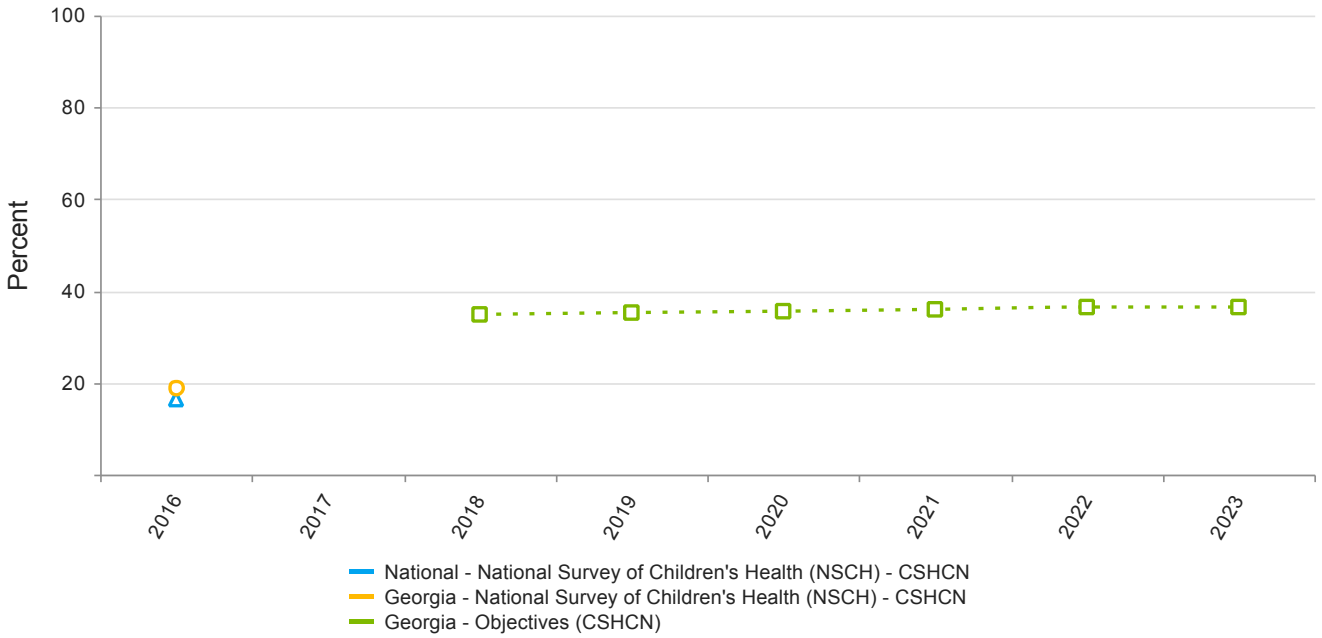
**Children with Special Health Care Needs**

**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system | NSCH-2016 | 13.8 % | NPM 12 |

## National Performance Measures

**NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care**
**Baseline 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** | | |
| | **2016** | **2017** |
| Annual Objective | | |
| Annual Indicator | | 19.0 |
| Numerator | | 44,578 |
| Denominator | | 234,699 |
| Data Source | | NSCH-CSHCN |
| Data Source Year | | 2016 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | 34.9 | 35.3 | 35.6 | 36.0 | 36.5 | 36.5 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 12.1 - 9.1.1 Number of youth, families and professionals trained on health care transition**

| Measure Status: | Active |
|---|---|

| State Provided Data | | |
|---|---|---|
| | 2016 | 2017 |
| Annual Objective | | |
| Annual Indicator | 250 | 434 |
| Numerator | | |
| Denominator | | |
| Data Source | Children Medical Services | Children Medical Service |
| Data Source Year | 2016 | 2017 |
| Provisional or Final ? | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | 250.0 | 325.0 | 350.0 | 375.0 | 500.0 | 500.0 |

**ESM 12.2 - 9.3.1. Number of pediatric and adult medical providers who have a health care transition policy within their practice**

| Measure Status: | Active |
|---|---|

| State Provided Data | | |
|---|---|---|
| | 2016 | 2017 |
| Annual Objective | | 5 |
| Annual Indicator | 0 | 0 |
| Numerator | | |
| Denominator | | |
| Data Source | Children Medical Services Program | Children Medical Services Program |
| Data Source Year | 2016 | 2017 |
| Provisional or Final ? | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | 15.0 | 25.0 | 35.0 | 40.0 | 40.0 | 40.0 |

**State Performance Measures**

**SPM 2 - Rate of children and youth with special health care needs that have accessed their specialty health care visit through a telehealth clinic.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | |
|---|---|---|
| | 2016 | 2017 |
| Annual Objective | | 1.3 |
| Annual Indicator | 1.5 | 1.6 |
| Numerator | 704 | 781 |
| Denominator | 477,000 | 494,310 |
| Data Source | CMS Program Data and Kids Count | CMS Program Data and Kids Count |
| Data Source Year | SFY 2016 | SFY 2017 |
| Provisional or Final ? | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
| Annual Objective | 1.5 | 1.7 | 1.9 | 2.0 | 2.0 | 2.0 |

**State Action Plan Table**

State Action Plan Table (Georgia) - Children with Special Health Care Needs - Entry 1

### Priority Need

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

### NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

### Objectives

9.1. By 2020, outreach and awareness activities on health care transition will reach 2,500 community stakeholders, youth and families.

9.2. By 2020, 500 health professionals will receive training and educational opportunities on health care transition.

9.3. By 2020, improve the standards of care for youth and young adults by implementing evidence-based health care transition protocols within 40 public and private practice settings.

## Strategies

9.1.a. Develop health care transition materials for stakeholders, youth and families

9.1.b. Develop a Health Care Transition Resource Portal

9.1.c. Provide health care transition presentations to community stakeholders

9.1.d. Establish and maintain community partnerships to facilitate the distribution of health care transition resources and materials

9.1.e. Provide 20 health care transition planning workshops for families and youth

9.2.a. Provide an online continuing education module on the six core elements of health care transition targeting a minimum of 10% of public health nurse workforce

9.2.b. Provide continuing education opportunities on the six core elements of health care transition for medical and nursing students, pediatric and adult providers

9.2.c. Provide an annual stakeholder meeting with continuing medical education credit for pediatric and adult providers to discuss evidence based practices, medical home and transition and coordination of care across pediatric and adult systems

9.3.a. Establish an advisory group to include youth, families, and providers to support practice improvement efforts for health care transition

9.3.b. Incorporate the use of transition readiness assessments and planning tools within the 18 district Children's Medical Services (CMS) programs

9.3.c. Assess family and youth satisfaction of the health care transition services and supports upon transitioning out of the program

9.3.d. Partner with pediatric and adult medical providers to provide guidance and support in the development and implementation of a health care transition policy within their practice

| ESMs | Status |
|---|---|
| ESM 12.1 - 9.1.1 Number of youth, families and professionals trained on health care transition | Active |
| ESM 12.2 - 9.3.1. Number of pediatric and adult medical providers who have a health care transition policy within their practice | 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

Improve access to specialty care for CYSHCN

### SPM

SPM 2 - Rate of children and youth with special health care needs that have accessed their specialty health care visit through a telehealth clinic.

### Objectives

10.1. By 2020, increase outreach and awareness activities on telehealth to reach 500 health care professionals and families.

10.2. By 2020, improve the telehealth infrastructure required to support children and youth with special health care needs access to medical care by increasing children's medical services telemedicine clinics provided from 96 to 175.

10.3. By 2020, increase the types of pediatric specialty practices participating in the DPH telehealth network from 2 to 6.

### Strategies

10.1.a. Provide comprehensive telehealth information to providers

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

10.2.a. Assess the infrastructure needs of the Children's Medical Services (CMS) Program telehealth clinics

10.2.b. Collaborate with the Department's Telehealth team and Waycross Health District to expand telemedicine sites

10.2.c. Expand the telemedicine provider network

10.2.d. Establish a telehealth stakeholder workgroup for CSHCN

10.2.e. Collaborate with the Department's EPI team to conduct a needs assessment and to develop a program evaluation plan

10.3.a. Utilize telehealth to improve care coordination efforts for CSHCN

10.3.b Utilize telehealth to improve access to audiological and speech therapy services for CSHCN

10.3.c Utilize telehealth to improve access to services for children and youth with sickle cell disease

*Priority Need: Improve Systems of Care for CYSHCN*

NPM 12: Transition to Adult Care for All Children

Transition to adult care for youth and young adults is a National Performance Measure for the State of Georgia. The goal is to ensure an improvement in the percentage of youth and young adults who successfully transition from pediatric to adult health care services. Georgia's transition improvement efforts are focused on the families, youth and young adults as well as the pediatric and adult health care providers.

During the reporting year, the following strategies are used to drive the improvement process:

- Outreach and awareness activities geared towards youth, families and community stakeholders
- Training opportunities for health care professionals
- Implementation of health care transition protocols and standards in public and private health care settings

With implementation of the strategies outlined above, youth and young adults' successful transition should include:

- Transition education as early as 12 years of age
- Access to a variety of coaching and educational trainings to assist with independent health care skills
- Opportunities to take part in transition planning and preparation with their parent/caregiver(s)
- Seamless transfer to an adult primary care and specialty provider(s)
- Appropriate linkages to adult –focused community based resources and supports
- Access to adequate information for continued health coverage

*Children's Medical Services (System of Care for CYSHCN)*
Strengthening the system of care for youth and young adults transitioning from pediatric to adult care as well as for families with CYSHCN to access timely pediatric medical care in rural areas of the state are priority areas for the Children's Medical Services (CMS) program.

The CMS program partners with health care providers, state agencies and community based resources to coordinate health care services and supports for eligible CYSHCN and their families. Children and youth (ages 0-20) with eligible chronic medical conditions, and family income at or below 247% of the federal poverty level are served by CMS. In State Fiscal Year 2017 (July 2016-June 2017); 8,664 children and youth were served by the CMS program. During this time, 91% of transition age youth, ages 16 -21, received support to transition from pediatric to adult centered health care.

Continuity in medical care for CYSHCN is critical to achieving optimal outcomes for these children and preventing death. CMS serves as the payer of last resort for health care and medical expenses for families that do not qualify for the State's Medicaid, SCHIP programs, or, are without insurance during the time of CMS program enrollment. In addition to filling in the gap with health care coverage, CMS will also support CYSHCN and their families by coordinating appointments, identifying resources, assisting with social supports such as transportation and support groups with other families. Helping CYSHCN and their families feel confident about managing their health care needs and navigating through complex social issues is a very important goal for the CMS program.

For youth ages 16 and older, the care coordinator facilitates the transition process from pediatric to adult health care. Approximately 988 CMS program participants and their families received transition planning, support and education by care coordinators in SFY 2017. The care coordinator's role in the transition process is one of planner, facilitator and support to the adolescent and family. The coordinator assists with transitioning the youth from pediatric care to

physicians trained in adult medicine, ensuring that families and youth understand the health care systems available and learn to navigate services for adults with disabilities and chronic illnesses.

Pediatric specialty care clinics for children and youth living in rural counties in Georgia are offered where pediatric medical specialist's services are limited. The CMS program offers specialty clinics in nine public health districts and coordinates services with more than 30 specialty providers for face to face as well as telemedicine clinic visits. During SFY 2017, approximately 374 clinic days were offered, 98 of those provided via telemedicine, and 3,397 children and youth served via the specialty clinics. Specialty clinics types include endocrinology, nephrology, cardiac, chronic lung, genetics, hematology/sickle cell, orthopedic, hearing, neurology and cystic fibrosis.

CMS care coordinators frequently participate in a variety of outreach activities to assist with building partnerships with community stakeholders to effectively support families' wide range of medical and social needs and improving the timeliness of families accessing services. Some of the activities include participation in local Department of Family and Children Services community collaborative meetings held to share information on community resources. CMS program staff also provide asthma education for school nurses, university students and parent groups involved with summer asthma camps. Countless health fairs are attended to market and promote services to families and providers, including the Pigs N Peaches Market Fair in Kennesaw, GA and the Templo Bautista Hispana Health Fair in Warner Robins, GA.

Since the initiation of the project, there have been 11 Parents as Partners trained and supporting families with children and youth with special health care needs. The most frequent requests for assistance that come from parents include; community resources, early childhood services, education, parent and family support, and healthcare. The Parents as Partners have coordinated trainings for parents and professionals in the community. Parent to Parent (P2P) also maintains the Statewide Central Directory database and hotline, funded by the CMS and early intervention programs and houses approximately 6,000 resources. The Directory allows users to search for information and referral resources or one on one assistance over the phone for families of children ages birth to 26 years with developmental delays, disabilities and chronic health care conditions.

**Health Care Transition Projects**

During the reporting year, the CMS Program partnered with stakeholders to improve Georgia's systems of care and improve transitions for CYSHCN.

*Outreach and awareness activities geared towards youth, families and community stakeholders*
In partnership with P2P, youth and parent/caregivers have access to annual workshops on preparing for the transition from pediatric to adult model of care. The curriculum used to facilitate these workshops are adapted from the Waisman Center and has accompanying workbooks for families and youth to document their transition goals as well as activities to help youth practice independent health care skills such as setting appointments, scheduling transportation and filling prescriptions. During this time, four workshops were provided with 65 attendees which represents about a 10% increase in attendees from the previous year.

To assist with efforts in educating the public on transition, the CMS program has a collection of transition materials specifically developed for families and youth. These materials are marketed at annual outreach events such as health fairs, expos, family nights and conferences. During the reporting year, more than 500 youth and parent booklets were distributed.

*Training opportunities for health care professionals*
Through continued partnerships with the Georgia Academy of Family Physicians and the Georgia Chapter of the

American Academy of Pediatrics, the CMS program can provide annual health care transition training opportunities to pediatricians, family physicians and pediatric nurse members. Trainings are offered via face to face encounters at the annual fall and summer conference meetings as well as via webinar. During this reporting period, there were five training opportunities provided with approximately 185 attendees.

The CMS program also utilized telehealth technology and hosted the live broadcast of the 18th Annual Chronic Illness and Disability Conference: Transition from Pediatric to Adult-based Care for public health district staff and community partners. This is the program's third year to participate and there were approximately 65 attendees who received continuing education credits. From this conference, the CMS program was introduced to the innovative transition program, "Good 2 Go," based in Toronto. Collaboration with the "Good 2 Go" program offered the opportunity to review their resource manual and supplemental documents. The Good 2 Go program's transition clinic flow sheet was used as a reference in creating a transition planning flow sheet for the CMS program.

*Implementation of health care transition protocols and standards in public and private health care settings*
The continued partnership with and funding for the Adult Disability Medical Home (ADMH) provides a vital resource to young adults with intellectual and developmental disabilities and their families. In SFY17, approximately 47 patients were seen by ADMH for transition services and supports. ADMH is housed within a family physician practice and transition clinics are supported by several disciplines, which includes: family physicians, behavioral analyst, clinical social worker, medical assistant and family/patient advocate.

During the reporting period, Dr. Clay, a leader in spearheading the Sickle Cell Transition Program, served as Physician Champion for health care transition and has participated in many training activities coordinated by the CMS program. In July 2017, Dr. Clay was invited to be a speaker at the 44th Annual Haitian Physician Abroad Conference at Decameron, Haiti. Her presentation was entitled: "Transition from Pediatric care to Adult Care in Patients with Sickle Cell Disease."

*Priority Need: Promote Oral Health to All Populations*

NPM 13: Preventive Dental Visits

The Oral Health program and Children's Medical Services partnered to identify dental offices serving children and youth with special healthcare needs and create a web-based referral resource (database). Data has been collected in six communities around the state on dental practices offering special needs services, Medicaid acceptance, general anesthesia and location. The data will be used to map the practices to facilitate easier access for families. The Oral Health program contacted the Georgia Academy of Pediatric Dentistry for a list of member dentists who treat special needs children. The Oral Health Team continued to provide education to public health district staff on special considerations and treatment needs for special needs patients.

SPM 2: Improve Access to Specialty Care for CYSHCN

In the reporting year, CMS partnered with health care providers and community-based resources to coordinate care for CYSHCN and their families. The Georgia Department of Public Health's (DPH) Office of Telehealth and Telemedicine, in partnership with county health departments, oversees a robust telehealth network which encompasses all 159 counties in the state. The telehealth and telemedicine programs aim to improve access to healthcare services, address workforce shortages, and reduce health disparities across Georgia.

The CMS program used telehealth and telemedicine to provide developmental and genetic services, asthma-

management, as well as endocrinology, nephrology, pediatric neurosurgery, pulmonology and sickle cell follow-up care. As the presentation/origination site, the CMS program was able to facilitate reimbursement with appropriate Medicaid telehealth billing codes.

CMS has worked with specialty clinics for over a decade through partnerships with pediatric healthcare systems, university systems and private specialty providers. With increasing provider shortages, CMS recognized the necessity for more robust telehealth services to meet the needs of these children. Telehealth services through CMS were first implemented at a pulmonology clinic in Valdosta, in South Georgia, and slowly expanded to other counties throughout the state. During this reporting period, there were seven district CMS sites capable of providing telemedicine services.

*Georgia Autism Initiative*
DPH will provided educational outreach and training to medical providers (pediatricians, family physicians, physician's assistants, nurse practitioners, and nurse managers) utilizing evidence based practices, such as academic detailing. Autism educational outreach and training will include information on topics, including the importance of screening, listening to parental concerns, using screening tools during well-child visits, implementing standardized screening practices, billing for reimbursement, as well as referring children for diagnosis, early intervention services, and community supports. In addition to academic detailing, outreach will be conducted using a variety of strategies, such as webinars, tele-health, and practice visits.

**Current Year: Oct 2017 – Sept 2018**

*Priority Need: Improve Systems of Care for CYSHCN*

NPM 12: Transition to Adult Care for All Children

*Children's Medical Services (System of Care for CYSHCN)*
In the current year, CMS continues to engage various partners to improve the successful transition for youth and young adults from pediatric to adult care.

*Outreach and awareness activities geared towards youth, families and community stakeholders*
P2P continues to provide annual training workshops on preparing for the transition from pediatric to adult model of care for youth and families. With the increase in demand for this training from our care coordinators, the CMS program is in the process of increasing the number of workshops funded within the contract with P2P from four to six annual trainings.

Additional support and training opportunities are available to families from the Parents as Partners located across six public health districts and one private therapy provider office. Parents as Partners receive trainings on developing a health care transition plan for children and youth ages 14 and older as well as transition coaching strategies. During this time, the P2P transition pilot project in the Hall County area included the coordination of health care and vocational rehabilitation activities for families. The Parents as Partners supporting the Gainesville health district teamed up with the vocational rehabilitation transition coordinator to offer several transition education opportunities for families residing within the Hall County area.

The CMS program has also partnered with the Adult Disability Medical Home to provide an annual training to families on how to support the transition needs for youth and young adults with intellectual and developmental disabilities. This training will be held in June and more than 50 participants are expected to attend. Medical transition, educational transition, access to adult services and Medicaid waivers as well as long term support will be

discussed.

Through the CMS program's partnership with the Department's Newborn Screening program there is on-going collaboration with condition specific organizations to ensure transition planning is incorporated within their direct services. The Sickle Cell Foundation of Georgia utilizes community health workers to support outreach and coordination of care efforts for clients. Community health workers incorporate age appropriate transition planning and the foundation also incorporates transition education during the annual Camp New Hope activities for adolescents. Hemophilia of Georgia utilizes outreach nurses and social workers to address transition education and preparation with clients. During this time, there was also a teen retreat at Camp Jekyll where educational sessions were designed to help the teens with self-determination.

To support the families, youth and stakeholders with transition education and planning, the CMS program is in the final development phases of the "Georgia's Youth S.T.E.P.S. into Transition" tool kit. STEPS is an acronym that will help individuals remember how to address a successful transition and stands for:

1. START EARLY. Begin having conversations with your physicians about transition early
2. TALK. Begin talking with your parents and physician about transition and what it means for you
3. EDUCATE. Begin educating yourself about your specific condition
4. PLAN. Begin developing and creating a plan for your transition
5. SUPPORT. Begin creating a support system

The tool kit will include:

- My Must Have Paperwork for Transition
- Guardianship and Alternatives for Decision-Making Support
- My Health Report
- Differences in Pediatric and Adult Care
- Emergency Care Plan.
- "Taking Charge of My Healthcare. A Workbook for Youth," which includes additional resources, worksheets and scripts to help facilitate a successful transition from pediatric to adult healthcare.

The tool kit will be marketed to care coordination programs led by managed care organizations, condition specific organizations and parent organizations. The CMS program will also approach Department of Education to gauge their interests with utilizing the tool kit with their transition efforts during the Individualized Education Planning process.

*Training opportunities for health care professionals*

This year marks the third annual transition conference in partnership with the Georgia Chapter of the American Academy of Pediatrics. Each year, the planning committee consists of representatives from different health systems. This year's planning committee included Grady Health System, Wellstar Health System, Children's Healthcare of Atlanta and the Department of Public Health. *Resources for Transitioning Youth with Special Needs from Pediatrics to Adult Care* was this year's theme and was held in May 2018. This conference was designed to help family physicians, internists, OB/GYNs, pediatricians and clinical healthcare professionals to address issues surrounding transitioning youth with special health care needs from pediatric to adult care. Continuing medical education credits were provided with approximately 20 participants in attendance. Margaret McManus, MHS Co-Project-Director for Got Transitions was the guest speaker and discussed Directions and Innovations in Health Care Transition as well as Payment Strategies for Transition.

In the current year, the CMS program continues to also partner with the Georgia Academy of Family Physicians to

support health care transition activities, which include lecture presentation at their Fall and Summer meetings as well as live webinars. During this reporting period, the program worked with Got Transitions to provide a webinar on the Innovations in Transition from Pediatric to Adult Health Care presented by Patience White, MD, MA, Co-Project Director, Got Transition and Margaret McManus, MHS Co-Project Director, Got Transition to family physician members. The webinar was well attended with more than 20 participants.

Both medical societies have updated their websites to include health care transition information, resources and links to the Got Transition website.

*Implementation of health care transition protocols and standards in public and private health care settings*
During this reporting period, CMS began the process of revising the transition policies, programmatic forms and communication materials to improve the transition preparation and planning procedures for children and youth beginning at 12 years of age and their caregivers enrolled in the program. The CMS program utilized the Six Core Elements of Health Care Transition as a framework. The primary focus of the revisions were to ensure an enhanced transition process that is family and youth focused and developmentally age appropriate. The core goals of the revamped transition planning for the CMS program include:

A. Increase the number of youth and young adults whose self-care skills are regularly assessed.
B. Increase the number of youth and young adults with a developed plan of care that incorporates transition readiness goals and prepares youth for an adult model of care.
C. Increase the number of youth and young adults that are transferred to an adult provider**.**
D. Increase the number of youth and young adults and their parent/caregivers that report satisfaction with the CMS health care transition process.

Once the revised policies are rolled out and fully implemented, the CMS program will provide ongoing technical assistance to care coordinators responsible for leading this work to ensure commitment and reliability to this enhanced approach to transition preparation and planning.

SPM 2: Improve Access to Specialty Care for CYSNCN

In the current reporting period, CMS continues to expand clinical services to other areas of Georgia and enhance telemedicine services by leveraging existing partnerships with the medical community. During SFY15, there were only two local district (Waycross and Valdosta) CMS programs that offered telemedicine services for neurology, nephrology, pulmonology and endocrinology. In coordination with the Department's Telehealth team, the CMS program expanded services to eight local district (Athens, Valdosta, Albany, Columbus, Macon, Dublin, Cordele, and Waycross) CMS programs for patients needing sickle cell and genetic care.

The sickle cell telemedicine program was established in 2016 through a partnership with Augusta University, the Department's Newborn Screening program and the CMS program. The telemedicine program provides follow up care for patients receiving hydroxyurea therapy as well as testing and genetic counseling for abnormal newborn screening results. Telemedicine clinics are scheduled every other month in Dublin, Albany, Valdosta and Waycross. Utilizing telemedicine improves medical management of hydroxyurea therapy for individuals living with sickle cell disease in rural communities.

During this reporting period, the CMS program and the Department's Telehealth team expanded the endocrinology telemedicine provider network to two network providers. Navicent Health Center which is the second-largest hospital in Georgia and serves central part of the state, became a provider for telemedicine services. Navicent currently supports one CMS district site with plans to expand to other sites.

**Early Intervention Services**

*Babies Can't Wait*

The BCW Policy Manual was finalized in October 2017 and made available to the Health Districts. New Category 1 conditions (Severe Birth (perinatal) asphyxia; Shaken baby syndrome; Cleft lip and palate unrepaired; Congenital reduction deformities of the lower limb; Congenital reduction deformities of the upper limb; Down Syndrome, unspecified; Turner's Syndrome, unspecified; Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side; Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side; Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side; Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side; "Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side"; "Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side") have been added to the list of diagnosed conditions for program eligibility consideration. A new Child Outcome Summary (COS) policy was implemented that specifies team composition and procedures for developing COS ratings, data entry into the BCW database as well as training requirements for practitioners who develop child outcome ratings. The Early Childhood Technical Assistance (ECTA) Center and IDEA Early Childhood Data Systems (DaSy) online COS Process training module was added as planned to BCW's professional development website managed by Valdosta State University (VSU) effective July 1, 2017. All new providers are now required to complete the online COS training module within 60 days of hire or contract date. A second cohort of Pyramid trainings was delivered to Service Coordinators and Special Instructors this year in the four State Systematic Improvement Plan (SSIP) implementation districts (Dalton, Columbus, Coastal, and Gwinnett) and a fifth district (Dublin) to implement evidence-based practices that will lead to improvements in the SiMR. The Master Cadre trainers in each SSIP implementation district conducted trainings with assistance and support provided by Georgia State University (GSU) staff. GSU staff and the Master Cadre from each SSIP implementation district were previously trained during Cohort 1 of Pyramid.

*Georgia Autism Initiative*

DPH has established a comprehensive statewide plan for autism spectrum disorder (ASD) early detection through screening, evaluation and intervention.

A. Professional Development and Capacity Building
   In collaboration with Emory Autism Center (EAC), the department implemented a Board Certified Behavior Analyst (BCBA) Training and Supervision Program which allows children with ASD 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 a behavioral health national certification. Approximately 200 children have received behavioral support services through this initiative.

B. Awareness and Early Identification
   In collaboration with Marcus Autism Center (MAC), DPH has established Professional Learning Communities in three of five Child Health Regions where Resource Specialist lead monthly webinars on early identification and understanding signs of ASD. MAC also continues to provide one-on-one coaching and access to a 30-hour webinar course that includes five modules on early identification of ASD for select provider groups.

   In collaboration with EAC, DPH has developed an online webinar for providers to receive training on the Modified Checklist for Autism in Toddlers – Revised Follow-Up (MCHAT-R/F). The MCHAT Training is a one-hour live webinar and focus how to identify "red flags" for ASD, how to administer the MCHAT – R/F with

children and how to discuss results with families. In May 2018, Qualified health care providers (QHCP) will undergo MCHAT-R Training and conduct the assessment with children enrolled in Babies Can't Wait (BCW) at recommended periodic intervals (18 and 24 months).

C. Diagnostic Evaluation
DPH has developed a memorandum of understanding (MOU) for the purpose of establishing formal partnership with Georgia Autism Assessment Collaborative (GAAC) professionals – psychologist trained to conduct diagnostic evaluations using a standardized tool, Autism Diagnostic Observation Schedule, Second Edition (ADOS-2). The MOU outlines standards and guidelines for GAAC professionals working throughout the 18 public health districts and serving as receptive referral sources.

- GAAC professionals associated with said MOU will adhere to the following
  a) Conducting a diagnostic evaluation within 30 days of program referral.
  b) Reporting diagnostic outcome to the program within 15 days of a completed diagnostic evaluation.

In January 2018, DPH established GAAC Early ID Specialty Clinics in five public health districts. Specialty Clinics will work together to establish, implement and evaluate standards and systems to provide timely accessible, quality evaluations of children suspected of having ASD by age three to facilitate meaningful supports in partnership with families and the community.

D. Behavioral Intervention
In June 2018, DPH will begin to identify 18 Board Certified Behavior Analyst (BCBA's) – at least one per Public Health District and up to 54 Registered Behavior Technicians (RBTs) – at least three per public health district.

E. Transition
To address adolescent to adulthood transition for youth with ASD, DPH and EAC has developed an Individualized Transition to Adulthood Plan (ITAP) Project that will be utilized by DPH, other educators and autism healthcare providers throughout Georgia. The Department has developed implementation models, best practices, materials and resources for educators and healthcare providers to offer services aimed at helping young people with autism spectrum disorder adopt a more independent and empowered lifestyle as they transition into adulthood. To help inform its development and improvement of the ITAP, an Individualized ITAP Advisory Board was established, consisting of key community stakeholders and experts.

EAC is implementing the current ITAP through services it is providing to at least 10 students between the ages of 14 and 22. The services include administering Transition Assessments, developing distinct ITAPs for each student and implementing ITAPs.

In 2017, legislation increased funds to establish an Adolescent to Adulthood Transition model to improve the outcome of adults with ASD.

*Family Engagement*
*Babies Can't Wait* district coordinators participated in over 200 local community events, which included health fairs, races, literacy events, social events, educational fairs, book drives, transition events, back-to-school events, preschool/daycare events, youth events, fall/spring festivals, support groups, and trainings/workshops.

*Babies Can't Wait State/Local Interagency Coordinating Council(s)* (*SICC/LICCs*) - The mission of the Georgia

SICC/LICCs for Early Intervention Programs is to advise and assist DPH and other agencies responsible for serving infants and toddlers, birth to age three with developmental delays and disabilities and their families, in providing an appropriate, family-centered, comprehensive service delivery system which promotes optimal child development and family functioning. Regular meetings of the council are held quarterly, and are open to the public. Family members are encouraged to attend. Travel expenses are covered.

*Children Medical Services*– CMS' Parents as Partners Project provides community level support for families of CYSHCN. The CMS program partners with Parent to Parent of Georgia (P2P), Georgia's Family to Family Health Information Center, to implement the Parents as Partners Project. The Parents Partners are themselves parents of CYSHCN. The Parents Partners are paid as part-time employees of P2P and support local district child health programs and private pediatric medical practices. Parents Partners provide information, resources, emotional support, and coordinate free training opportunities for parents served at their site.

**Children with Special Health Care Needs - Application Year**

*Priority Need: Improve Systems of Care for CYSHCN*

NPM 12: Transition to Adult Care for All Children

*Children's Medical Services*
In the coming year, the CMS program will continue to work with programs, state agencies, health systems, health plan, families, youth and stakeholders to enhance and expand the system of services for CYSHCN. Monitoring and documenting the implementation of the revised transition policies and procedures for the CMS program including youth and family satisfaction with transition planning is a priority. Documenting lessons learned from the CMS program care coordinators during the transition improvement process will help to offer recommendations and training opportunities to other programs and agencies providing care coordination services to adolescents 12 years of age and older. Ensuring that the Georgia's Youth S.T.E.P.S. into Transition tool kit is widely marketed and easily accessible for youth and health care professionals serving youth and providing educational opportunities on health care transition preparation and planning for staff coordinating the Individualized Education Plan activities for youth and families within target school district sites will continue in the coming year. Work will continue with school district parent mentors and transition coordinators to provide tools and resources for students and families.

*Priority Need: Promote Oral Health to All Populations*

NPM 13: Preventive Dental Visits

In the coming year, the Oral Health program will continue to educate public health district's oral health staff on special considerations and treatment needs for special needs patients. Education and training on caring for children and youth with special health care needs will be condition-specific and include evidence informed practices. Education and training for school-based programs that include all children will continue.

*Priority Need: Improve Systems of Care for CYSHCN*

SPM 2: Improve Access to Specialty Care for CYSHCN

*Babies Can't Wait (BCW)*
In the application year, BCW will continue to serve children birth to three with developmental delay and category 1 chronic conditions. BCW will continue to focus on increasing provider capacity and working on addressing strengths and challenges within the program and redefining the program infrastructure and areas to target for the upcoming year. A statewide QA/QI program that allows ongoing monitoring and review of program documentation and ensures timely and accurate recording will be implemented in the application year.

*Autism*
Qualified Health Care Professionals (QHCP) and paraprofessionals will receive MCHAT Training throughout May and June of 2018. QHCPs include BCW Service Coordinators, Children 1st (C1st) Coordinators or Developmental Specialist. Beginning in February 2018, trained professionals will implement ASD screening at the recommended 18 and 24 month intervals.

In the upcoming year, children zero to three enrolled in BCW will have access to comprehensive services that address ASD such as screening, diagnostic referral, behavioral evaluations and intervention. DPH is committed to ongoing professional development and capacity building, therefore, will continue contracting with certified behavioral

analyst to offer a quality standard of care.

Collaboration with internal and external partners has been vital to the Autism Initiative. DPH will maintain and establish partnerships with key stakeholders to leverage resources and expand access to care.