Georgia Department of Public Health

Board of Public Health Meeting

Tuesday, December 11, 2012

We Protect Lives.

Board Member Introduction

Katie C. Miller

Commissioner's Update

James C. Howgate, MPH
Chief of Staff, DPH

Georgia Department of Public Health

Telehealth Project for Georgia

Presentation to: GDPH Board December 2012

Presented by: Kathryn K. Cheek MD,FAAP

Date: December 11, 2012

We Protect Lives.

Telemedicine vs. Telehealth

- Telemedicine – The use of medical information exchange from one site to another via electronic communications. Two-way, real time interactive audio and video telecommunication equipment

- Telehealth- The use of telecommunication technologies for clinical care, patient teachings and home health, health professional education , administrative and program planning

Telemedicine Overview

- Originating Site

- Medical Cart

- Distant Site

- Originating Site - the actual location a patients is located
- Medical Cart – interactive and secure telecommunications system
- Distant Site – The site where physician or practitioner is located

The Commissioners Goals

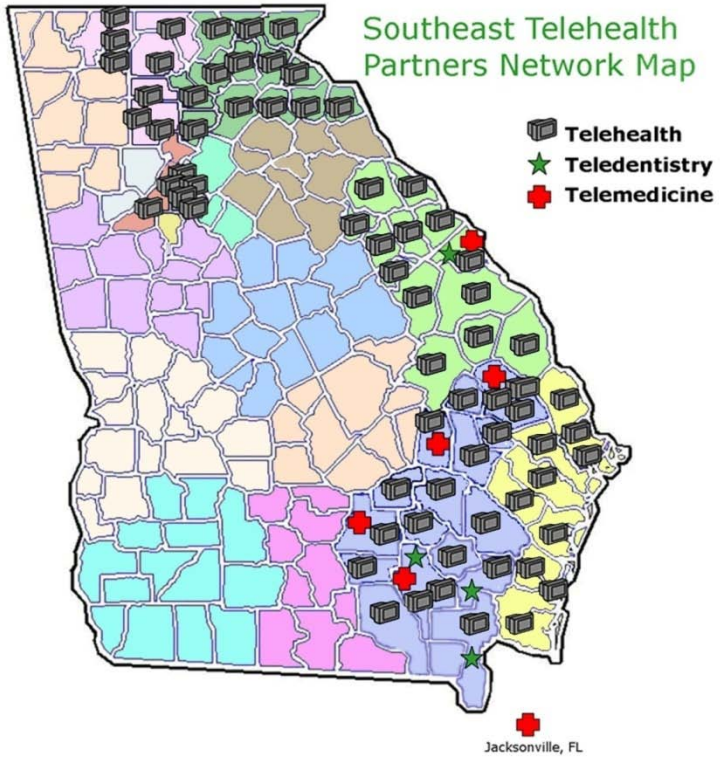
- Implement Telehealth In Every Health Department In Georgia
- Leverage our Videoconferencing system
- Expand access to successful programs statewide
- Leverage our Telemedicine Partnerships
- Increase access to quality medical care through Telemedicine
- Complement our local medical delivery systems both private and public by strengthen and preserving the medical home.

Leverage our Videoconferencing system

- WIC has established a rural network based in Waycross Ga. to administer and manage the WIC Visual Collaboration network
- Georgia Department of Public Health purchases network capacity from WIC
- Districts and Counties will have access to WIC administered programs and DPH supported telehealth/med offerings statewide

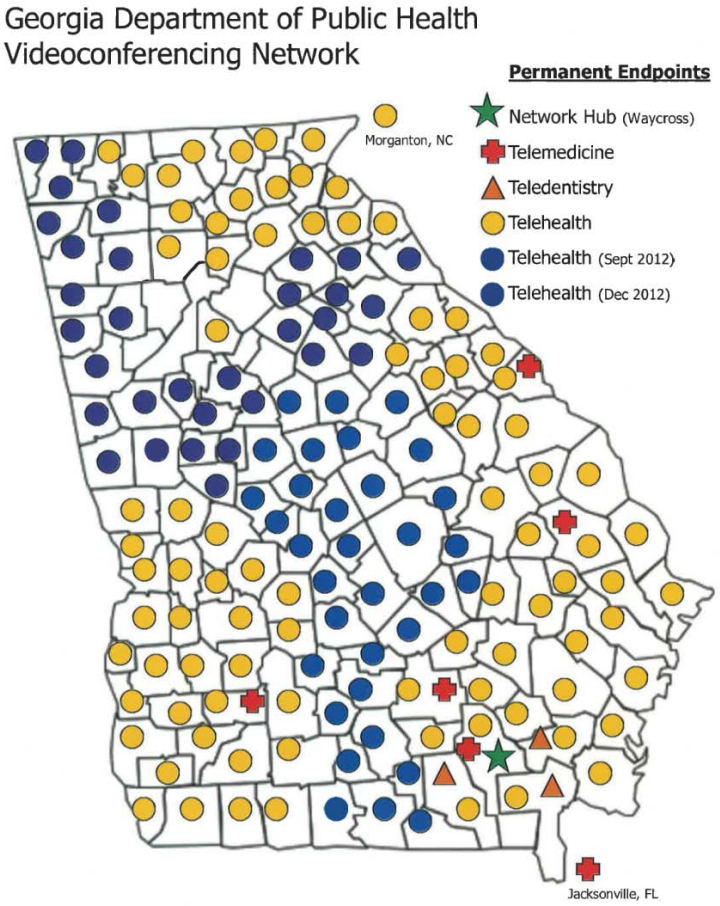
Where we were one year ago

- DPH had 5 rural Health Districts wired
- Augusta was a stand alone district
- Most districts were self administered



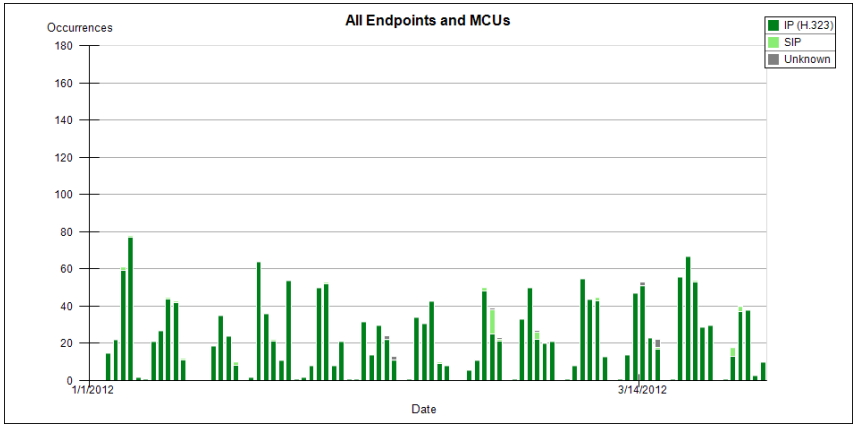
Network 1st Quarter 2013

- All districts routed managed & administered through Waycross
- Start to deploy the 13 medical carts to 12 of the rural underserved Health Districts
- Continue to plan new clinics programs/projects



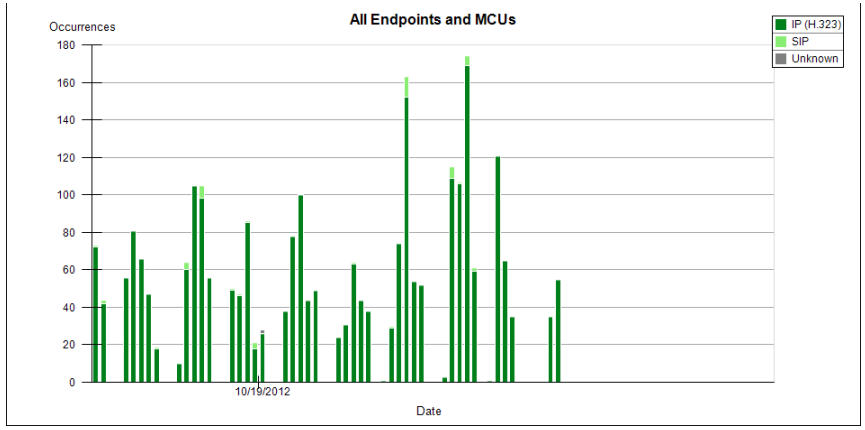
Seeing Video Conferencing Results

First Qtr. 2012 Usage



- Internal Program usage
- 1st quarter average usage 15 sites per day

Fourth Qtr 2012 Usage



- On Sept 19th WIC had a meeting to require usage
- 4th quarter averaging 45 sites per day using system

Leverage our Telemedicine Partnership Network

- Meeting with Public and Private Networks to partner
- Sign up Doctors to participate as they are joining our Georgia Volunteer Healthcare Program (GVHP)
  https://gavhcp.collaborativefusion.com
- Use our workforce to engage local doctors and educate them about telemedicine
- Use our network and DPH locations to provide access to doctors who do not own equipment but would be willing to provide services to remote clients

Expand access to successful programs statewide

- Service offerings / program/project such as
  - Albany's Centering Program
  - CHOA case reviews and clinics
  - AIDS clinic in Waycross
  - Neuro program in Waycross
- Other programs that can be accomplished as we add partners
- Develop new ways to deliver Public Health Programs
- Partner with medical associations to provide continuing education via our network

Increase access to quality medical care through telemedicine

- Work from a referral based system only
- Remove the barriers to care by providing a medical access point in every county in Georgia.
- Enhance local Doctors access to specialists
- Staff, train and equip health departments to provide an enhanced level of care by facilitating and presenting patient encounters

Complement the local medical delivery systems both private and public

- Work with the local Doctors and Dentist for referrals
- Establish and build networks to provide access to needed specialists
- Reduce travel expense for patients and providers
- Improve patients treatment follow up visits remotely thus improving outcomes.

Keys to success

- Affordable access
- Reduce travel, meeting and training cost
- Maximize Medicaid and private insurance dollars
- Identifying and training personnel to support the programs at the county and district level
- Expand access to doctors and medical networks
- Better patient outcomes across our programs

Funding

- Reduce travel and meeting expenses
- Consolidate the GDPH video conferencing networks
- Collect fees at the district level to offset local cost
- Utilization of other rebates and sources to further reduce the counties and district network cost
- Identify sources such as grants, private industry and charities we can partner with to complete or enhance the networks resources
- Including Telemedicine and Telehealth into our grant proposals

Medicaid

- DCH has worked and included DPH as they have been revising and updating their policies as it relates to telemedicine.
- The Department of Community Health's Telemedicine and Telehealth policy group and the Department are working together to further explore opportunities.
- Medicaid has established $20.52 facility fee effective November 1, 2012

Questions ?

Georgia Department of Public Health

Georgia's Infant Mortality Task Force Update

Mitch Rodriguez, MD
Georgia Department of Public Health
Board Member
December 11, 2012

We Protect Lives.

Infant Mortality – Georgia

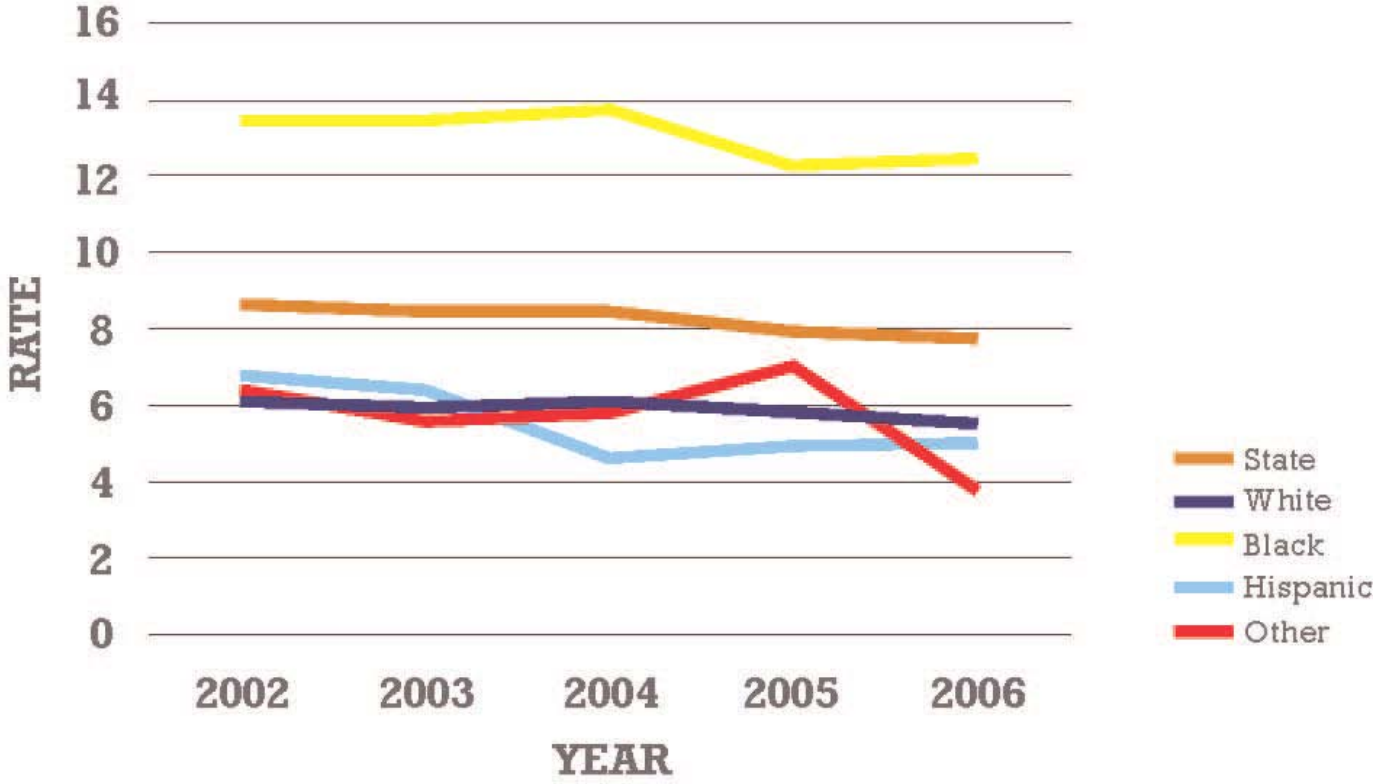
- Between 2002-2006:
  - An infant died in Georgia every 7 hours and 36 minutes
  - 5,743 Georgia babies died before their first birthday
  - Georgia's IMR remained 15-20% higher than the national average (8.4/1,000)
  - Georgia's IMR was 42% higher than the HP 2010 goal

Georgia Improves on Preterm Births, Still Gets Low Grade

- Georgia lowered its preterm birth rate last year, but the state still received a "D" grade on the annual preterm birth report card released Tuesday by the March of Dimes.

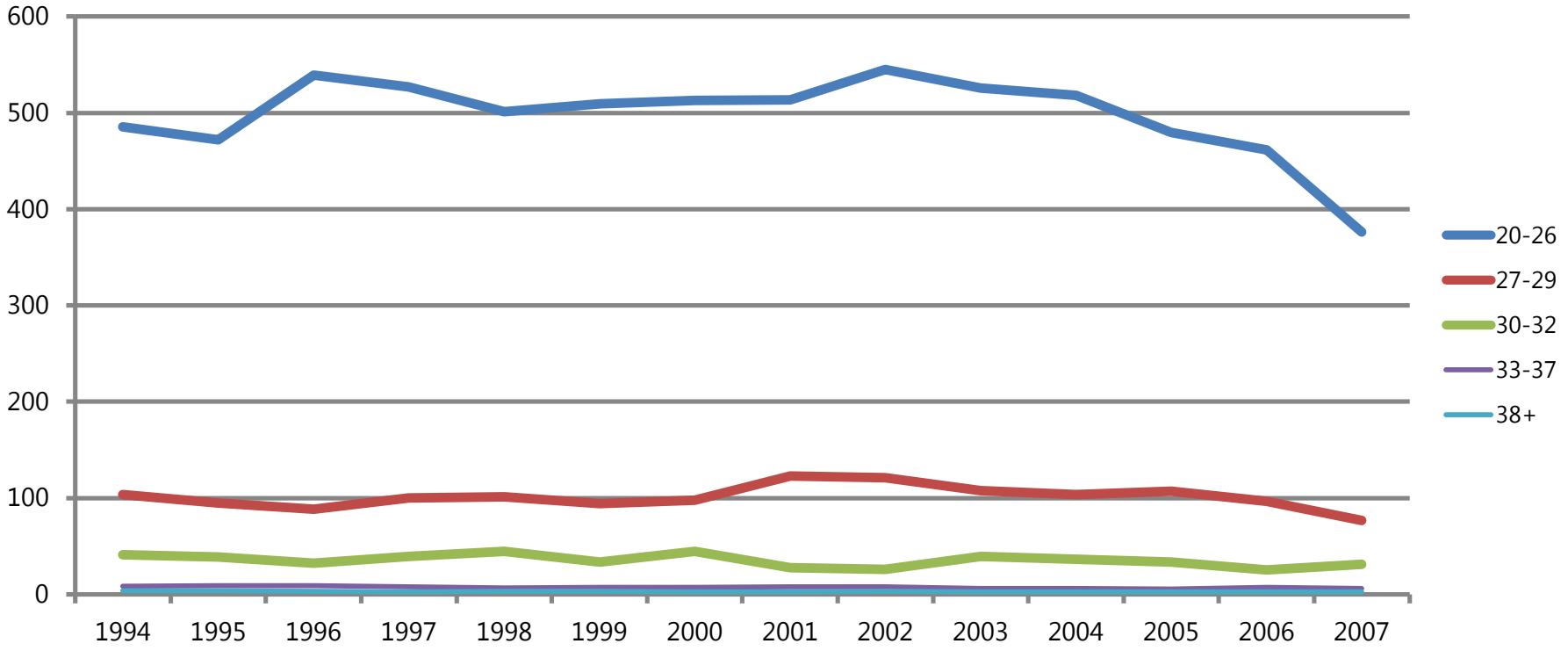
- The reduction of Georgia's preterm birth rate – from 13.8 percent to 13.2 percent – is part of a national trend. Forty states saw improvement in their rates between 2010 and 2011, the March of Dimes reported. The largest declines occurred among babies born at 34 to 36 weeks of pregnancy.

Infant Mortality – Georgia by Race/Ethnicity



Rates are infant (under 1 year) deaths per 1,000 live births.
All racial groups are exclusive of the Hispanic ethnicity.

Impact of Preterm Birth on Infant Mortality



Challenge

- March of Dimes and ASTHO prematurity challenge
  - To reduce the prematurity rate in Georgia by 8% by 2014
  - This would mean that we would reduce our preterm birthrate from 12% to 11% by 2014

COIIN

- Collaborative Improvement & Innovative Network

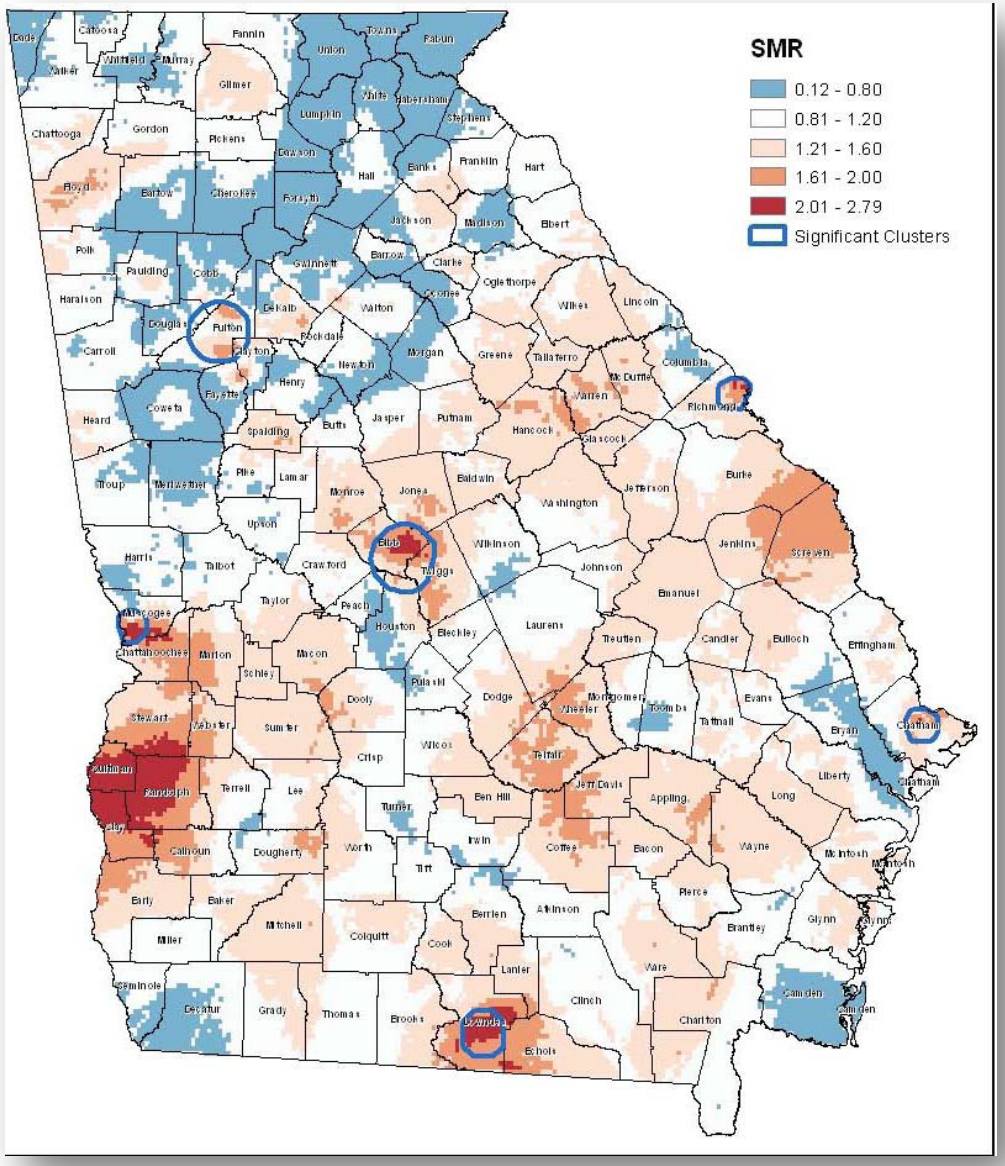
- 13 States in Public Health Region IV and VI

COIIN

- Five Priority Strategies
  - Reduce elective deliveries at < 39 weeks
  - Expand access to interconception care through Medicaid
  - Increase smoking cessation among pregnant women
  - Prevent SIDS/SUID
  - Expand perinatal regionalization

Infant Mortality Clusters

- Cluster A: Fulton, Douglas, Cobb, Clayton
- Cluster B: Bibb, Twiggs, Houston, Jones
- Cluster C: Muscogee, Chattahoochee
- Cluster D: Lowndes
- Cluster E: Richmond
- Cluster F: Chatham



Significant Clusters

- Georgia's IMR 8.4 per 1,000 live births
- Atlanta area 11.8
- Augusta area 15.1
- Columbus area 15.8
- Macon area 14.7
- Savannah area 13.3
- Valdosta area 17.5

Infant Mortality Task Force

- Members of the Task Force include:
  - Georgia Department of Public Health*
  - Regional Perinatal Centers*
  - Georgia Hospital Association*
  - Medical Societies (AAP,* FP, OBGYN*)
  - Private Foundations*
  - March of Dimes*
  - Community Organizations
  - Georgia Department of Community Health/Medicaid*
  - Care management organizations (CMO)*
  - Private Insurers
  - Private Industry*
  - Nurse Midwife*
  - Hospitals*
  - Academia*
  - Faith Based organizations
  - Family/Consumer
  - Legislature

Infant Mortality Strategic Plan

Measurable Objective #1: Strengthen the regional perinatal system through defined standards of care by 2016.

- Strengthen the regional perinatal system through the development of standards of care to improve health outcomes
  - Adopt AAP levels of care
- Develop a perinatal quality collaborative with multiple partners modeled after existing quality collaboratives in other states
- Develop a maternal mortality review committee
  - Improved maternal health = improved birth outcomes
- Identify 2 communities with high rates of infant mortality for targeted interventions
  - Savannah (Chatham County) and Columbus (Muscogee County)

Infant Mortality Strategic Plan

Measureable Objective # 2: Develop targeted educational campaign on IM related issues. Three campaigns developed by 2016.

- Work with partners to develop a targeted educational campaign regarding breastfeeding with a focus on baby-friendly hospitals and the business case for breastfeeding
- Work with partners to develop a targeted educational campaign regarding safe sleep to reduce infant deaths
- Work with partners to develop a targeted educational campaign regarding smoking cessation to reduce poor birth outcomes and infant deaths

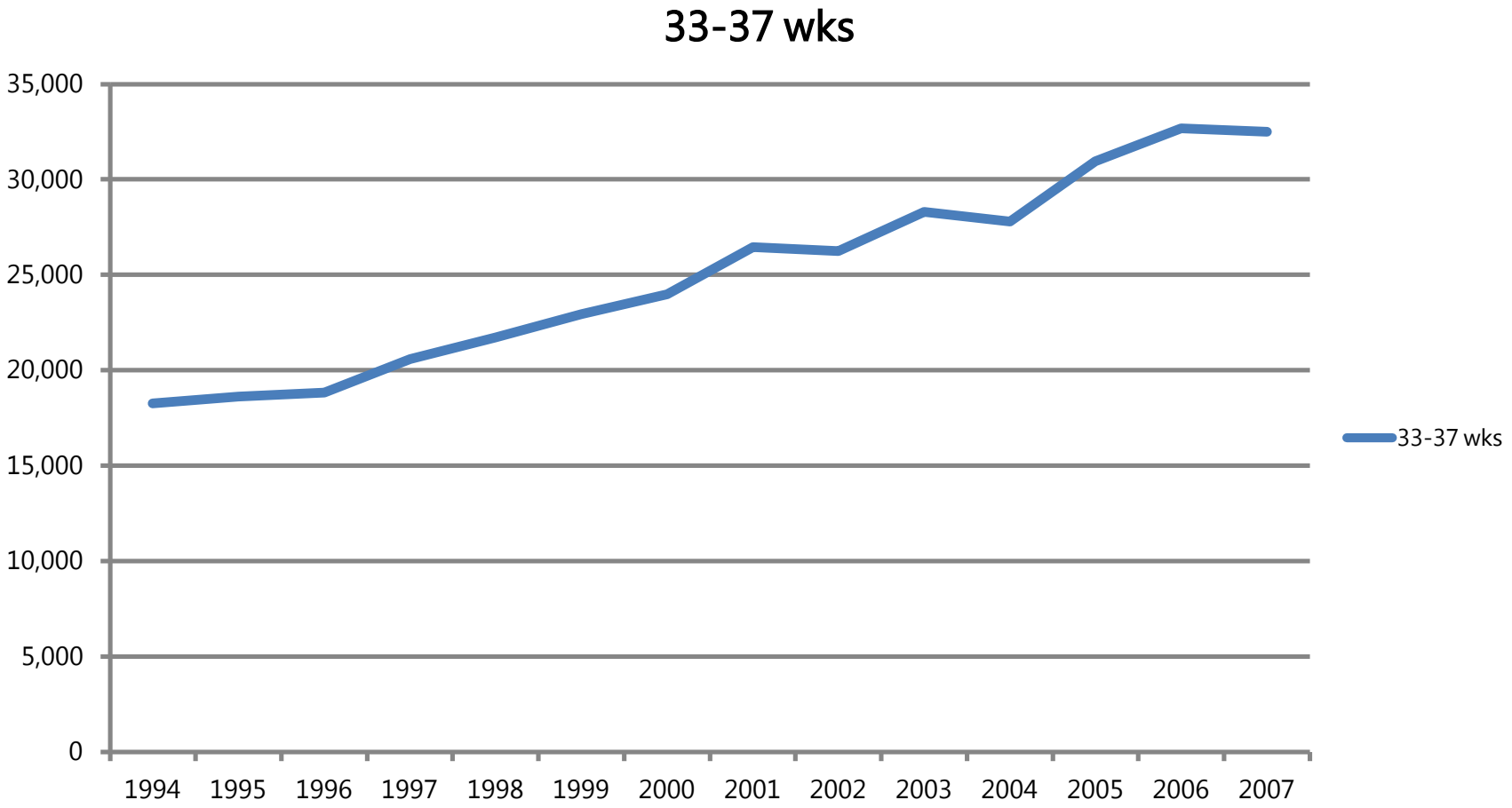
Infant Mortality Strategic Plan

Measureable Objective # 3: Develop external collaborations to support IM initiatives of other organizations by 2013.

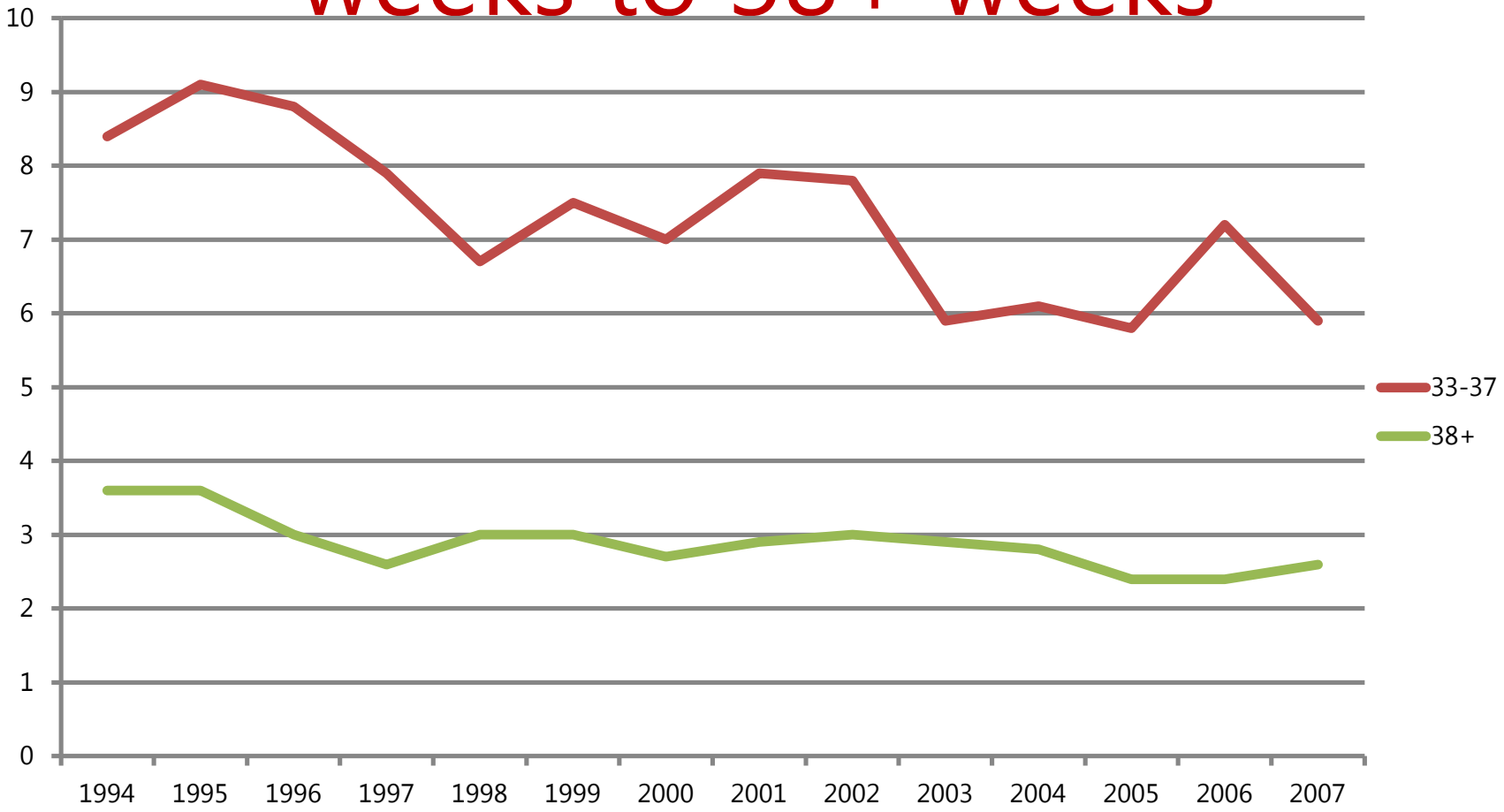
- Work with DCH and others to improve utilization of the 1115 waiver

- Work with the Georgia Hospital Association, the March of Dimes, and others to reduce early elective deliveries

Late Preterm Deliveries



Mortality comparison 33-37 weeks to 38+ weeks



Infant Mortality Task Force

- IMR in Georgia for 2010- down to 6.3 per thousand (down from 8 in 2008)
  - White 5.7
  - African-American 10
- For 2008 Georgia's IMR ranked 43rd in the US (US 6.6)
- For 2010 Georgia's prematurity rate of 12.2% ranked 46 in the US

Progress to Date

- ✓ Infant Mortality Task Force
- ✓ Regional Perinatal System
- ✓ Georgia Perinatal Quality Collaborative
- ✓ Maternal Mortality Review Committee
- ✓ Target Interventions in Savannah and Columbus
- ✓ Georgia 5-Star Hospital Initiative
- ✓ Mother Friendly Businesses
- ✓ Safe To Sleep Campaign
- ✓ Reducing Early Elective Deliveries

Leading Causes of Infant Death

Table 1. Infant mortality rates for the 10 leading causes of infant death, Georgia, 2002–2006

Causes of death	Number	% of total deaths	Mortality rate	Rank
All causes	5743	100	8.24	—
Disorders related to short gestation and low birth weight, not elsewhere classified	1117	19.5	1.62	1
Congenital malformations, deformations and chromosomal abnormalities	964	16.8	1.39	2
Sudden infant death syndrome	621	10.8	0.90	3
Newborn affected by complications of pregnancy	321	5.6	0.46	4
Respiratory distress of newborn	245	4.3	0.35	5
Accidental/unintentional injuries	181	3.2	0.26	6
Bacterial sepsis of newborn	169	2.9	0.24	7
Newborn affected by complications of placenta, cord and membranes	164	2.9	0.24	8
Necrotizing enterocolitis of newborn	134	2.3	0.19	9
Disease of circulatory system	131	2.3	0.19	10

Rates are infant (under 1 year) deaths per 1,000 live births.

Potential Impact – No Elective Deliveries prior to 30 Weeks

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Actual	154	170	165	162	146	172	169	208	206	167	170	181	236	191
Expected	88	103	108	108	81	103	104	131	127	85	92	107	158	106
Impact	66	67	57	54	65	69	65	77	79	82	78	74	78	85
IMR at 38+	3.6	3.6	3	2.6	3	3	2.7	2.9	3	2.9	2.8	2.4	2.4	2.6
IMR 33-37	8.4	9.1	8.8	7.9	6.7	7.5	7	7.9	7.8	5.9	6.1	5.8	7.2	5.9
Births	18,271	18,624	18,847	20,604	21,735	22,952	23,974	26,441	26,261	28,313	27,802	30,956	32,677	32,512

Georgia Department of Public Health

Georgia CAPUS Demonstration Project

J. Patrick O'Neal, MD, Director of Health Protection

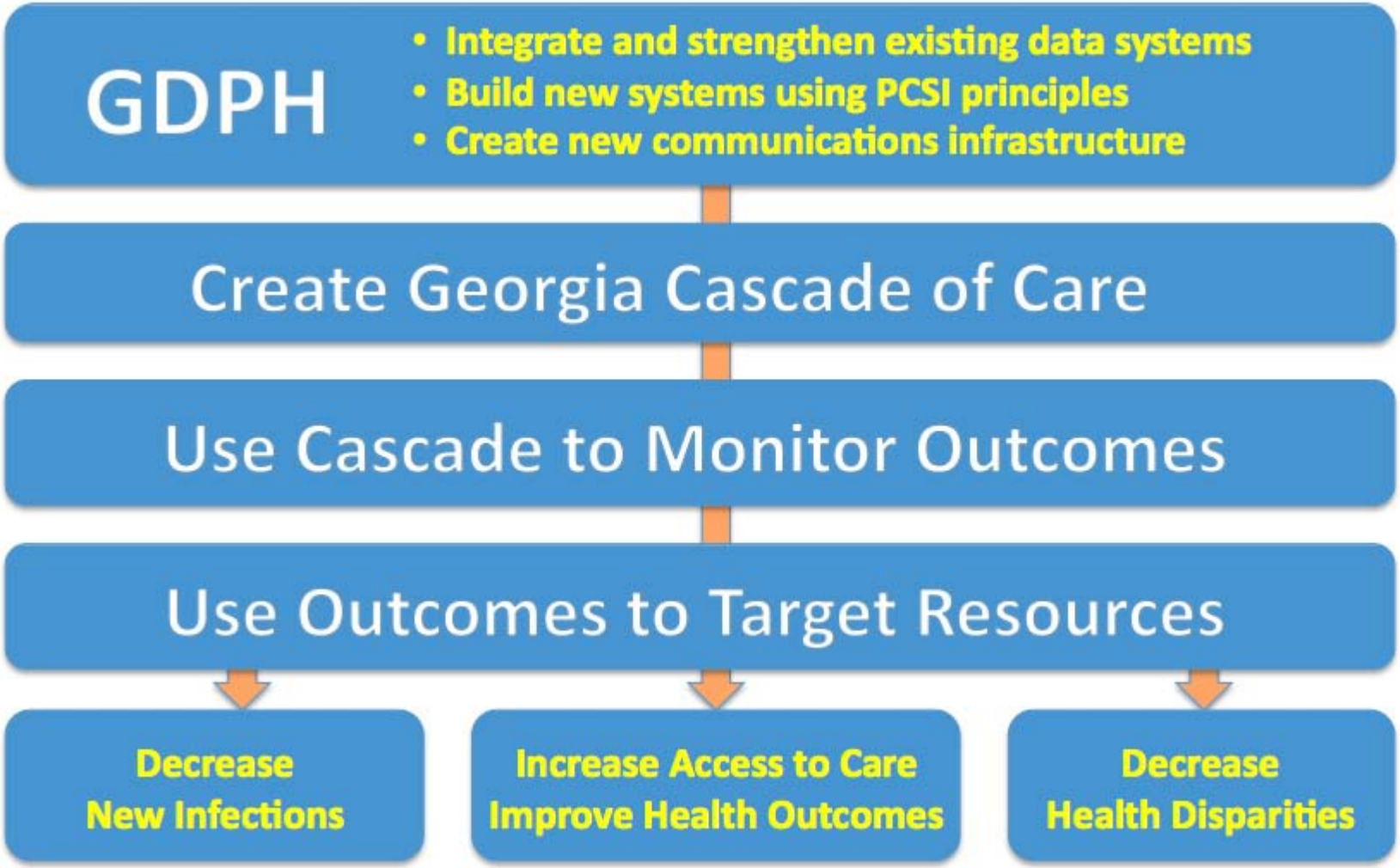
December 11, 2012

With Credit to

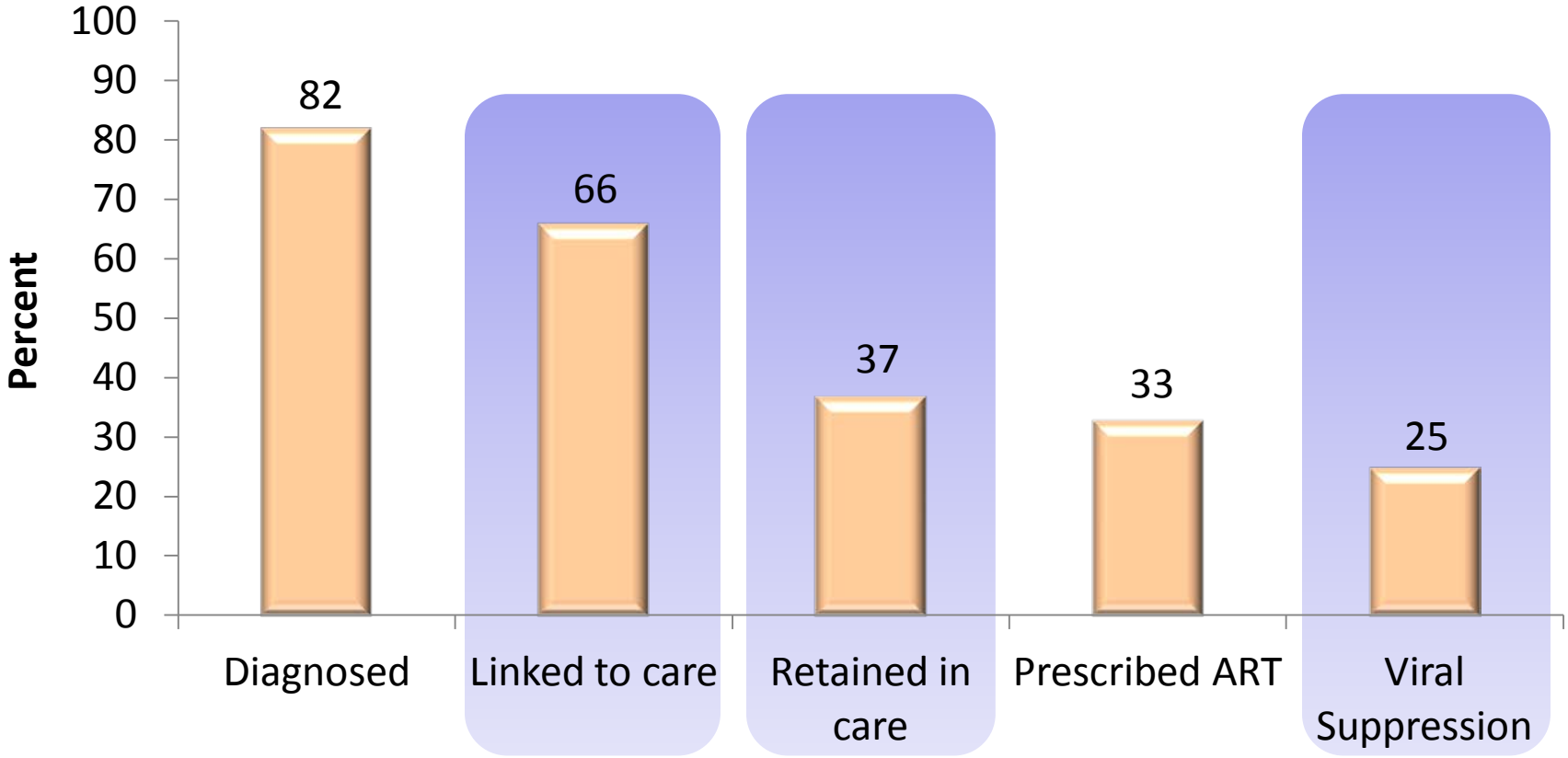
Drs. Jane Kelly, Melanie Thompson, and Pat Sweeney

We Protect Lives.

Georgia CAPUS Demonstration Project



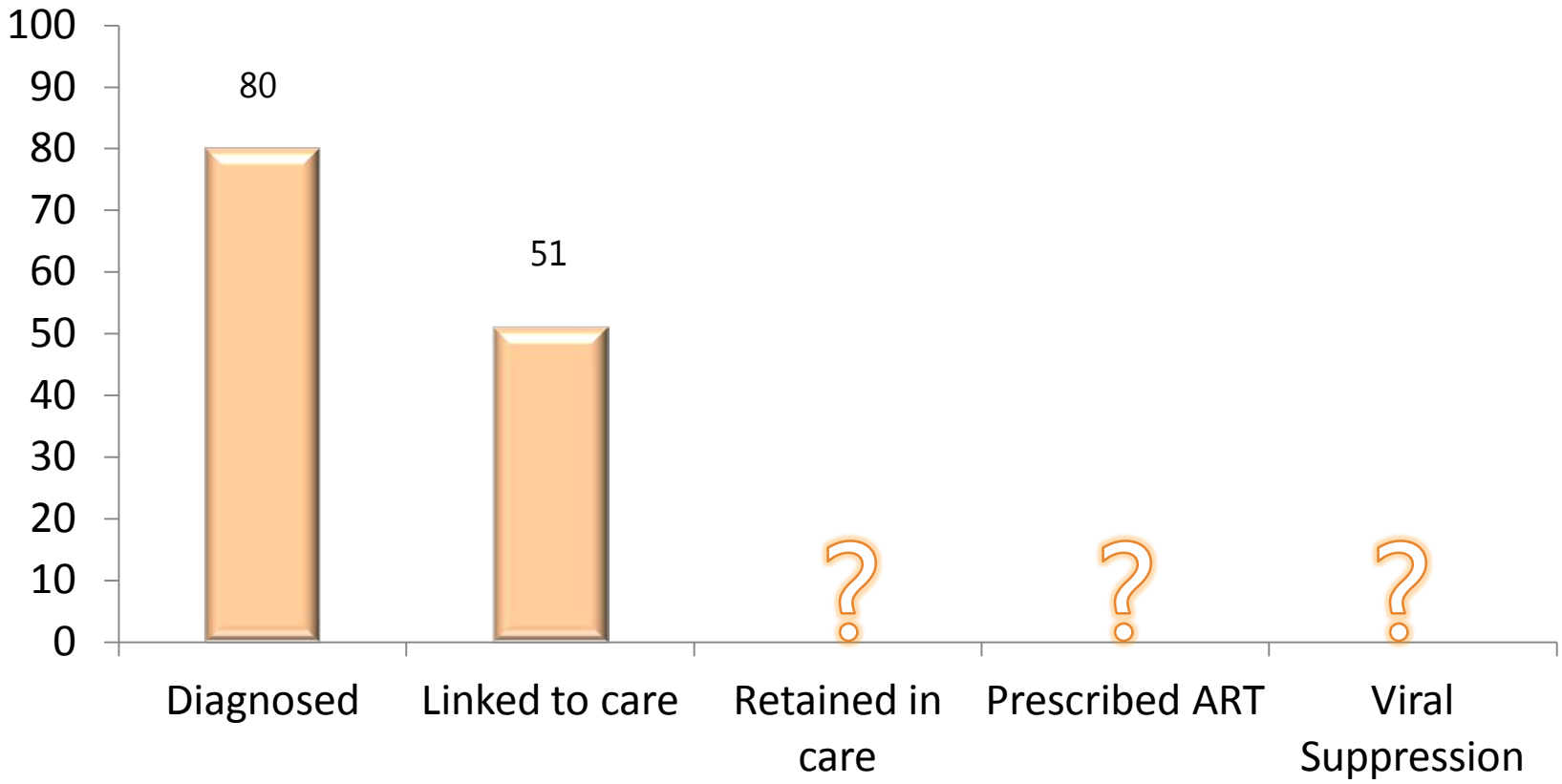
Persons with HIV Engaged in Selected Stages of the Continuum of Care, United States



Hall et al. XIX International AIDS Conference, 2012

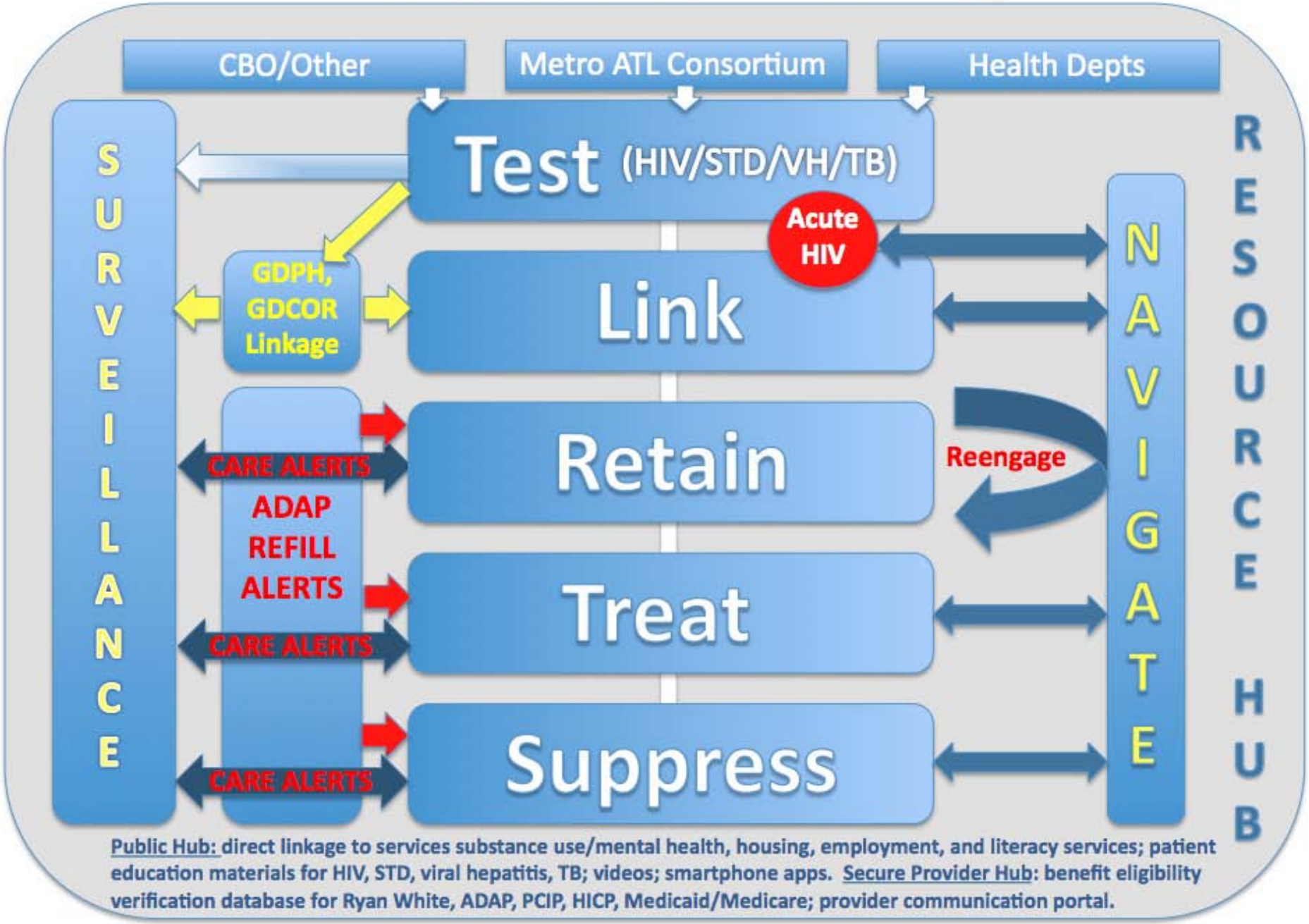
ART, antiretroviral therapy

HIV Care Cascade in Georgia, 2010



Diagnosed 1,970 with HIV infection
Estimated 2,375 individuals with HIV infection (1,970 + 20%)
Linked 1,026 (51%) to care within 3 months of HIV diagnosis

Care and Prevention in Georgia



HRSA HIV Health Information Exchange Project

- Three year grant to develop, implement and evaluate a Health Information Exchange (HIE) system to integrate GA HIV surveillance data with electronic health records (EHRs) of
  - Grady Health System (20-county metro Atlanta)
  - Fulton County Department of Health and Wellness,
  - St. Joseph's Mercy Care (FQHC)
- By month 24, expand to 3 additional health care providers
- Final evaluation by month 36

Chinese curse

"May you live in interesting times"

Questions?

Mapping Meeting

Dan Fesperman

Closing Comments

Gary Nelson, Ph.D.

Happy Holidays and New Year!

The next Board of Public Health meeting is on Tuesday, January 8, 2013 @ 1:00 PM.

To get added to the notification list for upcoming meetings, send an e-mail to rmshaw@dhr.state.ga.us

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