V Medicaid IAA_MOU.pdf](#)

V. Supporting Documents

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

Supporting Document #01 - [FY24 Application Overview of the State References.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [Division Women Children and Nursing ORG CHART 7-2023.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Georgia

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 17,274,806	
A. Preventive and Primary Care for Children	\$ 6,057,185	(35%)
B. Children with Special Health Care Needs	\$ 7,193,099	(41.6%)
C. Title V Administrative Costs	\$ 1,597,962	(9.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 14,848,246	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 114,234,014	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 211,219,876	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 325,453,890	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 36,079,622		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 342,728,696	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 49,649,743	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 392,378,439	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	\$ 620,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 370,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	\$ 275,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 166,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 6,949,710
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 16,816,481
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	\$ 1,031,261
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 235,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 912,693
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	\$ 1,596,523
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 19,090,633
Department of Health and Human Services (DHHS) > Other > CAPTA	\$ 1,386,442
US Department of Education > Office of Special Education Programs > OSEP Leadership Grant	\$ 200,000

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 19,613,858 (FY 22 Federal Award: \$ 17,360,856)		\$ 17,133,015	
A. Preventive and Primary Care for Children	\$ 6,998,735	(35.7%)	\$ 5,801,492	(33.8%)
B. Children with Special Health Care Needs	\$ 7,146,252	(36.4%)	\$ 7,709,679	(44.9%)
C. Title V Administrative Costs	\$ 1,499,921	(7.6%)	\$ 1,323,615	(7.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 15,644,908		\$ 14,834,786	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 108,962,207		\$ 98,436,370	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 193,945,994		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 5,166,374		\$ 199,279,326	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 308,074,575		\$ 297,715,696	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 36,079,622				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 327,688,433		\$ 314,848,711	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 32,799,832		\$ 23,745,088	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 360,488,265		\$ 338,593,799	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 6,491,772	\$ 6,534,647
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	\$ 1,114,121	\$ 1,174,633
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 160,000	\$ 126,219
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 235,000	\$ 159,186
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 15,275,074	\$ 13,388,888
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 370,000	\$ 258,761
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 1,592,933	\$ 386,311
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > American Rescue Plan Act Funding for Home Visiting	\$ 948,874	\$ 614,190
US Department of Education > Office of Special Education Programs > Individuals with Disabilities Education Act/American Rescue Plan Act of 2021 (ARP)	\$ 6,612,058	\$ 1,102,253

Form Notes for Form 2:

ARP funding for MIECHV (Plan 1) and Babies Can't Wait end 9/30/2023 and is not included in application. New Division - Women, Children, & Nursing Services as of January 1, 2023. This Division is composed of Previous Maternal & Child Programs, Women's Health and Nursing Services.

Field Level Notes for Form 2:

1.	Field Name:	1.FEDERAL ALLOCATION
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	These expenditures are lower due to Covid.
2.	Field Name:	Federal Allocation, A. Preventive and Primary Care for Children:
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	These expenditures are lower due to Covid.
3.	Field Name:	Federal Allocation, C. Title V Administrative Costs:
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	These expenditures are lower due to Covid.
4.	Field Name:	5. OTHER FUNDS
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	These expenditures are lower due to Covid.
5.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2022
	Column Name:	Annual Report Expended
	Field Note:	These expenditures are lower due to Covid.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: Georgia

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	\$ 2,342,560	\$ 2,074,766
2. Infants < 1 year	\$ 84,000	\$ 223,463
3. Children 1 through 21 Years	\$ 6,057,185	\$ 5,801,492
4. CSHCN	\$ 7,193,099	\$ 7,709,679
5. All Others	\$ 0	\$ 0
Federal Total of Individuals Served	\$ 15,676,844	\$ 15,809,400

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	\$ 31,136,998	\$ 26,316,429
2. Infants < 1 year	\$ 114,170,269	\$ 105,532,921
3. Children 1 through 21 Years	\$ 134,104,202	\$ 128,309,330
4. CSHCN	\$ 46,042,422	\$ 38,099,890
5. All Others	\$ 0	\$ 0
Non-Federal Total of Individuals Served	\$ 325,453,891	\$ 298,258,570
Federal State MCH Block Grant Partnership Total	\$ 341,130,735	\$ 314,067,970

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	Field Name:	IA. Federal MCH Block Grant, 1. Pregnant Women
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	Made changes to funding for this category.

2.	Field Name:	IA. Federal MCH Block Grant, Federal Total of Individuals Served
	Fiscal Year:	2024
	Column Name:	Application Budgeted
	Field Note:	Made changes to funding due to increase in administrative costs.

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services
State: Georgia

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	\$ 9,770,438	\$ 9,789,153
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 1,389,724	\$ 1,203,604
B. Preventive and Primary Care Services for Children	\$ 3,345,545	\$ 3,162,586
C. Services for CSHCN	\$ 5,035,169	\$ 5,422,963
2. Enabling Services	\$ 5,038,385	\$ 4,713,042
3. Public Health Services and Systems	\$ 2,465,983	\$ 2,630,820
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 265,678
Physician/Office Services		\$ 37,031
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 46,812
Dental Care (Does Not Include Orthodontic Services)		\$ 300,158
Durable Medical Equipment and Supplies		\$ 167,473
Laboratory Services		\$ 0
Other		
Various Programs and Services		\$ 8,972,001
Direct Services Line 4 Expended Total		\$ 9,789,153
Federal Total	\$ 17,274,806	\$ 17,133,015

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	\$ 265,152,047	\$ 221,804,046
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 121,268,413	\$ 99,253,830
B. Preventive and Primary Care Services for Children	\$ 107,132,274	\$ 99,503,830
C. Services for CSHCN	\$ 36,751,360	\$ 23,046,386
2. Enabling Services	\$ 40,294,753	\$ 43,671,217
3. Public Health Services and Systems	\$ 29,766,388	\$ 38,456,380
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 265,678
Physician/Office Services		\$ 84,817
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 65,251
Dental Care (Does Not Include Orthodontic Services)		\$ 1,531,425
Durable Medical Equipment and Supplies		\$ 294,993
Laboratory Services		\$ 0
Other		
Various Programs and Services		\$ 219,561,882
Direct Services Line 4 Expended Total		\$ 221,804,046
Non-Federal Total	\$ 335,213,188	\$ 303,931,643

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated
State: Georgia

Total Births by Occurrence: 125,935

Data Source Year: 2022

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	123,187 (97.8%)	11,825	314	314 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methylglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Holocarboxylase Synthase Deficiency	Homocystinuria
Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)
Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Primary Congenital Hypothyroidism	Propionic Acidemia	S, β -Thalassemia
S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiencies	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	β -Ketothiolase Deficiency
Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy	

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Hearing Loss	121,093 (96.2%)	6,261	157	137 (87.3%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Emory University, Augusta University, and Children's Healthcare of Atlanta are contracted to conduct short-term follow-up on abnormal NBS results. NBS short-term follow-up encompasses the time between receiving an abnormal result to the confirmation of a diagnosis. Each contractor utilizes a database to track newborns during the short-term follow-up process which includes a minimum of 12 steps to locate and recall infants who screen positive for a condition identified by NBS. All diagnosed cases are referred to Children 1st, the single point of entry for public health services, which leads to an assessment to determine the newborn's eligibility for IDEA Part C, Babies Can't Wait, or the Children and Youth with Special Health Care Needs Program- Children's Medical Services.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	Field Name:	Core RUSP Conditions - Total Number Receiving At Least One Screen
	Fiscal Year:	2022
	Column Name:	Core RUSP Conditions
	Field Note:	Determined by an algorithm to match newborn screens to vital records. Ninety-three percent of records match automatically; 7% require manual matching. This is a deduplicated number of screens by kit number and patient ID for GA resident births. The Georgia Public Health Laboratory (GPHL) tested > 140,000 blood samples in 2022, including repeat and unsatisfactory screens.
2.	Field Name:	Core RUSP Conditions - Total Number of Out-of-Range Results
	Fiscal Year:	2022
	Column Name:	Core RUSP Conditions
	Field Note:	Data retrieved from GPHL and Emory University's Department of Genetics monthly/annual reports uploaded in SendSS (State Electronic Notifiable Disease Surveillance System) on April 18, 2023.
3.	Field Name:	Core RUSP Conditions - Total Number Confirmed Cases
	Fiscal Year:	2022
	Column Name:	Core RUSP Conditions
	Field Note:	Confirmed cases are provided through Emory Genetics Follow-up Program, Hemoglobin Follow-up at Children's Hospital of Atlanta (CHOA) and Augusta University Hospital, Early Hearing Detection and Intervention (EHDI), and SendSS. This report was prepared on April 18, 2023. Thus, it might be possible that later on some numbers would be added in confirmatory cases due to delayed/late diagnosis.
4.	Field Name:	Core RUSP Conditions - Total Number Referred For Treatment
	Fiscal Year:	2022
	Column Name:	Core RUSP Conditions
	Field Note:	Emory University Department of Human Genetics refers and treats everyone confirmed with metabolic and other genetic disorders. CHOA, Augusta University Hospital, and Sickle Cell Foundation providers referral services to all confirmed cases of Hemoglobinopathies. Early Hearing Detection and Intervention (EHDI) provides referral services for confirmed cases of Hearing Loss.
5.	Field Name:	Hearing Loss - Total Number Confirmed Cases
	Fiscal Year:	2022

Column Name: Other Newborn

Field Note:

Confirmed cases of hearing loss retrieved from State Diagnostic Report downloaded from SendSS on April 18, 2023 and linked to de-duplicated EBC records and Hearing Summary Report Linelist on Patient ID.

6. **Field Name:** Hearing Loss - Total Number Referred For Treatment

Fiscal Year: 2022

Column Name: Other Newborn

Field Note:

Referral for treatment data retrieved from Hearing Summary Report Linelist downloaded from SendSS on April 18, 2023 and linked to de-duplicated EBC records and State Diagnostic Report on Patient ID. These numbers are subject to change as more confirmed cases are identified from presumptive positive screens (failed hearing screens) and are referred to treatment (early intervention) over time.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Georgia

Annual Report Year 2022

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	11,392	46.0	0.0	48.0	6.0	0.0
2. Infants < 1 Year of Age	1,059	46.0	0.0	48.0	6.0	0.0
3. Children 1 through 21 Years of Age	16,623	36.0	0.0	56.0	8.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	6,366	50.0	0.0	43.0	7.0	0.0
4. Others	0					
Total	29,074					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	124,073	Yes	124,073	94.7	117,497	11,392
2. Infants < 1 Year of Age	125,059	No	125,935	97.8	123,164	1,059
3. Children 1 through 21 Years of Age	2,998,541	Yes	2,998,541	91.5	2,743,665	16,623
3a. Children with Special Health Care Needs 0 through 21 years of age^	654,956	Yes	654,956	91.5	599,285	6,366
4. Others	7,680,729	Yes	7,680,729	91.5	7,027,867	0

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2022
	Field Note:	Data Source: Number of pregnant women who received services at a Regional Perinatal Center (RPC) according to Hospital Discharge Data. The insurance data was provided by HRSA reference data (National Vital Statistics System- Pregnant Women/Infants, 2021).
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2022
	Field Note:	Data Source: Total number of infants less that 1 year of age who received a car seat through the Child Occupant Safety Project (COSP) from October 2021-September 2022. This number remains lower than it was pre-pandemic as the local programs are hosted through the health departments and their focus was shifted during the COVID-19 pandemic/response. The Oral Health Program (OHP) has a new database and now only collects data for children in two age categories (birth-12 months and children over 12 months-21 years). There were 217 children who received an oral health screening at an oral health clinic. Will only report COSP data for this age category it has the highest reach and to avoid deduplication. The insurance data was provided by HRSA reference data (National Vital Statistics System- Pregnant Women/Infants, 2021).
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2022
	Field Note:	Data Source: Total number of children who received an oral health screening (in a school-based program or public health dental clinic) from October 2021-September 2022. The Oral Health Program (OHP) has a new database and is not comparable to last year. The OHP database now only collects data for children in two categories (birth-12 months and children over 12 months-21 years). COSP distributed 1,080 convertible seats to children 1-3 years of age from October 2021-September 2022.To avoid duplications, only oral health data was used in this age category as it has the highest reach. The insurance data was provided by HRSA reference data (American Community Survey- Children 1-21, 2021). The sum of insurance coverage for this population was 101%. The percentage for column "(E) None %" was changed from 9% to 8% to avoid a data alert.
4.	Field Name:	Children with Special Health Care Needs 0 through 21 Years of Age
	Fiscal Year:	2022
	Field Note:	Data Source: Total number of children served by the state's Title V Children and Youth with Special Health Care Needs program from October 2021-September 2022. The insurance data was provided by HRSA reference data (National Survey of Children's Health- CSHCN, 2020-2021).
5.	Field Name:	Others
	Fiscal Year:	2022
	Field Note:	Currently, Georgia does not have a way to collect and measure the individuals served by Title V in the "Other" category (women and men over the age of 21).

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women Total % Served
	Fiscal Year:	2022
	Field Note:	In the reporting year, most of the hospitals throughout the State of Georgia participated in the Safe to Sleep Hospital Initiative. This program had the highest public health outreach for the pregnant women population. According to Hospital Discharge Data, there were 117,455 delivering women in the reporting year. Reference data was used for the denominator. The total percentage served was 94.67% ($117,455/124,073 \times 100\% = 94.67$).
2.	Field Name:	Infants Less Than One Year Total % Served
	Fiscal Year:	2022
	Field Note:	Newborn screening data from Form 4 was used. 123,187 newborns received at least 1 screening (numerator). The total number of births by occurrence was 125,935 (denominator). The total percentage served was 97.8% ($123,187/125,935 \times 100\% = 97.8\%$).
3.	Field Name:	Infants Less Than One Year Denominator
	Fiscal Year:	2022
	Field Note:	Newborn screening data from Form 4 was used. 123,187 newborns received at least 1 screening (numerator). The total number of births by occurrence was 125,935 (denominator). The total percentage served was 97.8% ($123,187/125,935 \times 100\% = 97.8\%$).
4.	Field Name:	Children 1 through 21 Years of Age Total % Served
	Fiscal Year:	2022
	Field Note:	3. (Children 1-21 Years): Starting in 2020, Georgia uses Water Fluoridation data to better capture and represent the total percent of population served for the "Children" and "Other" categories as this public health service/system has the highest outreach. The Community Water Fluoridation Programs ensure that Georgia residents on community water systems have access to optimally adjusted fluoridation. According to the 2020 Water Fluoridation Reporting System (latest available year), approximately 10 million Georgians are served by the community water systems. The proportion of the population served was calculated using the total number of individuals provided in the reference data ($10,000,000/10,928,402 \times 100\% = 91.5\%$). For Children and CSHCN: Georgia previously attempted to combine multiple data sources (e.g., BCW, CMS, Children 1st, etc.) to calculate the percentage served, but the percentage was low and unable to deduplicate.
5.	Field Name:	Children with Special Health Care Needs 0 through 21 Years of Age Total % Served
	Fiscal Year:	2022

Field Note:

Starting in 2020, Georgia uses Water Fluoridation data to better capture and represent the total percent of population served for the "Children" and "Other" categories as this public health service/system has the highest outreach. This includes Children with Special Health Care Needs. as they are a subset of all infants and children. The Community Water Fluoridation Programs ensure that Georgia residents on community water systems have access to optimally adjusted fluoridation. According to the 2020 Water Fluoridation Reporting System (latest available year), approximately 10 million Georgians are served by the community water systems. The proportion of the population served was calculated using the total number of individuals provided in the reference data (10,000,000/10,928,402*100%= 91.5%).

For Children and CSHCN: Georgia previously attempted to combine multiple data sources (e.g., BCW, CMS, Children 1st, etc.) to calculate the percentage served, but the percentage was low and unable to deduplicate.

6.	Field Name:	Others Total % Served
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	Fiscal Year:	2022
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Field Note:

Starting in 2020, Georgia uses Water Fluoridation data to better capture and represent the total percent of population served for the "Children" and "Other" categories as this public health service/system has the highest outreach. The Community Water Fluoridation Programs ensure that Georgia residents on community water systems have access to optimally adjusted fluoridation. According to the 2020 Water Fluoridation Reporting System (latest available year), approximately 10 million Georgians are served by the community water systems. The proportion of the population served was calculated using the total number of individuals provided in the reference data (10,000,000/10,928,402*100%= 91.5%).

Data Alerts:

- | | |
|----|--|
| 1. | Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note. |
|----|--|

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

State: Georgia

Annual Report Year 2022

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	117,455	48,795	39,873	16,537	281	4,665	152	5,120	2,032
Title V Served	11,392	4,030	5,663	685	16	210	15	666	107
Eligible for Title XIX	58,511	17,665	26,007	9,926	87	871	66	2,967	922
2. Total Infants in State	125,019	50,793	41,694	20,116	252	5,401	203	6,560	0
Title V Served	124,507	51,138	42,741	18,476	239	4,753	230	3,715	3,215
Eligible for Title XIX	62,632	18,388	27,195	12,074	78	1,008	88	3,801	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

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

State: Georgia

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(855) 707-8277	(855) 707-8277
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health Hotline	Maternal and Child Health Hotline
3. Name of Contact Person for State MCH "Hotline"	Kathy Welborn	Kathy Welborn
4. Contact Person's Telephone Number	(404) 618-4912	(470) 618-4912
5. Number of Calls Received on the State MCH "Hotline"		4,930

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names	Help Me Grow, Electronic Birth Certificate Initial Screenings	Help Me Grow, Electronic Birth Certificate Initial Screenings
2. Number of Calls on Other Toll-Free "Hotlines"		4,930
3. State Title V Program Website Address	https://dph.georgia.gov/women-and-children	https://dph.georgia.gov/MCH
4. Number of Hits to the State Title V Program Website		267,881
5. State Title V Social Media Websites	https://twitter.com/gadph https://facebook.com/gadph	https://twitter.com/gadph https://facebook.com/gadph
6. Number of Hits to the State Title V Program Social Media Websites		0

Form Notes for Form 7:

Georgia's Title V social media is housed within the department-wide social media; therefore, no individual analytics are captured for Title V.

Form 8
State MCH and CSHCN Directors Contact Information

State: Georgia

1. Title V Maternal and Child Health (MCH) Director	
Name	Diane Durrence
Title	Division of Women, Children, and Nursing Services Director
Address 1	200 Piedmont Avenue S.E.
Address 2	West Tower, 19th Floor
City/State/Zip	Atlanta / GA / 30334
Telephone	(404) 205-3112
Extension	
Email	Diane.Durrence@dph.ga.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Sharifa Peart
Title	CYSHCN Director, Children's Medical Services
Address 1	200 Piedmont Avenue S.E.
Address 2	West Tower, 15th Floor
City/State/Zip	Atlanta / GA / 30334
Telephone	(470) 303-0264
Extension	
Email	Sharifa.Peart@dph.ga.gov

3. State Family Leader (Optional)

Name	Sherry Richardson
Title	Title V Family Engagement manager
Address 1	200 Piedmont Avenue SE
Address 2	West Tower, 15th Floor
City/State/Zip	Atlanta / GA / 30334
Telephone	(404) 651-7692
Extension	
Email	Sherry.Richardson@dph.ga.gov

4. State Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Georgia

Application Year 2024

No.	Priority Need
1.	Prevent Maternal Mortality
2.	Prevent Infant Mortality
3.	Promote developmental screenings among children
4.	Increase the number of children, both with and without special health care needs, who have a medical home
5.	Increase bullying and suicide prevention
6.	Improve systems of care for CYSHCN
7.	Promote oral health among MCH populations
8.	Increase father involvement among MCH populations

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Prevent Maternal Mortality	Continued
2.	Prevent Infant Mortality	Continued
3.	Promote developmental screenings among children	Continued
4.	Increase the number of children, both with and without special health care needs, who have a medical home	New
5.	Increase bullying and suicide prevention	New
6.	Improve systems of care for CYSHCN	Continued
7.	Promote oral health among MCH populations	Continued
8.	Increase father involvement among MCH populations	New

**Form 10
National Outcome Measures (NOMs)**

State: Georgia

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	77.4 %	0.1 %	95,227	123,043
2020	75.5 %	0.1 %	91,631	121,287
2019	75.1 %	0.1 %	92,938	123,734
2018	74.4 %	0.1 %	91,781	123,321
2017	74.8 %	0.1 %	94,939	126,946
2016	74.8 %	0.1 %	92,505	123,648
2015	74.9 % ⚡	0.1 % ⚡	84,535 ⚡	112,864 ⚡
2014	74.6 % ⚡	0.1 % ⚡	80,348 ⚡	107,749 ⚡
2013	73.6 % ⚡	0.1 % ⚡	80,053 ⚡	108,806 ⚡
2012	73.1 % ⚡	0.1 % ⚡	82,491 ⚡	112,902 ⚡
2011	72.0 % ⚡	0.1 % ⚡	79,004 ⚡	109,704 ⚡
2010	73.0 % ⚡	0.1 % ⚡	74,389 ⚡	101,886 ⚡
2009	73.0 % ⚡	0.1 % ⚡	73,094 ⚡	100,098 ⚡

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None



NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	93.0	2.8	1,090	117,246
2019	87.2	2.7	1,051	120,586
2018	80.7	2.6	972	120,433
2017	75.9	2.5	942	124,161
2016	80.1	2.5	1,002	125,138
2015	69.4	2.7	649	93,488
2014	80.2	2.6	1,002	124,876
2013	87.2	2.7	1,075	123,218
2012	81.0	2.6	1,011	124,826
2011	77.5	2.5	984	127,039
2010	85.6	2.6	1,106	129,183
2009	73.8	2.4	969	131,368
2008	73.4	2.3	1,039	141,459

Legends:

-  Indicator has a numerator ≤10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2021	33.4	2.3	210	628,332
2016_2020	29.5	2.2	187	634,301
2015_2019	32.2	2.2	207	643,232
2014_2018	32.9	2.3	213	647,807

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)


Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	10.6 %	0.1 %	13,140	124,007
2020	9.9 %	0.1 %	12,072	122,403
2019	10.0 %	0.1 %	12,655	126,299
2018	10.1 %	0.1 %	12,733	126,106
2017	9.9 %	0.1 %	12,772	129,072
2016	9.8 %	0.1 %	12,704	129,769
2015	9.5 %	0.1 %	12,464	131,326
2014	9.5 %	0.1 %	12,385	130,738
2013	9.5 %	0.1 %	12,064	127,627
2012	9.3 %	0.1 %	12,014	129,553
2011	9.4 %	0.1 %	12,333	131,791
2010	9.7 %	0.1 %	12,912	132,745
2009	9.4 %	0.1 %	13,190	140,396

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)


Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	11.9 %	0.1 %	14,740	124,020
2020	11.4 %	0.1 %	13,980	122,428
2019	11.7 %	0.1 %	14,763	126,335
2018	11.5 %	0.1 %	14,509	126,135
2017	11.4 %	0.1 %	14,756	129,184
2016	11.2 %	0.1 %	14,577	129,973
2015	10.8 %	0.1 %	14,133	131,349
2014	10.8 %	0.1 %	14,058	130,764
2013	10.7 %	0.1 %	13,665	128,164
2012	10.9 %	0.1 %	14,139	129,705
2011	11.0 %	0.1 %	14,473	131,865
2010	11.3 %	0.1 %	15,093	133,000
2009	11.3 %	0.1 %	15,859	140,367

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)


Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	30.5 %	0.1 %	37,885	124,020
2020	29.4 %	0.1 %	35,970	122,428
2019	28.9 %	0.1 %	36,488	126,335
2018	28.3 %	0.1 %	35,660	126,135
2017	27.7 %	0.1 %	35,749	129,184
2016	27.1 %	0.1 %	35,177	129,973
2015	26.8 %	0.1 %	35,183	131,349
2014	26.0 %	0.1 %	33,960	130,764
2013	26.1 %	0.1 %	33,440	128,164
2012	27.8 %	0.1 %	36,044	129,705
2011	28.5 %	0.1 %	37,579	131,865
2010	29.4 %	0.1 %	39,104	133,000
2009	31.1 %	0.1 %	43,614	140,367

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	2.0 %			
2019/Q4-2020/Q3	1.0 %			
2019/Q1-2019/Q4	1.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None



NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.7	0.2	821	122,920
2019	7.3	0.2	925	126,826
2018	7.0	0.2	881	126,591
2017	7.2	0.2	934	129,682
2016	7.7	0.2	1,008	130,519
2015	7.7	0.2	1,012	131,878
2014	7.2	0.2	946	131,369
2013	7.4	0.2	957	129,227
2012	6.6	0.2	867	130,753
2011	6.7	0.2	894	132,892
2010	6.3	0.2	843	134,409
2009	7.0	0.2	993	141,829

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.3	0.2	769	122,473
2019	7.0	0.2	887	126,371
2018	7.0	0.2	889	126,172
2017	7.2	0.2	928	129,243
2016	7.5	0.2	972	130,042
2015	7.8	0.2	1,024	131,404
2014	7.5	0.2	985	130,946
2013	7.0	0.2	899	128,748
2012	6.2	0.2	812	130,280
2011	6.9	0.2	908	132,409
2010	6.3	0.2	849	133,947
2009	7.3	0.2	1,036	141,377

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	3.9	0.2	477	122,473
2019	4.6	0.2	587	126,371
2018	4.7	0.2	596	126,172
2017	4.6	0.2	599	129,243
2016	5.0	0.2	648	130,042
2015	5.1	0.2	666	131,404
2014	5.0	0.2	654	130,946
2013	4.8	0.2	619	128,748
2012	4.1	0.2	534	130,280
2011	4.3	0.2	570	132,409
2010	3.9	0.2	516	133,947
2009	4.9	0.2	696	141,377

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	2.4	0.1	292	122,473
2019	2.4	0.1	300	126,371
2018	2.3	0.1	293	126,172
2017	2.5	0.1	329	129,243
2016	2.5	0.1	324	130,042
2015	2.7	0.1	358	131,404
2014	2.5	0.1	331	130,946
2013	2.2	0.1	280	128,748
2012	2.1	0.1	278	130,280
2011	2.6	0.1	338	132,409
2010	2.5	0.1	333	133,947
2009	2.4	0.1	340	141,377

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	190.2	12.5	233	122,473
2019	256.4	14.3	324	126,371
2018	271.9	14.7	343	126,172
2017	251.5	14.0	325	129,243
2016	290.7	15.0	378	130,042
2015	292.2	14.9	384	131,404
2014	287.1	14.8	376	130,946
2013	281.9	14.8	363	128,748
2012	234.1	13.4	305	130,280
2011	216.8	12.8	287	132,409
2010	221.0	12.9	296	133,947
2009	258.2	13.5	365	141,377

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None



NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	131.5	10.4	161	122,473
2019	128.2	10.1	162	126,371
2018	122.1	9.8	154	126,172
2017	132.3	10.1	171	129,243
2016	123.8	9.8	161	130,042
2015	129.4	9.9	170	131,404
2014	123.0	9.7	161	130,946
2013	105.6	9.1	136	128,748
2012	104.4	9.0	136	130,280
2011	125.4	9.7	166	132,409
2010	120.9	9.5	162	133,947
2009	96.9	8.3	137	141,377

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.6 %	1.0 %	5,497	118,967
2020	7.9 %	1.4 %	9,329	117,651
2019	4.1 %	0.9 %	4,942	120,869
2018	6.3 %	1.2 %	7,527	119,374
2017	5.6 %	1.1 %	6,824	122,368
2013	4.4 %	1.1 %	2,852	64,607
2012	3.9 %	0.8 %	4,881	125,314
2011	6.2 %	1.1 %	7,842	127,353
2010	6.1 %	1.2 %	7,754	128,235
2009	5.1 %	1.1 %	6,938	134,961
2008	6.6 %	1.2 %	9,282	141,155
2007	4.9 %	1.2 %	7,094	144,786

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None



NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	3.0	0.2	344	115,300
2019	2.9	0.2	353	119,804
2018	3.4	0.2	401	119,101
2017	3.4	0.2	413	120,117
2016	3.3	0.2	401	122,474
2015	2.8	0.2	255	91,918
2014	2.9	0.2	358	122,387
2013	2.3	0.1	275	118,735
2012	1.8	0.1	218	123,712
2011	1.5	0.1	182	123,707
2010	1.2	0.1	157	128,527
2009	0.8	0.1	110	138,677
2008	0.7	0.1	103	144,048

Legends:

-  Indicator has a numerator ≤10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year


Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	11.3 %	1.1 %	266,322	2,348,926
2019_2020	11.1 %	1.2 %	261,336	2,356,325
2018_2019	12.0 %	1.4 %	285,865	2,388,712
2017_2018	12.8 %	1.5 %	306,995	2,394,967
2016_2017	12.9 %	1.5 %	305,114	2,371,509
2016	13.3 %	2.0 %	312,525	2,356,995

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None



NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	21.7	1.3	260	1,200,526
2020	19.9	1.3	241	1,209,848
2019	21.0	1.3	255	1,215,012
2018	19.3	1.3	235	1,216,366
2017	19.7	1.3	241	1,223,518
2016	20.9	1.3	257	1,230,747
2015	21.0	1.3	259	1,234,835
2014	19.7	1.3	244	1,238,114
2013	21.8	1.3	271	1,240,503
2012	18.8	1.2	234	1,243,459
2011	20.2	1.3	251	1,245,086
2010	23.8	1.4	297	1,248,768
2009	22.4	1.3	279	1,247,044

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None



NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	48.3	1.8	725	1,500,638
2020	42.4	1.7	618	1,458,842
2019	35.1	1.6	512	1,459,536
2018	35.7	1.6	520	1,456,128
2017	35.3	1.6	510	1,446,100
2016	38.0	1.6	543	1,429,712
2015	36.5	1.6	518	1,418,744
2014	31.5	1.5	443	1,405,878
2013	33.6	1.6	470	1,400,810
2012	29.1	1.4	408	1,402,316
2011	32.6	1.5	456	1,398,831
2010	35.4	1.6	495	1,399,683
2009	31.8	1.5	444	1,396,065

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None



NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	13.1	0.8	290	2,216,976
2018_2020	12.6	0.8	277	2,192,448
2017_2019	12.5	0.8	273	2,184,226
2016_2018	14.2	0.8	308	2,167,363
2015_2017	15.1	0.8	325	2,146,364
2014_2016	14.3	0.8	302	2,118,795
2013_2015	13.8	0.8	289	2,098,804
2012_2014	12.4	0.8	260	2,091,081
2011_2013	13.0	0.8	272	2,095,858
2010_2012	13.3	0.8	281	2,110,591
2009_2011	13.2	0.8	280	2,123,186
2008_2010	14.9	0.8	318	2,129,778
2007_2009	18.8	0.9	398	2,114,902

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	11.4	0.7	252	2,216,976
2018_2020	10.2	0.7	223	2,192,448
2017_2019	9.8	0.7	213	2,184,226
2016_2018	9.6	0.7	209	2,167,363
2015_2017	9.5	0.7	203	2,146,364
2014_2016	8.1	0.6	172	2,118,795
2013_2015	7.9	0.6	166	2,098,804
2012_2014	6.8	0.6	143	2,091,081
2011_2013	6.7	0.6	141	2,095,858
2010_2012	6.0	0.5	126	2,110,591
2009_2011	6.1	0.5	129	2,123,186
2008_2010	6.1	0.5	130	2,129,778
2007_2009	5.4	0.5	114	2,114,902

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17


Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	21.0 %	1.2 %	523,657	2,496,821
2019_2020	21.3 %	1.4 %	531,719	2,497,861
2018_2019	19.4 %	1.4 %	486,615	2,504,985
2017_2018	19.3 %	1.6 %	485,463	2,510,041
2016_2017	20.5 %	1.6 %	512,169	2,502,041
2016	19.8 %	2.0 %	494,310	2,497,183

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	16.6 %	2.7 %	86,904	523,657
2019_2020	13.8 %	2.5 %	73,295	531,719
2018_2019	12.4 %	2.5 %	60,190	486,615
2017_2018	15.5 %	3.7 %	75,282	485,463
2016_2017	17.8 %	3.4 %	90,927	512,169
2016	15.1 %	3.3 %	74,664	494,310

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	2.9 %	0.5 %	61,894	2,109,350
2019_2020	2.3 %	0.5 %	49,303	2,101,584
2018_2019	3.1 %	0.7 %	65,860	2,108,835
2017_2018	4.3 %	1.0 %	91,914	2,157,943
2016_2017	3.2 %	0.9 %	69,912	2,181,524
2016	1.5 % ⚡	0.5 % ⚡	32,685 ⚡	2,165,278 ⚡

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)


Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	10.6 %	1.1 %	222,750	2,110,694
2019_2020	11.9 %	1.2 %	249,504	2,100,371
2018_2019	12.2 %	1.2 %	252,944	2,077,993
2017_2018	12.0 %	1.4 %	253,601	2,121,962
2016_2017	10.4 %	1.3 %	225,262	2,170,039
2016	8.9 %	1.4 %	192,003	2,157,314

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	47.9 %	4.7 %	129,648	270,649
2019_2020	48.0 %	4.9 %	141,352	294,626
2018_2019	54.9 % ⚡	5.4 % ⚡	138,412 ⚡	252,145 ⚡
2017_2018	48.9 % ⚡	6.1 % ⚡	139,803 ⚡	286,014 ⚡
2016_2017	42.3 % ⚡	5.6 % ⚡	128,623 ⚡	304,159 ⚡
2016	41.1 % ⚡	7.1 % ⚡	112,671 ⚡	274,010 ⚡

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	92.8 %	0.8 %	2,312,284	2,491,703
2019_2020	90.2 %	1.3 %	2,252,933	2,496,906
2018_2019	88.3 %	1.4 %	2,211,056	2,503,207
2017_2018	88.5 %	1.4 %	2,221,452	2,509,218
2016_2017	89.3 %	1.4 %	2,234,510	2,501,317
2016	90.3 %	1.6 %	2,253,994	2,495,736

Legends:

■ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	12.9 %	0.2 %	5,514	42,661
2018	13.6 %	0.1 %	9,337	68,537
2016	12.5 %	0.1 %	9,778	78,023
2014	13.0 %	0.1 %	12,165	93,386
2012	13.4 %	0.1 %	14,527	108,699
2010	14.4 %	0.1 %	15,122	104,959
2008	15.3 %	0.1 %	14,377	93,912

Legends:

🚩 Indicator has a denominator <20 and is not reportable

⚡ Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	17.0 % ⚡	5.7 % ⚡	81,613 ⚡	480,910 ⚡
2019	18.3 %	0.9 %	94,798	517,643
2013	12.7 %	0.8 %	54,683	431,995
2011	15.0 %	1.1 %	65,759	439,590
2009	12.3 %	1.0 %	54,797	444,782
2007	13.7 %	1.0 %	61,537	448,896
2005	12.3 %	1.0 %	51,907	420,547

Legends:

🚩 Indicator has an unweighted denominator <100 and is not reportable

⚡ Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	16.8 %	1.8 %	183,890	1,093,791
2019_2020	18.0 %	2.1 %	196,756	1,091,005
2018_2019	14.9 %	2.0 %	169,954	1,141,927
2017_2018	16.0 %	2.3 %	179,021	1,122,017
2016_2017	18.4 %	2.5 %	202,978	1,100,842
2016	18.6 %	3.3 %	207,930	1,118,321

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance


Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	6.2 %	0.3 %	156,733	2,522,406
2019	7.1 %	0.3 %	177,231	2,502,012
2018	7.6 %	0.3 %	190,101	2,503,080
2017	6.9 %	0.3 %	172,717	2,512,910
2016	6.4 %	0.3 %	161,540	2,511,414
2015	7.0 %	0.3 %	174,459	2,502,055
2014	7.5 %	0.3 %	187,590	2,490,299
2013	9.5 %	0.3 %	236,951	2,487,378
2012	8.9 %	0.4 %	221,352	2,490,232
2011	9.5 %	0.4 %	236,836	2,488,159
2010	9.8 %	0.3 %	245,304	2,492,676
2009	10.7 %	0.3 %	277,133	2,583,204

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	60.1 %	4.5 %	78,000	130,000
2017	68.9 %	4.1 %	92,000	133,000
2016	70.0 %	3.7 %	92,000	131,000
2015	64.0 %	3.8 %	86,000	134,000
2014	69.8 %	3.6 %	93,000	133,000
2013	72.6 %	4.0 %	96,000	132,000
2012	68.2 %	4.3 %	92,000	134,000
2011	69.3 %	4.5 %	94,000	135,000

Legends:

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2
- ⚡ Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	50.7 %	1.5 %	1,182,614	2,331,018
2020_2021	46.9 %	1.6 %	1,098,538	2,342,298
2019_2020	55.6 %	1.5 %	1,416,386	2,547,456
2018_2019	55.5 %	1.4 %	1,315,708	2,371,928
2017_2018	51.3 %	1.5 %	1,208,749	2,355,023
2016_2017	54.4 %	1.8 %	1,271,860	2,337,119
2015_2016	51.3 %	1.7 %	1,186,889	2,311,822
2014_2015	58.0 %	2.0 %	1,344,382	2,319,499
2013_2014	51.4 %	2.0 %	1,197,580	2,328,179
2012_2013	52.4 %	2.4 %	1,209,331	2,310,105
2011_2012	44.4 %	2.7 %	1,077,374	2,425,933
2010_2011	48.8 %	2.7 %	1,173,494	2,404,700
2009_2010	36.0 %	2.2 %	885,197	2,458,880

Legends:

■ Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	78.6 %	3.2 %	580,772	738,432
2020	73.1 %	3.3 %	534,406	731,501
2019	65.9 %	3.4 %	477,405	724,263
2018	68.1 %	3.1 %	491,901	721,869
2017	64.3 %	3.3 %	463,334	720,279
2016	67.3 %	3.1 %	482,021	715,804
2015	52.6 %	3.2 %	372,693	708,217

Legends:

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None


NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine


Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	92.7 %	2.2 %	684,223	738,432
2020	90.8 %	2.2 %	664,176	731,501
2019	92.5 %	1.9 %	669,758	724,263
2018	94.2 %	1.4 %	679,936	721,869
2017	93.3 %	1.7 %	672,313	720,279
2016	92.8 %	1.8 %	664,117	715,804
2015	90.2 %	2.0 %	639,026	708,217
2014	86.1 %	2.4 %	606,772	704,533
2013	82.0 %	3.4 %	570,798	696,071
2012	80.5 %	3.1 %	554,543	688,649
2011	68.0 %	3.0 %	470,206	691,435
2010	62.2 %	3.0 %	412,380	662,735
2009	50.8 %	3.1 %	350,121	689,156

Legends:

 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

 Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None


NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine


Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	92.5 %	2.2 %	683,184	738,432
2020	96.2 %	1.3 %	703,970	731,501
2019	95.5 %	1.3 %	691,903	724,263
2018	94.8 %	1.4 %	684,621	721,869
2017	95.3 %	1.3 %	686,645	720,279
2016	91.4 %	1.8 %	654,281	715,804
2015	87.0 %	2.4 %	615,842	708,217
2014	74.9 %	3.1 %	527,722	704,533
2013	76.9 %	3.6 %	535,512	696,071
2012	73.1 %	3.5 %	503,360	688,649
2011	67.7 %	3.0 %	467,831	691,435
2010	63.5 %	2.9 %	420,582	662,735
2009	53.3 %	3.1 %	367,515	689,156

Legends:

 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

 Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None



NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	16.6	0.2	6,141	370,346
2020	18.2	0.2	6,572	360,551
2019	19.7	0.2	7,090	360,287
2018	20.6	0.2	7,385	357,658
2017	21.9	0.3	7,778	354,918
2016	23.6	0.3	8,248	350,110
2015	25.5	0.3	8,829	345,650
2014	28.4	0.3	9,661	340,458
2013	30.4	0.3	10,322	339,239
2012	33.7	0.3	11,488	341,282
2011	37.9	0.3	12,991	343,097
2010	41.5	0.4	14,378	346,765
2009	47.0	0.4	16,345	347,660

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	10.5 %	1.4 %	12,294	116,603
2020	8.6 %	1.3 %	9,921	115,696
2019	14.5 %	1.6 %	17,335	119,745
2018	13.6 %	1.6 %	16,088	118,626
2017	12.4 %	1.6 %	15,049	120,978
2013	9.2 %	1.7 %	5,936	64,349
2012	8.1 %	1.1 %	10,035	124,724

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	4.4 %	0.7 %	107,933	2,480,582
2019_2020	5.0 %	0.9 %	125,438	2,486,227
2018_2019	5.5 %	0.9 %	136,451	2,493,550
2017_2018	5.7 %	1.1 %	143,892	2,504,234
2016_2017	5.5 %	1.1 %	136,676	2,491,340
2016	5.6 %	1.4 %	139,440	2,483,820

Legends:

■ Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)
State: Georgia

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	2019	2020	2021	2022
Annual Objective			72	70.5	71
Annual Indicator		75.5	70.1	70.6	72.5
Numerator		1,443,474	1,345,915	1,359,329	1,409,595
Denominator		1,912,418	1,918,848	1,926,441	1,944,801
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

i Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	2024	2025
Annual Objective	71.5	72.0	72.5

Field Level Notes for Form 10 NPMs:

None

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	83	84	85	87.5	88
Annual Indicator	85.8	87.5	85.9	85.6	86.2
Numerator	1,875	1,934	1,754	1,863	1,790
Denominator	2,186	2,211	2,042	2,176	2,077
Data Source	State Statistical File	State Statistical File	State Statistical File	State Statistical File	State Statistical File
Data Source Year	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	88.5	89.0	89.5

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

Data Source: GA DPH, Office of Health Indicators for Planning (OHIP)

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	2019	2020	2021	2022
Annual Objective	80	81	84	84.2	84.8
Annual Indicator	84.0	84.1	83.5	80.9	82.6
Numerator	106,087	109,903	98,519	98,232	90,076
Denominator	126,348	130,643	117,976	121,472	109,007
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	2024	2025
Annual Objective	85.5	86.2	86.9

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	2019	2020	2021	2022
Annual Objective	21	22	23	23.7	25.2
Annual Indicator	22.1	27.0	22.1	24.3	18.7
Numerator	26,140	33,943	25,731	29,042	19,941
Denominator	118,097	125,804	116,332	119,505	106,373
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	2024	2025
Annual Objective	26.8	28.3	29.9

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	2020	2021	2022
Annual Objective			73.7	75.2
Annual Indicator	73.7	72.2	71.3	73.1
Numerator	87,074	85,632	82,301	85,380
Denominator	118,209	118,648	115,447	116,850
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

Annual Objectives			
	2023	2024	2025
Annual Objective	76.8	78.3	79.8

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	2020	2021	2022
Annual Objective			24.6	24.9
Annual Indicator	21.7	24.4	25.5	29.2
Numerator	25,317	28,716	29,201	33,719
Denominator	116,405	117,523	114,325	115,536
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

Annual Objectives			
	2023	2024	2025
Annual Objective	25.1	25.4	25.6

Field Level Notes for Form 10 NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2019	2020	2021	2022
Annual Objective			40.9	41.3
Annual Indicator	44.0	40.5	37.4	44.0
Numerator	50,752	47,803	43,071	51,145
Denominator	115,426	117,894	115,015	116,279
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021

Annual Objectives			
	2023	2024	2025
Annual Objective	41.7	42.1	42.5

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	2019	2020	2021	2022
Annual Objective	38	41	42	40.6	41
Annual Indicator	40.8	49.4	40.2	26.4	33.1
Numerator	107,598	135,738	118,669	68,664	85,293
Denominator	263,952	274,649	295,208	260,348	257,448
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	41.4	41.8	42.2

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2019	2020	2021	2022
Annual Objective			40.3	39.9
Annual Indicator	25.1	18.3	18.3	18.3
Numerator	110,846	98,922	98,922	98,922
Denominator	442,284	540,678	540,678	540,678
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2013	2019	2019	2019
Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2019	2020	2021	2022
Annual Objective			40.3	39.9
Annual Indicator	14.2	13.6	10.5	8.9
Numerator	106,312	108,009	89,060	77,416
Denominator	750,443	796,760	852,021	865,391
Data Source	NSCHP	NSCHP	NSCHP	NSCHP
Data Source Year	2018	2018_2019	2019_2020	2020_2021
Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Victimization				
	2019	2020	2021	2022
Annual Objective			40.3	39.9
Annual Indicator	33.7	40.7	36.6	26.5
Numerator	257,779	327,333	311,850	229,248
Denominator	765,064	804,071	851,494	865,841
Data Source	NSCHV	NSCHV	NSCHV	NSCHV
Data Source Year	2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	39.5	39.1	38.7

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2019	2020	2021	2022
Annual Objective			40.7	41.1
Annual Indicator	40.3	40.3	43.3	48.5
Numerator	195,620	196,063	230,304	254,036
Denominator	485,463	486,615	531,719	523,657
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	41.5	41.9	42.3

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Child Health - NONCSHCN

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN				
	2019	2020	2021	2022
Annual Objective			46.5	46.9
Annual Indicator	46.8	46.0	46.7	49.2
Numerator	948,129	927,933	916,888	971,433
Denominator	2,024,578	2,016,279	1,964,051	1,972,586
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	47.4	47.8	48.3

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	2019	2020	2021	2022
Annual Objective	19	15	15	22.7	23
Annual Indicator	14.0	14.2	22.7	18.2	14.9
Numerator	32,898	27,235	43,153	42,606	31,411
Denominator	234,571	192,079	190,472	234,140	211,314
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	23.2	23.4	23.6

Field Level Notes for Form 10 NPMs:

None

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	2019	2020	2021	2022
Annual Objective	29	39	40	41	41
Annual Indicator	39.3	37.9	31.5	27.7	33.6
Numerator	48,597	45,805	38,297	32,519	40,090
Denominator	123,575	120,710	121,626	117,577	119,458
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives			
	2023	2024	2025
Annual Objective	42.0	42.0	43.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	2019	2020	2021	2022
Annual Objective	83	84	84	84	85
Annual Indicator	83.5	82.4	79.7	76.2	74.4
Numerator	1,992,442	1,971,820	1,890,764	1,783,309	1,742,723
Denominator	2,384,889	2,393,072	2,372,140	2,340,717	2,341,165
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	85.0	86.0	86.0

Field Level Notes for Form 10 NPMs:

None

**Form 10
State Performance Measures (SPMs)**

State: Georgia

SPM 1 - Percent of congenital syphilis cases averted

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			81	81.6
Annual Indicator	79.2	71.6	54.2	60.3
Numerator	118	136	97	141
Denominator	149	190	179	234
Data Source	SendSS	SendSS	SendSS	SendSS
Data Source Year	CY 2018	CY 2019	CY 2020	CY 2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	82.3	83.0	83.7

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Rate of infant mortality (per 1,000 live births) in the Black Population

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			10.6	9.5
Annual Indicator	10.7	10.7	9.6	9.6
Numerator	468	468	406	400
Denominator	43,657	43,657	42,351	41,752
Data Source	OASIS	OASIS	OASIS	OASIS
Data Source Year	CY 2019	CY 2019	CY 2020	CY 2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	9.4	9.3	9.2

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Percent of fathers (ages 18-55) whose knowledge increased using a Father Involvement curriculum in Georgia Healthy Start sites.

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	45.5
Annual Indicator			45.5	55.6
Numerator			5	10
Denominator			11	18
Data Source			Father Involvement Curriculum Pre-/Post-Test	Father Involvement Curriculum Pre-/Post-Test
Data Source Year			CY 2021	CY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	50.0	54.5	59.1

Field Level Notes for Form 10 SPMs:

None

**Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)**

State: Georgia

ESM 1.1 - Percent of women (30 years or older) who have never been screened or not screened within the last 10 years, who received an initial program cervical screening test

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			20	35
Annual Indicator			25.3	33.4
Numerator			564	961
Denominator			2,226	2,874
Data Source			BCCP Data	BBCP Data
Data Source Year			SFY 2021	SFY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	35.0	35.0	35.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2021
	Column Name:	State Provided Data

Field Note:

The SFY 2021 data was updated using the CDC algorithm.

ESM 3.1 - Number of hospitals verified annually through the Levels of Neonatal Care Designation Program

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	10
Annual Indicator			0	1
Numerator				
Denominator				
Data Source			Levels of Neonatal Care Designation Program Data	Levels of Neonatal Care Designation Program Data
Data Source Year			FFY 2021	FFY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	10.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2022
	Column Name:	State Provided Data

Field Note:

The verification process has been temporarily placed on hold while the AAP updates their national standards.

ESM 4.1 - Percent of the 10-Steps to Successful Breastfeeding training slots utilized by staff and providers from the state's birthing hospitals

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	21
Annual Indicator			19.1	19.1
Numerator			64	64
Denominator			335	335
Data Source			Womens Health 5 STAR Initiative Program Data	Womens Health 5 STAR Initiative Program Data
Data Source Year			FFY 2021	FFY 2022
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2022
	Column Name:	State Provided Data

Field Note:

In July 2023, the Lactation Educations Resources (LER) First Latch healthcare/provider training for the 10-Steps to Successful breastfeeding changed its course to better align with changes coming in Baby Friendly USA. The course with the training slots will be converted to competency-based training courses, and will therefore not be compatible for reporting. Will inactive this measure and replace with percent of hospitals actively implementing the Optimizing Nutrition for Georgia Newborns.

ESM 4.2 - Number of home visitors who report increased knowledge of breastfeeding best practices

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	0
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			Loving Support Training	AAP Breastfeeding Pre-/Post- Test
Data Source Year			CY 2021	CY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

- Field Name:** 2022

Column Name: State Provided Data

Field Note:
 There have been data issues in collecting the pre-/post- data from the Loving Support Training. Georgia will now use the American Academy of Pediatrics (AAP) breastfeeding training(s) going forward to capture the number of home visitors who report increased knowledge of breastfeeding best practices.
- Field Name:** 2023

Column Name: Annual Objective

Field Note:
 Georgia is collecting baseline data for this measure. Will create annual objectives next reporting year.

ESM 4.3 - Number of MIECHV and Healthy Start women who are referred to WIC services

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			65	201
Annual Indicator			191	307
Numerator				
Denominator				
Data Source			GHVP Program Data	GHVP Program Data
Data Source Year			CY 2021	CY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	322.0	338.0	353.0

Field Level Notes for Form 10 ESMs:

- Field Name:** 2021

Column Name: State Provided Data

Field Note:
 182 participants were referred from MIECHV and 9 from Healthy Start (HS).

 In comparison, the HS sites received 126 referrals from WIC in CY 2021, of which 64 enrolled and became HS clients. MIECHV currently does not collect referral source on their intake forms.
- Field Name:** 2022

Column Name: State Provided Data

Field Note:
 195 participants were referred from MIECHV and 112 from Healthy Start (HS).

ESM 4.4 - Percent of Georgia hospitals actively implementing the Optimizing Nutrition for Georgia Newborns

Measure Status:		Active
State Provided Data		
	2022	
Annual Objective		
Annual Indicator	37.5	
Numerator	27	
Denominator	72	
Data Source	GaPQC Enrollment Data	
Data Source Year	CY 2022	
Provisional or Final ?	Final	

Annual Objectives		
	2024	2025
Annual Objective	41.7	45.8

Field Level Notes for Form 10 ESMs:

None

ESM 5.2 - Number of professionals trained to education on, identify, and model safe infant sleep environments

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			390	397
Annual Indicator		382	402	406
Numerator				
Denominator				
Data Source		Georgia Safe to Sleep Program Data	Georgia Safe to Sleep Program Data	Georgia Safe to Sleep Program Data
Data Source Year		FFY 2020	FFY 2021	FFY 2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	405.0	413.0	420.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.3 - Number of safe infant sleep educational materials distributed by the Program

Measure Status:		Active
State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	115,473	
Numerator		
Denominator		
Data Source	Georgia Safe to Sleep Program Data	
Data Source Year	FFY 2021	
Provisional or Final ?	Final	

Annual Objectives			
	2023	2024	2025
Annual Objective	90,028.0	90,911.0	91,794.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.1 - Number of providers that receive developmental screening education and training who report promoting developmental screenings with parents in their practices

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	3
Annual Indicator			0	54
Numerator				
Denominator				
Data Source			Children 1st Quarterly Report submissions	Children 1st Quarterly Report submissions
Data Source Year			SFY 2021	SFY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	57.0	59.0	62.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.2 - Percent of children that screen with concern that are referred to appropriate intervention services by providers

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			12	13
Annual Indicator	11.8	11	13	15.5
Numerator	951	855	767	855
Denominator	8,038	7,792	5,900	5,503
Data Source	SendSS	SendSS-NB	SendSS-NB	SendSS-NB
Data Source Year	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	14.0	15.0	16.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.3 - Number of community partners who promote developmental screenings and make referrals to their local public health district

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	5
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			Children 1st Quarterly Report Data	Children 1st Quarterly Report Data
Data Source Year			FFY 2021	FFY 2021
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2022
	Column Name:	State Provided Data

Field Note:

This ESM is difficult to measure and track. Will replace with a new ESM on developmental screenings among children enrolled in Home Visiting.

ESM 6.5 - Percent of children participating in Home Visiting with at least one developmental screening using a validated instrument.

Measure Status:		Active
State Provided Data		
	2022	
Annual Objective		
Annual Indicator	79.5	
Numerator	1,446	
Denominator	1,820	
Data Source	GEOHVIS	
Data Source Year	SFY 2022	
Provisional or Final ?	Final	

Annual Objectives		
	2024	2025
Annual Objective	80.0	80.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2024
	Column Name:	Annual Objective

Field Note:

SFY 2022 is a baseline year. The annual objectives will be established with SFY 2023 data.

ESM 9.1 - Number of schools, individuals, and organizations that receive guidance on evidence-based strategies to prevent bullying

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	0
Annual Indicator			0	125
Numerator				
Denominator				
Data Source			Injury Prevention Program Data	Injury Prevention Program Data
Data Source Year			FFY 2021	FFY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	131.0	138.0	144.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2021
	Column Name:	State Provided Data

Field Note:

The wording of the ESM was modified. Will start collecting data for the next reporting year.

ESM 11.2 - Number of telehealth/telemedicine providers in the network

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			14	18
Annual Indicator	10	15	15	12
Numerator				
Denominator				
Data Source	CYSHCN program/ DPH Office of Telehealth and Telem	CYSHCN program/ DPH Office of Telehealth and Telem	CYSHCN program/ DPH Office of Telehealth/Telemedic	CYSHCN program/ DPH Office of Telehealth/Telemedic
Data Source Year	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	22.0	26.0	30.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.3 - Number of callers connected to resources through Help Me Grow (HMG)

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			3,809	4,000
Annual Indicator	3,809	3,218	4,499	4,499
Numerator				
Denominator				
Data Source	Help Me Grow Data	Help Me Grow Data	Help Me Grow Data	Help Me Grow Data
Data Source Year	SFY 2020	SFY 2021	SFY 2022	SFY 2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	4,190.0	4,381.0	4,571.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2019
	Column Name:	State Provided Data

Field Note:

There were 3,809 calls to HMG during SFY 2020 with 5,869 referrals to services/resources.

ESM 11.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	0
Annual Indicator			0	0
Numerator			0	0
Denominator			180	180
Data Source			Help Me Grow Data	Help Me Grow Data
Data Source Year			SFY 2022	SFY 2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2021
	Column Name:	State Provided Data

Field Note:

Data was collected from January-June of 2022. As this is a new measure, the lack of available baseline precludes projecting target objectives. Targets will be provided once baseline data is obtained.

ESM 12.1 - Percent of youth/young adults enrolled in the Department's Title V program for Children and Youth with Special Health Care Needs (CYSHCN) that transfer to an adult provider.

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			23	49
Annual Indicator		25.6	49.1	42.5
Numerator		141	274	232
Denominator		551	558	546
Data Source		CMS Quarterly Report	CMS Quarterly Report	CMS Quarterly Report
Data Source Year		SFY 2020	SFY 2021	SFY 2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	54.0	59.0	64.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.2 - Number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs.

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			15	20
Annual Indicator		10	15	22
Numerator				
Denominator				
Data Source		CYSHCN Annual Assessment Survey	CYSHCN Annual Assessment Survey	CYSHCN Annual Assessment Survey
Data Source Year		SFY 2020	SFY 2021	SFY 2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	25.0	30.0	35.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.1.2 - Number of oral health resource bags distributed to pregnant women and caregivers of young children through internal and external partners

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	2022
Annual Objective			2,566	2,592
Annual Indicator		2,541	3,000	300
Numerator				
Denominator				
Data Source		Oral Health Program Data	Oral Health Program Data	Oral Health Program Data
Data Source Year		FFY 2020	FFY 2021	FFY 2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	2,617.0	2,643.0	2,668.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2022
	Column Name:	State Provided Data

Field Note:

There was a drop in the number of distributed resource bags as the Oral Health Program as some of the items in the bags were not available. The Oral Health Program also distributed more bags than anticipated in the previous year.

ESM 13.2.1 - Number of children screened at school-based/ school-linked programs

Measure Status:			Active	
State Provided Data				
	2019	2020	2021	2022
Annual Objective			2,500	2,500
Annual Indicator			119	552
Numerator				
Denominator				
Data Source			Oral Health Program Database	Oral Health Program Database
Data Source Year			2020-2021	2021-2022
Provisional or Final ?			Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	600.0	700.0	800.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	The school-based/school-linked programs were affected by the COVID-19 pandemic. Services were halted when in-person learning transitioned to virtual learning. Data source year: 2019-2020 school year.
2.	Field Name:	2021
	Column Name:	State Provided Data
	Field Note:	The data was submitted into a new system from the previous year and is therefore no longer comparable. The school-based/school-linked programs were affected by the COVID-19 pandemic. New annual objectives were created.
3.	Field Name:	2022
	Column Name:	State Provided Data
	Field Note:	The school-based/school-linked programs were affected by the COVID-19 pandemic. The sealant program is slowing going back into the schools, but have not reached their full capacity before the pandemic.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Georgia

SPM 1 - Percent of congenital syphilis cases averted
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active									
Goal:	By 2025, increase the percentage of congenital syphilis cases averted from 80.3% to 85%									
Definition:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of reported pregnant women with syphilis - the number of reported congenital syphilis cases</td> </tr> <tr> <td>Denominator:</td> <td>Total number of reported pregnant women with syphilis</td> </tr> </table>		Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of reported pregnant women with syphilis - the number of reported congenital syphilis cases	Denominator:	Total number of reported pregnant women with syphilis
Unit Type:	Percentage									
Unit Number:	100									
Numerator:	Number of reported pregnant women with syphilis - the number of reported congenital syphilis cases									
Denominator:	Total number of reported pregnant women with syphilis									
Data Sources and Data Issues:	Data Source: SendSS surveillance data									
Significance:	<p>Congenital syphilis can cause miscarriage, stillbirth, deformed bones, meningitis, and nerve problems leading to blindness or deafness. The CDC considers congenital syphilis to be a winnable battle, partly because it can be prevented by testing the mother in the first and third trimesters and providing treatment at least 30 days before delivery. In 2018, Georgia reported 31 congenital syphilis cases and ranked 10th in the U.S. for congenital syphilis. Georgia has seen an increase in syphilis cases among women for the past 5 years. As syphilis cases rise in women, there is an increased potential for rises in congenital syphilis cases.</p>									

SPM 2 - Rate of infant mortality (per 1,000 live births) in the Black Population
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active								
Goal:	By 2030, reduce the rate of infant mortality in the Black Population to 9.6 per 1,000 live births								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>1,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of deaths among Black Non-Hispanic children less than 1 year of age</td> </tr> <tr> <td>Denominator:</td> <td>Total number of infants identified as Black Non-Hispanic on their birth certificates</td> </tr> </table>	Unit Type:	Rate	Unit Number:	1,000	Numerator:	Number of deaths among Black Non-Hispanic children less than 1 year of age	Denominator:	Total number of infants identified as Black Non-Hispanic on their birth certificates
Unit Type:	Rate								
Unit Number:	1,000								
Numerator:	Number of deaths among Black Non-Hispanic children less than 1 year of age								
Denominator:	Total number of infants identified as Black Non-Hispanic on their birth certificates								
Healthy People 2030 Objective:	MICH-02: Reduce the rate of infant deaths Most recent data: 5.8 infant deaths per 1,000 live births (2017) 2030 Target: 5.0 per live births								
Data Sources and Data Issues:	Data Source: OASIS (Georgia Vital Statistics Records- Birth and Death Certificates)								
Significance:	<p>Infant mortality, or the death of a child within the first year of life, is a sentinel measure of population health that reflects the underlying well-being of mothers and families, as well as the broader community and social environment that cultivate health and access to health-promoting resources.</p> <p>The U.S. infant mortality rate has continued to decline to record low levels below 6 per 1,000 live births. However, significant disparities continue to persist between racial groups, especially for infants born to non-Hispanic black women.</p> <p>The infant mortality rate in Black, non-Hispanic, infants in Georgia is two times higher than White, non-Hispanic or Hispanic infants supporting the need to expand collaborative capacity to decrease the prevalence of, and disparities surrounding, infant mortality.</p>								

SPM 3 - Percent of fathers (ages 18-55) whose knowledge increased using a Father Involvement curriculum in Georgia Healthy Start sites.

Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active								
Goal:	Increase the percentage of fathers whose fathering knowledge increased by using a Father Involvement curriculum in Georgia Healthy Start sites.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of fathers who had at least a 5% knowledge gain on the Father Involvement curriculum pre-/post- test</td> </tr> <tr> <td>Denominator:</td> <td>Total number of fathers who completed the Father Involvement curriculum in the Healthy Start sites</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of fathers who had at least a 5% knowledge gain on the Father Involvement curriculum pre-/post- test	Denominator:	Total number of fathers who completed the Father Involvement curriculum in the Healthy Start sites
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of fathers who had at least a 5% knowledge gain on the Father Involvement curriculum pre-/post- test								
Denominator:	Total number of fathers who completed the Father Involvement curriculum in the Healthy Start sites								
Data Sources and Data Issues:	Data Source: Father Involvement curriculum Pre- and Post- Test conducted at the Georgia Healthy Start sites								
Significance:	<p>In the United States, about 700 women die each year of pregnancy or delivery related complications, causing the U.S. ranks as one of only thirteen countries in the world where maternal mortality is worse now than it was 15 years ago. Representative of the data, Black women are three to four times more likely to die from pregnancy-related complications than white women, and disparities persists across socioeconomic and educational levels.</p> <p>Data shows Georgia as having one of the highest mortality rates among African American mothers and infants in the nation. Ranking number one, Georgia has the worst maternal mortality rates at 46.2 deaths per 100,000 live births, with a 60% higher mortality for Black women at 95.6 per 100,000 live births compared to all racial and ethnic groups, surpassing that of the U.S (66.3 per 100,000).</p> <p>Father involvement in Maternal and Child Health has been recognized as a strategy to reduce disparities in perinatal health outcomes. However, there is currently a shortage of the data that indicates father’s impact on perinatal health outcomes for our state. The Georgia Department of Public Health Fatherhood Initiative is working to increase father engagement and involvement opportunities in Maternal and Child Health programs and services through three main strategies, capacity building, collaboration, and coordination, including providing resources that encourage father inclusion.</p>								

Form 10
State Outcome Measure (SOM) Detail Sheets
State: Georgia

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Georgia

ESM 1.1 - Percent of women (30 years or older) who have never been screened or not screened within the last 10 years, who received an initial program cervical screening test

NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active									
Goal:	Meet or exceed the CDC guideline of providing initial program cervical cancer screenings to >= 35% of women (30 years or older) who have never been screened within the last 10 years									
Definition:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of women (30 years or older) who have never been screened or not screened within the last 10 years, who received an initial program cervical screening test (valid Pap or HPV test), funded through the Breast and Cervical Cancer Program (BCCP)</td> </tr> <tr> <td>Denominator:</td> <td>Total number of women (30 years or older) who received a valid Pap test or HPV test, funded through BCCP</td> </tr> </table>		Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of women (30 years or older) who have never been screened or not screened within the last 10 years, who received an initial program cervical screening test (valid Pap or HPV test), funded through the Breast and Cervical Cancer Program (BCCP)	Denominator:	Total number of women (30 years or older) who received a valid Pap test or HPV test, funded through BCCP
Unit Type:	Percentage									
Unit Number:	100									
Numerator:	Number of women (30 years or older) who have never been screened or not screened within the last 10 years, who received an initial program cervical screening test (valid Pap or HPV test), funded through the Breast and Cervical Cancer Program (BCCP)									
Denominator:	Total number of women (30 years or older) who received a valid Pap test or HPV test, funded through BCCP									
Data Sources and Data Issues:	Data Source: Breast and Cervical Cancer Program (BCCP) Clinical Data									
Significance:	<p>A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of diseases to optimize the health of women before, between, and beyond potential pregnancies. A key component of a well-woman visit for a reproductive-aged woman is the development and discussion of her reproductive life plan to align with her current and future plans. Prevention, screening, and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced with a well-woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit is recommended by the American College of Obstetrics and Gynecologists (ACOG).</p>									

ESM 3.1 - Number of hospitals verified annually through the Levels of Neonatal Care Designation Program
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active								
Goal:	Verify all Georgia birthing hospitals are operating at the level of care designation authorized through the DCH Certificate of Need program.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of hospitals verified annual through the Levels of Neonatal Care Designation Program</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	100	Numerator:	Number of hospitals verified annual through the Levels of Neonatal Care Designation Program	Denominator:	
Unit Type:	Count								
Unit Number:	100								
Numerator:	Number of hospitals verified annual through the Levels of Neonatal Care Designation Program								
Denominator:									
Data Sources and Data Issues:	Data Source: DPH Office of Women's Health- Levels of Neonatal Care Designation Program Data								
Significance:	Very low birth weight infants (<1,500 grams or 3.25 pounds) are the most fragile newborns. Although they represented less than 2% of all births in 2010, VLBW infants accounted for 53% of all infant deaths, with a risk of death over 100 times higher than that of normal birth weight infants (≥2,500 grams or 5.5 pounds). VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a subspecialty facility equipped to handle high-risk neonates. In 2012, the AAP provided updated guidelines on the definitions of neonatal levels of care to include Level I (basic care), Level II (specialty care), and Levels III and IV (subspecialty intensive care) based on the availability of appropriate personnel, physical space, equipment, and organization. Given overwhelming evidence of improved outcomes, the AAP recommends that VLBW and/or very preterm infants (<32 weeks' gestation) be born in only level III or IV facilities.								

ESM 4.1 - Percent of the 10-Steps to Successful Breastfeeding training slots utilized by staff and providers from the state's birthing hospitals

NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Inactive - Replaced								
Goal:	By 2025, have at least 85% of the available 10-Steps to Successful Breastfeeding training slots utilized annually by staff and providers from the state's birthing hospitals.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of training slots utilized by staff and providers from the state's birthing hospitals</td> </tr> <tr> <td>Denominator:</td> <td>Total number of available training slots</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of training slots utilized by staff and providers from the state's birthing hospitals	Denominator:	Total number of available training slots
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of training slots utilized by staff and providers from the state's birthing hospitals								
Denominator:	Total number of available training slots								
Data Sources and Data Issues:	Data Source: Women's Health 5-STAR Initiative Program Data								
Significance:	<p>The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer.</p>								

ESM 4.2 - Number of home visitors who report increased knowledge of breastfeeding best practices
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active								
Goal:	Increase the number of home visitors who reported increase knowledge of breastfeeding best practices from trainings and coaching.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>1,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of MIECHV and Healthy Start Home Visiting Staff who report increased knowledge of breastfeeding best practices</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	1,000	Numerator:	Number of MIECHV and Healthy Start Home Visiting Staff who report increased knowledge of breastfeeding best practices	Denominator:	
Unit Type:	Count								
Unit Number:	1,000								
Numerator:	Number of MIECHV and Healthy Start Home Visiting Staff who report increased knowledge of breastfeeding best practices								
Denominator:									
Data Sources and Data Issues:	Data Source: American Academy of Pediatrics (AAP) Breastfeeding Training Pre-/Post-Test								
Significance:	The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer.								

ESM 4.3 - Number of MIECHV and Healthy Start women who are referred to WIC services
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active								
Goal:	Increase the number of MIECHV and Healthy Start women who are referred to WIC services								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>1,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of MIECHV and Healthy Start women who are referred to WIC services</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	1,000	Numerator:	Number of MIECHV and Healthy Start women who are referred to WIC services	Denominator:	
Unit Type:	Count								
Unit Number:	1,000								
Numerator:	Number of MIECHV and Healthy Start women who are referred to WIC services								
Denominator:									
Data Sources and Data Issues:	Data Source: Georgia Home Visiting Program (GHVP) Data								
Significance:	The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer.								

ESM 4.4 - Percent of Georgia hospitals actively implementing the Optimizing Nutrition for Georgia Newborns NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active								
Goal:	By the end of 2025, 50% of Georgia hospitals that serve newborns will be actively implementing the Optimizing Nutrition for Georgia Newborns.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of Georgia hospitals that actively implement the Optimizing Nutrition for Georgia Newborns (within a CY)</td> </tr> <tr> <td>Denominator:</td> <td>Total number of Georgia hospitals with a Mother/Baby unit or NICU (within a CY)</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of Georgia hospitals that actively implement the Optimizing Nutrition for Georgia Newborns (within a CY)	Denominator:	Total number of Georgia hospitals with a Mother/Baby unit or NICU (within a CY)
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of Georgia hospitals that actively implement the Optimizing Nutrition for Georgia Newborns (within a CY)								
Denominator:	Total number of Georgia hospitals with a Mother/Baby unit or NICU (within a CY)								
Data Sources and Data Issues:	Data Source: Georgia Quality Improvement (GaPQC) Enrollment Data								
Evidence-based/informed strategy:	<p>1) Provider Education/ Hospital Policies</p> <p>2) MCHevidence.org</p> <p>3) Optimizing Nutrition for Georgia Newborns is a two-year, hospital-based quality improvement initiative focused on increasing the percent of newborns who received human milk (maternal or donor) as their first feeding and breastfeeding or expression within six hours of birth. All Georgia hospitals with Mother/Baby units or NICU are encouraged to enroll in the initiative. There are educational webinars and self-paced microlessons.</p>								
Significance:	<p>The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer.</p> <p>1) This strategy is measuring the number of hospitals participating in the quality improvement learning collaborative and/or active improvement cohort to increase the percentage of newborns who receive human milk as their first feeding.</p> <p>2) By measuring the number of hospitals participating in the Optimizing Nutrition for Georgia Newborns, we hope to see an increase in the percentage of newborns who receive human milk as their first feeding.</p>								

ESM 5.2 - Number of professionals trained to education on, identify, and model safe infant sleep environments
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active								
Goal:	Increase the number of professionals (e.g. nurses, home visitors, first responders) trained in safe infant sleep practices.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>500</td> </tr> <tr> <td>Numerator:</td> <td>Number of professionals that attend safe infant sleep trainings</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	500	Numerator:	Number of professionals that attend safe infant sleep trainings	Denominator:	
Unit Type:	Count								
Unit Number:	500								
Numerator:	Number of professionals that attend safe infant sleep trainings								
Denominator:									
Data Sources and Data Issues:	Data Source: Safe Infant Sleep Program Data								
Significance:	Successful methods for improving parent safe sleep knowledge range from hospital staff education to crib distribution programs. Such efforts have been shown to increase parental knowledge, reduce bed-sharing rates, increase supine sleeping rates, and decrease incidences of Sudden Unexpected Infant Death (SUID). An increase in the number of professionals modeling safe sleep behaviors/environments should lead to an increase in parents following best practices related to safe sleep environments.								

ESM 5.3 - Number of safe infant sleep educational materials distributed by the Program

NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active								
Goal:	Expand reach of safe infant sleep educational materials by increasing the number of items distributed to families throughout Georgia during the reporting period.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>300,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of safe sleep educational materials (e.g., handouts, brochures, crib cards) distributed to birthing facilities, hospitals, community partners, etc. to be given to parents/families</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	300,000	Numerator:	Number of safe sleep educational materials (e.g., handouts, brochures, crib cards) distributed to birthing facilities, hospitals, community partners, etc. to be given to parents/families	Denominator:	
Unit Type:	Count								
Unit Number:	300,000								
Numerator:	Number of safe sleep educational materials (e.g., handouts, brochures, crib cards) distributed to birthing facilities, hospitals, community partners, etc. to be given to parents/families								
Denominator:									
Data Sources and Data Issues:	Georgia Safe to Sleep Program Data								
Evidence-based/informed strategy:	<p>1) Caregiver Education (e.g., mothers, family members)</p> <p>2) MCHevidence.org</p> <p>3) Most of the hospitals throughout the State of Georgia participate in the Safe Sleep Hospital Initiative. As part of the initiative, the hospital staff educate and empower new parents with safe sleep knowledge (including distributing educational materials for easy reference at home). This should lead to an increase in parents following best practices related to safe sleep environments.</p>								
Significance:	<p>Successful methods for improving parent safe sleep knowledge range from hospital staff education to crib distribution programs. Such efforts have been shown to increase parental knowledge, reduce bed-sharing rates, increase supine sleeping rates, and decrease incidences of SUID. An increase in the number of professionals modeling safe sleep behaviors/environments should lead to an increase in parents following best practices related to safe sleep environments.</p> <p>1) This strategy is measuring the quantity of educational material shared to caregivers.</p> <p>2) We hope to see an increase in safe infant sleep behaviors by expanding the reach of safe infant sleep education materials.</p>								

ESM 6.1 - Number of providers that receive developmental screening education and training who report promoting developmental screenings with parents in their practices
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active								
Goal:	Increase the number of providers who are interested in promoting developmental screenings with parents in their practices by providing education and training events.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of providers that receive developmental screenings screening education and training</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	100	Numerator:	Number of providers that receive developmental screenings screening education and training	Denominator:	
Unit Type:	Count								
Unit Number:	100								
Numerator:	Number of providers that receive developmental screenings screening education and training								
Denominator:									
Data Sources and Data Issues:	Data Source: Children 1st Quarterly Report Data as reported by Children 1st District Coordinators and programmatic reports								
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP.								

ESM 6.2 - Percent of children that screen with concern that are referred to appropriate intervention services by providers

NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active								
Goal:	Increase the percentage of children that screen with concern that are referred to appropriate intervention services by providers								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of children that screen with concern that are referred to appropriate intervention services by providers</td> </tr> <tr> <td>Denominator:</td> <td>Total number of children referred to intervention services</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of children that screen with concern that are referred to appropriate intervention services by providers	Denominator:	Total number of children referred to intervention services
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of children that screen with concern that are referred to appropriate intervention services by providers								
Denominator:	Total number of children referred to intervention services								
Data Sources and Data Issues:	Data Source: SendSS								
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP.								

ESM 6.3 - Number of community partners who promote developmental screenings and make referrals to their local public health district

NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - Replaced									
Goal:	Increase the number of community partners who are interested in promoting developmental screenings with clients and families by providing education and training events.									
Definition:	<table border="1"> <tr> <td style="background-color: #1f4e79; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #1f4e79; color: white;">Unit Number:</td> <td>100</td> </tr> <tr> <td style="background-color: #1f4e79; color: white;">Numerator:</td> <td>Number of community partners who promote developmental screenings and make referrals to their local public health district</td> </tr> <tr> <td style="background-color: #1f4e79; color: white;">Denominator:</td> <td></td> </tr> </table>		Unit Type:	Count	Unit Number:	100	Numerator:	Number of community partners who promote developmental screenings and make referrals to their local public health district	Denominator:	
Unit Type:	Count									
Unit Number:	100									
Numerator:	Number of community partners who promote developmental screenings and make referrals to their local public health district									
Denominator:										
Data Sources and Data Issues:	Data Source: Children 1st Quarterly Report as reported by Children 1st District Coordinators and other Maternal and Child Health Program Data, including ASQ online report data utilizing community partner referrals to HMG for developmental screening.									
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP.									

ESM 6.5 - Percent of children participating in Home Visiting with at least one developmental screening using a validated instrument.

NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active								
Goal:	Increase the percentage of children enrolled in Home Visiting who receive developmental screening.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of children enrolled in Home Visiting who were administered an ASQ-3 developmental screening within the SFY</td> </tr> <tr> <td>Denominator:</td> <td>Number of children enrolled in Home Visiting for SFY</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of children enrolled in Home Visiting who were administered an ASQ-3 developmental screening within the SFY	Denominator:	Number of children enrolled in Home Visiting for SFY
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of children enrolled in Home Visiting who were administered an ASQ-3 developmental screening within the SFY								
Denominator:	Number of children enrolled in Home Visiting for SFY								
Data Sources and Data Issues:	GEOHVIS (Georgia Home Visiting Information System)								
Evidence-based/informed strategy:	<p>1) Home Visiting Programs</p> <p>2) MCHevidence.org</p> <p>3) By actively working with our Home Visitors, we can increase the number of enrolled children who receive a developmental screening and therefore increase the total percentage of children who receive a developmental screening in Georgia.</p>								
Significance:	<p>Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP.</p> <p>1) The strategy looks at the number of children already enrolled in Home Visiting that receive a developmental screening using a validated instrument and working towards increase the percentage</p> <p>2) This measure is important because Georgia’s Home Visiting programs is a strengths-based, family-centered support strategy to help expectant and at-risk families with children. Home Visitors can provide education about the importance developmental screenings and offer support during visits to the family.</p>								

ESM 9.1 - Number of schools, individuals, and organizations that receive guidance on evidence-based strategies to prevent bullying

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

Measure Status:	Active								
Goal:	To increase the number of schools, individuals, and organizations in Georgia that receive guidance on evidence-based strategies to prevent bullying								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of schools, individuals, and organizations that receive guidance</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	100,000	Numerator:	Number of schools, individuals, and organizations that receive guidance	Denominator:	
Unit Type:	Count								
Unit Number:	100,000								
Numerator:	Number of schools, individuals, and organizations that receive guidance								
Denominator:									
Data Sources and Data Issues:	Data Source: Injury Prevention Program Data								
Significance:	<p>Bullying, particularly among school-age children, is a major public health problem. Estimates suggest nearly 30% of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. Bullying experiences are associated with a number of behavioral, emotional, and physical adjustment problems. Adolescents who bully others tend to exhibit other defiant and delinquent behaviors, have poor school performance, be more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation; poor school performance; suicidal ideation; and suicide attempts. Bullying victims who also perpetrate bullying (i.e., bully-victims) may exhibit the poorest functioning, in comparison with either victims or bullies. Emotional and behavioral problems experienced by victims, bullies, and bully-victims may continue into adulthood and produce long-term negative outcomes, including low self-esteem and self-worth, depression, antisocial behavior, vandalism, drug use and abuse, criminal behavior, gang membership, and suicidal ideation. www.stopbullying.gov.</p>								

ESM 11.2 - Number of telehealth/telemedicine providers in the network
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active								
Goal:	Increase the number of telehealth/telemedicine providers in the network								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of telehealth/telemedicine providers in network</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	100	Numerator:	Number of telehealth/telemedicine providers in network	Denominator:	
Unit Type:	Count								
Unit Number:	100								
Numerator:	Number of telehealth/telemedicine providers in network								
Denominator:									
Data Sources and Data Issues:	Data Source: CYSHCN program/ DPH Office of Telehealth and Telemedicine								
Significance:	<p>The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org</p>								

ESM 11.3 - Number of callers connected to resources through Help Me Grow (HMG)

NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active								
Goal:	To increase the number of callers connected to resources through HMG								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of HMG callers connected to resources</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	10,000	Numerator:	Number of HMG callers connected to resources	Denominator:	
Unit Type:	Count								
Unit Number:	10,000								
Numerator:	Number of HMG callers connected to resources								
Denominator:									
Data Sources and Data Issues:	<p>Data Source: Help Me Grow Data</p> <p>Unable to link number of individuals who are connected to resources as there may be repeat callers asking for different/additional resources. Will track the number of callers connected to resources.</p>								
Significance:	<p>The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org</p>								

ESM 11.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs

NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active								
Goal:	Increase the percentage of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of families that report linkage to a medical home/service during follow-up call from HMG</td> </tr> <tr> <td>Denominator:</td> <td>Total number of families contacted during follow-up call from HMG</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of families that report linkage to a medical home/service during follow-up call from HMG	Denominator:	Total number of families contacted during follow-up call from HMG
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of families that report linkage to a medical home/service during follow-up call from HMG								
Denominator:	Total number of families contacted during follow-up call from HMG								
Data Sources and Data Issues:	Data Source: Help Me Grow Data								
Significance:	<p>The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org</p>								

ESM 12.1 - Percent of youth/young adults enrolled in the Department's Title V program for Children and Youth with Special Health Care Needs (CYSHCN) that transfer to an adult provider.

NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active								
Goal:	Increase the percentage of youths/young adults enrolled in the Department's Title V program for Children and Youth with Special Health Care Needs (CYSHCN) that transfer to an adult provider.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of youths/young adults enrolled in the Department's Title V program for CYSHCN that report successful transfer to an adult provider</td> </tr> <tr> <td>Denominator:</td> <td>Number of youths/young adults enrolled in the Department's Title V program for CYSHCN who need to transfer to an adult provider</td> </tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of youths/young adults enrolled in the Department's Title V program for CYSHCN that report successful transfer to an adult provider	Denominator:	Number of youths/young adults enrolled in the Department's Title V program for CYSHCN who need to transfer to an adult provider
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of youths/young adults enrolled in the Department's Title V program for CYSHCN that report successful transfer to an adult provider								
Denominator:	Number of youths/young adults enrolled in the Department's Title V program for CYSHCN who need to transfer to an adult provider								
Data Sources and Data Issues:	Data Source: Children's Medical Services Quarterly Report								
Significance:	Health care transition is an importance process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.								

ESM 12.2 - Number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs.

NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active								
Goal:	Increase the number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs.								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> <tr> <td>Numerator:</td> <td>Number of stakeholders, state agencies, and community partners in collaboration with the Department</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	100	Numerator:	Number of stakeholders, state agencies, and community partners in collaboration with the Department	Denominator:	
Unit Type:	Count								
Unit Number:	100								
Numerator:	Number of stakeholders, state agencies, and community partners in collaboration with the Department								
Denominator:									
Data Sources and Data Issues:	Data Source: CYSHCN Annual Assessment Survey								
Significance:	Health care transition is an importance process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.								

ESM 13.1.2 - Number of oral health resource bags distributed to pregnant women and caregivers of young children through internal and external partners

NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active								
Goal:	Increase the number of oral health resource bags distributed to pregnant women and caregivers of young children through internal and external partners annually								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>5,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of oral health resource bags distributed</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	5,000	Numerator:	Number of oral health resource bags distributed	Denominator:	
Unit Type:	Count								
Unit Number:	5,000								
Numerator:	Number of oral health resource bags distributed								
Denominator:									
Data Sources and Data Issues:	Data Source: Oral Health Program Data								
Significance:	<p>Oral health is a vital component of overall health. Access to oral health care, oral health education and improved oral health literacy, good oral hygiene, practicing good oral health behaviors and adequate nutrition are essential components of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at great risk for oral diseases.</p> <p>Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Poor oral health during pregnancy has been linked to preterm birth, low birth weight babies, gestational diabetes, and preeclampsia. Therefore oral health should be considered a vital component of comprehensive prenatal care. Additionally, pregnant women who receive oral health care are more likely to take their children to get oral health care.</p> <p>State Title V Maternal and Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increase the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increase the number of community health centers with an oral health component.</p>								

ESM 13.2.1 - Number of children screened at school-based/ school-linked programs

NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active								
Goal:	Increase access to oral health prevention services to low-income children through school-based/ school-linked programs								
Definition:	<table border="1"> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>5,000</td> </tr> <tr> <td>Numerator:</td> <td>Number of children screened at school-based/ school-linked programs</td> </tr> <tr> <td>Denominator:</td> <td></td> </tr> </table>	Unit Type:	Count	Unit Number:	5,000	Numerator:	Number of children screened at school-based/ school-linked programs	Denominator:	
Unit Type:	Count								
Unit Number:	5,000								
Numerator:	Number of children screened at school-based/ school-linked programs								
Denominator:									
Data Sources and Data Issues:	Data Source: Oral Health Program (OHP) Database								
Significance:	<p>Oral health is a vital component of overall health. Access to oral health care, oral health education and improved oral health literacy, good oral hygiene, practicing good oral health behaviors and adequate nutrition are essential components of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at great risk for oral diseases.</p> <p>Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Poor oral health during pregnancy has been linked to preterm birth, low birth weight babies, gestational diabetes, and preeclampsia. Therefore oral health should be considered a vital component of comprehensive prenatal care. Additionally, pregnant women who receive oral health care are more likely to take their children to get oral health care.</p> <p>State Title V Maternal and Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increase the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increase the number of community health centers with an oral health component.</p>								

**Form 11
Other State Data**

State: Georgia

The Form 11 data are available for review via the link below.

[Form 11 Data](#)

**Form 12
MCH Data Access and Linkages**

State: Georgia

Annual Report Year 2022

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	0		<ul style="list-style-type: none"> • Vital Records Death (Infants) • Vital Records Death
2) Vital Records Death	Yes	Yes	Daily	0	Yes	<ul style="list-style-type: none"> • Vital Records Death (Infants)
3) Medicaid	Yes	Yes	Semi-Annually	0	No	<ul style="list-style-type: none"> • Vital Records Death
4) WIC	Yes	Yes	Daily	0	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	<ul style="list-style-type: none"> • Children 1st • Newborn CCHD Screening • EHDI

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	<ul style="list-style-type: none"> • Children 1st • Newborn CCHD Screening • Newborn Bloodspot Screening
7) Hospital Discharge	Yes	Yes	Quarterly	4	Yes	<ul style="list-style-type: none"> • Vital Records Death (Infants) • Vital Records Death
8) PRAMS or PRAMS-like	Yes	Yes	Annually	12	Yes	<ul style="list-style-type: none"> • Vital Records Death (Infants) • Vital Records Fetal Death

Other Data Source(s) (Optional)

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) Newborn CCHD Screening	Yes	Yes	Daily	0	Yes	<ul style="list-style-type: none"> • Newborn Bloodspot Screening • EHDI • Children 1st
10) Children 1st	Yes	Yes	Daily	0	Yes	<ul style="list-style-type: none"> • Newborn Bloodspot Screening • EHDI • Newborn CCHD Screening
11) Vital Records Fetal Death	Yes	Yes	Daily	0	No	
12) Induced Termination of Pregnancy	Yes	Yes	Daily	0	No	
13) Birth Defects Registry	Yes	Yes	Daily	0	Yes	<ul style="list-style-type: none"> • Vital Records Death • Vital Records Fetal Death • Newborn Hearing Screening • Newborn CCHD Screening • Children 1st • CMS

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None