Maternal and Child Health Services
Title V Block Grant

State Narrative for Georgia

Application for 2014
Annual Report for 2012

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Georgia's assurances and certifications are available on file in the state's Title V agency, the Department of Public Health's Maternal and Child Health Program located on the 11th floor of 2 Peachtree Street, Atlanta, Georgia 30303. For further information, please contact the MCH Program Director's Office at 404/657-2851.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2013; expires January 31, 2015.
An attachment is included in this section. ID - Table of Contents

E. Public Input

The MCH Program has made a significant commitment to ensuring adequate and varied public comment opportunities. As part of Georgia's 2010 Needs Assessment process, efforts were made to ensure a mix of parents/consumers and health care providers in the community. Outreach efforts to the Hispanic population in Georgia communities were deployed, and as a result, several focus groups were conducted in Spanish. Additional focus groups were conducted to ensure involvement of MCH internal stakeholders in District Health Offices through the use of VICS, the two-way video-conferencing system operated by the Georgia Department of Community Health. A total of 182 Georgia citizens were engaged through 15 needs assessment community focus groups. A day-long focus group that included 45 non-governmental maternal and child health providers and advocacy groups from throughout Georgia provided an additional opportunity for public comment. The input received through these focus groups was used to identify a comprehensive list of needs in the MCH community in Georgia.

Following the focus groups, 55 needs were identified from which the top ten priority needs in Georgia were to be selected. Public input was sought in the selection of these needs. A web- based survey sent to all Division of Public Health employees was conducted to ensure that all staff had an opportunity to identify the needs they believed to be of greatest priority among the 55 needs identified previously. There were 311 responses from staff throughout Georgia. A meeting was held that included more than 50 participants representing advocacy groups, academia, local MCH staff, other HRSA grantees, and parents of children with special health care needs to evaluate each need on several dimensions. Participants were divided into several tables where they shared their individual expertise and discussed each need prior to each participant completing an individual assessment.

Following the selection of the top ten priority needs, the completion of the quantitative and qualitative data report, and the activity plan for FY11, these three documents were posted on a

dedicated web page where each docuemnt could be downloaded and/or reviewed for public comments submitted. All focus group participants who provided an email address, district health directors, advocacy groups, Georgia's AMCHP CSHCN family delegate, non-governmental agencies, and Division of Public Health program directors received an email from the Title V MCH Director with a link to the public comment web page and a request for their input and for them to forward the link as broadly as possible. The initial email was sent to more than 250 people throughout Georgia. The comment period lasted from June 10, 2010 through June 24, 2010. There were 537 unique page views. Forty-three comments were entered, of which nine were
from parents or family members of children with special health care needs. Overall, the comments were supportive and complementary of the FY11 activity plan, top priority needs, the detail and presentation of the assembled data, and the process for engaging partners and developing the documents. The comments also identified some key areas of concerns that, if addressed, could help to improve the health status of the MCH population throughout Georgia. All submitted comments are included in the attachment. Comments have been shared with leadership in the Division of Public Health and MCH Program.

Following the submission and review of the FY11 application, the final document will be posted on the MCH Program website (http://health.state.ga.us/programs/family), and one copy will be distributed to each public health district director, all MCH Program staff, and all Division of Public Health Leadership. The quantitative and qualitative data will be developed into a report on the state of women, infants, and children in Georgia with a formal release to MCH partners, stakeholders, and the media.

/2012/For the 2012 application, a draft of the entire application was posted on the Department of Public Health (DPH), Maternal and Child Health (MCH) webpage (http://health.state.ga.us/programs/family/index.asp) with the following message:

"Statewide MCH Partners,

Title V is initiating its annual comment period. On this page, you will find a draft copy of the FY2012 Title V Block Grant. We ask that you review this document and provide comments through the following link (Click here to take survey). We welcome comments not only on the actual document, but on any changes or comments you may have on the MCH Program and the operation of Title V. Your comments will help us improve our programs and ensure that we are moving in the best direction possible. The comment period will close on Tuesday, July 12, 2011. Thank you in advance for your assistance."

In addition to posting the documents to the webpage, e-mail messages were distributed to partners, advocates, parents, and consumers who have an existing relationship with the MCH Program or are on an existing list serv.

A SurveyMonkey link was created to accept comments. Thirty-six individuals accessed this link. Each respondent was asked to identify themselves. The characteristics of these 36 respondents is below. Note that each individual respondent could select multiple characteristics.

District staff - 2
Advocates - 20
State office staff - 4
Consumers - 12
Provider/Provider association staff - 25
University faculty - 5

Overall, comments were extremely positive. There was broad based support for the direction in which the Georgia MCH Program is progressing. This is the second grant application submitted by the new leadership in the Georgia MCH Program.

The full text of all comments received was included in an attachment.//2012//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2014/

a. Any changes in the population strengths and needs in the State priorities since the last Block Grant application.

Population strengths and needs of the state remain the same since the last Block Grant application, however, due to the economic downturn, more women and families have lost jobs and health insurance, thus relying on public services.

b. Any changes in the State MCH program or system capacity in those State priorities since the last Block Grant application.

Family Planning, Perinatal Health and Oral Health are now under new leadership and are incorporated within the Office of Family and Community Health. Family Planning and Perinatal Health have new directors and are operating via strategic work plans. Under Perinatal Health, 6 Regional Perinatal Centers (RPCs) have executed contracts and efforts have been made to integrate the 18 public health districts collaboratively with the RPCs. In terms of Family Planning, the federal scope of work has been aligned with the district scope of work. In addition, for 2015, a new funding allocations formula has been approved that will include specific weights to funding streams. Training plans have been developed and implemented to ensure a high quality workforce.

c. A brief description of any activities undertaken to operationalize the 5-Year Statewide Needs Assessment, such as: 1) ensuring that the State addresses the findings and recommendations resulting from the Needs Assessment, 2) monitoring the timelines of the action plans, 3) reporting by a designated person or group responsible for accountability, and 4) linking the Needs Assessment process back into State program planning.

The UNHSI program has incorporated the activities from the Block Grant into their work plan and the UNHSI Advisory Group meets quarterly to advise them on their implementation and progress on the work plan.

Key staff are designated as point persons on activities in the work plan to ensure the activities are being addressed, monitored, and reported quarterly.

d. A brief description of ongoing activities to gather information from the community and to evaluate implementation of the 5-Year Statewide Needs Assessment. Examples of these activities include: data collection and analysis, key informant interviews, public forums, establishing an advisory group, and surveys. It is important to gather input from general community members as well as providers and community leaders.

Consumer input is provided via comment cards regarding the quality of service received in the family planning program. In perinatal health an RPC Scope of Work advisory group was convened to review and update the Core Requirements and Recommended Guidelines for Perinatal Care in Georgia.

Through contract work with the Department of Early Care and Learning, the developmental screening work group has advised the staff and provided updates. Key informant interviews were conducted as well as focus groups on developmental and other screenings.//2014//

III. State Overview

A. Overview

ADMINISTRATIVE STRUCTURE AND FUNCTIONS

Georgia Title V

The purpose of Georgia Title V is to address the overall intent of the Maternal and Child Health Services Block Grant to improve the health of all mothers, women of childbearing age, infants, children, adolescents and children with special health care needs (CSHCN). The state of Georgia has responsibility to provide and assure access to quality MCH services for mothers and children; provide and promote family-centered, community-based, coordinated systems of care for CSHCN and their families; and facilitate the development of community-based systems of care for the MCH and CSHCN populations. The Georgia Title V Program is located within the MCHP.
/2014/The MCHP underwent a name change in July 2012 to MCH Section.//2014//

Georgia Maternal and Child Health Program

The Director of the MCHP also serves as the Title V MCH Services Block Grant MCH Director. In addition to the Georgia Title V Program, the MCHP includes the Georgia Family Planning Program (Title X and XX); Babies Can't Wait Program (Part C Early Intervention); newborn hearing and metabolic/genetic screening follow-up and referral; the Special Supplemental Program for Women, Infants, and Children; MCH epidemiology; Children 1st Program; Oral Health Program; Children's Medical Services (CMS); and other grant-funded and quality assurance work that includes the State Systems Development Initiative, Early Childhood Comprehensive Systems Grant, and the Health Check Program. Each of these programs is described in detail on the MCHP website (http://health.state.ga.us/programs/family/). Within the context of the MCHP, Georgia Title V is a driver for integration across programs, within and beyond the MCHP, and, with all Title V- associated performance measures either explicitly or implicitly required among all other MCHPs, the Title V application and annual activity plan serves as the cornerstone of MCHP strategic activities. The organizational structure and scope of the MCHP is undergoing review. Organizational and structural changes may be proposed to increase staff accountability, facilitate staff professional growth that supports the engagement of key stakeholders and partners, implement evidence-based programming, and deliver excellent customer service. /2012/The Office of Title V and Integration (OTVI) was established to ensure Georgia's Title V Block Grant activity plan is implemented and operated efficiently and is not duplicative.//2012//

/2012/ The Office of Title V and Integration (OTVI) has been established to ensure Georgia's Title V Block Grant activity plan is implemented throughout the state in accordance with our annual application and that funds, services, and programs are operated efficiently and are not
duplicative. Arianne Weldon, M.P.H. serves as the MCH Title V Administrator and Director of the Office. //2012//

/2013/Renamed the Office of MCH Integration (MCHI) in 2012, MCHI works with internal and external MCH partners. The Office provides support through coordination, planning, research, evaluation and sustainability of programs and population-based strategies.
//2013//

/2014/The Office of MCH Integration (formerly the Office of Title V and Integration – OTVI) was eliminated July 1, 2012.
The Special Supplemental Program for Women, Infants, and Children is no longer part of the MCHS as of December 1, 2012.
The Health Check Outreach and Monitoring Program was discontinued at the State office as of January 1, 2013.

The Perinatal Health Program and Infant Mortality Strategic Plan were instituted July 1, 2012.//2014//

In March 2010, the MCHP (MCHP) implemented new mission and vision statements. Mission Statement: To

implement measurable and accountable services and programs to
improve the health of women, infants, children, fathers, and families throughout Georgia.

Vision Statement: Through the implementation of evidence-based strategies, maximization of resources through integration and collaboration, and the use of program and surveillance data, identify and deliver public health information, population-based interventions, and direct services that have an impact on the health status of women, infants, children, fathers, and families throughout Georgia.

The primary change from previous mission and vision statements and the primary driver for the development of these new statements was to increase the focus on measurement and accountability. Integral to the success of the MCHP is the implementation of a data to action culture founded on strong measurement and accountability principles. The MCHP is committed to creating synergy between research and practice by advancing data-driven decision making and strategic planning through the collection, analysis, and interpretation of state and national data to identify trends and challenges that can be addressed through identified best practices or innovative practice solutions. This data to action approach drives all MCHP including Georgia
Title V.

The MCHP mission and vision statements are supported by five programmatic goals.

Goal 1: Ensure compliance and operational excellence for all federally and state funded activities. Ensuring

compliance and operational excellence will be achieved through the timely submission
of all required products; development and implementation of a quarterly performance measure
process track and react to program developments; conducting a review of current MCHP organizational structure and making necessary changes; and ensuring programmatic accountability. Achieving success for Goal 1 also requires the development of annual activity plans that are integrated across programs that have clear expected outcomes and are monitored routinely for progress.

Goal 2: Increase the evidence-base for decision making through improved data collection at the state, district, and county level.

Increasing the evidence-base is directly related to increasing the surveillance, evaluation, and MCH epidemiology capacity of the MCHP. This coincides with infrastructure building activities in the Title V Services Pyramid. For Goal 2, evidence-base is broadly understood to mean implementing best practices, appropriate and thorough programmatic data collection, expanded surveillance, supported MCH research that can inform program development, and the distribution of research and data findings in a manner that is easily consumable by all stakeholders and partners.

Goal 3: Increase population-based services and infrastructure building.

The MCHP will work to identify training needs that, if addressed, would benefit the entire MCH community. Increased public health media messages are of immediate interest in response to Goal 3.

Goal 4: Ensure improved integration within and between the Maternal and Child Health Program and other Division of Public Health (DPH) Programs.

Ensuring improved collaboration and integration within the MCHP and between programs within the Division of Public Health is necessary to accomplish MCHP objectives, ensure efficient and effective program operation, and maximize the resources and benefits available to Georgia's women, infants, children, youth, fathers, and families. The MCHP must work with its internal partners to ensure that client contacts are leveraged to achieve the programmatic objectives of all applicable programs. Several activities planned for the national and state performance measures in FY11 support this goal.

Goal 5: Provide statewide leadership in the MCH community.

Providing state leadership in the MCH community as well as engaging family partners in all

aspects of decision-making will help provide vision and direction for collaborative projects between MCHP and other programs and the MCH community. The MCHP made significant progress in reaching this goal while developing its response to this application. In preparing for the FY11 application, the MCHP made documents available prior to the completion of the application for comment and edits; conducted sixteen focus groups to gather information from consumers, stakeholders, advocates, and partners; and engaged consumers, stakeholders,
advocates, and partners in the selection of the state's priority needs. At all opportunities for public input and participation, enhanced efforts were made to ensure the involvement of families with children with special healthcare needs. While much of this activity was driven by the development of the needs assessment, it is the responsibility of the MCHP to ensure that there are opportunities for public, stakeholder, and advocate comment, input, and involvement in the
annual Title V application process and the operation of all MCHPs.

Division of Public Health (DPH)

The DPH includes the MCHP and six other programs. Health Promotion

and Disease Prevention
Epidemiology
State Laboratory
Immunization and Infectious Disease
Environmental Health
Vital Records

Each of these programs works with the MCHP to accomplish joint goals and enhance the health of MCH populations throughout Georgia. A brief description of each program follows.

The mission of the Health Promotion Disease Prevention (HPDP) Program is to encourage Georgians to improve the quality of their lives by achieving healthy lifestyles, creating healthful environments, and preventing chronic disease, disability, and premature death. The HPDP Program includes Asthma Control Program, Adolescent Health and Youth Development Program, Comprehensive Cancer Control Program, Breast and Cervical Cancer Program, Tobacco Use Prevention Program, Rape Prevention and Education Program, the Nutrition and Physical Activity Initiative, and several others. A complete listing of the all programs within the HPDP Program can be found at http://health.state.ga.us/programs/chronic/index.asp. The HPDP Program
collaborates with the MCHP to address National Performance Measures 8 and 15 and State
Performance Measure 1.

The Epidemiology Program is responsible for acute disease, chronic disease, injury, and environmental epidemiology. The Epidemiology Program is responsible for the administration of the Georgia Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System. The Office of Health Indicators for Planning is located within the Epidemiology Program and provides access to several data sets that include MCH indicators through the Online Analytical Statistical Information System (OASIS). OASIS is used to query data sets and population projections needed to report on measures required as part of the Title V MCH Services Block Grant application.

The mission of the State Laboratory Program is to improve the health status of Georgians by providing accurate, timely and confidential clinical and non-clinical laboratory testing in support of Division of Public Health programs, activities, and initiatives as well as performing tests for Emergency Preparedness. The State Laboratory processes all state mandated newborn metabolic/genetic screening tests. The State Laboratory works closely with the MCHP to complete Form 6 and address National Performance Measure 1.

Through collaboration with public and private providers, advocacy groups, and other stakeholders, the mission of the Infectious Disease and Immunization (IDI) Program is to work to

increase immunization rates for all Georgians and decrease the incidence of vaccine-preventable diseases. Vaccine-preventable disease levels are at or near record lows. Even though most infants and toddlers have received all recommended vaccines by age 2, many under-immunized children remain, leaving the potential for outbreaks of

disease. Many adolescents and adults are under-immunized as well, missing opportunities to protect themselves against diseases such as Hepatitis B, influenza, and pneumococcal disease. Strong collaboration is needed with IDI Program to address National Performance Measure 7.

The mission of the Environmental Health Program is to provide primary prevention through a combination of surveillance, education, enforcement, and assessment programs designed to identify, prevent and abate the environmental conditions that adversely impact human health.

The mission of the State Office of Vital Records is to provide accurate records and data concerning vital events to Georgians and other stakeholders in an expeditious and friendly manner. Many of the reportable measures required as part of the Title V MCH Services Block Grant application could not be reported without the data provided by the State Office of Vital Records.

Department of Community Health (DCH)

DPH is located in the Department of Community Health (DCH). /2012/On July 1, 2011, Public Health will become an independent agency.//2012// The mission of DCH is:

• Access to affordable, quality health care in our communities
• Responsible health planning and use of health care resources
• Healthy behaviors and improved health outcomes

/2013/ The Department of Public Health (DPH) was established on July 1, 2012. DPH's mission is to promote and protect the health of people in Georgia wherever they live, work, and play. We unite with individuals, families, and communities to improve their health and enhance their quality of life. The new DPH Commissioner, Brenda Fitzgerald, MD, has ten members on her executive team overseeing the following areas:
* Health Protection, including Emergency Preparedness, Epidemiology, Environmental Health, Infectious Disease and Immunization and EMS.
* District and County Operations overseeing Nursing and Pharmacy at the district level.
* Health Promotion which includes Maternal and Child Health, Health Promotion and Disease Prevention, Volunteer Health Care Program, and the Office of Health Equity.
* The Chief Financial Officer overseeing financial services, grants management and the DPH budget.
* The Office of the Inspector General which leads audits, investigations and contract compliance.
* The General Counsel Office which includes Contract and Programs attorneys, Risk Management and the IRB process.
* The Chief Information Officer overseeing Vital Records, Information Security, Project Management, Applications Development and Support and Enterprise Services.
* Communications which includes health, media, digital, internal and risk communications.
* Chief Operating Officer overseeing Facilities and Support Services, Human Resources, the Public Health Laboratory, Contracts Administration and Procurement Services.//2013//

The vision of DCH is to be a results-oriented, innovative, and productive state agency that seeks to address the health care needs of all Georgians by serving as a national leader in the areas of health planning, health promotion, and health care quality by the year 2011. The DCH mission and vision statements are consistent with the Georgia Title V Program. In addition to the Division of Public Health, DCH includes nine divisions and six offices. A brief description of each follows. Emergency Preparedness and Response Division works to ensure a safe and healthy environment for all Georgians. The Emergency Preparedness and Response Division includes the Injury Prevention Program. The mission of the Injury Prevention Program is to prevent injuries by empowering state and local coalitions through the provision of data, training, and leadership, and the leveraging of resources for prevention programs. The Injury Prevention Program is responsible for the Child Occupant Safety Interventions and Education Program and Residential Fire Prevention Program. Through collaboration with the MCHP, the Injury Prevention Program works to address National Performance Measures 10 and 16 and State Performance Measures 2 and 4./2012/ The Injury Prevention Program is now located in the MCHP.//2012//

The Division of Financial Management represents the financial interests of the Department. It is comprised of the

Office of Planning and Fiscal Analyses, Financial and Accounting Services, Reimbursement Services and the Budget Office.

The General Counsel Division provides overall guidance and direction for the operations of the Division; drafts and reviews procurement documents; provides legal services for all aspects of the State Health Benefit Plans; develops policies and procedures for compliance with federal and state privacy and public records requirements; drafts rules, regulations and policies for consideration by the Board of Community Health; and provides staff support for the Health Planning Review Board. Also contains the Certificate of Need Section and Division of Health Planning.

Healthcare Facility Regulation is responsible for protecting the residents of Georgia by ensuring the highest quality of health care and safety through professional standards regulation.

Information Technology is responsible for promoting project management standards throughout DCH. The Medicaid Management Information System (MMIS) unit supports the various systems used for the processing, collecting, analyzing and reporting of information needed to support all Medicaid and PeachCare for Kids claim payment functions

The Office of Inspector General is responsible for DCH's efforts to detect, prevent and investigate fraud and abuse in Medicaid, PeachCare for Kids™ and the State Health Benefit Plan.

The Division of Medical Assistance Plans administers the Medicaid program, which provides health care for children, pregnant women, and people who are aging, blind and disabled.

The Operations Division consists of the Office of Vendor and Grant Management, Human Resources, Support Services, the Office of Health Policy and Strategy, and the Department's five Health Improvement Programs, which are the Office of Minority Health, the Office of Women's Health, the Georgia Commission on Men's Health, the Georgia Volunteers in Health Care program and the State Office of Rural Health.

The State Health Benefit Plan (SHBP) provides health insurance coverage to state employees, school system employees, retirees and their dependents. The Georgia Department of Community Health's Public Employee Health Benefits Division is responsible for day-to-day operations.

SOCIODEMOGRAPHIC FACTORS IN GEORGIA

The success of the state's and the Title V Program's efforts to craft and implement a strategic direction depends on an ability to predict, understand, and develop strategies around factors that impact the health and well-being of women and children in the context of their communities. The following information provides an overview of some of the characteristics of Georgia that potentially may have the most significant impacts on the maternal and child health populations.

Geography and Urbanization

Georgia's land mass (59,425 square miles) makes it the largest state east of the Mississippi River and the 24th largest in the United States (U.S.). Since 1990, Georgia's population has increased over 50%, moving it from the 11th to the 9th largest state in the nation. The state's growth comes from a combination of natural increase (i.e., births versus deaths) and domestic and international migration. The explosive increase experienced by the "Sunbelt" states, including Georgia,
through most of this decade, slowed dramatically with the onset of the economic recession beginning in late 2007. Nevertheless, from July 2000 to July 2009, the state's population increased by 1.6 million, reaching a total population of 9,829,211. While the rate of population growth has slowed, Georgia has remained among the fastest growing states in the nation, exceeded only by Texas, California, and North Carolina. Georgia was 4th largest in terms of new residents and 9th largest in terms of percent gain. The result of this fundamental shift in Georgia's population has changed the state from a largely rural area with urban clusters to an urban state with rural areas. /2012/The 2010 U.S. Census showed that Georgia's population has grown
18.3% over the last decade, increasing to 9,687,653 people. The state had the 7th largest percentage of growth among all states and gained one new seat in the U.S. House of Representatives. //2012//
/2014The 2012 population estimate for Georgia is 9,919,945, a 3% increase from the 2010 census

population.//2014//

Population

While population is a significant consideration in service and delivery planning, the political framework is also an important factor. With 159 counties, Georgia has the second highest number of any state. Four of these counties, all in the Atlanta MSA, have populations in excess of 700,000 (Fulton, Cobb, DeKalb and Gwinnett) with no other county in the state exceeding a population of 276,000. In addition to these four, there are 18 counties having populations of over 100,000, with 10 of these 18 counties located in the Atlanta MSA. The remaining 137 counties have fewer than 100,000 population with 87 of them having populations of less than 25,000 and 30 counties with a population of fewer than 10,000. /2012/ Approximately 54% of all Georgia residents live in metro Atlanta. The region, which accounted for almost two-thirds of the state's growth over the past decade, has a population of nearly 5.3 million and ranks as the 9th largest metro area in the country.//2012// /2013/ 2010 census data suggest there has been a slowdown in the growth in the state's "exurban" counties on the fringe of big cities, with Georgians moving to core counties and inner cities at an increasing rate. Growth in Fulton and DeKalb Counties outpaced Gwinnett and Cobb in 2011 by 26%, a significant reversal of the prior decade's growth patterns. //2013//

Census data highlight the exceptional growth and increasing diversity of Georgia. Adding to the already large number of Blacks residing in Georgia has been a steady stream of Black people moving to the state. Georgia ranks 3rd nationally, behind New York and Florida, in the number of Black people (2,864,431) and 3rd in the percentage of Black people (30.1%) in the overall population of the state, trailing Mississippi and Louisiana. /2012/Atlanta has replaced Chicago as the metro area with the 2nd largest number of Blacks in the country.//2012//

Reflecting national trends, the number of Asian people and Hispanic people in Georgia have shown dramatic increases, which are projected to continue. Hispanic people, primarily Mexican people, are the most rapidly growing minority group (729,604) and now reside throughout Georgia. This growth impacts the provision of government and health, education, and human services in the state. Of individuals five years of age or older living in Georgia in 2006 through 2008, 12% spoke a language other than English at home. /2012/ 2010 census data show that Georgia's Hispanic population has increased 96.1% over the last decade, growing from 435,337 people who identified themselves as Hispanic in 2000 to 865,689 (8.8% of all Georgians) in 2010.//2012//

/2014/Hispanics make up approximately 9% of Georgia's population, while African-Americans account for 31% of the population. Georgia is now one of 13 states with minority groups accounting for roughly 40% of the population.//2014//

According to the US Census Bureau, Georgia's population continues to be younger compared to the U.S. as a whole, ranking 5th in terms of the percentage with the largest population under 18 years old. In 2008, of the state's population, 740,521 (29.2%) were under the age of five years, with another 2,075,140 million children school-age (five through nineteen years of age). In 2008, women accounted for 50.8% of Georgia's residents. Of all women in Georgia, 42.0% are considered to be of childbearing age (15 to 44 years of age). Annually, there are approximately 150,000 resident births in Georgia. Of all children 17 years of age and younger in Georgia, 352,567 (13.9%) have special health care needs. /2012/ According to U.S. Census 2009 population estimates, children under five years of age account for 7.6% of the state's population compared to 6.9% nationally. Children and youth under 18 years of age make up 26.3% of Georgia population compared to 24.3% for the U.S. //2012// /2013// More than 1.6 million children are educated through Georgia's K-13 public school system. Under a new federally mandated formula, the state's graduation rate was reset from 80% to 67.4%, with nearly a third of Georgia students failing to finish high school in four years.//2013

Poverty

Georgia's per capita income has been lower than the national average since 1997. However, the lower per capita

income, a measure of well-being, has been offset until recently by the state's cost of living which has remained relatively low, enabling Georgia residents to do more with the income they do earn. Reflecting the economic downturn, the state's per capita personal income decreased from $34,612 in 2008 to $33,786 in 2009, which ranks 39th among all states. /2012/ Georgia's 2010 per capita personal income was $35,490 (87.4% of the national average of $40,584), ranking 37th among all states.//2012//
/2014/Approximately 16% of Georgia residents live in poverty. Georgia's 2012 per capita personal income was $36,869 (86.4% of the national average of $42,693), ranking 40th among all states.//2014//

According to the National Center for Children in Poverty (NCCP), of Georgia's 1,402,694 families, with 2,484,182 children, 42% of these children lived in low-income (income below twice the FPL) families in 2008. In particular, young children (birth to age five) are likely to live in low-income families. Twenty-six (26%) of Georgia's young children (birth to age five) live in a low-income family with income less than 100% of FPL, 22% live in families with incomes 100-200% of FPL, and 52% live above low income in 2008. Fifty-eight percent (58%) of the young children in low-income families lived with a single parent. Children living in minority families and children of foreign-born parents have a greater chance of living in a low-income family. Thirty percent (30% of young white children lived in a low- income family in 2008 compared to 64% of young black children and 71% of young Hispanic children. /2012/According to NCCP estimates, there were 1,283,185 families in Georgia with 2,535,780 children in 2009. Forty-five percent of these children lived in low- income families.//2012// /2013/In 2010, Georgia's poverty rate was the 3rd highest in the U.S. compared to 5th in 2009. Approximately 1.8 million Georgia residents are poor. The state's high poverty rate is reflected in the number of people requesting food stamps, which has increased every year since 2007. In 2010, more than 590,000 households (1.4 million people)received food stamps, up from 497,000 in 2009.//2013//
/2014/According to the National Center for Children in Poverty, in 2011, 1,259,217 Georgia families with 2,410,753 children, lived in poverty. Forty seven percent (47%) of children in Georgia live in low-income families (national average is 45%). Minority children have a greater chance of living in low-income families with 62% of black children and 72% of Hispanic children living in low-income families compared to 32% of white children. Fifty two percent (52%) of children under age 6 live in low-income families.//2014//

Despite noted success in enrolling children into Georgia's Medicaid and PeachCare for Kids (State Child Health Insurance Program) programs, 282,247 (10.9%) children are uninsured in Georgia. The vast majority of these children (86.2%) come from families where at least one parent works and over half (55.4%) live in two-parent households. Almost three-quarters of the
uninsured children live in families with low or moderate incomes, less than $40,000 for a family of four, an income within the current Medicaid and PeachCare eligibility range. /2012/ The Commonwealth Fund's 2011 Child Health Scorecard ranked Georgia 42nd in the percent of children age birth to 18 years who are insured and 2nd in the percent of insured children whose health insurance coverage is adequate to meet the child's needs.//2012// /2013/ Georgia ranked
8th in the nation in 2010 in number of uninsured residents (19.4% or about 1.9 million Georgians).//2013//
/2014/In 2011, 20% of Georgians were uninsured (1.87 million). Of children 0-18, 11% were uninsured.//2014//

Georgia continues to experience declining employment. In March 2010, Georgia had 3,807,500 jobs, down 3% (116,000 jobs) from March 2009. The state's March 2010 unemployment rate was a record 10.6%. Reflecting the high unemployment rate, Georgia has the 7th highest foreclosure rate. Despite the continued rise in the state's unemployment rate, there are signs of improvement. The pace of new layoffs is slowing significantly, first-time claims for unemployment insurancedecreased 28% from a year earlier; and modest job growth has been seen over two consecutive months (February and March 2010), suggesting that the worst of the recession may be over and the state's fledgling recovery may be gaining traction. /2012/ Georgia's unemployment rate has decreased from 10.6% in March 2010 to 9.9% in April 2011. The state rate remains higher than the national rate (9.0% in April 2011) with some unemployed/underemployed parents no longer able to afford child care, contributing to the loss of 1,395 child care programs in Georgia since March 2010. A 2011 child care survey also found an increased number of children are coming to their child care program hungry. The state's economy is forecasted to show modest improvement in 2011. By 2012, the state should see a boost in employment with new 51,800 jobs.//2012//

/2013/ Georgia continues to experience high foreclosure rates. In January 2012, the state had the 4th highest rate of foreclosure filings in the country. However, in a sign that the state's economy is slowly improving, Georgia collected almost 5% more in taxes and fees in March 2012 and income tax collections were up 8.6% from the same time the previous years. The unemployment rate peaked at 10.5% in October 2009, but has fallen recently to 8.9%, higher than the national rate of 8.1%.//2013//
/2014/The Georgia unemployment rate is 8.3%, higher than the national rate of 7.6%.//2014//

GEORGIA'S HEALTH CARE SYSTEM

Georgia's health system consists of five interconnected components: private providers, hospitals, community health clinics, regional behavioral health and developmental disabilities services, and the state's public health system which has two separate elements, the Medicaid/PeachCare payment system and county public health services. Service delivery in the state's public health system is carried out by 159 county boards of health. These boards of health are combined into 18 district units, ranging from one to 16 counties in size, and are administratively overseen by a district office that provides management services and programmatic support. The county boards of health provide direct health care services, environmental health activities, and work with community partners in their county around issues of common concern. /2013/ Twenty-one cents of every dollar spent on programs funded through taxes and fees was allocated to health care in FY 2012. Public Health received $191,626,675, 1.2% of the FY 2012 General Funds Budget. DCH, the state Medicaid agency, received $2,352,643,655 (14.4%).//2013//

Private Providers

The Georgia Department of Labor (DOL) employment projections to 2012 indicate that healthcare and social assistance employment is expected to grow the fastest of all industry sectors in the state, with an annual rate of 3.2% and the addition of more than 125,000 new jobs. Eight of the 20 fastest growing occupations are in the health services industry. DOL projects a growth rate of 5.4% for medical assistants, 5.1% for dental hygienists, 4.9% in dental assistants, 4.8% in physician assistants and in medical records and health information technicians, 4.3% in home health aides, 4.1% respiratory therapists, and 3.6% in surgical technologists. Registered nurses (RN), the largest of all healthcare occupations is the occupation with the second most expected job growth, with a projection of 19,880 newly created RN positions.

Georgia faces challenges in meeting the demand for healthcare occupations. The Georgia Board for Physician Workforce, the state agency responsible for advising the Governor and General Assembly on physician workforce and medical policy and issues concluded in 2006 that growth in medical specialties was minimal or negative; there were substantial problems in geographic distribution of primary care physicians, pediatricians, and obstetricians/gynecologists; and the state will require new physicians just to maintain current capacity.

A 2007 State Senate Study Committee report on the shortage of doctors and nurses in Georgia also concluded that the state is facing a severe shortage of physicians and nurses. Data gathered by the American Medical Association (AMA) supports this conclusion. The AMA found that Georgia ranked 40th in the nation in per capita number of practicing physicians and 42nd in its per capita supply of registered nurses. Georgia ranks 34th in the number of medical students per capita and 37th in medical residents per 100,000 population. /2012/ Georgia ranked 40th (38th in 2009) in the U.S. in the United Healthcare's 2010 American Health Rankings for number of primary care physicians per 100,000.//2012// /2013/Georgia has 207 active physicians per 100,000 citizens, 20% below the national rate of 258.7. The Georgia Board for Physician Workforce groups the state's 159 counties into 96 Primary Care Service Areas (PCSAs). Fifty-two percent of the state's physicians are located in five of the 96 PCSAs, which account for 38.1% of Georgia's population. In 2008, 22 PCSAs did not have a pediatric provider; 3 were deficient in family medicine, 33 in internal medicine, 53 in pediatrics, 40 in OB/GYN and 25 in general surgery. Between 2000 and 2008, the number of dentists per capita in Georgia decreased by 17.9%. The state has one school of dentistry that graduates fewer than 60 dentists a year. //2013//

The Senate Committee also recommended that medical school enrollment in Georgia be increased. A 2008 medical education study on behalf of the University System of Georgia of the Georgia Board of Regents is serving as a road map for statewide expansion of Georgia's public medical education system. A partnership is being developed between the Medical College of Georgia (MCG), the state's only public university devoted exclusively to health sciences, and the University of Georgia (UGA), the leading public research university. With full implementation of the plan, through its partnership with UGA, MCG School of Medicine could expand from its current level of 745 students to 1,200 by 2020, an increase of approximately 60% in medical students.

As of July 2009, there were 101,762 registered nurses (RNs) licensed in Georgia; however, not all of these RNs were practicing full-time. Some were retired, but maintained their licensure; others were working only part-time as a nurse or were employed in a nearby state. Several federal labor sources suggest that only approximately 65,000 of the nurses licensed in Georgia in
2009 were working full-time. Georgia consistently ranks in the bottom ten states in terms of the number of RNs per population (670/100,000 in 2008).

Despite the recession, nursing employment rates have remained relatively steady in Georgia and the U.S. as a whole, and there are still more jobs than there are nurses. A shortfall of an estimated 16,400 registered nurses in Georgia in 2010 is expected to grow to 37,700 by 2020. One impact in Georgia's economic downturn has been an increase in the number of former part- time nurses who are returning to the workforce as full-time workers, as well older nurses who are delaying plans to retire. This has expanded the pool of experienced nurses in the workforce.
/2012/ Although the state's nursing work force shortage has improved, it is anticipated that with the state's improving economy the shortage of nurses may begin to increase. Currently about
106,000 registered nurses hold licenses in Georgia, but only about 65,000 are estimated to be working in the state. A shortage of 26,300 nurses in Georgia is projected by 2015.//2012//

In response to the Senate Committee recommendation to increase nursing school enrollment, the state University System, Technical College System, and private institutions have been working to address the state's shortage of RNs. In 2008, the University System and Technical College System graduated 2,231 new pre-licensure nurses, approximately 1,000 more graduates than in
2002. This gain reflects an increase in the number of nursing programs operated by the Technical College System. In addition, approximately 300 RNs graduated from private nursing institutions as part of the 2007-2009 academic year.

Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs): Health Professional

Shortage Areas (HPSAs) are designated by the federal Health Resources
and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). Medically Underserved Areas/Populations are areas or populations

designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population. Georgia has 125 Mental Health Professional Shortage Areas (MPHSAs), 136 Primary Health Professional Shortage Areas (HPSAs), and 94 Dental Health Professional Shortage Areas.

Georgia Statewide Area Health Education Center (AHEC) Network: The Georgia Statewide AHEC Network is a partnership between the Medical College of Georgia and Mercer University School of Medicine. The Statewide AHEC Network has represented a growing partnership of health providers, health professions, educators, state agencies, and communities joined together to respond to the problems of health professional supply and distribution in rural and underserved areas of the state.

The state's six AHECs work with secondary youth, college and technical college students, displaced workers, older adults, and second career seekers. Programs include general health careers recruitment presentations, health career fairs, and a wide range of video, manual and classroom resources. In addition, intensive programs include health career camps and clubs, as well as academies designed for middle and high school math and science teachers. In 2009, the AHEC network served 48,562 health careers participants and over 150,662 participated between
2007 and 2009. Only 11 of the state's 159 counties did not have an AHEC sponsored health careers recruitment

or education program.

The AHEC Network also provides assistance and support for health professions students completing community-based clinical training, including identification and credentialing of training sites, faculty development of community-based preceptors, providing student orientation to the community, providing student travel, and/or housing support during rotations, and conducting site visits. Over 11,160 health professions completed community-based clinical rotations supported by one of the six regional AHEC centers between 2007 and 2009, including 3,893 in 2009. The 11,160 health professionals included 3,035 physicians, 1,601 physician assistants, 656 nurse practitioners, 1,706 nurses, and 4,169 "other."

The Statewide AHEC Network also works to retain health care providers in the workforce. Professional isolation in rural areas of the state is addressed by connecting community-based providers to academic institutions as well as providing relevant and accessible continuing education opportunities for all levels of providers. Between 2007 and 2009, 32,882 AHEC participants completed AHEC sponsored continuing education courses. Participants came from all 159 Georgia counties with 9,071 completing continuing education courses in 2009. /2012/ In FY 2010, the Georgia Statewide AHEC Network provided health careers, clinical training, continuing education or learning resources to 23,547 minority students, residents, trainees, or practicing health professionals. Over 2,600 health professions students and residents were placed in 3,704 rotations in clinical training sites. The Network provided 36,232 youth with health care opportunities.//2012// /2013/ In 2011, the Statewide AHEC Network made health career presentations to 27,778 students, 60+% of whom were minority students.//2013//

Hospital System

There are approximately 200 hospitals in Georgia, including 149 acute care facilities. There is at least one hospital located in 111 of the state's 159 counties. According to a 2008 American Hospital Association survey, the state's hospitals employed more than 138,000 persons; delivered 142,000 babies yearly; provided 959,000 inpatient admissions, 3.8 million emergency room visits, and 10.3 million other outpatient visits; and had an average daily census totaling almost 17,000.

Trauma Centers: One critical aspect of the hospital-based delivery system is the availability of trauma and emergency care. Georgia, which does not have a statewide trauma system, has 15 Trauma Centers. The state's Trauma Centers are ranked as Levels 1, 2, 3, or 4. A Level 1 Trauma Center is the most comprehensive and has a full spectrum of capacity with surgical subspecialties and a clinical research programs. Most of Georgia's Level 1 Trauma Centers are academic facilities. Like a Level 1, a Level 2 Trauma Center has a full spectrum of capacity with surgical subspecialties, but is not required to have a clinical research program. A Level 3 Trauma Center is a community hospital with general surgical, orthopedic, and anesthetic capacity, but without a full spectrum of surgical subspecialty capacity. A Level 4 Trauma Center is generally a small facility which has the capacity to evaluate, stabilize, and transfer major trauma patients to other facilities for more definite care. All of the state's Trauma Centers function within a complex system that includes pre-hospital care and transport, definitive surgical or critical care, rehabilitation, and injury prevention. In addition, all levels of Trauma Centers participate in the state's trauma data registry.

The trauma facilities are primarily clustered around metro Atlanta, Augusta, Columbus, Macon, and Savannah, leaving huge gaps in the state for persons requiring timely, quality trauma care. Another issue affecting trauma care is the lack of direct dial 911 in 21 counties in south and middle Georgia, areas traversed by I-75, I-20, I-16, and I-95. The lack of facilities and the ability to rapidly get trauma patients to quality definitive care during the initial "golden hour" negatively impacts patient survival and outcomes.

Critical Care Access Hospitals: Sixty-seven rural hospitals are eligible for Critical Care Access designation; 34 hospitals are currently designated. This federal program raises Medicare reimbursement rates for eligible facilities and provides cost-based reimbursement from Medicaid and the Georgia State Health Benefit Plan for outpatient services in return for agreeing not to: 1) operate any more than 25 beds, 2) team with a larger facility to deliver inpatient care, and 3) limit inpatient care provided to an average of no more than 96 hours.

Tertiary Hospitals: Six designated regional tertiary hospitals provide a system of high-risk maternal and infant care services including transportation, prenatal care, delivery, post-partum care, and newborn care. These tertiary

hospitals, located in Atlanta, Macon, Augusta, Columbus, Albany, and Savannah, also provide outreach and education to area providers to ensure a seamless community-based system. All women and infants who are high-risk are accepted for services at the six regional tertiary hospitals without regard to income. Women and infants who meet program medical criteria (high-risk) and whose incomes are below 250% of the FPL are eligible to receive services.

Impact of the economic downturn on Georgia's hospitals: In 2009 the Georgia Hospital Association surveyed its membership to help determine the impact of the state's economic downturn on hospitals throughout the state. Sixty-three (63) hospitals and health systems responded to the survey. The data showed, like other Georgia businesses, the state's hospitals have had to make difficult operating decisions while still trying to meet the health care needs of the individuals they serve. Survey respondents indicated that:

-- More than six of 10 Georgia hospitals had to, or were considering, reducing staffing
-- One of three had to, or were considering, reducing services; Nearly three out of out four hospitals had experienced increases in bad debt and charity care since October 2008
-- Six of 10 hospitals reported that the recession had affected their ability to meet day-to-day operating expenses
-- Nearly three of four hospitals were postponing or reconsidering capital expenditures
-- Over half had experienced declines in elective procedures (often the most profitable procedures for hospitals)
-- More than half had seen a decline in charitable contributions/philanthropy
-- More than eight of 10 hospitals reported an increase in physicians who were seeking support from the hospital (i.e., hospital employment, increased payment for services)

With the continued economic downturn and the increasing number of individuals who have lost their jobs and health insurance, hospital emergency rooms, which by law must see all patients regardless of ability to pay, provide a safety net for the state's uninsured and underinsured. As a

result, Georgia hospitals are experiencing even greater financial pressure.

The state's Medicaid shortfall has added to the financial pressures Georgia hospitals are facing. To fund Medicaid in FY 2011, the 2010 Georgia General Assembly passed a 1.45% bed tax on hospital beds. The full impact of this tax on Georgia's public and private hospitals has not been determined. Major changes are also anticipated with implementation of federal health care reform signed into law in March 2010. The increase in insured individuals as a result of the legislation could help hospitals, particularly safety net hospitals that currently serve many uninsured patients. It could also mean an increase in the number of Medicaid patients that a hospital serves. Hospitals may lose money if their Medicaid patient population increases significantly because Medicaid does not reimburse hospitals the full cost of a Medicaid patient's care.

Community Health Centers

Georgia's CHCs offer a comprehensive range of primary health care and other services including around the clock care, acute illness treatment, prenatal care, well-child care, physicals,
preventive services, health education, nutritional counseling, laboratory, x-ray and pharmacy services. The state's network of 28 Community Health Centers serves over 238,000 Georgians each year in over 70 of the state's 159 counties. /2012/ Georgia's current network of 26
Community Health Centers and 138 delivery sites serves over 300,000 residents in 76 of the state's 159 counties.//2012//
/2014/The state has 27 Community Health Centers serving over 317,000 Georgians in 152 delivery sites.//2014//

Behavioral Health and Developmental Disabilities

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) provides treatment and support services to Georgia citizens with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD has nearly 9,000 employees whose work is structured in three divisions by disability area: Mental Health, Addictive Diseases, and Developmental Disabilities.

DBHDD operates seven regional state hospitals and provides and oversees community-based services across the state. Five regional DBHDD offices negotiate contracts, manage resources assigned to the regions for community-based and state hospital services, and ensure service access, protection of client rights, and prevention of client neglect and abuse. Each region is required to have an array of mental health and substance abuse services available through a variety of contracted providers. Determination of service needed is based on individual assessment. /2012/In October 2010, Georgia entered into a five-year settlement agreement to increase services to individuals with mental illness and developmental disabilities in community settings and although the state increased funding for these efforts, the waiting list for community services remains.//2012//

In July 2006, the State of Georgia implemented the Georgia Crisis and Access Line (GCAL), a single toll-free telephone number (1-800-715-4225) that individuals can call 24 hours/seven days a week to be connected to local services for mental health, developmental disabilities, and addictive diseases. Previously, each region of the state had a different access number. Managed by Behavioral Health Link (BHL), GCAL was one of sixteen finalists for the 2009 Innovations in American Government Awards from the Harvard Kennedy School's ASH Institute for Democratic Governance and Innovations Award. BHL Call Center clinicians provide brief clinical screening, triage, and service linkage for 25,000 incoming calls per month. Last year, BHL answered over
300,000 incoming calls.

Target populations include adults with chronic mental illness, adults with severe addiction problems, parents or caregivers of children or adolescents with severe emotional disturbances, and adults and adolescents struggling with suicidal thoughts or a psychiatric crisis. Telephone interpreting services are provided to callers with limited English proficiency. The level of service needed is determined and callers are offered a choice of providers. GCAL is staffed with

professional social workers and counselors to assist those with urgent and emergency needs. Those callers who need more routine services are directly connected with the agency of their choice and given a scheduled appointment. In addition, a website, www.mygcal.com, offers users a list of DBHDD providers and services by county as well as contact information for the regional office that services the user's community.

DBHDD's Developmental Disabilities services are focused on people with developmental disabilities with chronic conditions that were developed before age 22 and that limit their ability to function mentally and/or physically. State-supported services are aimed at helping the family continue to care for a relative when possible, serving people who do not live with their families in a home setting, and promoting independence and self-determination. The services a person receives depend on a professional determination of level of need and the services and other community resources available. Services may include family support, supported employment, respite services, inpatient services in one of seven state-operated hospitals that serve people
with severe and profound mental retardation (individuals may be admitted only under special circumstances for temporary and immediate care during a crisis), community residential alternative or community living support, and community access services that help meet an individual's needs and preferences for active community participation.

Medicaid

The Department of Community Health (DCH) administers the state's Medicaid and PeachCare for Kids State Child Health Insurance (CHIP) programs. Of DCH's $12.3 billion FY 2010 budget, Aged, Blind and Disabled Medicaid accounts for 42.9% of the DCH budget, Low-Income Medicaid
38.9%), and PeachCare for Kids 4.2%. Medicaid's FY 2010 state appropriation of $1,390,745,935 reflected a cut of $664,946,931 from the FY 2009 base. /2012/ Georgia's Medicaid and PeachCare programs comprise $1.88 billion of state funds appropriated to DCH in FY 2012, an increase compared to the FY 2011 budget due to expiration of funding from the Recovery Act.
The FY 2012 budget allocation for Medicaid and PeachCare could be underfunded as result of potential enrollment growth and may need to be addressed by the Georgia General Assembly.//2012// /2013/ From FY09 to FY12, state funding for Medicaid and PeachCare for Kids programs combined remained essentially flat. However, the Georgia Budget and Policy Institute estimates that at least 100,000 more Georgians will be served in FY 2012 than in FY 2009. In addition to health care inflation and enrollment growth due to a weak economy in the state, Georgia's Medicaid program faces additional financial challenges including funding shortfalls and expiration of hospital fees currently in the Medicaid base budget by 2014. The FY13 Medicaid: Low Income Medicaid State General Fund

allocation is $1,107,417,540.

DCH is conducting a process to redesign its Medicaid and CHIP programs. DCH engaged Navigant Consulting to identify redesign options. Three state task forces are providing redesign input. MCH leadership serves on the Children and Families Task Force.//2013//

Georgia's Medicaid program provides health care for 1.4 million children, pregnant women, and people who are aging, blind and disabled. The average monthly Medicaid enrollment in FY 2008 was 1,253,453. The average annual payment per Medicaid recipient was $5,005. /2012/ Georgia's Medicaid and PeachCare programs serve about one in six Georgians or approximately
1.7 million people. The combined programs contribute nearly $8 billion to Georgia's health care sector.//2012//

To be eligible for Low-Income Medicaid, adults and children must meet the standards of the former Aid to Families with Dependent Children (AFDC) program (family of four income limit of
$6,000 per year). Pregnant women and their infants with family income at or below 200% of the FPL are eligible for Right from the Start Medicaid for Pregnant Women and Their Infants (RSM Adults and Newborns). Children under the age of one whose family income is at or below 185% of the FPL, children ages one to five whose family income is at or below 133% of FPL, and

children ages six to nineteen whose family income is at or below 100% of the FPL are eligible for
Right from the Start Medicaid Children (RSM Children).

Pregnant women, children, aged, blind, and disabled individuals whose family income exceeds the established income limit may be eligible under the Medically Needy program. This program allows a person to use incurred/unpaid medical bills to "spend down" the difference between their income and the income limit to become eligible.

For the Katie Beckett program, which covers children up to age 18, income is not considered. Eligibility is based on medical need of institutional care. For individuals who do not meet legal immigration criteria, Georgia's Medicaid program provides coverage for emergency medical services as long as the individual meets all other Medicaid eligibility requirements.

The Children's Intervention Service (CIS) program offers coverage for restorative and rehabilitative services in non-institutional settings (i.e., home, therapist's office, child care, or community setting) for Medicaid-eligible members from birth up to age 21 with physical disabilities or with a developmental delay. CIS services must be determined to be medically necessary, and be recommended and documented as appropriate intervention by a physician. Beginning September 1, 2006, a prior authorization was required for units over eight per member per month for therapy in the same specialty. These units include the evaluation visit. A prior authorization is based on medical necessity and can be approved for up to six months.

In June 2009, 997,488 adults and children were enrolled in Low-Income Medicaid. DCH has projected an increase of 7.7% in enrollment between June 2009 and June 2010 (1,074,482 enrollment) and a 2% increase from June 2010 to June 2011 (1,096,502 enrollment). In Georgia, the State Children's Health Insurance Program (SCHIP) is called PeachCare for Kids. It provides health care for children through the age of 18 years whose families' incomes make them ineligible for Medicaid but who cannot afford their own health insurance. The children must live in a home where the income is at or below 235% of the FPL. Health benefits include primary, preventive, specialist, dental care and vision care. PeachCare for Kids also covers hospitalization,
emergency room services, prescription medications and mental health care. Each child in the program has a Georgia Healthy Families Care Management Organization (CMO) who is responsible for coordinating the child's care. /2012/According to the Georgia Budget and Policy Institute's Budget Primer 2011 report there was a 20% increase in the number of Medicaid recipients served in the Low-Income Medicaid program between June 2008 and July
2010.//2012//

PeachCare for Kids exceeded its two year enrollment goal in its first year of operations. Georgia ranks fourth nationally in numbers of enrolled children. Only California, New York, Florida, and Texas have enrolled more children. In June 2009, 205,370 children received services funded by PeachCare for Kids, down from the 250,000

children enrolled in 2008. Enrollment is projected to increase by 8% by June 10, 2010 (221,972 enrollment) and 8% between June 2010 and June
2011 (239,917 enrollment). The average annual payment per child was $1,399.
/2012/ PeachCare enrollees represent nearly 17% of total individuals served by DCH's Division of Medicaid, but are responsible for only 5% of programmatic costs.//2012//

In Federal Fiscal Year (FFY) 2010, the state's enhanced SCHIP Federal Medicaid Assistance Percentage (FMAP) is 75.57 percent, with Georgia eligible to receive $3 in federal funding for every $1 of state funding. The FY10 state appropriation was $87,937,542, a cut of $10,735,387 from the FY09 base. /2013/ The FY13 state appropriation is $79,578,343.//2013//

Effective June 1, 2006, Georgia implemented Georgia Families, a managed care program through which health care services are delivered to members of the state's Medicaid and PeachCare for Kids programs. Georgia Families is a partnership between DCH and private Care Management Organizations (CMOs) to ensure accessible and quality health care services for Medicaid and PeachCare for Kids managed care members. DCH contracts with three CMOS:

AMERIGROUP Community Care, Peach State Health Plan, and WellCare of Georgia, Inc.

By providing a choice of health plans, Georgia Families intends to enable members to select a health care plan that fits their needs. DCH's Medicaid Division monitors the CMOs to ensure compliance with contractual requirement standards for contract management, member services, provider services, and quality services.

Georgia Families provides health care services to children enrolled in PeachCare for Kids and certain men, women, children, pregnant women, and women with breast or cervical cancer covered by Medicaid. Excluded populations include children in foster care and the remainder of Georgia's Medicaid population, including aged, blind, and disabled citizens.

Children with disabilities who have not been determined eligible for Supplemental Security Income (and do not therefore receive the previously mentioned Children's Intervention Services under Medicaid Aged, Blind and Disabled program), receive services from the CMOs through the Low Income Medicaid program.

Public Health

Service delivery in the state's public health system is carried out by 159 county boards of health. These boards of health are combined into 18 districts, ranging from one to 16 counties in size. Each district is led by a physician district health officer who reports to the state office of the DCH Division of Public Health. The county boards of health provide direct health care services, environmental health activities, and work with community partners in their county around issues of common concern. Approximately 97% of the county health departments' funding comes from the state in the form of general Grants-in- Aid (GIA). The FY10 general GIA state appropriation was $68,154,008; a decrease of $3,703,320 from the FY09 base. /2012/The FY12 budget
separates funding for public health functions from DCH and provides funding for the new cabinet- level Department of Public Health. The budget appropriates $174 million in General Fund
support, plus $12 million in Tobacco Settlement funding, for a total of $186 million. Although a
1.5% increase from FY11, it is 1.4% ($23 million) below the pre-recession FY09 appropriation.//2012// /2013/ DPH's FY13 General Fund appropriation is $218,182,964. Total DPH funding, including federal funds and grants, other grants, state funds, and intra-state government transfers, is $684,337,564. The State General Fund allocation includes
$8,903,663 for Adolescent and Adult Health Promotion, $2,505,125 for Immunization,
$22,079,771 for Infant and Child Health Essential Health Treatment Services, and
$12,203,798 for Infant and Child Health Promotion. Included in the Infant and Child Health Promotion allocation was $2,200,000 to maintain Children 1st.//2013//

B. Agency Capacity

The Maternal and Child Health Program (MCHP), part of the Division of Public Health (DPH), Department of Community Health (DCH), is Georgia's Title V agency. The charge of the MCHP is to improve the health of mothers, children, and their families through education, provision of direct services (family planning, children with special health care needs, early intervention, and Special Supplemental Nutrition Program for Women, Infants, and Children -- known as WIC), population- based interventions (newborn screening and oral health preventive services), and the support of the public health infrastructure through the administration of Title V Block Grant funds.

Core MCH services include:

- Universal Newborn Hearing Screening Initiative (UNHSI)
- Newborn Metabolic and Hemoglobinopathy Screening
- Early intervention
- Coordinated care for children with special health care needs (CSHCN)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Family planning
- Regional Perinatal Centers
- Coordinated care and outreach for children
- Prenatal care
- Health education including breastfeeding support, nutrition, and Sudden Infant Death Syndrome (SIDS)
- Oral health preventive services
- Children and Youth with Special Needs, Children's Medical Services
- Injury Prevention

Funding sources include: WIC = $320 million (federal)

- Title X (family planning) = $8 million (federal) and a 10% state match
- Early intervention = $14.7 million (federal), $15.9 million (American Recovery and Reinvestment Act), and $9.7 million (state)
- Universal Newborn Hearing Screening Initiative = $1.3 million (state) and $0.2 million (federal)
- Newborn Metabolic and Hemoglobinopathy Screening = $3.5 million (state) and $0.6 million (federal)
- Regional Perinatal Centers = $15 million (federal), 35%/65% state/Medicaid match
- Oral health preventive services = $2.3 million (state) and $0.6 million (federal)
- Title V Maternal and Child Health Block Grant = $16 million (federal) and $12 million (state)

STATE STATUTES RELEVANT TO TITLE V PROGRAM: The mission of Public Health in Georgia is to promote and protect the health of Georgians. The Official Code of Georgia (31-2-1 and 31-3-5) supports this mission by empowering DCH and the local county boards of health to employ all legal means to promote the health of the people. County Boards of Health develop and establish community-based systems for preventive and primary care services for pregnant
women, mothers and infants, children and adolescents through local planning, direct provision of services and collaboration. Relevant DCH O.C.G.A. Titles include 4, 8, 10-1-393, 12, 15-11, 15-
21, 16, 17-18-1, 19, 20, 34, 36, 40, 42, 43, 45, 46, 49, and 50. Other relevant state statutes include: Newborn Metabolic -- O.C.G.A. 31-12-6 and 31-12-7; Well Child -- O.C.G.A. 31-12-6 and
31-12-7; UNHS -- O.C.G.A. 31-1-1-3.2; School Health -- O.C.G.A. 20-2-771.2; Children 1st -- O.C.G.A. 31-12-6, 31-12-7, 31-1.3.2; Newborn Hearing Screening -- O.G.G.A. 31-1-3; Family Planning -- O.C.G.A. 49-7-03; and Perinatal Case Management -- 31-2-2. /2012/The 2011
Georgia General Assembly passed House Bill 214 which creates a stand-alone Department of Public Health with its own commissioner and board that report directly to the governor. The legislation, which had the support of the governor, elevates Public Health to a cabinet-level
position and increases visibility for public health care issues in Georgia.//2012// /2013/Effective
July 2011, Public Health became a separate department. In October, the Governor appointed a nine-person Board of Health to establish the general policy of DPH. The 2012 legislature passed several bills that impact maternal and child health populations in Georgia. House Bill 861 requires drug testing of individuals seeking welfare assistance. Legislation was also passed that reduced the time for elective abortions from 26 to 20 weeks. An exemption is

included for "medically futile" pregnancies that gives physicians the option to perform an abortion when a fetus has congenital or chromosomal defects. HB1166 made Child-Only Health Insurance plans available in Georgia for children who do not qualify for PeachCare or Medicaid and who cannot access health insurance any other way. HB 879 requires designated school personnel, in addition to the school nurse, be trained on how to attend to children with diabetes while they are at school. SB 403 provides funding for school nurses. //2013//

Two governing bodies, the Board of Community Health and the 159 county boards of health, have key oversight and regulatory responsibilities. The State Board of Community Health's nine members are appointed by the Governor. The Board of Community Health establishes the general policy to be followed by DCH and makes budget recommendations. At the county level, boards of health, each with seven members, are required by state statute. These boards oversee the activities and budgets of the local public health departments and have regulatory and enforcement powers.

Georgia law permits the establishment of administrative multi-county health districts with the consent of county governments and boards of health in the counties involved. Georgia's 18 public health districts range in size from one to 16 counties. Each district has a health director,
appointed by the DCH Commissioner and approved by the boards of health of the concerned counties. Typically, each district health office is staffed by a health director (a physician), administrator, program manager, community epidemiologist, chief of nursing, environmentalist, and program and support staff. District health offices are located in the "lead" county of the district, usually the largest county in population. Local level responsibilities are set forth in county Grant-in-Aid (GIA) contracts which describe programmatic activities and provide financial support to carry them out. Direct services are provided by the county health departments. Funds to support county health departments come from fees, state Grant-in-Aid, county taxes and grants.

CAPACITY TO PROVIDE TITLE V SERVICES: The MCHP's capacity to provide: 1) preventive and primary care services for pregnant women, mothers, and infants; 2) preventive and primary care services for children and adolescents; 3) services for children with special health care needs; 4) rehabilitation services for blind and disabled children under the age of 16 receiving benefits under Title XVI; and 5) family-centered, community-based, coordinated care including care coordination services for children with special health care needs and facilitate development of community-based systems of services for such children and their families is described below.

The Maternal and Child Health Program, led by Brian C. Castrucci, M.A., is organized into five areas: Child Health; Community Health Services; MCH Epidemiology; Nutrition and WIC; and Capacity Building. /2013/ Mr. Castrucci resigned in January 2012 and Seema Csukas, MD, PhD was appointed as Interim Program Director.//2013//
/2014/Dr. Csukas was made MCH Section Director in July 2012.//2014//

The Child Health Section includes:

- Children and Youth with Specials Needs

* Babies Can't Wait
* Children's Medical Services

- Comprehensive Child Health

* Children 1st
* First Care
* Health Check
* Early Childhood Comprehensive Systems (ECCS Initiative)
* SIDS/Other Infant Death

- Newborn Screening Unit

* Newborn Metabolic and Genetic Screening

* Universal Newborn Hearing Screening and Intervention

Babies Can't Wait (BCW) is Georgia's statewide interagency service delivery system for infants and toddlers with developmental delays or disabilities and their families. The Georgia Division of Public Health is the lead agency responsible for administering the BCW program in Georgia. Through the MCHP, DPH ensures that services are provided in accordance with federal guidelines; that families have access to the services which are needed to enhance their child's development; and training is available to ensure that professionals who work with children and families have up-to-date information. Core services provided at no cost to families include developmental evaluation/assessment, individualized family service plans (IFSP), procedural safeguards (parent's rights), service coordination, and transition planning. Services subject to a system of payment (i.e., private insurance, Medicaid, family cost participation) include assistive technology, health services, nutrition services, physical therapy, special instruction, audiology, medical diagnostic services, psychology services, speech/language therapy, family training and counseling, nursing services, physical therapy, occupational therapy, social work, and vision services. BCW is administered through the 18 public health district offices throughout the state, and Easter Seals of North Georgia in the Gwinnett District. Parent to Parent of Georgia manages a statewide directory of information about local BCW programs that can be accessed by calling 1-800-229-2038.

Children's Medical Services (CMS) serves children and youth with disabilities age birth to 21 that have a medical diagnosis on the approved CMS list and meet financial eligibility criteria. CMS provides care coordination, specialty medical evaluations and treatment for eligible children and youth who have complex medical conditions. Core CMS services include care coordination with a comprehensive plan of care, assurance that a child has a medical home with a primary care provider, and transition planning for youth ages 16 to 21 years of age. Services for eligible conditions include comprehensive medical evaluations, specialty medical/surgical care,
diagnostic tests, durable medical equipment, inpatient/outpatient hospitalization, and medications.

Children 1st is the "single point of entry" to a statewide collaborative system of public health and other prevention based programs and services. This system allows children at risk for poor health and developmental outcomes to be identified early and gives them a chance to grow up healthy and ready for school. Participation is voluntary and there are no financial requirements for enrollment into the program. Core services include identifying high-risk births in Georgia; screening all births and children up to age five; assessing children and families at risk; referral/linkage of children and families with risk conditions to appropriate services; and
monitoring of individual children from birth to age five with risk conditions. The Electronic Birth Certificate assists Children 1st in identifying newborns with or at risk for poor health and development. In addition, many health and community providers refer families to Children 1st. Children 1st refers families to other public health programs as appropriate, including BCW and CMS. Linkages are made to Medicaid and PeachCare for Kids as appropriate. Families may also access services from agencies such as Healthy Families Georgia and Head Start. Children 1st is present in all 18 public health districts with services implemented in all Georgia counties to provide a system of support for families. /2013/Children 1st is coordinating Central Intake and the statewide Call Center for the MIECHV initiative for Georgia.//2013//
/2014/Central Intake identified children and families at-risk and referred to appropriate services, such as evidence based home visiting or public health services, by coordinating services through a community based early childhood system of care network.//2014//

First Care provides services to infants, birth to age one, who are at increased risk for health and developmental problems due to medical conditions at birth primarily caused by low birth weight or prematurity. Services may include voluntary in- home or clinic-based nursing assessment, nursing intervention, and care coordination. Services are designed to provide families education, support, and linkage with a medical home and community resources and programs to improve health and developmental outcomes and enhance parenting skills.
/2014/In 2013, 1st Care standardized the nursing assessment and conducted a Nursing Head-to-Toe Assessment to all districts implementing the service. Currently, twelve of the eighteen districts are providing 1st Care.//2014//

Health Check is Georgia's well child or preventive health care program for Medicaid-eligible children birth to 21 years of age and PeachCare for Kids-eligible children birth to 19 years of age. Health Check screenings provide children and adolescents access to comprehensive medical care to support early detection and treatment of health conditions and aid in prevention of advanced illness and disability. Health Check screenings are provided by eligible providers

according to a schedule based on recommendations of the American Academy of Pediatrics and include the following services: comprehensive health and developmental history, comprehensive physical exam, vision and hearing screening, appropriate immunizations, health education/ anticipatory guidance, laboratory tests, and dental referrals.

The Early Childhood Comprehensive Systems (ECCS) Initiative is focused on developing a framework that fosters integrated early childhood systems at the state and community levels to support children, ages birth to five, who are healthy and ready to learn. The federally funded ECCS Grant is working to build a comprehensive early childhood system through the collaboration of Georgia service providers, families, communities, and policymakers. ECCS addresses five core elements: access to medical and dental care, social-emotional development and mental health, early care and education, parenting education, and family support. The Initiative has two goals: 1) State partnerships around ECCS principles and elements are strengthened through collaborative projects, including assessing, prioritizing, and addressing early childhood statewide resources, gaps and barriers; and 2) All children birth to five receive coordinated, ongoing standardized developmental screening at recommended levels as well as when observation yields concerns about delayed or disordered development. ECCS work is guided by the ECCS Collaborative Partners Steering Committee, which includes representatives from numerous partnering agencies, all of whom work with or have an interest in children ages birth to five.

Sudden Infant Death (SIDS)/Other Infant Death provides new parents and infant caretakers with information about sleep safety and how to reduce the risk of SIDS, and links families who experience the death of a baby with community resources to assist them with their grief. The Georgia Crib Matching Program began in late 2007. Participating agencies must complete SIDS Risk Reduction Training and agree to purchase a minimum of five new/unused portable cribs with a bassinet. MCH will match three cribs to the respective agency. Families receiving a crib must meet specific eligibility requirements. /2013/The Crib Matching program has been discontinued.//2013//

The goal of Newborn Metabolic and Genetic Screening is to assure that every newborn in Georgia has a specimen collected for newborn screening tests prior to discharge from the hospitals; all infants with results outside the normal limits receive prompt and appropriate follow- up testing; and those diagnosed with a disorder are entered into and maintained on appropriate medical therapy. Core services include population screening for all newborns (approximately
150,000 live births/year); follow up of unsatisfactory or abnormal screening results; and diagnosis and referral to intervention.

Universal Newborn Hearing Screening and Intervention's goal is to screen every newborn (approximately 150,000 live births/year) for hearing loss prior to hospital discharge, and ensure infants not passing the initial and a repeat screening receive appropriate diagnostic evaluation before three months of age and when appropriate, are referred to intervention by six months of age.

The Community Health Services Section includes:

- Oral Health Unit

- Perinatal and Women's Health Unit

* Family Planning
* Regional Perinatal Centers

The mission of the Oral Health Unit is to prevent oral disease among Georgia's children through education, promotion of healthy behaviors, preventive interventions (such as sealants), and early treatment. Eligible populations include children with Medicaid/PeachCare for Kids; low income, uninsured children in need of oral health care; special needs children; pregnant women on Medicaid; and in some district practices, adults on a sliding fee scale. School sealant programs are directed at schools with more than 50% of the children on free or reduced lunch. Core services include school-based oral disease prevention and treatment programs for low income children; clinic-based dental treatment and prevention services for low income children and adults; and monitoring, supervision, and surveillance of public community water fluoridation programs. Approximately 96% of Georgians using community water services receive optimally fluoridated water.

Family Planning provides comprehensive reproductive health services to women of childbearing age and their partners. Services include physical exams; birth control counseling and supplies; abstinence skills training; immunizations; and screening for cancer, high blood pressure, diabetes, HIV and other sexually transmitted infections. The Georgia Family Planning Program also provides screening, counseling and referral for risk factors affecting women's health such as substance abuse, poor nutrition, cigarette smoking and exposure to violence. Services are provided in accordance with the federal guidelines.

In April 2009, DCH, in collaboration with community and agency partners, embarked on an initiative, known as Planning for Healthy Babies (P4HB), to reduce Georgia's low birth weight rate from 9.5% to 8.6% over a five year time span. Currently, the Georgia Medicaid Program provides prenatal coverage for pregnant women with monthly incomes at or below 200% of federal poverty level (FPL). These women are eligible for family planning services through the end of the month
in which the 60th postpartum day falls. After 60 days, women whose income exceeds the categorical limits for participation in the traditional Medicaid program lose eligibility for all benefits, including family planning. Implementation of the P4HB program will extend eligibility for family planning services to women ages 18 to 44 years who are at or below 200% of the most current FPL; and provide inter-pregnancy care to women at or below 200% of FLP who have previously delivered a very low birth weight baby. The waiver will begin in January 2011 and end December
31, 2015. /2012/ The P4HB program was launched in January 2011. It is the country's first 1115 Demonstration waiver to place a particular focus on reducing low birth weight rates.//2012// /2013/The interconception care component of the waiver is informing development of one of HRSA's five strategies to address infant mortality through the Regions IV and VI Infant Mortality Collaborative.//2013//

The Designated Regional Perinatal Centers provide multidisciplinary care to high risk mothers and infants through six designated regional perinatal centers. Core services include high-risk perinatal services including transportation, prenatal care, delivery, post-partum care, newborn care, high-risk developmental follow-up and referrals to community and public health providers including, family planning, WIC, Children's 1st, and BCW. Additional services include physician outreach and education to area providers to ensure a seamless community-based system.

Perinatal/Women's Health is an outreach partner/sponsor of text4baby, a new free mobile information service providing timely health information to pregnant women and new moms from pregnancy through a baby's first year. These messages focus on a variety of topics critical to maternal and child health, including birth defects prevention, immunization, nutrition, seasonal flu, mental health, oral health, and safe sleep. Text4baby messages also connect women to prenatal and infant care services and other resources. /2012/Text4baby has moved under MCH OTVI.//2012// /2013/ Georgia customized various Text4Baby messages and currently 2,502 enrollees (English: 1,949; Spanish: 553) in the program. //2013//

The MCH Epidemiology Section works to increase the access, use, and quality of MCHP relevant data; ensuring that MCHPs and program partners have access to the science necessary to effectively guide program and policy development.

The goal of Georgia's Nutrition and WIC Section is to provide quality supplemental nutritious foods through a complex network of over 1,600 authorized retailers; nutrition and breastfeeding education, counseling, and support; and applicable referral-related services to assure that its targeted populations are eating healthy; practicing breastfeeding for recommended durations; being adequately physically active; and accessing complementary health services. In addition to providing technical assistance to Georgia's WIC, the Nutrition Services Unit conducts population- based services within the three core Public Health functions (assessment, policy development, and assurance); increases the demand and provides options for achieving healthy eating lifestyles; enables Georgia citizens to make informed food choices; and creates public/private

partnerships to promote nutrition-related policies, practices, and system development statewide. Georgia's WIC, the nation's fifth largest, provides various types of services to over 310,000 participants through Georgia's 18 public health districts, two contract agencies, and its authorized retailers. /2012/ In March 2011, the MCH Director assumed operational authority for the WIC Program.//2012//

/2014/Effective December 2012 the WIC Program was established as a freestanding section under Health Promotion; WIC no longer falls under MCH leadership.//2014//

The Capacity Building Section supports the application of best practices and standards of care in order to enhance programs at the state and local levels by providing continuous quality improvement (CQI) and technical assistance (TA). The office is charged with leveraging resources, eliminating duplication of effort, ensuring accountability, and assuring a competent work force. The CQI Unit is responsible for developing, implementing, and supporting a standardized system of monitoring and compliance for MCHPs and initiatives. The TA Unit is responsible for ensuring that MCH services are delivered to children and families by competent
staff and providers through technical assistance and training. /2012/The Office has been renamed the Office of Capacity Building.//2012//
/2014/This office was been eliminated 7/15/12./2014//

/2012/ The Office of Title V and Integration is responsible for ensuring implementation of Georgia's Title V Block Grant activity plan and the efficient use of MCH funds, services and programs. //2012//
/2014/The Office of Title V and Integration was eliminated 7/1/12.//2014//

BUILDING MCH CULTURAL AND LINGUISTIC COMPETENCY: Many of the state's health districts have identified growing immigrant populations and increases in clients with limited English proficiency as emerging trends that are having an impact on service delivery in the districts. Latinos, primarily Mexicans, are the most rapidly growing minority group in Georgia. DPH is committed to ensuring that limited English proficient (LEP) and sensory impaired (SI) clients have meaningful access to all programs and activities conducted or supported by the department. DPH's strategy for providing meaningful access for LEP and SI customers involves assessing language access needs statewide; recruiting and training "qualified" interpreters and bilingual staff; developing a centralized databank of language resources; translating vital forms and informational documents; forming partnerships with community groups for outreach and education; providing diversity training to DPH employees; and implementing a procedure for monitoring services and resolution of complaints. DPH is also working to reduce and eliminate
access barriers that discourage the enrollment of all eligible program participants, including those in immigrant and mixed-status families. State and local public health staff, including MCH staff, are also able to draw on several key cultural competency resources, including the DPH's State Refugee Resettlement and Health Programs and Office of Communications, and DCH's Office of Health Improvement, Minority Health. The Office of Communications has widely disseminated a "Directory of Qualified Interpreters and Translators and Multi-Ethnic Community Resource Guide.
Minority Health's Information Center has resource materials that focus on health issues relating to
minority populations.

Racial and ethnic minorities make up over one-third of Georgia's population, but their disease burden is significantly higher. The DCH Office of Health Improvement, Minority Health works to eliminate the discrepancy in health status between minority and non-minority populations in Georgia. Major focus areas include:

- Identifying, assessing, and analyzing issues related to the health of minority populations;
- Working with public and private organizations to address specific minority community health needs;
- Monitoring state programs, policies, and procedures to assure that they are inclusive and responsive to minority community health needs; and
- Facilitating the development and implementation of research enterprises and scientific investigations to produce minority-specific findings.

Minority Health's work is supported by the Georgia Minority Health Advisory Council. Twelve members, including representatives from the Centers for Disease Control and Prevention, Georgia Rural Health Association, National Center for Primary Care, Center for Pan Asian Services, Medical Interpreter network of Georgia

(MING), Children's HealthCare of Atlanta, Georgia Academy of Family Physicians, Georgia Dental Society, DCH, and medical providers, address health disparities and other health care concerns of Georgia's African American, Hispanic/Latino, Asian/Pacific Islander, and American Indian/Alaska Native populations. The Council has provided leadership in the development of a health care strategic plan to address improvement in the health status of minority populations in Georgia and in the work of the Georgia Health Equity Initiative. The "Georgia Health Equity Initiative -- Health Disparities Report
2008: A County-Level Look at Health Outcomes for Minorities in Georgia" provides data and information to help providers and the public understand health disparities, identify gaps in health status, and target interventions in areas of greatest need. The report is the first of its kind to focus solely on minority health outcomes for each of Georgia's 159 counties.

At the local level, public health districts efforts to meet the needs of non-English speaking clients have included hiring bilingual staff and/or utilizing translators or interpreters, conducting staff cultural diversity training, using language assistance phone lines, special health fairs in collaboration with local churches and other community organizations, and offering forms and patient education materials in Spanish and other languages. Districts have also engaged in social marketing and outreach to inform non English speaking clients of available public health services.

To provide meaningful access to services for LEP and sensory impaired (SI) customers, DPH service sites are required to have: 1) Notice of Free Interpretation Service Wall Posters prominently displayed in all reception and intake areas; 2) Notice/Policy of Nondiscrimination prominently displayed in all reception and intake areas; 3) the "I Speak" DPH card, which accommodates the identification of 38 languages likely to be encountered, accessible for DPH staff use; 4) State LEP/SI Plan and accompanying LEP/SI Policy and Procedures accessible for reference for all staff; 5) LEP/SI Intake and Tracking Form, with instructions, accessible for staff use: 6) "Waiver of Right to No-Cost Interpreter Services" form and Discrimination Complaint Form accessible for DPH staff use; 7) a sign posted identifying the Language Access Coordinator and Language Access Team Member for the Division or Office; 8) current listing of DPH Language Contractors, other contractors providing services, and contact information for a telephone interpretation service; 9) list of translated materials by title, date, form number, and language; 10) method of tracking the number of LEP/SI customers receiving services; 11) LEP/SI central file or appropriate alternative for paperless offices; 12) completed Local Language Access Plan; and 13) LEP/SI Reference Notebook (including items listed above) for use by staff, generally housed at
the front desk.

All health districts are provided funding through Grant-in-Aid to cover the cost of language interpreters for families receiving hearing follow-up services.

BUILDING MCH COMPETENCIES: DPH offers state and local staff coordinated training and development activities to improve knowledge and job performance. DPH use of the video interactive conferencing systems (VICS) is increasing local public health staff participation in coordinator meetings and trainings. A range of VICS training is provided including New Employee Orientation (Parts I and II), Civil Rights Training, Policy and Procedures revisions, ARRA Stimulus and Stimulus Money Requirements, Data Overview, Family Planning, WIC Food Package Policy, WICS PARS Time Reporting, CMS training, and Infection Control Updates. Quarterly district Women's Health, CMS, and WIC coordinators meetings are held either via VICS or face-to-face
to share information and identify opportunities to collaborate.

All new DPH state and district staff receive employee orientation training. In addition, new state MCH staff receive information on the Health Resources and Services Administration's Maternal and Child Health Bureau and the Maternal and Child Health Block Grant.

BUILDING PUBLIC AWARENESS FOR MCH: The Office of Communications serves as DCH's primary point of contact for all marketing, branding, media relations, and internal and external communications activities. The Communications team focuses its efforts on creating and maintaining a consistent brand and messaging for DCH. Specifically the team creates fact sheets for all of DCH's offices, divisions and programs, writes and distributes press releases and media advisories, designs and implements member and provider educational and promotional campaigns, and works with subject matter experts to create legislative briefs. The Office of Communications is also responsible for Intranet and Internet Web site maintenance, and oversees the Governor's Office of Customer Service program at DCH. The DCH

website (http://dch.georgia.gov) includes division and program descriptions, a link to DCH publications, public notices, public meeting schedules, grant announcements, press releases, and general assembly presentations. The DPH web site (http://health.state.ga.us/) provides overviews of all public health programs and services, including MCH. Each program description includes state office contact information. /2013/The new DPH organizational structure includes a Communications team. DPH's web-based Live Healthy Georgia campaign serves as the umbrella for an outreach initiative that aims to raise awareness about the risk factors associated with chronic diseases and to provide Georgians with information about ways to live healthier. Key messages include: Get Checked, Eat Healthy, Be Active, Be Smoke Free, and Be Positive. The web site features a new interactive map of Healthy Community resources in Georgia, including farmer's markets, free medical clinics, local health departments, and smoking cessation programs. In addition, the DPH Commissioner has identified childhood obesity and infant mortality as key focus areas.//2013//
/2014/The DPH website is currently undergoing changes. The new site should go live summer 2013.//2014//

C. Organizational Structure

The Department of Community Health (DCH) framework in which MCH functions is depicted in the attached organizational charts. The Georgia General Assembly created DCH in 1999 by combining the four state agencies that were responsible for purchasing and regulating healthcare into a single, new agency. The DCH is now the main state agency in Georgia that provides health care planning and purchasing. In 2009, the DCH took over the duties of the Division of Public Health and Emergency Preparedness, formerly located in the Department of Human Resources, in addition to its normal functions. The DCH is also the sole state agency for Medicaid. /2012/ Effective July 1, 2011, Public Health will become a separate department that includes the MCHP. The new department has a $600 million budget and more than 1,000 employees. //2012//

The DCH Commissioner is appointed by the governor of Georgia and is accountable to the State Board of Community Health. The Board provides general oversight of DCH's activities by establishing policy, approving goals and objectives and other appropriate activities. The Commissioner is in charge of overseeing the ten divisions and six offices that make up the DCH. Clyde L. Reese, III, Esq. serves as the DCH Commissioner. Mr. Reese has previous experience as an Assistant Attorney General for the State of Georgia, General Counsel for the State Health Planning Agency, and Deputy General Counsel and General Counsel of DCH. /2012/ In January 2011, Georgia's new governor, Nathan Deal, appointed David Cook to serve as Commissioner of the Georgia Department of Community Health. Mr. Cook has previous experience as the executive director and chief executive officer with the Medical Association of Georgia (MAG).//2012// /2013/ In June 2011, Governor Deal appointed Brenda Fitzgerald, M.D. to serve as Commissioner of the new Georgia Department of Public Health (DPH) and State Health Officer. Dr. Fitzgerald, a board-certified Obstetrician-Gynecologist and a Fellow in Anti-Aging Medicine, has practiced medicine for three decades. //2013//

The DCH Management Team includes the Chief Operating Officer; Chief Financial Officer; Director of Communications; Director of Healthcare Facility Regulation; Director of Legislative and External Affairs; Chief of the Medicaid Division; Inspector General and Chief of the Program Integrity Unit, Internal Affairs, and Audit Unit; Director of the Division of Public Health; Director of the State Health Benefit Plan; and Chief of Emergency Preparedness and Response Division. DCH Divisions:

-The Emergency Preparedness and Response Division manages the CDC's Public Health Emergency Preparedness Cooperative Agreement and the Health and Human Services Assistant Secretary for Preparedness and Response Hospital Preparedness Program Cooperative Agreement. Its activities include planning support for pandemic influenza and the distribution of medication during disease outbreaks. Injury Prevention, located in the Division along with the EMS and Trauma Programs, provides technical assistance in program evaluation and coalition building to local community groups; provides injury data to community groups and the public at large; distributes safety equipment such as child safety seats, bike helmets, smoke detectors, and dissemination of knowledge on proper use of safety equipment; and provides general support to local coalitions in helping promote safe and injury free life styles and behaviors.

-The Division of Financial Management deals with the DCH's financial needs, including its accounting and budgeting.

-The Office of General Counsel takes care of several administrative and legal tasks for the DCH. It creates policies to comply with federal and state record requirements, drafts rules and regulations to be considered by the Board of Community health, and supplies services for the legal part of the State Health Benefit Plans.

-Healthcare Facility Regulation Division ensures that healthcare providers are safe and competent and comply with professional standards.

-Information Technology is in charge of maintaining the systems for processing and collecting Medicaid and PeachCare for Kids payments.

-The Office of Inspector General prevents and investigates fraud related to Medicaid, PeachCare for Kids, and the State Health Benefit Plan.

-The Division of Public Health promotes healthy lifestyles for all Georgians and works to reduce preventable deaths.

-The State Health Benefit Plan gives health insurance to state employees and their dependents.

-The Division of Medical Assistance Plans runs the state Medicaid program, which offers medical help to children, pregnant women, and people with disabilities.

-The Operations Division is in charge of human resources for the DCH as well as several other initiatives including the Office of Minority Health, Office of Women's Health, Georgia Commission on Men's health, Georgia Volunteers in Health Care program, and State Office of Rural Health.

DCH Offices:

-The Office of Communications serves as the DCH's liaison with the media and the public and maintains the DCH website.

-The Office of Health Improvement is a part of the Operations Division and is comprised of the Office of Minority Health, the Office of Women's Health and the Georgia Commission on Men's Health.

-The Office of Health Information Technology and Transparency (HITT) facilitates the exchange of information regarding healthcare between healthcare providers, professionals, and consumers.

-The Office of Legislative Affairs and External Affairs works with the Georgia General Assembly to evaluate and provide input on legislation that relates to public health in the state of Georgia.

-The Office of Procurement Services (OPS) is responsible for procuring the highest quality services possible at the lowest cost possible to fulfill the DCH's need. This office works closely with the Department of Administrative Services.

-The State Office of Rural Health is in charge of providing increased access to healthcare throughout rural Georgia.

Division of Public Health:

At the state level, DPH is divided into numerous branches, sections, programs and offices, and at the local level, DPH functions via 18 health districts and 159 county health departments. The county public health departments offer direct healthcare to low-income people and people in underserved areas of the state, and work with private medical providers to assure these groups receive needed care. /2013/Public Health became a stand-alone department on July 1, 2011. DPH's organizational structure is outlined in the attached organizational charts. State public health programs include Health Promotion and Disease Prevention (HPDP), MCH, 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. //2013//

M. Rony Francois, M.D. M.A., M.S.P.H. is Director of the Division of Public Health (DPH). Prior to becoming Director in January 2010, Dr. Francois served as Assistant Secretary of Louisiana's Department of Health and Hospitals Office of Public Health, where he was responsible for the direction and management of the state's public health programs. He has also served as the Secretary of the Florida Department of Health. /2012/ On February 8, 2011, Brenda Fitzgerald, M.D., was appointed to serve as the new Director of DCH's Division of Public Health. Dr. Fitzgerald, a board-certified Obstetrician-Gynecologist, oversees Public Health's seven main program areas: Maternal and Child Health, Health Promotion and Disease Prevention, Infectious Disease and Immunization, Environmental Health, Epidemiology, Vital Records, and the State Public Health Laboratory. She also directs the state's 18 health districts and 159 county health departments, including the 222 family planning clinics. In June 2011, Governor Deal appointed Dr. Fitzgerald to serve as Commissioner of the new Department of Public Health.//2012// /2013/ Yvette Daniels, J.D., serves as the Director of Health Promotion for DPH, where she oversees four programs including MCH, HPDP, the Volunteer Health Care Program and Office of Health Equity. She was the Deputy Director of Legislative and External Affairs
and was responsible for the development and direction of the legislative goals and agenda for areas impacting Public Health.//2013//
/2014/Ms. Daniels also oversees the WIC section as Director of Health Promotion.//2014//

Miriam T. Bell, M.P.H., Deputy Director, Public Health Programs and Services, provides administrative supervision of Public Health's programs and services. In addition, she supports the Public Health Director and works closely with the Deputy Director of Administration to manage the day-to-day operations of public health, develops and meets strategic goals and priorities for the Division, and ensures the provision of quality programs and services. Prior to her appointment as Deputy Director, Ms. Bell served for 20 years at H. Lee Moffitt Cancer Center & Research Institute in Tampa, Florida. In her last position she served as their Director of Patient Advocacy and Rehabilitation. /2012/ Ms. Bell left DCH in June 2011.//2012//

The Advisory Council for Public Health is responsible for providing assistance and guidance to DPH and DCH on all matters regarding public health programs. Eight council members, appointed by the governor, serve one to two year terms.

DPH programs include Health Promotion and Disease Prevention, Maternal and Child Health (see Section B -- Agency Capacity), Infectious Disease and Immunizations, Environmental Health, Epidemiology, the State Laboratory Programs, and Vital Records. Each DPH program and service has responsibilities that inter-relate with MCH activities, requiring strong working relationships.

Health Promotion and Disease Prevention (HPDP) programs implement population-based programs and services aimed at reducing disease risks, promoting healthy youth development, targeting unhealthy behaviors, providing access to early detection and treatment services, and improving management of chronic diseases. Targeted risk behaviors include smoking, physical inactivity, unhealthy eating, lack of preventive healthcare, sexual violence, and reducing risky behaviors in youth. HPDP's Office of Cancer Screening and Treatment includes the Georgia Breast and Cervical Cancer Program, Cancer State AID Program, and breast and cervical cancer treatment for eligible women through the Women's Health Medicaid Program. Office of Chronic Disease Prevention and Wellness programs and services include comprehensive tobacco use prevention activities including tobacco cessation services through the Georgia Tobacco Quit Line; population-based strategies to address chronic disease prevention and management; primary sexual violence prevention; health communication and education; primary prevention strategies to address obesity in children, youth, and adults; adolescent health and youth development; and community capacity building through the provision of technical assistance to community-based organizations to address chronic disease prevention, risk reduction, and positive youth development.

Infectious Disease and Immunization includes the HIV, STD, Tuberculosis (TB), and Immunization Programs. HIV coordinates services through Georgia's HIV Care Ryan White Part B Program and the HIV Prevention Program. The STD Program works to reduce morbidity associated with sexually transmitted disease in Georgia by preventing STDs and their complications in both the public and private sectors through coordinated, comprehensive statewide STD prevention; statewide STD screening; and surveillance of STDs. The TB Program, which has legal responsibility for all TB clients in Georgia regardless of who provides the direct services, identifies and treats persons who have active TB disease; finds, screens, and treats contacts; and screens high-risk populations.

The work of the Immunization Program is carried out through the efforts of trained state staff and through partnership and collaboration with medical organizations, other state agencies, and community coalitions. Vaccine financing is accomplished through the use of state and federal funds to provide vaccines for uninsured and under-insured children in Georgia, and for certain adult populations. The Immunization Program oversees the acquisition, distribution, and management of vaccines through the Vaccines for Children (VFC) Program, as well as vaccines acquired through state and other federal funding.

All health care providers are mandated by law to report to the Georgia Registry of Immunization Transactions and Services (GRITS) all immunizations given to persons of any age. They also can access this database to get updated information on their clients' immunization status. In addition to housing immunization records, GRITS allows providers to track their vaccine inventory, print
the Georgia Certificate of Immunization and send reminder/recall notices to clients.

Environmental Health provides primary prevention through a combination of surveillance, education, enforcement, and assessment programs designed to identify, prevent and abate environmental conditions that adversely impact human health. Programs include Chemical Hazards, Food Service, Land Use (On-Site Sewage), Swimming Pools, Tourist Accommodations, Well Water, and Other Programs (i.e., Mosquito-borne Viral Diseases, Indoor Air Quality Assistance).

Epidemiology includes Acute Disease Epidemiology; Chronic Disease, Injury and Environmental; the Office of Health Indicators for Planning (OHIP), and the Georgia Epidemiology Report (GER). OHIP leads DPH's health assessment component, providing evidence about the health status of Georgia's population. OHIP's internal operations include information quality; health statistics; epidemiological modeling and information mining; Geographic Information Systems and spatial analysis; and web-based distribution of health statistics and forecasting models. OHIP's Online Analytical Statistical Information System (OASIS), a suite of interactive tools, provides access to DPH's standardized health data repository. The repository is currently populated with Vital Statistics (births, deaths, infant deaths, fetal deaths, induced terminations), Georgia Comprehensive Cancer Registry, Hospital Inpatient and Emergency Room Discharge, Arboviral Surveillance, Risk Behavior Surveys, and Population data.

The Georgia Public Health Laboratory Program (GPHL) provides screening, diagnostic and reference laboratory services to Georgia citizens through county health departments, public health clinics, physicians, other clinical laboratories, hospitals and state agencies. GPHL's five broad areas of testing and support include: chemistry (Newborn Screening Unit, Lead Screening and Fluoride Testing), Emergency Preparedness (Biological/Chemical Terrorism and Molecular Biology Units), Facilities Support, Microbiology (Bacteriology, Microbial Immunology, Mycobacteriology/ Mycology, Parasitology, and Virology Units), and Operations.

The State Vital Records Office maintains Georgia vital records and events, which are defined as birth, death, fetal deaths (stillbirth), induced termination of pregnancy, marriage and divorce certificates and reports.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Title V funds 155 MCH state and district positions. (See attached table.) SENIOR MCH

STAFF QUALIFICATIONS AND CAPABILITIES:

Brian C. Castrucci, MA, Director of the MCHP in the Division of Public Health and Title V Maternal and Child Health Block Grant Director, provides leadership for the statewide maternal and child health program. Provide oversight for 140 FTEs and a budget of approximately $500M. He provides oversight for programs including Georgia's Special Supplemental Nutrition Program for New WIC Director? Does Yvette Daniels oversee WIC? Should org chart be changed?Women, Infants, and Children (WIC), family planning (Title X), Babies Can't Wait (Part C Early Intervention program), Early Childhood Comprehensive Systems grant, the Children First
program (Georgia's single point of entry for health-related early childhood services), Title V Maternal and Child Health Block Grant, newborn screening, services for children with special health care needs, oral health, and the

Office of Performance Management and Support
Services. Prior to serving as MCHP Director, Mr. Castrucci was the Manager of the Family Health Research and Program Development Unit in the Office of Title V and Family Health at the Texas Department of State Health Services. He has worked with Healthy Start projects in Philadelphia and Texas; has developed case management and other health promotion programs; has implemented surveillance systems to monitor local child death review findings, infant sleep practices, and breastfeeding; and has provided support to the Texas Family Planning Program, the Texas Children with Special Health Care Needs Program, and the Texas Women, Infants, and Children Program. He has published research on topics that include adolescent tobacco use, breastfeeding, HIV/AIDS policy, and pregnancy. Mr. Castrucci also worked at the Philadelphia Department of Public Health, The Robert Wood Johnson Foundation, and the Centers for Disease Control and Prevention. (See attached resume.) /2012/In October 2010, as part of the 75th Anniversary celebration for Title V, Mr. Castrucci was awarded the Young Leadership in MCH Award.//2012 /2013/ With Mr. Castrucci's resignation, Seema Csukas, MD, PhD was appointed as MCH Interim Program Director in January 2012. //2013//
/2014/Dr. Csukas was named MCH Section Director July 15, 2012.//2014//

Debbie Cheatham, RN, DNP, Director for the Children and Youth with Special Needs Unit and Title V CSHCN Director, is a doctorally prepared Registered Nurse with over 26 years of experience. She has over 15 years of experience in public health at the state level. Prior to joining the Georgia MCHP in 2009, she was the Program Administrator for Early Childhood Programs at the Ohio Department of Health where she worked closely with the CSHCN program and instituted a public health nurse consultation visit for all children with a medical diagnosis served in the early intervention program. /2013/ Dr. Cheatham has been promoted to the Director of Child Health Services. In this capacity, she oversees CYSHCN, CCH and NBS. //2013//
/2014/Dr. Cheatham is the Clinical Director for Child Health. Gayle Jones is the new Director of the Office of Child Health.

Gayle Jones, PhD, MPH, CHES, Director of the Office of Child Health, received a Bachelor's in Biology from the University of South Carolina Aiken, Masters of Public Health in Health Administration from the University of South Carolina Arnold School of Public Health, and a PhD in Public Health from Walden University. Dr. Jones has over 10 years of experience in various areas of public health.//2014//

Beverly Stanley, BA, MCH Deputy Director, provides administrative leadership and guidance for all programs in MCH. She earned her BA in Human Resource Management at the University of South Carolina. She has over 20 years of experience working in the governmental and private sectors providing management of day to day operations, including financial, human resources, contract, and facility services, maximizing resources for effective and prompt delivery of services to local programs. Most recently, Ms. Stanley served as the Operations Director, providing a comprehensive system for all operational needs, including the Standard Operating Procedures (SOP) in the MCHP, the development of the only Supervisor's Guide for Orienting New Employees, and a systematic contract management process.

Abdul K. Lindsay, MScFT, RD, LD, CPT, is Director of the Georgia Women, Infants, and Children (WIC) Program. Mr. Lindsay earned his Master of Science and Bachelor of Science degrees in Food Technology and Dietetics, Nutrition and Fitness from the University of Georgia and Florida State University, respectively. He is registered nationally and licensed as a Dietitian and within the State of Georgia. Mr. Lindsay has held leadership positions overseeing and providing various dietetic components including food and nutrition services as well as nutrition education/counseling in Georgia, Florida and North Carolina as a School Nutrition Director, School Nutrition Administrator, Clinical Nutrition Manager, Public Health Community Nutritionist, Public Health WIC Nutritionist and Administrative Dietitian. /2012/ With Mr. Lindsay's resignation, the MCH Director assumed responsibility for the WIC Program in March 2011.//2012// /2013/ Dr. Csukas assumed responsibility for the WIC program in January 2012.//2013//
/2014/The WIC Program was established as a freestanding section under Health Promotion after the appointment of Debra Keyes as WIC director in November 2012; WIC no longer falls under MCH leadership.//2014//

Rhonda Simpson, MS is the Director of the Capacity Building Section. She has served in various roles for the MCHP

for the last nine years. Ms. Simpson has a Master of Science degree in Human Resources from East Central Oklahoma State University and over 16 years of health- related administrative and counseling experience. /2012/ The Office of Performance Management and Support Services has been renamed as the Office of Capacity Building. //2012//
/2014/The Office of Capacity Building has been eliminated. Ms. Simpson is now the Perinatal Health Director providing leadership, funding, training, technical assistance, and a public health framework to 6 Regional Perinatal Centers (RPC's) statewide in an effort to prevent infant mortality and improve birth outcomes in Georgia. She serves as Business Owner for Maternal and Child Health contracts including 5 Star Hospital Recognition Initiative, Healthy Mothers Healthy Babies, Text for Babies and Georgia Obstetrical and Gynecological Society (GOGS). Ms. Simpson has served in various roles for the Maternal and Child Health Program for ten years, including Director, Principal of Investigator and Program Manager. This position reports to the Director of the Office Family and Community Health.//2014//

Elizabeth C. Lense, DDS, MSHA, the Georgia Oral Health Program Director, received her dental degree and completed a residency in Oral Maxillofacial Pathology at Emory University School of Dentistry, and went on to teach Oral Pathology at West Virginia University Schools of Medicine and Dentistry. After returning to Georgia, Dr. Lense taught Oral Histology and Embryology at Georgia Perimeter College School of Dental Hygiene, as well as served as a clinical instructor for oral diagnosis and radiology. While working as a dentist in the dental public health system, she received a Master's degree in Healthcare Administration from Georgia State University, and went on to serve as Director of the Pediatric Dental program for Grady Health System at Hughes Spalding Children's Hospital from 1999-2006. She is an Assistant Clinical Professor in the Department of Pediatrics at Emory School of Medicine, and an adjunct instructor in Pediatrics for Morehouse School of Medicine. She has been on the Board of Directors of the Healthy Mothers, Healthy Babies Coalition since 2000, and served as both Vice-President and President. She is also a member of the Hispanic Health Coalition, Hispanic Dental Association, and the Georgia Dental Society. Dr. Lense completed a Fellowship in Public Health at the CDC Division of Oral Health and now serves as the Georgia's State Oral Health Director. /2013/ Dr. Lense resigned in December 2011; Dr. Dwayne Turner is serving as the Acting Director of Oral Health.
//2013//
/2014/In February 2013, the Oral Health Program under the leadership of Carol Smith (unit director) moved into the structure of the newly established Office of Family and Community Health.//2014//

/2013/ Dwayne Turner, DDS, MBA is the Interim Dental Director. He is also the Director of Dental Health Services for the DeKalb County Board of Health. Dr. Turner received his BA degree at the University of Rochester, his Doctor of Dental Surgery at Howard University, and an MBA from Brenau University. He completed his postgraduate training at Provident Hospital/University of Maryland, where he became certified in General Practice. Prior to joining DeKalb County in 2004, Dr. Turner was the Atlanta Program Coordinator for the Colgate-Palmolive Company's Bright Smiles, Bright Futures program. Dr. Turner also

served as Clinical Instructor for the Georgia Perimeter College, Department of Oral Hygiene and as the managing and treating dentist for the Ryan White HIV oral healthcare program at the Fulton County Department of Health & Wellness.//2013//

Sharon C. Quary, MS is the Manager of the Newborn Screening Unit. She received her Master of Science in Medical Genetics/Genetic Counseling in 1997 from Howard University, Washington, D.C. Prior to joining Public Health, she served as the Coordinator of the Newborn Screening Follow-Up Program and piloted a Duchene Muscular Dystrophy Infant Screening Program at Emory University, Department of Human Genetics, Division of Medical Genetics. /2013/ Ms. Quary resigned April 2012. DPH is currently recruiting for this position.//2013//
/2014/This position has been filled by Ms. Kelli Rayford, formerly Interim Program Director for Comprehensive Child Health. This position reports to the Director of the Office of Child Health.//2014//

Kelli E. Rayford, RN, MSN, PNP is the Program Director for the Comprehensive Child Health Services Unit. She has worked in various areas of Public Health for over 11 years, including positions as a Nurse Practitioner, Nurse Manager, and Nurse Consultant. In her current position, she has oversight of several Public Health programs and services, including Children 1st, Health Check. /2012/ Ms. Rayford is currently the Children and Youth with Special Needs Nurse Consultant. //2012// /2013/ Ms. Rayford is serving as the Interim Program Director for Comprehensive Child Health.//2013//

/2014/Ms. Rayford is now the Manager of the Newborn Screening Unit where she provides guidance and oversight to the Universal Newborn Hearing Screening and Intervention program and the newborn screening metabolic program. The Program Director for the Comprehensive Child Health Services Unit position is currently vacant.//2014//

/2013/ Audrey M. Blake, MPH, Director for the CYSHCN Unit, holds a BA degree in Psychology and a MPH degree in Health Administration. Her professional career over the past 25 years has centered on the Health and Human Services and Public Health fields, including working a social worker at the Department of Social Services -- Economic Services and a Program Information Coordinator at the University of South Carolina's School of Medicine: Center for Developmental Disabilities. In this capacity she provided counseling, referral and advocacy to parents and professionals nationwide. She has also worked as a Health Planning Administrator at the Ohio Department of Health. //2013//

Patricka D. Wood, RN, MPH is the Director of the Perinatal/Women's Health Unit. She received her RN training from the University Hospital of the West Indies School of Nursing in Kingston, Jamaica. In 1983, she completed midwifery training at Foresterhill College, Aberdeen Maternity Hospital in Scotland. She received her M.P.H. from Emory University in 1995. She has been employed in high-risk maternal and infant care since 1983. /2013/ Ms. Wood resigned in December 2011. Interviews for this position are in process. //2013//
/2014/Dr. Relda Robertson-Beckley was hired as the Women's Health Director in June 2012 and was promoted to the Director of the Office of Family and Community Health. Wanda Prince was hired as the Director for the Family Planning Program in April 2013.

Relda Robertson-Beckley, BSN, MPH, PhD is our Family and Community Health Director. She brings to this position 20 years of public health experience working at the local, state and federal levels. She also has years of experience in academia. As an Assistant Professor, she taught undergraduate and graduate courses in the School of Nursing at San Francisco State University and at Samuel Merritt College. She also teaches Population-based Planning, Public Health Promotion and Public Health Planning and Evaluation courses in the PHD program in the School of Health Science at Walden University. Most recently, she served as the Director of Public Health Nursing, Policy and Planning for Alameda County Public Health. During her tenure as the Director of Public Health Nursing, she developed and launched the Foster Care Initiative, Universal Health Screening targeting OUSD schools and the Pre-eligibility and School-based units. She is also a grant reviewer for the Center for Medicaid and Medicare's Innovation grants.//2014//

/2012/Arianne B. Weldon, MPH, Director of the Office of Title V Integration and Title V Administrator, administers the statewide Title V Maternal and Child Health (MCH) Block Grant, managing the planning and implementation of Title V activities. Prior to joining the Georgia MCHP in 2010, Ms. Weldon was the Director of State Partnership Strategies for Georgia Family Connection Partnership (GaFCP) where she served as a liaison to state-level population-based initiatives across multiple state agencies, private sector organizations, and communities to assure coordination and collaboration in efforts to improve child and family well-being. Ms. Weldon's training includes serving as a guest researcher with CDC conducting active surveillance of bacterial meningitis and conducting research at Grady Memorial Hospital with the Emory University School of Medicine on overcoming barriers to care for African-Americans with Type II diabetes.//2012//
/2014/Ms. Weldon resigned in November 2012. DPH is currently recruiting for this position.//2014//

/2012/ Theresa Chapple-McGruder, BA, MPH, PhD, Director of the Office of Maternal and Child Health Epidemiology, received her Bachelor's Degree in Psychology from Clark Atlanta University in 2002, Master of Public Health in Maternal and Child Health from the University of North
Carolina at Chapel Hill in 2005, and her Doctor of Philosophy in Epidemiology from the University of Illinois at Chicago in 2009. Prior to joining the Georgia MCHP, she was the Acting of Chief of Epidemiology at the Memphis and Shelby County Health Department. She has also worked as
the Lead Epidemiologist for the University of Chicago OB/GYN Department and as a Data
Coordinator for the University of Illinois at Chicago Perinatal Center.//2012//

Medical Oversight: To assure that MCHPs and services reflect sound clinical practice and medical research, the MCHP has contracted with medical consultants to work with MCHPs and services. /2012/Seema Csukas, MD, PhD,

Maternal and Child Health Medical Director, is a board-certified pediatrician and a fellow of the American Academy of Pediatrics. Dr. Csukas has worked as a primary care physician serving low-income families for over 12 years. She joined
Children's Healthcare of Atlanta in 1994 and in her 16 years of tenure there served in a number of leadership roles including Medical Director for Primary Care Services, Director of Child Health Promotion, and Medical Director for Child Wellness. Dr. Csukas earned her bachelor's degree from Emory University in Atlanta She received her medical and doctorate degrees from the Georgia Health Sciences University (formerly the Medical College of Georgia) in Augusta. Prior to coming to Atlanta, Dr. Csukas was on faculty in the Department of Pediatrics at the Medical College of Wisconsin in Milwaukee.//2012// /2013/ Dr. Csukas was named Interim Director of the MCHP and WIC in January 2012. //2013//
/2014/Dr. Csukas was named Director of the Maternal and Child Health Section in July 2012.//2014//

Family and community involvement: There are currently nine parent educators who assist the BCW Program with policy development/review, federal grant review, training and support for family members and providers, and encouragement of local and state parent involvement. Eight of the parent educators serve the Dalton, Cobb/Douglas, Clayton, Gwinnett, DeKalb, Valdosta, Albany, and Athens public health districts. In addition, one of the parent educators, who is Hispanic, serves as a statewide multicultural specialist for Georgia's Hispanic families. Recruitment is underway to hire parent educators in the Columbus, Rome, and Waycross districts. Parents of children in BCW and CMS participate in local Interagency Coordinating Council (ICC) meetings in all 18 Georgia public health districts.

The State CMS Office has developed and is facilitating public health district use of a family support group template to foster the establishment of CMS or CYSN family support groups in each district. Currently, all 18 districts have either a Family Action and Support Team (FAST) or a family support group. Goals of these groups include: providing families with special needs
children the opportunity to review and advise on development or revision of current policies and procedures for CMS; providing families with the opportunity to advise CMS of the concerns of children with special health care needs and their families in order to improve and develop programs, using a family-centered approach, that are responsive to the identified needs; providing families an opportunity to come together to network and offer each other support and
information; increasing public awareness of programs that are community-based, family-centered, and that provide coordinated, culturally-competent services for children with special health care needs; and establishing a Youth Advisory Council within FAST to guide CMS on the needs and concerns of youth with special health needs and to provide FAST with the youth perspective on the execution of FAST goals.

CMS involves parents in the development of their child's plan of care (POC) and the identification and prioritization of the child's needs as well as the needs of the family. CMS district staff also support clients and their families through various methods, including providing funding for attendance at diabetes and asthma camps; coordinating mothers' nights out; supporting grandparents groups; holding parent workshops; offering sickle cell training for local school nurses; and providing support for asthma coalitions, parent advisory committees, and other community advisory committees, and task forces.

At the district level, CMS staff attend and support local ICC activities. District staff also participate in local Family Connection Partnership initiatives and other community advocacy activities. The Family Connection Partnership Collaborative brings together more than 3,000 local and state- level partners committed to strengthening children and families so they can learn from their peers, share resources, and replicate best practices. The collaborative organizations in the Family Connection Partnership network, which branches out into all 159 counties in Georgia, are committed to improving the quality of life in their communities. Local collaborative organization membership includes concerned citizens, civic groups, local businesses, faith communities, elected officials, and representatives and leaders from state agencies.

Families are surveyed yearly to obtain information about how best the healthcare services their child receives can be improved. Survey findings assist the state office in identifying program strengths as well as areas for improvement.

The Universal Newborn Hearing Screening and Intervention (UNHSI) Stakeholder Committee currently has one

parent representative. Sherry Richardson, Director of the Georgia Family Voices Program with Parent of Parent of Georgia, is MCH's Association of Maternal and Child Health Programs (AMCHP) parent representative. She is also one of two regional field coordinators for Family Voices. As Director of the Family Voices Project, she supports families as they negotiate the complex levels of health care systems and policies in the state of Georgia. Parent to Parent of Georgia supports families of children and youth with special health care needs. Parent to Parent currently serves as Georgia's Family to Family Health Information
Center. (See Section F -- Other Program Capacity for additional information on Parent to Parent services.) /2013/ Ms. Richardson was recently hired as a Program Consultant to assist CSHCN in increasing parent involvement. //2013//
/2014/BCW utilizes Parent Trainers in all in-person training modules for the Skilled Credentialed Early Interventionists (SCEIS) Credentialing process for new BCW Special Instructors and Service Coordinators. DPH was awarded a federal Integrated Community Systems for Children and Youth with Special Health Care Needs Grant, for which families and youth play an integral role in implementing grant activities. CMS recruited Family leaders from each of its 18 districts to participate in its program improvement project. Family leaders were involved in decision-making alongside their CMS district coordinator on workgroups for data, services, and financing.//2014//

E. State Agency Coordination

Input from Georgia's broad array of public and private sector organizations is key in assisting with the state's MCH policy, planning, and service delivery efforts.

STATE AGENCIES:

Bright from the Start: The Department of Early Care and Learning (DECAL) is responsible for meeting the child care and early education needs of Georgia's children and their families. DECAL oversees a wide range of programs focused on children ages birth to school age and their families. These programs include: 1) administering Georgia's Pre-K Program; 2) licensing and monitoring the state's center-based and home-based child care facilities (approximately 10,000);
3) overseeing the federal Child and Adult Care Food Program and the Summer Food Service Program; 4) maintaining the Standards of Care Program and Family Homes of Quality to help child care providers enhance their program quality; 5) housing the Head Start State Collaboration Office; 6) administering the federal Even Start dollars to promote family literacy; and 7) providing technical assistance, training, and support to families and child care providers who care for
children with special needs. DECAL collaborates with Head Start, Family Connection Partnership, the Department of Human Services Family and Children Services, DPH, and Smart Start Georgia to blend federal, state, and private dollars to enhance early care and education. DECAL and DPH have a memorandum of agreement for enhanced services to support early childhood health and development for children and youth. DECAL is implementing an "Agency Accepted Trainer" pilot program with other state agencies to provide for-credit-training for Georgia child care providers. The MCHP has been identified as the first "Agency Accepted Trainer." MCH Ages and Stages training opportunities have been posted on the DECAL website and local training will be initiated by summer 2010. In addition, DECAL staff serves on MCH's Early Childhood Comprehensive Systems (ECCS) Steering Committee and on ECCS subcommittees. /2012/ The MCHP is developing a partnership with DECAL to support shared goals. //2012// /2013/ DECAL recently developed a Quality Rating Improvement System; MCHP assisted in creating the system's child health and nutrition component. Over 500 child care providers have enrolled in the voluntary system to assess, improve and communication of the level of quality in early
care and education programs. DECAL's pre-kindergarten program received its first 10 out of 10 measures of quality for 2010-2011 from the National Institute for Early Education. Only 5 of 39 state programs met all 10 standards. DECAL serves as administrative home for federal funding that supports Georgia's Early Childhood Advisory Council. DECAL has contracted with MCH to conduct work around developmental screening follow up. MCH Healthy Development work includes developing an updated social-emotional resource list,
providing training on social-emotional awareness, and developing a Health Screening Plan that includes identified state resources, a gap analysis, recommendations, and a roadmap.
//2013//
/2014/The Health Screening Healthy Development project ended May 31, 2013. The final report with key

findings and recommendations has been submitted to DECAL. DECAL is compiling a final report for HHS and will be shared with the Early Childhood Advisory Council (now the Children's Cabinet) for review and determining next steps.//2014//

The Department of Behavioral Health and Developmental Disabilities (DBHDD) provides treatment and support services to people with mental illness and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD has five regions. Regional offices oversee the network of state-supported DBHDD community and hospital services in the region.

Georgia's services for children and youth who are seriously emotionally disturbed (SED) focus on family support and intervention and preventing crises whenever possible. When crises do occur, public mental health services aim to serve the child in the home or close to home if possible, and to avoid hospitalization, which can be traumatic for young children. The services a child and
family receives depends on a professional determination of level of need and the services and other community resources available. Services vary by region and may include: crisis, outpatient, and/or community support services; intensive family intervention; and outdoor therapeutic programs. Current child and adolescent mental health initiatives include Community Based Alternatives for Youth (CBAY) and KidsNet Georgia. The CBAY 1915(c) Waiver Home and Community-Based Services demonstration program uses a systems approach that targets youth served by multiple agencies, striving to coordinate, blend, and braid programs and funding to create a comprehensive behavioral system that ensures youth are placed in and remain in intensive residential treatment only when necessary and that a coordinated system of services at the community level is available.

DBHDD's KidsNet Georgia Project is designed to support the transformation of the state's child behavioral health system by strengthening and enhancing the capacity to develop, expand, and sustain behavioral health services across all child-serving agencies for children and adolescents experiencing SED and/or substance abuse and their families. The project is supported by two federal grants (Child and Adolescent State Infrastructure Grant and State Adolescent Coordination Grant). The First Lady's Children's Cabinet serves as the oversight body for the KidsNet Georgia Project. The DCH Commissioner and DPH Director serve on the Cabinet. The MCHP is represented in the KidsNet Collaborative, the project's operational body which governs the project, and in several of KidsNet workgroups. MCH's ECCS Initiative has been integrated
into the project as a subcommittee to help support efforts involving early childhood developmental screening and socio-emotional health. DBHDD staff, including the KidsNet Director, serves on the ECCS Steering Committee. DBHDD also is a member of the Georgia ECCS State Team. As a result of these collaborative activities, the KidsNet Part C Finance Committee has been moved to the ECCS Initiative as an ECCS Partnership Subcommittee work group.

DPH works with DBHDD around a number of state and local level concerns that relate to the MCH population such as youth risk prevention and tobacco use prevention. A DBHDD Mental Health representative serves on the BCW Interagency Coordinating Council. DBHDD's Division of Addictive Diseases Office of Prevention Services provided Substance Abuse Block Grant funding to help support DPH's 2008-2009 Healthy Families Georgia Mental Health Screening Project which was designed to help decrease the risk of suicide in pregnant and parenting women with depression and address associated issues with mother/child attachment and positive parenting in mothers participating in Healthy Families Georgia programs. /2013/ MCH and DBHDD partnered to enhance suicide prevention protocols in Georgia's schools and universities.//2013//

The Department of Education (DOE) oversees public education throughout the state, ensuring that that laws and regulations pertaining to education are followed and that state and federal money appropriated for education is properly allocated to the Georgia's 180 local school systems. DOE is comprised of five offices under the State Superintendent of Schools: Policy and External Affairs; Standards, Instruction, and Assessment; Education Support and Improvement; Finance and Business Operations; and Technology Services. The Divisions for Special Education Services and Supports, located in Standards, Instructions, and Assessment, include programs and services that support local school districts in their efforts to provide special education and related services to students with disabilities. These services focus on enhancing student achievement and post-secondary outcomes through implementation of regional and statewide activities for students, families, educators, administrators, and other stakeholders. Targeted areas for services and supports include accessible instructional materials, assistive technology,

curriculum access and alignment, dropout prevention, family engagement, least restrictive environment, positive behavior supports, and transition. Additional services include ensuring compliance with federal and state regulations for special education, collecting and analyzing data on education services and outcomes, providing guidance and oversight for federal and state special education funds, and coordinating resolution requirements as required by state and
federal requirements. DOE has a memorandum of agreement with the DCH that endorses and encourages joint health and human services and education planning and programming targeting reductions in teen pregnancy, substance abuse, school failure and delinquency. In many parts of the state, strong relationships have been developed between Public Health and the schools.
/2012/ As part of the first statewide school-based flu vaccination project in Georgia, MCH allocated $1 million to purchase flu vaccine to vaccinate children in school-based settings. In 2010, 15 of Georgia's 18 health districts participated in the project with 74,271 doses of flu vaccine administered between November 2010 and March 2011 in 733 schools.

Starting with the 2011-2012 school year, the fitness of students grades 1-12 in Georgia public schools who participate in classes taught by certified physical education teachers will be assessed. Physical education teachers in participating schools will receive training on FITNESSGRAM, a comprehensive health-related physical fitness and activity assessment and computerized reporting system developed by The Cooper Institute. Parents will receive a copy of their child's "FITNESSGRAM" report card, which will offer recommendations for fitness improvement. The goal is to motivate kids to score in the "Healthy Fitness Zone." SHAPE partners include the Governor's Office, CHOA, DOE, and the Arthur M. Blank Family Foundation.//2012//
/2014/One hundred and forty trainings were held between July 2011 and December 2011 for teachers. Georgia DOE, in partnership with HealthMPowers, developed a comprehensive professional learning model and training manual. Trainings were developed to ensure consistency of fitness test administration, data collection, and messaging about fitness testing, as well as to improve knowledge about health and fitness. Trainings were scheduled across Georgia to ensure access and minimal travel for teachers from all Georgia public schools. Over 3,000 physical education teachers, paraprofessionals, and other school staff members were trained in a six month period.

Data were collected on 998,774 students. Out of Georgia's 2,231 schools, 97% completed fitness assessments. Fitness scores were reported for 998,774 physical education students from 2,156 schools, representing 67% of the total population of students in grades 1-12. Of those tested, 37% of students assessed are not in the Healthy Fitness Zone (HFZ) for aerobic capacity, 43% of students assessed are not in the HFZ for BMI, 20% of all students across all grade levels (4-12) did not achieve the HFZ in any of the five assessments (0 of 5), and only 16% of all students across all grade levels (4-12) achieved the HFZ in all five assessments (5 of 5).//2014//

/2013/ The FY 2013 State General Fund allocation for DOE includes $26,399,520 to provide funding for school nurses who provide health procedures for students at school. Included in this allocation is funding for a statewide nursing coordinator. MCHP is working with DOE to update mandated reporter training for all educational personnel and parent volunteers. //2013//
/2014/A representative from DOE serves on the early intervention program (Babies Can't Wait) State Interagency Coordinating Council (SICC). There is a collaborative relationship between the Part C Coordinator (SPH) and the Part B Coordinator in DOE. Open communication is maintained and allows for continuous dialogue to address issues or concerns and positive solutions. The Part C Coordinator and the Director of the Children and Youth with Special Needs Unit (as needed) attends the DOE State Advisory Panel (SAP). The DOE representative gives valuable input regarding the Part C Annual Performance Report. Consequently, the Director of the Children and Youth with Special Needs Unit participated in the review and feedback process for the DOE Annual Performance Report.

A discussion regarding transition (at age three) memorandum of agreements for each school district to ensure that eligible children transition smoothly from early intervention to pre-school service has occurred and will be explored further.//2014//

The Department of Human Services (DHS) provides Georgia with customer-focused human services that promote child and adult protection, child welfare, stronger families and self- sufficiency. DHS includes the Division of Family

and Children Services (DFCS), the Division of Aging Services (DAS), the Division of Child Support Services (DCSS), the Office of Residential Child Care (RCC), and support offices. DFCS is responsible for investigating child abuse; finding foster homes for abused and neglected children; helping low income, out-of-work parents get back on their feet; assisting with childcare costs for low income parents who are working or in job training; and providing support services and programs to help troubled families./2013/ MCHP staff support DFCS on their federal Child and Family Services Review, Citizen Review Panel and CAPTA PIP. Office of MCH Integration and Injury Prevention staff provide leadership on two of the three CAPTA required Citizen Review Panels. //2013
/2014/The Memorandum of Understanding between Georgia Department of Human Services and the Georgia Department of Public Health was executed effective January 1, 2013, regarding children under age 3 who will be referred by DFCS to Babies Can't Wait through Children 1st.//2014//

The Department of Juvenile Justice (DJJ) provides supervision, detention, a range of treatment and education services for youths referred to DJJ by the Juvenile Courts, and provides assistance or delinquency prevention services for at-risk youth through collaborative efforts with other public, private, and community entities. Over 52,000 youth are served annually, including youth who are placed on probation, sentenced in short-term incarceration, or committed to DJJ's
custody by Juvenile Courts. DJJ, Corrections, Pardons and Parole, and MCH work collaboratively to strengthen relationships and create a continuum of care for youth leaving the state's youth detention centers to address their need for community-based health and mental health services.

The Department of Labor (DOL) operates five integrated and interdependent programs that share a primary goal -- to help people with disabilities become fully productive members of society by achieving independence and meaningful employment. The largest of the programs are the Vocational Rehabilitation (VR) Program, Disability Adjudication Services, and the Roosevelt
Warm Springs Institute for Rehabilitation. Two other programs serve consumers with visual impairments, the Business Enterprise Program and Georgia Industries for the Blind.

The Governor's Office for Children and Families (GOCF) mission is to build capacity in communities to improve outcomes for Georgia's children, youth and families. GOCF was created in 2008 to ensure that Georgians are using child welfare resources -- funding, policy, and personnel -- in a way that is targeted, consistent, and most effective. This initiative united the Children's Trust Fund Commission, Children and Youth Coordinating Council, Office of the Child Advocate, and Office of Child Fatality Review in the newly organized GOCF.

GOCF supports and strengthens families and improves outcomes for Georgia's children and youth through a community-based system of prevention and intervention services, known as Caring Communities for Children and Families. The Caring Communities system of care approach integrates care planning and management through partnerships with community organizations, children, youth and families. Organizations work in partnership to develop a network in which children, youth and families can access the programs and services that meet their needs.

GOCF is leading Partnerships for Healthy Communities, an interagency collaborative project supported by the University of North Carolina at Chapel Hill's PREVENT Institute. In addition to GOCF, partner agencies include DFCS and Children's Healthcare of Atlanta. Partnerships for Healthy Communities seeks to decrease the rate of physical abuse and abuse related injuries in Georgia's children from infancy to three years of age. To accomplish this, Partnerships for Healthy Communities is assisting health-care providers -- including pediatricians, family practice physicians, and their staff -- in preventing, recognizing and reporting physical and sexual abuse as well as neglect.

GOCF, in partnership with DECAL, leads Strengthening Families Georgia, an interagency collaborative project that seeks to create a child abuse and neglect prevention initiative that can help program developers, policymakers and advocates embed effective prevention strategies into existing systems. The project uses the Strengthening Families assets-based framework of protective factors in all systems, programs, services and activities supporting families with young children.

/2012/GOCF is the governor-designated Maternal and Infant Early Childhood Home Visiting Project (MIECHV) lead

for Georgia. The MCHP conducted the needs assessment and works in partnership with GOCF to implement the MIECHV program.//2012// /2013/ GOCF received a
2011 Competitive MIECHV Grant which support two components, a Call Center and Central Intake function. The statewide Call Center will be coordinated by MCHP. The Central Intake component is being implemented in the counties targeted by MIECHV (six in year 1 and an additional county in year 2). Beginning January 2012, Central Intake is providing Core Screening using a tool developed with DPH and GOCF that incorporates the Children 1st Screening/Referral form with MIECHV risk factors (i.e., military, tobacco/substance use, etc.). In October 2012, coordination of Central Intake and the statewide call system will move to Children 1st/Public Health. //2013// **/2014/In October of 2012, Children 1st and the DPH/MCHS assumed primary coordination of Central Intake to support the MIECHV federal grant. DPH/MCHS is providing a centralized record of all referrals via a data system that was launched on October 1 by DPH and is utilized by all agencies involved with the MIECHV system of care. DPH/MCHS also contracted with a statewide Information and Referral Center/Call Center to process all referrals. In the seven MIECHV-funded counties the Health Districts are also contributing to the community level system of care through partnership with other agencies and by providing Comprehensive Core Screenings for those referred via an Electronic Birth Certificate.//2014//**

The Social Security Administration, Rehabilitation, and Disability Unit contracts with the DOL Office of Rehabilitation Services for state disability adjudication services and determines the eligibility of children birth to age 21 for Supplemental Security Income (SSI).

MATERNAL AND CHILD HEALTH PARTNERS IN GEORGIA: There are a number of advocacy, service, and professional organizations in Georgia that are working to improve outcomes for the state's women, infants, children, and children with special health care needs. Brian Castrucci, who joined DPH in January 2010 as the new MCH Director/Title V MCH Block Grant Director, and his staff are working to engage the state's MCH stakeholders and identify opportunities for collaboration. (See the Georgia 2010 Title V MCH Block Grant Five Year Needs Assessment for a summary of a focus group held on March 18,
2010 with MCH stakeholders to provide input on the critical health and healthcare needs for Georgia's MCH populations.) Several key maternal, child, and family partnerships in the state are highlighted below. A more in-depth description of partners and stakeholders is provided in the Needs Assessment.

The Family Connection Partnership is a public/private partnership created by the State of Georgia and funders in the private sector to help communities address the serious challenges facing Georgia's children and families. As a nonprofit intermediary organization, the Partnership works closely with community, state, and national partners to provide training and technical assistance
to Family Connection county collaboratives; enhances public awareness, understanding, communication, and commitment to improve results for children and families; and uses research and evaluation to promote effective practices and programs. Family Connection serves on the ECCS Steering Committee and on the ECCS Planning Committee.

The Georgia Children's Health Alliance (GCHA) is a statewide collaboration uniting public,
private, not-for-profit, business sectors, and pediatric health experts to create healthier futures for Georgia children. Children's Healthcare of Atlanta (CHOA), March of Dimes, and Prevent Child Abuse Georgia serve as the lead agencies for GCHA. /2012/ Prevent Child Abuse Georgia closed in March 2011. The agency's helpline is now out of service. A network of over 40 independent local organizations is still alive and continuing to work to prevent child abuse. //2012// In 2009,
GCHA and DPH joined together to lead the development of the 2010 "REFOCUS on Child Health
in Georgia" report. The purpose of the report, which was released in April 2010, is to: 1) establish a baseline showing where the health of Georgia's children is today and create a starting point for conversations about child health issues, and 2) highlight what data are missing or need improvement and to bring organizations together to work on filling those data gaps. The report not only highlights health issues facing Georgia, but also looks at obstacles to families, individuals, health professionals, and organizations that are looking to improve health outcomes for Georgia's children. In addition to the report, GCHA is leading implementation of the SHAPE act to track fitness levels in school children and improve those levels as well as supporting curriculum in child care centers promoting healthy eating and physical activity. GCHA also supports reduction in
child abuse and neglect through parent interventions and evaluation of home visitation models.
/2012/ The functions of GCHA have been absorbed within CHOA. //2012//

/2013/ The Georgia Campaign for Adolescent Pregnancy Prevention (G-CAPP) is a statewide nonprofit organization that works to eliminate adolescent pregnancy in Georgia through innovative strategies that address underlying causes such as poverty, school dropout, and fragile families. Through CDC funding, G-CAPP is leading a public-private partnership (P3) to develop a strategic plan to reduce teen pregnancy, targeting the 11 counties with the highest populations and birth rate.//2013//

The Georgia Early Childhood Comprehensive Systems (ECCS) Initiative Steering Committee is composed of key early childhood partners across the state. Funded by a grant from the federal Maternal and Child Health Bureau, Initiative activities include the development of two electronic survey tools to: 1) assess the current and potential contributions of existing ECCS partners and system capacity building potential and 2) identify public and private early childhood developmental screening practices and social emotional program systems capacity at the local level. Partnerships have been developed with the Centers for Disease Control and Prevention (CDC) "Learn the Signs, Act Early" State Team and with KidsNet Georgia. A medical/dental home brochure is in the final stage of development to be used with families and non-medical early childhood case managers. /2012/ 2011 ECCS accomplishments have included branding of the Initiative as the Peach Partners ECCS Initiative, completion of the medical and dental home booklet for families, two statewide early childhood provider surveys, and convening of a joint ECCS Steering Committee meeting with the Georgia Team of the Learn the Signs/Act Early Summit. //2012// /2013/ The medical and dental home booklet has received MCH leadership approval and is expected to be disseminated widely in summer 2012 after Departmental approval. The ECCS clearinghouse is being redesigned to broaden its focus. Peach Partners has continued to meet jointly with the Learn the Signs, Act Early State Team and Peach Partner steering committee members are providing input in the development of the Georgia Autism Plan.//2013//

/2014/Training was provided by Sheltering Arms: Georgia Training Institute to various child care and program leadership on the medical and dental home booklet and how to communicate and share information with parents. The Learn the Signs, Act Early developmental brochure was also distributed to attendees during this training.//2014//

Healthy Mothers, Healthy Babies Coalition of Georgia (HMHB) is a strong, statewide voice for improved access to healthcare and improved maternal and child health outcomes through a statewide network of grassroots advocates. HMHB operates the PowerLine, Georgia's toll-free, bilingual helpline for healthcare referrals funded by the MCHP. The PowerLine maintains a database of Georgia's low-cost and sliding-scale providers, free clinics, public health program such as Babies Can't Wait, and community health services. They also refer callers to appropriate WIC Clinics and record reports of complaints or fraud.

Parent to Parent of Georgia is a statewide agency that serves children and youth with disabilities and their families. Parent to Parent offers an on-line data base of various resources such as child care, respite care or support groups that are available in local areas, provides parent-to-parent matching service, training sessions for parents on a wide variety of topics and assist local areas in organizing parent support groups. Parent to Parent of Georgia is a free service and is funded in part by DPH.

Voices for Georgia's Children is an independent, non-profit organization whose mission is to substantially improve the state's low "Kids Count" child well-being ranking by engaging lawmakers and the public in building a sustained, comprehensive, long-term agenda to impact the lives of Georgia kids in five distinct areas: health, safety, education, connectedness and employability.

/2013/Georgia Title V joined with the Kaiser Foundation to provide coordinated funding to United Way of Metropolitan Atlanta to promote CenteringPregnancy in Georgia and support reinvigoration of Grady Health System's Grady's CenteringPregnancy program.//2013//

/2014/Georgia American Academy of Pediatrics (GA-AAP) - The Georgia Chapter of the American Academy of Pediatrics is a non-profit organization with the following mission statement: To improve the health and welfare of all the infants, children and adolescents in the State of Georgia; to study the scientific, educational, social, economic and legislative aspects of medicine in order to secure and maintain the highest standards of practice in pediatrics; to promote excellence in pediatric care by organizing programs of post-graduate education; to unite qualified primary care pediatricians and pediatric medical & surgical

subspecialists of the state into a representative organization for the advancement of the practice of pediatrics; to further the policies and the objectives of the American Academy of Pediatrics at the state and local level. MCH partners with GA-AAP on a variety of training, education and outreach opportunities to educate providers and the medical community, as well as using their expertise on educating public health community.

Georgia Academy of Family Practitioners (GAFP) – The Georgia Academy of Family Practitioners is a non-profit professional medical association that is committed to delivering quality, timely service to our members. Family medicine is a medical specialty that provides continuing, comprehensive health care to individuals and families. MCH partners with GAFP on training, education and outreach opportunities to educate providers and the medical community, as well as using their expertise on educating public health community.

Georgia Obstetrical and Gynecological Society (GOGS) - The Georgia Obstetrical and Gynecological Society Inc is organized for the purposes of furthering the knowledge of obstetrics and gynecology among its members; to improve obstetrical and gynecological teaching in all levels and areas of training; to improve the practice of obstetrics and gynecology in the State of Georgia by requirement of the high standards of practice and maintenance of such standards by encouragement and promotion of continuing postgraduate education; to cooperate with all agencies and organizations who seek to improve obstetrical and gynecological care in our state and to institute such measures which will serve to stimulate interest, increase knowledge, and promote fellowship among our members. MCH partners with GOGS on training, education and outreach opportunities to educate providers and the medical community, as well as using their expertise on educating public health community.

March of Dimes Georgia is a non-profit national organization with a state chapter in Georgia. The mission of the organization is to help moms have full-term pregnancies and research the problems that threaten the health of babies. MCH partners with the March of Dimes in many ways. Currently, we are partnering on the Association of State and Territorial Health Officials (ASTHO) Challenge which is a challenge to improve birth outcomes by reducing infant mortality and prematurity in the United States. Specifically, the goal is to decrease prematurity in the United States by 8% by 2014. In addition to the ASTHO Challenge, March of Dimes is represented on our Georgia Infant Mortality Task Force and Georgia Perinatal Quality Collaborative work group.

Prevent Child Abuse Georgia (PCA-GA) provides statewide direction to promote healthy children and develop strong families in five ways: prevention network, public awareness, prevention programs, research and advocacy activities. In the last two years, PCA-GA has re-established itself as a leader of preventing child abuse in Georgia. PCA-GA recently received a $165K challenge grant from The Arthur M. Blank Foundation to re-establish the 1-800-CHILDREN helpline. Currently, a MCH representative serves on the Advisory Board, and continues to identify opportunities to support the work of PCA-GA.//2014//

RELEVANT COUNCILS:

The Governor's Council on Developmental Disabilities (DD Council) serves as an advisory body and provides broad policy advice and consultation to state agencies.

The Interagency Coordinating Council (ICC) for Early Intervention, mandated under Part C of IDEA, is appointed by the Governor to advise and assist DCH in planning, coordinating and implementing a statewide system of early intervention services for children with or at risk for developmental delays.

Federal Qualified Centers: Georgia's Community Health Centers (CHCs) offer a comprehensive range of primary health care and other services including around the clock care, acute illness treatment, prenatal care, well-child

care, physicals, preventive services, health education, nutritional counseling, laboratory, x-ray and pharmacy services. The state's network of 28 CHCs serves over 238,000 Georgians each year in over 70 of the state's 159 counties. A number of these CHCs provide perinatal case management services and newborn follow-up.

Tertiary Care Facilities: Relationships have been established throughout the state with tertiary care facilities with technical resources that have enhanced Georgia's capacity to offer services to women of childbearing age, infants, children and adolescents. The state has two Level II pediatric trauma centers, four children's hospitals, and two burn units. Regional perinatal services are provided statewide through six designated tertiary care hospitals located in Atlanta, Macon, Augusta, Columbus, Albany and Savannah. High-risk perinatal services provided include transportation, prenatal care, delivery, post-partum care, and newborn care. A regional perinatal planning process facilitates planning in each of the six perinatal regions, bringing together in each region representatives from hospitals, district public health, and community organizations.

Technical Resources: The MCHP collaborates with the state's Distance Learning and Telemedicine Program (GSAMS) network to bring specialty health care to areas with limited access. BCW also utilizes telehealth technology. All four of the state's medical schools (Medical College of Georgia, Emory University School of Medicine, Morehouse School of Medicine, and Mercer University School of Medicine) have faculty that participate in the CMS program. The Centers for Disease Control and Prevention (CDC) is a valuable resource in providing technical assistance and resources to the Program. The Rollins School of Public Health at Emory University works with DPH in many areas: internships for students; program and outcome evaluation; and technical assistance and consultation. Several other universities (Georgia State University, University of Georgia, and Clayton State) also work with MCH and DPH, providing technical assistance, research, and training. Georgia State University's Health Policy Center (GHPC) conducts, analyzes and disseminates qualitative and quantitative findings to connect decision makers, including DPH and its MCHP, with the objective research and guidance needed to make informed decisions about health policy and programs. The GHPC is working with DCH
on a low birth weight modeling project which dovetails with work on the Planning for Healthy Babies (P4HB) Medicaid waiver that will extend eligibility for family planning services to low income women.

Professional Organizations: MCH works on an ongoing basis with the Medical Association of Georgia, Georgia State Medical Association, Georgia Chapter of the American Academy of Pediatrics (GA-AAP), Georgia Academy of Family Physicians (GAFP), Georgia Chapter of the College of Obstetrics and Gynecology, and other professional groups to promote increased private sector involvement in serving women, children, and youth in need.

A more in-depth description of Georgia MCHP partners is provided in the Needs Assessment.

F. Health Systems Capacity Indicators

Introduction: The Health System Capacity Indicators identify opportunities to strengthen health care system in Georgia through improved collaboration between Medicaid and Georgia Title V. Health System Capacity Indicators 2, 3, 5A through D, 6A through C, 7A, and 7B are all associated with Medicaid. As described in this section, there are several MCH programs that support Medicaid enrollment and linkage to service. Improved collaboration between Medicaid and Georgia Title V may result in improvements in these indicators.

HSCI 1: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

The Georgia Asthma Control Program (GACP) is part of a national initiative launched by the Centers for Disease Control and Prevention (CDC), National Center for Environmental Health to reduce the burden of asthma and improve the health and quality of life for all persons affected by asthma through effective control of the disease. DPH established Georgia Addressing Asthma from a State Perspective (GAASP) in 2001 with CDC funding. GAASP includes representation from more than 30 organizations, including academic institutions, advocacy groups, professional organizations, private and public health care centers, and a private foundation.

The CMS Coordinators in all 18 public health districts provide asthma education to children with asthma and their

families. Education topics include recognition and avoidance of triggers in the home and in a child's environment; recognition of signs of distress and a plan of action; identifying signs of distress and importance of alerting an adult when away from home; the importance of having an asthma action plan; and the relationship of obesity to asthma. The CMS Coordinators also provide asthma education to school nurses that emphasizes avoidance of triggers and asthma management with the use of a child's asthma action plan. Some districts
provide funding for tuition for asthma camps, such as Camp Breathe Easy or Camp Huff and Puff, or they sponsor the camp in their district.

The GACP has provided funding to support asthma education efforts in seven health districts and their communities. GACP also partners with local health districts to promote the adoption of "Asthma Friendly School" policies. Through these partnerships, GACP targets school age
children and the birth to four age population.

GACP has an active statewide coalition, the Georgia Asthma Advisory Council, composed of over
45 medical and public health professionals, business and government agency leaders, community activities, and others dedicated to improving the quality of life for people with asthma through information-sharing, networking, and advocacy. The coalition is chaired by one of the directors of the Area Health Education Center (AHEC). Key stakeholders, such as the Healthcare Georgia Foundation and their asthma grantees, which include Children's Healthcare of Atlanta (CHOA), GASN, Galilee Outreach Ministry, Inc, and Area Health Education Centers (AHEC) are now GAAC members. The addition of these organizations to the GAAC membership has expanded the reach of GACP.

/2012/ There are no updates for this indicator.//2012// **/**2013/ There are no updates for this indicator.//2013//
/2014/ There are no updates for this indicator//2014//

HSCI 2: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Eligible Medicaid and PeachCare enrolled children are matched with one of three Georgia
Healthy Families Care Management Organizations (CMOs): Amerigroup Community Care, Peach State Health Plan, and WellCare. The MCHP supports and assists children and families enroll in Medicaid. This indicator is supported by the MCHP through Children 1st and Health Check.

Children 1st is the "Single Point of Entry" to a statewide collaborative system of public health and other prevention based programs and services. This system helps parents provide their young children with a healthy start in life. It allows at-risk children to be identified early and gives them a chance to grow up healthy and ready for school. Participation is voluntary and there are no financial requirements for enrollment into the program. Children 1st may assist Medicaid-eligible children access needed services.

Health Check is Georgia's well child or preventive health care program for Medicaid-eligible children birth to 21 years of age and PeachCare for Kids™-eligible children birth to 19 years of age. It is the Early and Periodic Screening, (EPS) component of the EPSDT program for the State of Georgia. The Diagnostic and Treatment (DT) service components are provided by either the Health Check screening provider, if qualified to perform those services, or upon referral to an appropriate service provider of the member's choice.

/2012/There are no updates for this indicator.//2012// /2013/ There are no updates for this indicator.//2013//
/2014/There are no updates for this indicator.//2014//

HSCI 3: The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

Eligible PeachCare children are matched with one of three Georgia Healthy Families Care
Management Organizations.

The MCHP supports and assists children and families enroll in Medicaid. This indicator is supported by the

MCHP through Children 1st and Health Check.

Children 1st is the "Single Point of Entry" to a statewide collaborative system of public health and other prevention based programs and services. This system helps parents provide their young children with a healthy start in life. It allows at-risk children to be identified early and gives them a chance to grow up healthy and ready for school. Participation is voluntary and there are no financial requirements for enrollment into the program. Children 1st may assist Medicaid-eligible children access needed services.

Health Check is Georgia's well child or preventive health care program for Medicaid-eligible children birth to 21 years of age and PeachCare for Kids™-eligible children birth to 19 years of age. It is the Early and Periodic Screening, (EPS) component of the EPSDT program for the State of Georgia. The Diagnostic and Treatment (DT) service components are provided by either the Health Check screening provider, if qualified to perform those services, or upon referral to an appropriate service provider of the member's choice.

/2012/There are no updates for this indicator.//2012// /2013/ There are no updates for this indicator.//2013//
/2014/There are no updates for this indicator//2014//

HSCI 4: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

The MCHP continues outreach efforts to increase access to prenatal care and referrals to prenatal providers during the first trimester of pregnancy. Referrals to providers that offer low-cost or no-cost prenatal care for uninsured and underinsured pregnant women also are made through PowerLine (Georgia's Title V toll-free number).

Through several MCHPs, including WIC and Family Planning, educational messages are delivered that promote planned pregnancies and the importance of preconception health. These messages may contribute to earlier engagement in prenatal care.

With the implementation of the 2003 Certificate of Live Birth in 2007, questions used to measure prenatal care initiation and visits changed. This change is seen in the approximately 20 percentage point drop in this indicator between 2006 and 2007.

From PRAMS data, the percent of women who received prenatal care in the first trimester remained consistent between 2004 and 2006. This indicator falls short of the Healthy People 2010 objective of 90 percent. Women with more than a high school diploma came closest to reaching the Healthy People 2010 objective. The percent of women who received prenatal care in the first trimester was less than 60 percent among women under the age of 20 years, Hispanic women, and women with less than a high school diploma. In half of Georgia's public health districts, between 80 percent and 89 percent of women received prenatal care in the first trimester. The Clayton Public Health District was the only district to have fewer than 75 percent of women receive prenatal care in the first trimester.

/2012/ The implementation of Planning for Healthy Babies, a Medicaid women's health waiver, will increase access to interconception care leading to early entry into prenatal care. Planning is underway to expand access to group prenatal care, which may increase early entry into prenatal care by offering a more interesting model than traditional care. Despite these improvements, the elimination of the Babies Born Healthy program limits prenatal care options for low income women who do not qualify for Medicaid.//2012//

/2013/A statewide conference was held to promote group care model as an approach to prenatal care. Sharon Rising, CNM, MSN, developer of the Centering model was a featured speaker and facilitator.//2013//

/2014/There are no updates for this indicator.//2014//

HSCI 5A: Percent of low birth weight (< 2,500 grams)

Georgia's Perinatal Regional System provides funding through the Department of Community Health to six designated regional tertiary hospitals to provide high-risk perinatal services, including transportation, prenatal care, delivery, postpartum care, and newborn care. Tertiary
hospitals also provide outreach and education to area providers to further a seamless community- based system in Georgia. Women who are at or below 250% of federal poverty level are eligible for these services.
High-risk perinatal factors are obstetrical conditions, medical conditions, surgical conditions, fetal conditions, maternal conditions and neonatal conditions.

In April 2009, DCH, in collaboration with community and agency partners, embarked on an initiative to reduce Georgia's LBW rate from 9.5% to 8.6% over a five year time span. Currently, the Georgia Medicaid Program provides prenatal coverage for pregnant women with monthly incomes at or below 200 percent of the FPL. These women are eligible for family planning services through the end of the month in which the 60th postpartum day falls. After 60 days, women whose incomes exceed the categorical limits for participation in the traditional Medicaid program lose eligibility for all benefits, including family planning. Implementation of the P4HB program will extend eligibility for family planning services to women aged 18 through 44 years who are at or below 200 % of the most current FPL; and provide inter-pregnancy care to women at or below 200% of poverty who have previously delivered a VLBW baby. The waiver will begin January 1, 2011 and ends December 31, 2015.

/2012/The P4HB Medicaid waiver program began on January 1, 2011 and will end December 31, 2015. P4HB consists of three services: Family planning; Inter-pregnancy care (IPC); Resource Mother (care management).

Both IPC and Resource Mother services are limited to women who give birth to a VLBW baby. Women who do not receive Medicaid benefits and give birth to a VLBW baby will be enrolled in the IPC section of the P4HB program, which also includes family planning and Resource Mother services. Women who currently receive Medicaid benefits and give birth to a VLBW baby are only eligible for Resource Mother services. The Resource Mother offers support to mothers and provides them with information on parenting, nutrition and healthy lifestyles.

In FY11, Title V provided $150,000 to support outreach activities to ensure public awareness of the P4HB initiative. In FY12, Title V will provide approximately $300,000 to evaluate engagement of mothers in the IPC program while in the NICU setting.//2012//

/2013/Implementation of "auto-enrollment" for the Family Planning waiver began December 2011 for women rolling off Medicaid at 60 days post-partum; females aging out of Medicaid or CHIP at age 19; women who have had a VLBW baby based on diagnosis codes in Medicaid claims history. There are 28,891 family planning waiver participants; 27 had a VLBW baby and are in IPC. Evaluation of IPC in the NICU began late fall, 2011 and study enrollment continues.//2013//
/2014/There are no updates for this indicator.//2014//

HSCI 5B: Infant deaths per 1,000 live births

MCH Epidemiology conducts analyses of infant deaths to identify groups at highest risk and to identify risk factors that may be potentially modifiable. Results from these analyses are being used to target intervention efforts in communities with the highest rates of infant death and to focus efforts on effective interventions.

The MCHP's Perinatal/Women's Health Unit is working with MCH Epidemiology to establish a Maternal Pregnancy Associated Mortality Review Committee. /2012/From 2002-2006, 5,743 babies in Georgia died before age one. While the National Infant Mortality Rate (IMR) decreased by 10% during this period, Georgia's IMR (8.23 per 1000 live births) remained 15 to 20 % higher than the average for the rest of the nation, and 42% higher than the Healthy People 2010 goal.

The most recent analysis identified six statistically significant geographic clusters with disproportionately high infant mortality rates among Georgia's 159 counties. The clusters fall into Bibb, Chatham, Fulton, Lowndes, Muscogee, and Richmond counties.

Each Peach Matters (EPM) is being developed as a collaborative initiative to implement multiple prevention and intervention strategies to improve conditions that underlie poor perinatal health outcomes related to infant mortality.

Baby LUV, a program developed in Lowndes County, was implemented in response to their high infant mortality rate (IMR) in 2004-2005. The rate in Lowndes County was 15.9, almost double the state of Georgia rate of 8.5. Enrollment is from admission to the infant's first birthday. Since the beginning of the program in 2008, 349 clients have been admitted with 1 infant death within that 3 year period. Title V funds have been provided to continue the program.//2012// /2013/Georgia is participating in the HRSA Region IV and VI infant mortality collaborative and drafted a state plan. A perinatal quality initiative is being developed.//2013//
/2014/Georgia participated in the ASTHO challenge to decrease PTB by 8% by 2014. As of 2012, Georgia has met and exceeded the ASTHO challenge target.//2014//

HSCI 5C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Early and adequate prenatal care is encouraged and supported through MCH and Medicaid case management programs. Delivery of high risk infants at centers that are appropriate for their needs is encouraged through education efforts conducted by outreach educators in their perinatal
region.

The MCHP's Perinatal/Women's Health Unit is collaborating with Medicaid and public health districts to increase the percentage of women with early entry into prenatal care. Program staff are also working with Healthy Start grantees and other community stakeholders to improve services for pregnant women in Georgia.
/2014/Program staff are working with internal and external stakeholders and community-based organizations to improve services for pregnant women in Georgia.//2014//

/2012/Medicaid data are not routinely linked to birth data; 2004 is the most current linkage available. In 2011, a data sharing agreement was established between Medicaid and WIC with discussions about the feasibility of linking data. On July 1, 2011, the DPH became a separate agency reporting to the governor. This changes the relationship with Medicaid from an intra- agency relationship to an inter-agency relationship.//2012// /2013/Monthly cadence meetings between DPH and Medicaid leadership began February 2012.//2013//

HSCI 5D: Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

MCHPs link patients with available programs and entitlements for which they are eligible to support the delivery of MCH services. As soon as a pregnancy is identified, eligible women are linked to Medicaid. Early and adequate prenatal care is encouraged and supported through MCH and Medicaid case management programs. Delivery of high risk infants at centers that are appropriate for their needs is encouraged through education efforts conducted by outreach educators in their perinatal region.

MCH works collaboratively with the GAFP and the GOGS to encourage linkage of pregnant women to early and adequate prenatal care. GOGS provides outreach, education and relationship development between physicians and public health entities throughout the state in coordination with PH programs including HIV/STD, Immunizations, Family Planning, Child Health and WIC. The Title V hotline provides women with referral and contact information for low cost obstetrical providers. The MCH also provides public health awareness and education based on CDC's recommended guidelines on preconception health, including encouraging women to make healthy lifestyle changes and to develop a reproductive life plan with their providers, in an effort to improve birth outcomes.

/2012/Medicaid data are not routinely linked to birth data. 2004 is the most current linkage available. In 2011, a data sharing agreement was established between Medicaid and WIC. Initial discussions have occurred pertaining to the feasibility of linking data. On July 1, 2011, the DPH became a separate agency reporting to the governor. This changes the relationship with Medicaid from an intra-agency relationship to an inter-agency relationship.//2012// /2013/A master data sharing agreement is being finalized.//2013// **/2014/There are no updates for this indicator.//2014//**

HSCI 6A: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs.
- Infants (0 to 1)

Georgia Medicaid is funded through $2,370,000,000 in state funds and $4,448,000,000 in federal funds. Georgia Medicaid serves 1.69 million clients and approximately half (823,000) are children. Of all Medicaid spending in Georgia, 30 percent is expended on children compared to 20.5
percent nationally, expending approximately $2,000 per child compared to $2,135 nationally. Medicaid spending declined 8.7 percent in Georgia, while increasing nationally by 3.6 percent.

Medicaid pays for approximately 60 percent of all deliveries in Georgia. There is no SCHIP support for pregnant women. A family planning waiver in Georgia will expand postpartum coverage to a greater number of women to improve birth outcomes and spacing.

PeachCare for Kids, the name for Georgia CHIP, is funded through $77,965,510 in state funds and $224,990,270 in federal funds. Enrollment in June 2009 was 198,951. The greatest enrollment was June 2007 with 276,551 enrolled./2012/There are no updates for this indicator.//2012// /2013/ There are no updates for this indicator.//2013// **/2014/There are no updates for this indicator.//2014//**

HSCI 6B: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs.
- Medicaid Children

See HSCI 6A.
/2013/ There are no updates for this indicator.//2013// **/2014/There are no updates for this indicator.//2014//**

HSCI 6C: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. See HSCI 6A.
/2013/ There are no updates for this indicator.//2013// **/2014/There are no updates for this indicator.//2014//**

HSCI 7A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

With implementation of Georgia's Medicaid managed care system and the family's choice of a CMO, the PCP member of the selected CMO is the child's "medical home."Each of the state's three CMO providers have a different agreement for services traditionally provided by the state's
159 county health departments. MCH staff work to educate families new to the managed care process to assist them in navigating the services and regulations of a CMO.

The MCHP supports and assists children and families enroll in Medicaid. This indicator is supported by the MCHP through Children 1st and Health Check.

Children 1st is the "Single Point of Entry" to a statewide collaborative system of public health and other prevention based programs and services. This system helps parents provide their young children with a healthy start in life. It allows at-risk children to be identified early and gives them a chance to grow up healthy and ready for school. Participation is voluntary and there are no financial requirements for enrollment into the program. Children 1st may assist Medicaid-eligible children access needed services.

Health Check is Georgia's well child or preventive health care program for Medicaid-eligible children birth to 21 years of age and PeachCare eligible children birth to 19 years of age. It is the Early and Periodic Screening, (EPS) component of the EPSDT program for the State of Georgia. The Diagnostic and Treatment (DT) service components are provided by either the Health Check screening provider, if qualified to perform those services, or upon referral to an appropriate service provider of the member's choice.

/2012/There are no updates for this indicator.//2012// /2013/ There are no updates for this indicator.//2013//
/2014/There are no updates for this indicator. //2014//

HSCI 7B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

The MCH Oral Health Section (OHS) and the district Georgia Oral Health Prevention Program (OHP) provide dental

services to underserved school children by targeting schools with greater than 50% free and reduced lunch program participants. Services include screenings or examinations, sealants, fluoride applications, preventive educational services, and fluoride mouth rinse programs when appropriate. The Oral Health district programs include 33 /2012/Number increased to 42//2012// fixed clinic sites and 14 mobile dental units in 11 health districts.
/2014/Three of these sites are rural Teledentistry programs located in schools. There are plans to increase the Teledentistry program in 2013.//2014//
OHP maintains a list of referral sources that accept Medicaid and PeachCare reimbursements, including public health facilities and sliding scale community centers for children needing more extensive dental care.
/2014/The OHU assisted the Georgia Oral Health Coalition with website mapping on access to oral health services; these clinics include low income dental services located at FQHC's, Community Health Clinics, Public Health Clinics and Faith Based clinics. This assists medical providers, schools and others with one easy site for low income oral health services. The partnerships with stakeholders and other oral health service clinics were enhanced while planning a state Oral Health Summit, "Oral Health Access: Collaborating to Bridge the Gap", August 2012. Over 145 attendees worked in regional breakout sessions while they applied the oral health presentation materials, surveillance, barriers and solutions, to their region of the state. These regional coalitions have continued to meet to address their local oral health access or literacy issues.//2014//

Population based services continue with a strong focus on prevention and collaboration with other medical providers. Expansion of the Medical college of Georgia School of Dentistry and HRSA workforce development grant provides more public health internships to senior dental students. Partnering includes support of the expansion of the Georgia Regents University College of Dental Medicine and HRSA workforce development grant providing more public health internships to senior dental students. The DPH dental directors serve as adjunct faculty supervising the dental students during their externship in public health facilities.
Planning has begun to lay the framework for the fall 2010 3rd grade survey. Eighty schools (over 60) have been randomly selected by the OH Epidemiologist and 3400 students were screened. To ensure reliable and valid data survey forms are being developed and pre-evaluated by the Epidemiologist. Opportunity for input on the 3rd grade survey was open to the Obesity and Nutrition Units. Questions developed by these units and a BMI will be included in the survey to support the initiatives of these programs. A search for a consultant to train the health care professionals doing the surveying has begun.
/2014/A consultant trained the health care professionals to ensure calibration of the screeners. A Head Start oral health BSS is planned for fall of 2014.//2014//

Significant inequalities in oral health remain in the U.S. based on income, race/ethnicity, disability and geographic location. Participation by staff in numerous outreach programs for children needing oral health services promotes the program and helps reach children presenting with these disparities. In 2009, the staff helped plan (and participated in as a provider) the Public Health- GDA collaboration for "Give Kids-A Smile" Day in Toombs County in Feb 2009. Over 120 children with limited access to dental care were provided comprehensive dental services. In February, 2010, staff participated in "Give Kids-A-Smile Day along with Georgia Perimeter College dental hygiene students and DeKalb Health department dental staff, and the Georgia Dental Association, with 842 participants, 244 sealants were placed, 175 fluoride varnish applications and other dental services. This was a school selected due to language barriers and the percentage of free lunch kids. With two OHU staff members bilingual in Spanish these children felt extra comfortable with the staff. Two staff members volunteered for the Baptist
Mobile Dental Van serving a Spanish population in the Decatur area. Patients were treated by staff members as they volunteered their services.
/2014/In 2013, the staff helped plan (and participated in as a provider) the Public Health-GDA collaboration for "Give Kids-A-Smile" Day in Dekalb County in February 2013. Sealant program have traditionally served elementary students, but the OHU is planning to expand the sealant programs to middle-school children in 2013. The OHU staff each year screen and seal teeth of children and adults during the Special Olympics event at Emory University.//2014//

/2012/The 2010 3rd Grade Oral Health survey was conducted from August through December
2010. Eighty public schools were randomly selected for inclusion in the survey. Nutrition questions were added to the survey, and all children receiving a dental screening were also measured for BMI. Analysis of the results will be used to guide initiatives for these programs.//2012///2013/Survey findings indicate the percentage of children with sealants in

3rd grade have not improved. Partnerships are continuing with FQHCs, Rural Health and other stakeholders to improve the oral health status of children in Georgia.//2013//

HSCI 8: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

The MCHP, through CMS, assists families of CSHCN in identifying and accessing insurance resources. Educational sessions have been provided to Health District Coordinators on Medicaid. The range of SSI beneficiaries varies greatly by health district. This indicator is monitored using district quarterly reports. /2013/ There are no updates for this indicator.//2013// **/2014/There are no updates for this indicator //2014//**

HSCI 9A: The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

DPH has implemented the Online Analytical Statistical Information System (OASIS), a suite of tools used to access the standardized health data repository. The standardized health data repository is currently populated with vital statistics, hospital discharge data, emergency room data, Georgia Comprehensive Cancer Registry, and population data. Youth Risk Behavior Survey data is also available by year, school level, and survey category.

The MCH Epidemiology Section annually links major data sets including infant birth and death certificates, birth certificates to Medicaid and WIC data, and birth certificates to Newborn Screening data. These linked sets are critical to evaluating MCHPs and providing data for surveillance and monitoring of the health status of the MCH population. Data from Georgia's statewide birth defects surveillance system are used for surveillance and monitoring of birth defects and to ensure that children with birth defects are identified through the Children 1st system.

MCH Epi conducts the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data are used to monitor the Georgia's performance on issues such as breastfeeding, prenatal care experiences, and how babies are put to bed.

Survey of Perinatal Capacity: Georgia is a state where perinatal levels are self designated, as documented on the initial Certificate of Need. No follow-up inspections of capacity occur unless a complaint is lodged with the state. To determine the current capacity, evaluate self-designation against TIOP II classification and infant and maternal outcomes, a survey has been developed. The survey, developed in collaboration with Emory University and with input from state and national experts, is currently being field tested in one of the state's perinatal regions.

Alternate Measures of Inappropriate Delivery: At the state and regional level, self designation and non-standard designation is a barrier to identifying inappropriate delivery. The MCHP is working at a state and regional level to identify alternative measures. An alternative to using perinatal level designation is to use volume -- one of the strongest associations with decreased risk of neonatal death among very low birthweight deliveries is with volume of very low birthweight deliveries. Using the birth-infant death linked file, we examined the distribution of facility specific volume of <1,250 gram deliveries, and the associated day 0, early, and late neonatal mortality within volume deciles. We identified 2 cut points where a large shift in neonatal mortality was observed (<15 per year, 15-24 per year, and 25 or more per year). Next steps are to repeat for <1,000 grams and <1,500 grams. Georgia is engaging regional partners in Mississippi and Kentucky to replicate this work to see if these cut-points are consistent across the region.

/2012/The perinatal capacity survey will be implemented in 2012. Georgia has successfully linked birth certificate data to education data. In FY2012, Georgia PRAMS data will be linked to education data. Meetings are occuring with Medicaid to ensure more routine linkages of Medicaid data. Medicaid and WIC signed a data sharing agreement in FY11 to ensure maximum enrollment.//2012//

/2013/Survey implementation has been postponed. Linkage of PRAMS to the birth- education linked dataset is underway.//2013//

/2014/ There are no updates for this indicator //2014//

HSCI 9B: The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.

The Youth Risk Behavior Surveillance System (YRBS) provides information on Georgia adolescents' tobacco use, including cigarette smoking, cigars, and smokeless tobacco. The state's annual federal Substance Abuse Mental Health Services Administration (SAMHSA) Synar Report provides an overview of tobacco youth enforcement activities in Georgia, including the number of tobacco enforcement investigations that resulted in the illegal sale of a tobacco
product to an underage youth.

MCH staff have collaborated with the DPH Chronic Disease and Health Promotion/Tobacco Use Prevention Section and the Youth Empowerment Coordinator to provide collateral cessation messages and materials for tobacco and non-tobacco using youth. MCH has also collaborated with Chronic Disease Epidemiology to successfully implement and disseminate findings of the Youth Tobacco Survey in Georgia schools. Staff serve on the Tobacco-Free School work group, facilitated by the Youth DPH/Empowerment Coordinator.

The YRBS Survey is conducted in Georgia in odd calendar years to obtain information on risky behaviors, including tobacco use, among middle and high school students. The Youth Tobacco Survey, also conducted in odd years in Georgia, provides additional information on knowledge, attitudes, and beliefs related to tobacco and secondhand smoke exposure. Data collected from these surveys are used to review, redesign, and evaluate existing preventive programs. Survey findings are published and distributed to schools, district public health offices, stakeholders, and legislators and presented at public health conferences and meetings. Findings are also made publicly available on the DPH website.

/2012/There are no updates for this indicator.//2012// /2013/ There are no updates for this indicator.//2013//
/2014/ There are no updates for this indicator. //2014//

IV. Priorities, Performance and Program Activities

A. Background and Overview

This current needs assessment and application occurred at a time of significant transition for the Georgia MCHP. Within the 12 months prior to the submission of the FY 11 Title V MCH Services Block Grant, DPH was reorganized into a different department, a new MCHP Director was selected, and both the Title V MCH and CSHCN Directors changed. These changes coupled with the implementation of the needs assessment and an application at the start of a new five-year cycle presented challenges, but also significant opportunity. The Georgia MCHP leadership capitalized on this opportunity by conducting a thorough analysis of existing quantitative data and collecting needed qualitative data from providers, advocates, and consumers throughout the state. These data provided the foundation for the identification and selection of the state's top priority needs. This process included significant involvement from the public, advocacy groups, statewide service organizations, professional societies, and state agencies. As described in Section B. State Priorities, most priority needs were aligned with national performances measures, others were addressed through the development of state performance measures or through activities linked to state and/or national performance measures. Section B also outlines the available capacity to address each priority measure. The success of this process is demonstrated, in part, by the public comments received pertaining to the needs assessment and selection of priority needs. Selected comments are provided below. All comments are included in the Attachment to I. General Requirements, E. Public Input.

"The data presented was thorough. It is great that the state involved many stakeholders."

"I am pleased to see Decrease Infant Mortality and Injury high on our list. I believe home visiting and parent education (as in Children 1st) to be the key to accomplishing this goal."

"I agree with the top 10 priority needs for Georgia mothers and children."

"I appreciate the very inclusive process used by MCH to help set priorities for Georgia."

"I am truly impressed with the new direction at the state office and am looking forward to making significant changes in the health outcomes of Georgia's maternal and child health population. The collaborations and partnerships that have been made and/or strengthened will be beneficial to Georgia's families."

"It appears that the strategies and approaches that you've come up with will eventually benefit all. There had to have been a lot of effort in orchestrating these processes. Job well done."

"I participated in the meetings held to select the 10 top priority needs for Georgia on June 3-4, 2010. I was impressed with the organization and method in which our groups worked to make these hard choices."

"I participated in the Title V Needs Selection Meeting in June 2010. I was very impressed with the focus group information presented, the 'real' grassroots process to identify the top ten priorities."

The MCH leadership also altered the activity planning and reporting process in FY11. In previous applications, Georgia Title V did not report on specific activities with the link between last year's accomplishments and the activities listed in Table 4a unclear. Beginning with the FY11 application, each year Georgia Title V will initiate a planning process that involves partners and stakeholders to yield a specific activity plan for each national and state performance measure for the upcoming year that includes expected outcomes and a monitoring methodology. Progress on the FY11 annual activity plan will be reported under current activities in the FY12 application. In the FY13 application, the activities included in the FY11 activity plan will be reported under last year's accomplishments and each activity will be reflected in Table 4a. Reporting will be specific

to each activity in the plan compared to the current process of listing broad accomplishments that relate to the performance measure. The activity planning process will occur each year to develop an annual activity plan for each upcoming year. It is expected that each annual activity plan will build on the accomplishments of the previous year. By implementing this activity planning and reporting process, Georgia Title V increases accountability for specific activities and increases the probability of impacting national and state performance measures by ensuring incremental improvements through successful completion of each activity. /2013/ Office of MCH Integration Staff met with each DPH program included in the activity plan, and with external partners, to refine activities related to each performance measure. //2013//

/2012/The MCHP added a medical director and Title V grant administration. A new director was hired for the Office of MCH Epidemiology, who will bring strong scientific leadership to the Georgia MCHP. As of July 1, 2011, the Division of Public Health was established as its own Department reporting to the governor. Streamlined processes and more direct access to the governor will present greater opportunities for the MCHP including increased participation on the First Lady's Children's Cabinet. It will be the responsibility of the MCHP to capitalize on the opportunities available due to these changes.

Research and evaluation projects of note include linking the Georgia birth record to education data. The inclusion of several MCH-specific questions to the 2011 Georgia BRFSS further enhances the surveillance capacity. Specifically, questions addressed the MCH priority need of increasing the public's awareness of the need for preconception health care. These questions will provide information that will be used for planning.

The MCHP worked to develop a plan that will lead to implementation in FFY12. Reducing infant mortality is a strategic initiative for the Department of Public Health, but is also an MCH priority need. A report on infant mortality has been prepared and will be published in the Fall of 2011 in partnership with a local healthcare foundation. /2013/ The Georgia Infant Mortality Report was published and distributed. //2013//

Obesity prevention and intervention is a focus of both Commissioner of the Georgia Department of Public Health and the governor. Obesity is also a priority need for the MCH population. The Georgia Title V program is the primary funder of the implementation of the Student Health and Physical Education Act, which requires a fitness assessment for all Georgia children enrolled in physical education classes. Through partnership with other agencies, there are significant opportunities for data linkages that will greatly increase the value of these data and the information that they can provide. The fitness assessment data will provide important data for Georgia to select and evaluate the interventions that will most effectively and efficiently impact the issue in Georgia.//2012// /2013/ The Georgia Student

Health and Physical Education (SHAPE) Act, passed in 2009, requires local school districts to conduct an annual fitness assessment program, beginning with the 2011-2012 school year, for all students in grades 1 - 12 enrolled in Georgia public school physical education classes taught by certified physical education teachers. The Department of Education selected FITNESSGRAM, a comprehensive health-related physical fitness and activity assessment and computerized reporting system developed by The Cooper Institute. Title V has funded an epidemiologist to be housed within the Department of Education to begin the FitnessGram evaluation.//2013//

B. State Priorities

Georgia's 2010 Needs Assessment submitted with the FY2011 Application identified nine priority needs. All state performance measures are associated with one or more of the nine priority needs. The pyramid levels, population groups, capacity to specific to the need, related national performance measures (NPMs) and state performance measures (SPMs), and the relationship between the need, NPMs, and/or SPMs is addressed for each need below.

Priority Need: Decrease infant mortality and injury

Pyramid Levels: Infrastructure building, Population based services, Enabling services, and Direct health care

Population Groups: Women and Infants

Capacity Specific to Need: There is significant capacity to address infant mortality and injury. To build infrastructure and understanding of infant mortality, capacity exists to perform detailed analyses of infant mortality at the county level including perinatal periods of risk analyses. Strategic coordination with WIC will allow the communication of messages to a high risk population. Through the Children 1st Program, very low birth weight infants receive home visiting follow-up care. By applying an algorithm to the electronic birth file, all infants born in Georgia are screened for socio-economic risk factors that may contribute to developmental delay or infant mortality. Through partnerships with the Georgia Chapter of the American Academy of Pediatrics, the Georgia Obstetrical and Gynecological Society, and Georgia Association of Family Physicians, strategies can be developed with the provider community that may include tailored messaging to clients. Through WIC and Title V, strong support for breastfeeding promotion also contributes to reducing infant mortality and injury. Developing partnerships with the Georgia Injury Prevention Program, Georgia Safe Infant Sleep Committee, and Georgia Child Death Review will strengthen and guide activity development to address this need. Related NPMs and

SPMs: NPMs 1, 10, 11, 15, 17 and SPMs 2, 7

Relationships between NPMs, SPMs, and Priority Needs: Several state and national performance measures contribute either directly or indirectly to addressing this priority need. SPM 2 is worded in a way that directly addresses this priority need. In response to SPM 2, activities can address such threats to infant health and survival as infant safe sleep, infant falls, and exposure to second hand smoke. SPM 7 and the NPMs listed each contribute indirectly to addressing this priority need. SPM 7 addresses the group at greatest risk for infant death by providing home visits to infants born weighing less than 1,500 grams. By identifying and providing follow-up for children who have failed a genetic screening, NPM 1 helps to ensure these children receive services necessary to prevent possible infant death. Through NPM 10, infant mortality resulting from motor vehicle crashes can be addressed through greater use of infant safety seats. Breastfeeding through the first six months of life and beyond (NPM 11) is associated with decreased morbidity and increased immunity. Activities focused on reducing cigarette smoking in the third trimester (NPM 15) and throughout the entire pregnancy will help to reduce poor birth outcomes that can contribute to infant death. NPM 17 helps to ensure that high risk deliveries occur in an environment that best supports infants who may have complicating conditions.

Priority Need: Decrease obesity among children and adolescents

Pyramid Levels: Infrastructure building, Population based services, Enabling services

Population Groups: Children, Children with Special Health Care Needs

Capacity Specific to Need: Decreasing obesity among children and adolescents will require significant collaboration. The MCH Program has several opportunities to impact the obesity rate in early childhood through WIC. New legislation requiring all students to receive a fitness assessment has created an opportunity for collaboration between the Division of Public Health, Department of Education, and the Georgia Children's Health Alliance. These partners are working together to ensure that the information collected through the assessment can be used to strengthen existing surveillance and to target and evaluate health promotion interventions.

Related NPMs and SPMs: NPM 14, SPM 1

Relationships between NPMs, SPMs, and Priority Needs: SPM 1 is worded to directly address this priority need. The focus of the state performance measure is to reduce obesity among adolescents. However, interventions will need to be implemented prior to adolescence. The activity plan associated with SPM 1 will need to include activities in early and middle childhood and will need to address physical activity and nutrition. By contributing to reduced rates of obesity in early childhood, NPM 14 also contributes to success in meeting this priority need.

Priority Need: Reduce motor vehicle crash mortality among children ages 15 to 17 years

Pyramid Levels: Infrastructure building, Population based services

Population Groups: Children

Capacity Specific to Need: Capacity to address this need reside in the Division of Emergency Preparedness, Injury Prevention Program. The Injury Prevention Program can identify training and population-based messages to reduce the motor vehicle crash mortality through a variety of interventions.

Related NPMs and SPMs: SPM 4

Relationships between NPMs, SPMs, and Priority Needs: SPM 4 is worded to directly address this priority need.

Priority Need: Reduce repeat adolescent pregnancy Pyramid Levels:

Infrastructure building, Enabling services Population Groups: Children

Capacity Specific to Need: Capacity exists within the MCH Program to analyze and produce annual reports on the prevalence of repeat adolescent pregnancies. Increased collaboration with delivery hospitals and medical providers could lead to increased referrals for adolescent mothers to family planning services provided through the public health districts or Title X. Protocols can
be developed between the WIC and the Family Planning Program to increase referrals and to ensure completion of referrals.

Related NPMs and SPMs: NPM 8

Relationships between NPMs, SPMs, and Priority Needs: This priority need will be addressed as an activity in NPM 8 activity plan.

Priority Need: Increase developmental screening for children in need

Pyramid Levels: Population based services, enabling services, direct health care

Population Groups: Children with special health care needs

Capacity Specific to Need: Through several MCH programs and improved collaboration, there is significant capacity available to address this need. The Part C Early Intervention Program (Babies Can't Wait), Children 1st, and Children's Medical Services all encounter children ages birth to five years of age. Additionally, discussions have occurred to develop plans to include developmental assessments throughout Georgia WIC clinics. Through existing partnerships with medical providers, the MCH Program can work to promote the need for every child in need to

have appropriate developmental screening. Related NPMs and

SPMs: SPM 5

Relationships between NPMs, SPMs, and Priority Needs: SPM 5 is worded to directly address this priority need. While the focus of the need is all children, SPM 5 limits the denominator to those children who are encountered through MCH programs.

Priority Need: Improve the maternal and child health surveillance and evaluation infrastructure

Pyramid Levels: Infrastructure building

Population Groups: Women and infants, Children, Children with special health care needs

Capacity Specific to Need: The MCH epidemiology capacity in the MCH Program is increasing. As recommended in Maternal and Child Health Epidemiology in State Health Agencies: Guidelines for Enhanced Functioning, MCH Epidemiology was moved to be administratively located within the MCH Program in April 2010. The administrative change ensures seamless interaction between epidemiology and program staff. The newly created MCH Epidemiology Section includes a section director and nine full-time FTEs. With increased staffing, the MCH Epidemiology Section Director will work with stakeholders to understand their data needs and the existing data gaps.

Related NPMs and SPMs: SPM 3

Relationships between NPMs, SPMs, and Priority Needs: SPM 3 is worded to directly address this priority need.

Priority Need: Improve childhood nutrition

Pyramid Levels: Population based services, Enabling services

Population Groups: Children, Children with Special Health Care Needs

Capacity Specific to Need: Capacity exists to improve nutrition childhood nutrition through the Nutrition Unit in the Nutrition and WIC Section. While the nutrition unit has focused on the WIC population, this focus can be expanded to provide increased population-based messaging. MCH Program staff have contributed to discussion pertaining to farm-to-school initiatives and initial plans have been made to develop an RFP to fund increased nutrition education in schools that also develop school-based gardens. To ensure inclusion for children with special health care needs, Nutrition Unit staff have provided training and nutritionists have been hired to support Georgia's Part C Early Intervention Program -- Babies Can't Wait.

Related NPMs and SPMs: SPM 1

Relationships between NPMs, SPMs, and Priority Needs: While SPM 1 directly addresses obesity, improvements in childhood nutrition will contribute to reductions in obesity. This priority need will be addressed by ensuring that activities to improve childhood nutrition are included in the SPM 1 activity plan.

Priority Need: Increase awareness of the need for preconception health care among women of childbearing age

Pyramid Levels: Population based services, Enabling services, Direct health care

Population Groups: Women and infants

Capacity Specific to Need: There are several opportunities for the dissemination of preconception health messaging through MCH programs. The Family Planning Program in the Women's Health Unit has opportunities to develop standard messages that can be delivered through client contacts. Through improved collaboration with Medicaid and the implementation of Georgia's Women's Health Waiver, there will be opportunities to increase population-based media messages pertaining to family planning and preconception health. Through coordination with WIC, women who have given birth can receive interconception health messages to increase the likelihood of healthy future pregnancies. The MCH Program will need to work with the Health Promotion and Disease Prevention Program and internal experts in communications to develop strategies to ensure broad dissemination of preconception health messages.

Related NPMs and SPMs: NPMs 15, 18 and SPM 8

Relationships between NPMs, SPMs, and Priority Needs: Several state and national performance measures can contribute to achieving success for this priority need. SPM 8 addresses folic acid consumption prior to conception. NPM 15 addresses cigarette smoking in the third trimester of pregnancy. By incorporating anti-smoking messages among child bearing age, NPM 15 can contribute to improvement in this priority need. NPM 18 addresses early entry into prenatal care. Early entry into prenatal care requires awareness and planning of pregnancy. Improved preconception messages to support NPM 18 will also positively impact this priority need.

Priority Need: Increase the percent of qualified medical providers who accept Medicaid and who serve children with special health care needs

Pyramid Levels: Infrastructure building

Population Groups: Children with special health care needs

Capacity Specific to Need: Current contracts with the Georgia Chapter of the American Academy of Pediatrics and the Georgia Association of Family Physicians provide access to practicing providers. With the assistance of these partners, surveys will be implemented to determine the current attitudes of practicing providers to treating children with special health care needs. MCH Program staff will work to develop recognition programs for providers who have positive attitudes toward treating CSHCN and who ensure family involvement in decision making.
/2014/The Georgia Department of Public Health holds regular meetings with the Georgia Department of Community Health (Medicaid) to address outstanding issues that present challenges in provider enrollment. Data collection on the specific challenges early intervention providers experience in Medicaid Fee for Service and Medicaid Care Management Organization enrollment are currently being addressed. The early intervention program contract requires all providers to be enrolled in Medicaid Fee for Service. Providers must also be enrolled in at least one of the State's three Medicaid Care Management Organizations.//2014//

Related NPMs and SPMs: SPM 6

Relationships between NPMs, SPMs, and Priority Needs: SPM 6 monitors the percent of pediatricians and family physicians with positive attitudes toward treating CSHCN. Provider willingness to care for CSHCN is central to ensuring adequate supply. Through activity plans associated with SPM 6, it is hypothesized that the percent of providers with positive attitudes can be increased, which may impact the supply of qualified providers serving CSHCN. Activities will equally focusing on the existing provider community and students still matriculating in medical schools throughout Georgia.

/2012/There have been no changes to the state's priority needs. Infant mortality and obesity prevention have been escalated as each is now a strategic objective for the Department of Public Health.//2012//

/2013/ There have been no changes to the state's priority needs. Infant mortality and obesity prevention continue as strategic objectives for DPH.//2013//
/2014/There have been no changes to the state's priority needs. Infant mortality and obesity prevention continue as strategic objectives for DPH.//2014//

C. National Performance Measures

Performance Measure 01: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	99.7	99.6	96.4
Numerator	210	327	318	230	268
Denominator	210	327	319	231	278
Data Source	Georgia NBS Progra	Newborn Screening Program	Newborn Screening Program	Newborn Screening	Newborn Screening
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3- year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	100	100	100	100	100

Notes-2012
2012 provisional data is supplied by Emory University Genetics Follow-up Program, contracted to investigate all positive metabolic newborn screens and provide services to confirmed cases.

Notes - 2010
As per Form 6, the data reported here are lagged by one year. Therefore, the data reported in the 2010 column are data collected in 2009.

Notes - 2009
As per Form 6, the data reported here are lagged by one year. Therefore, the data reported in the 2009 column are data collected in 2008.

a. Last Year's Accomplishments
The Newborn Screening (NBS) Program identified and monitored the top ten facilities with the highest unsatisfactory screening rates each month. Those hospitals were contacted and provided technical assistance. The NBS Program, Children's Medical Services Program and Memorial Health Medical Center partnered to improve follow-up for infants with sickle cell disease in Savannah, GA.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Monitoring referrals of infants diagnosed with metabolic and hemoglobinopathies to appropriate CSHCN programs.			X	
2. Providing funds for special formula through NBS Follow-up contract.		X		
3. Through the Georgia Public Health Laboratory and Newborn Screening Program, collaborating on policies, procedures, and the development of SendSS Newborn.				X
4. Continuing MCH Epidemiology linkage of newborn screening records with electronic birth certificates.			X	
5. Providing access to and monitoring hospital reports to identify each hospital's unsatisfactory specimens.				X
6. Following up on all abnormal screening test results.				X
7. Holding regular advisory committee and work group meetings to address and resolve issues within the NBS system.				X
8. Providing NBS education to parents and providers.			X	
9.				
10.				

b. Current Activities

Activity 1:
In the first quarter, 28% of all hospitals met the unsatisfactory screening rate goal of less than 1%. The significant decrease in the percent of hospitals that have met the goal could be due to a change in the screening assessment process done in the laboratory. Telephone consultations and on-site in-services with hospitals to improve satisfactory screens continue.

Activity 2:
SendSS Newborn is continuously being enhanced. Current enhancements include: improving the HL7 messages and updating the database tables. The Georgia Public Health Laboratory contacted hospitals that submitted specimens collected under 24 hours of age. Unsatisfactory screening rates have been included in the NBS Annual Performance Measures.

Activity 3:.
Education was provided during the GAAAP and GAAFP conferences.

Activity 4:
IT staff continue to work with Emory University to receive data in the appropriate format. An HL7 message is being tested to send files securely between the Emory database and SendSS Newborn.

c. Plan for the Coming Year

Activity 1: Reduce the number of unsatisfactory specimens (unsats) by identifying hospitals who submit unsats; notifying those providers of their specimen collection performance and conducting site visits and offering technical assistance and training to improve specimen collection techniques.

Output Measure(s): Percent of hospitals with unsat rates less than or equal to 1%; percent of unsatisfactory newborn screens; documentation of site visits, technical assistance and training activities.

Monitoring: Monthly review of site visits, technical assistance and training activities; percent increase/decrease in unsats, and percent increase/decrease of hospitals with unsats less than or equal to 1%.

Activity 2: Implement a protocol that identifies and tracks newborn screens from unsatisfactory to satisfactory.

Output Measure(s): Percent of newborns that receive an unsat screen who have a repeated screen; percent of newborns that receive a repeated satisfactory screen; and a protocol that identifies and tracks newborn screens from unsatisfactory to satisfactory.

Monitoring: Monthly review of newborns that receive repeated screens and repeated satisfactory screens.

Activity 3: Educate pre- and postnatal families and healthcare professionals about newborn screening (NBS) and the importance of follow-up for positive results by disseminating information via multiple communication methods, including PSAs, the NBS brochure and web site, social networking sites, newsletter articles, and training/ professional development.

Output Measure(s): Type and number of materials distributed; number of newsletter articles written; number of presentations given; number of friends and networks on social networking sites.

Monitoring: Quarterly review of education activities; bi-monthly monitoring and updates of social networking sites.

Activity 4: Improve the electronic database (SendSS) and monitoring capabilities by developing an unsatisfactory specimen tracking module, creating metabolic reports and improving matching algorithms.

Output Measure(s): Percent of newborn screens matched to the birth record; metabolic reports developed; completed module for unsatisfactory specimen tracking; protocol for the follow-up of unmatched birth certificates and newborn screens.

Monitoring: Notes from meetings to review the progress towards the completion of the module, the reports, and matching algorithm; meeting attendance.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**133824**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	104594	78.2	68	1	1	100.0
Congenital Hypothyroidism (Classical)	104594	78.2	4729	59	59	100.0
Galactosemia (Classical)	104594	78.2	715	1	1	100.0

Sickle Cell Disease	104594	78.2	204	130	129	99.2
Biotinidase Deficiency	104594	78.2	47	3	3	100.0
Cystic Fibrosis	104594	78.2	7374	16	16	100.0
Homocystinuria	104594	78.2	326	0	0	
Maple Syrup Urine Disease	104594	78.2	129	0	0	
beta-ketothiolase deficiency	104594	78.2	21	0	0	
Tyrosinemia Type I	104594	78.2	60	1	1	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	104594	78.2	110	2	2	100.0
Argininosuccinic Acidemia	104594	78.2	30	0	0	
Citrullinemia	104594	78.2	30	0	0	
Isovaleric Acidemia	104594	78.2	147	0	0	
Propionic Acidemia	104594	78.2	134	0	0	
Carnitine Uptake Defect	104594	78.2	77	1	1	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	104594	78.2	83	4	4	100.0
Methylmalonic acidemia (Cbl A,B)	104594	78.2	134	2	2	100.0
Multiple Carboxylase Deficiency	104594	78.2	83	0	0	
Glutaric Acidemia Type I	104594	78.2	49	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	104594	78.2	328	5	5	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	104594	78.2	91	5	5	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	104594	78.2	3	1	1	100.0
3-Hydroxy 3-	104594	78.2	83	0	0	

Methyl Glutaric Aciduria						

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

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

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

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

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

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

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

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

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

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available.

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

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

Notes - 2009
Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available. Numerator and denominator estimates based on the point estimate. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows.

a. Last Year's Accomplishments

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

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

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing family participation through development of CMS care coordination plan of care.		X		

2. Conducting CMS family satisfaction surveys statewide every three years as well as an ongoing survey as part of CMS quality assurance programmatic/ fiscal review (three year cycle).				X
3. Conducting client satisfaction surveys annually in the Genetics				X
and Sickle Cell clinics. Surveys are offered in English and Spanish.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

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

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

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

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

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

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

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

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

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

c. Plan for the Coming Year

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

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

Monitoring: Quarterly reports.

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

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

Monitoring: Quarterly reports.

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

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

Monitoring: Quarterly reports.

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

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	51	51	52	53.1	53.1
Annual Indicator	51.0	45.7	45.7	45.7	45.7
Numerator	179809	188908	182182	182330	194762
Denominator	352567	413365	398648	419440	426175
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	55.2	56.3	57.4	57.4	

Notes - 2011

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

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

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

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

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

Notes - 2009
Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available. Numerator and denominator estimates based on the point estimate. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows.

a. Last Year's Accomplishments

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

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

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

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

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

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

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

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

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

and Medical Home for youth with special health care needs.

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

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

Monitoring: Training registration; training schedule and plan.

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

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

Monitoring: Quarterly reports.

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

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

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

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	**62**	**62**	**62.4**	**63.7**	**63.7**
Annual Indicator	**61.2**	**62.2**	**62.2**	**62.2**	**62.2**
Numerator	**215771**	**257113**	**247959**	**248160**	**265081**
Denominator	**352567**	**413365**	**398648**	**398972**	**426175**
Data Source	**NS-CSHCN**	**NS-CSHCN**	**NS-CSHCN**	**NS-CSHCN**	**NS-CSHCN**
Check this box if you cannot report the numerator because					
therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	66.2	67.5	68.9	69.3	

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

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

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

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

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

Notes - 2009
Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available. Numerator and denominator estimates based on the point estimate. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows.

a. Last Year's Accomplishments

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

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

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

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

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

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

c. Plan for the Coming Year

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

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

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

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

Monitoring: Quarterly reports.

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

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

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

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of

the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

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

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

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

Notes - 2009
Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available. Numerator and denominator estimates based on the point estimate. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows.

a. Last Year's Accomplishments

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

The CMS program conducted clinics in 9 of the 18 public health districts. Clinics located in rural areas of the state provided access to communities with limited specialty services. Seven out of 9 districts provided data reports detailing clinic enrollment and the number of families served during the fourth quarter.

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Gathering data from other states and MCHB sponsored contracts that have completed previous work in this area.				X
2. Conducting CMS family satisfaction surveys statewide every three years as well as ongoing data collection as part of CMS				X
quality assurance programmatic/fiscal review (three year cycle).				

3. Sponsoring campers to attend the annual Metabolic Camp at Emory University for patients with Maple Syrup Urine Disease and Phenylketonuria.		X		
4. Promoting the use of Federally Qualified Health Centers to clients with Sickle Cell Disease (through Sickle Cell Foundation of Georgia).		X		
5. Providing funds to the public health districts to assist patients with the cost of genetic testing.	X			
6. Providing funds to the public health districts to increase the number of genetic clinics offered.	X			
7. Offering Transcranial Doppler (TCD) ultra-sonograms to pediatric Sickle Cell patients ages 2 to 16 years in 10 pediatric Sickle Cell outreach clinics.	X			
8. Holding telemedicine clinics in Waycross and Valdosta to enable families to see medical specialists at Georgia Health Sciences University in Augusta, Georgia and Shands Hospital in Jacksonville, Florida.	X			
9.				
10.				

b. Current Activities

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

CMS Coordinators and BCW Service Coordinators assist clients with identifying and connecting to needed available resources. CMS served 8806 clients in the first quarter and 8846 clients in the second. BCW child enrollment was 6640 and 7519 infants and toddlers in the first and second quarters, respectively. CMS Coordinators made have made a total of 675 referrals in the first and second quarters. Through our BCW contract with P2PGA, BCW and CMS families have access to online and one-on-one support to help find resources for families of children and youth with special needs.

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

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

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

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

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

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

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

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

Monitoring: Quarterly reports.

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

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

Monitoring: Quarterly reports.

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

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

Monitoring: Quarterly reports.

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

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

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

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers

for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

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

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

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

Notes - 2009
Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available. Numerator and denominator estimates based on the point estimate. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows.

a. Last Year's Accomplishments

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

A nurse consultant and parent consultant were hired at the state office to assist with updating CMS Transition

Manual. P2PGA was contracted to host groups with youth and families to provide input to updates needed for the Transition Manual.

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

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

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

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

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

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

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

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

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

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

c. Plan for the Coming Year

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

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

Monitoring: Quarterly reports from CMS staff.

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

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

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

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

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

Monitoring: Quarterly program reports.

Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	85	85	77	75.1	76.7
Annual Indicator	71.9	69.3	73.9	83.9	78.9
Numerator	149988	146680	144538	164312	167550
Denominator	208606	211659	195586	195843	212358
Data Source	NIS	NIS	NIS	NIS	NIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional
	2013	**2014**	**2015**	**2016**	2017
Annual Performance Objective	78.1	79.7	81.3	81.7	

Notes-2012

Data retrieved from http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2011.htm on May 28th, 2013.

2011 data were updated with final numbers based on NIS. Linear projections were used to derive population estimates and the annual indicator for 2012.

Notes - 2011
2009 - tables retrieved from http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2009.htm on May 18th, 2012.
2010 - tables retrieved from http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2010.htm on May 18th, 2012.
The 2007 estimate was updated to 79.6 using the table: http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2007.htm retrieved on May 18th, 2012.

2011 indicator estimate is based on a linear projection of data for 2007 - 2010.

The denominator was derived from population estimates provided by OASIS. Linear projections for the population estimates were made for 2011.

The number of 19-35 months old is estimated by taking the number of children age 1 year, dividing by 12 and multiplying by 5 plus all children age 2 years.

2007 and 2008 data have recalculated as follows:

2007: numerator 165,284; denominator 207,643; and annual indicator 79.6

2008: numerator 149,988; denominator 208,606; and annual indicator 71.9

Notes - 2010
Data reflect the 4:3:1:3:3:1 immunization series. Data retrieved from http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2009.htm on July 2, 2011. Numerator and denominator are estimates based on the percentage reported by the National Immunization Survey. Data are unavailable for 2010. The 2010 estimate is developed using a linear projection with data from 2000 through 2009. The number of children 19 to 35 months is estimated by taking the number of children age 1 year dividing by 12 and multiplying by 5 plus all children age 2 years. Population estimates are provided by the Georgia Online Analytical Statistical Information System.

This indicator is trending in an undesired direction. Annual performance objective is based on a 2% annual increase from the 2010 estimated point estimate.

Notes - 2009
Data reflect the 4:3:1:3:3:1 immunization series. Data retrieved from http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis on May 13, 2010. Numerator and denominator are estimates based on the percentage reported by the National Immunization Survey. Data are unavailable for 2009. The 2009 estimate is developed using a linear projection with data from 2000 through 2008. The number of children 19 to 35 months is estimated by taking the number of children age 1 year dividing by 12 and multiplying by 5 plus all children age 2 years. Population estimates are provided by the Georgia Online Analytical Statistical Information System.

To ensure data integrity across previous years, data were updated for 2007, 2008, and 2009.

The average annual percent change for this indicator is approximately zero (-0.02%). The annual performance objective estimates reflect Georgia's goal of building on the projected increase in FY09 and making progress toward achieving rates previously reported in 2006.

a. Last Year's Accomplishments

The Perinatal Hepatitis B Prevention Program collaborated with the Georgia OBGyn Society to author articles about hepatitis B and pregnancy in their newsletter, OBGyn News.

The Perinatal Hepatitis B Prevention Program developed a health education print package targeting pediatric providers. The print package included a poster, tear-off pads, brochures and wallet cards. The educational materials provided hepatitis B post-exposure guidance along with hepatitis B vaccination recommendations for infants exposed to hepatitis B at birth. Materials were professionally printed and disseminated throughout the state by PHBPP case managers and Immunization Program Consultants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participating in quarterly immunization coordinators meetings.				X
2. Promoting childhood immunizations during all activities that target young children (Children 1st, Healthy Childcare Georgia, Health Check, etc.).			X	
3. Including immunization assessment during desk audits and in programs (e.g., WIC).		X		
4. Collaborating with the Department of Community Health (DCH) and GA-AAP to assure that private providers offer appropriate services, including immunizations and developmental screenings to children who are enrolled.				X
5. Monitoring health status of at-risk children birth to age five years through Children 1st.			X	
6. Assessing immunization information at childcare facilities to ensure children are protected against vaccine preventable disease.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Implement a strategic plan and pilot project to improve immunization rates in WIC clinics.

Activity 2: Improve coordination with Children's Medical Services and Babies Can't Wait to increase immunization rates among children with special health care needs.

Activity 3: Improve compliance with recommended hepatitis B birth dose administration to decrease incidence of hepatitis B infection.

The PHBPP Coordinator conducted ten hospital site visits throughout metro-Atlanta to access hepatitis B policies and procedures. Paired maternal and neonatal records were reviewed to determine if HBsAg status was documented, documentation of administration of Hepatitis B Immune Globulin (HBIG) if warranted, and hepatitis B birth dose administration information. Data is being analyzed by a MPH student and results will be made available in the future

c. Plan for the Coming Year

Activity 1: Utilize WIC enrollment information sent monthly by WIC to assess immunization status by WIC enrollment.

Output Measure(s): Gather baseline data, monitor percent over baseline. Monitoring:

Quarterly reports.

Activity 2: Improve compliance with recommended hepatitis B birth dose administration to decrease incidence of hepatitis B infection.

Output Measure(s): Number of data sets queried to find mothers who are hepatitis B positive; number of hepatitis B surface antigen-positive women being tracked by the perinatal hepatitis B program.

Monitoring: Quarterly reports.

Activity 3: Use the best available data to identify coverage disparities among children and promote vaccination through key partnerships

Output Measure: Number of presentations, seminars, workshops and in-service trainings on immunization related topics for public and private health care professionals; number of collaborations with healthcare providers.

Monitoring: Quarterly reports.

Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	**28**	**27**	**26.3**	**25.4**	**29.4**
Annual Indicator	**27.7**	**23.7**	**21.0**	**18.9**	**20.6**
Numerator	**5493**	**4816**	**4297**	**3814**	**4356**

Denominator	198043	203359	204871	202149	211241
Data Source	Vital	Vital	Vital	Vital	Vital
Check this box if you cannot report					
Is the Data Provisional or Final?			Provisiona	Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	23.9	23.2	22.5	22.5	

Notes - 2011
Birth record and population data are unavailable for 2011. The provisional estimates have been developed using a linear projection with data from 2000 to 2010.

2007 and 2008 data have been recalculated as follows:

2008: numerator 5,493; denominator 198,403; and annual indicator 27.7.

2007: numerator 5,785; denominator 193,272; and annual indicator 29.4.

Notes - 2010
Birth record data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear projection with data from 2000 through 2008. Population data provided by the Georgia Online Analytic Statistical

Information System. Population data for 2009 and 2010 are estimated using a linear projection with data from 2000 through 2008.

Annual performance objective estimates are developed by applying the average annual percent change (-3.0%) between 2000 through 20010 to the 2010 point estimate.

Notes - 2009
Birth record data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009.

Annual performance objective estimates are developed by applying the average annual percent change (-3.0%) between 2000 through 2009 to the 2009 point estimate.

a. Last Year's Accomplishments

In January 2012, the AHYD program sustained a substantial budget reduction resulting in the closing of 40% of the Teen Center Programs and staff loss across the 18 public health districts. Of the more than 30 Teen Center Programs, only 15 remained open and provided limited services until June 30, 2012. Despite the reductions, staff loss and Teen Center closings, the Teen Center Programs exceeded FY2012 performance goals.

The Teen Center Programs have exceeded the FY 2012 performance goal of providing 6,665 unduplicated adolescents youth-focused group activities by nearly five-fold (31,638). The Teen Center Programs exceeded the FY 2012 performance goal of providing 78 professional trainings by more than 240% (267). They also provided 143 public awareness and community education activities, 26.5% more than the FY 2012 performance goal of 113.

The State AHYD Program continues to participate as an active member of P3, participating in 3 meetings to identify target populations and geographic areas across the state.

One fact sheet was developed by the State AHYD program and distributed to P3 members. The fact sheet included data teen pregnancy rates by race/ethnicity, geographic areas and age groups.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing training, technical assistance (TA) and monitoring of contract and Grant-in-Aid (GIA), both of which include deliverables that address community and parent education/collaboration, outreach, and youth development activities for adolescents				X
2. Collaborating with the Department of Community Health (DCH) to provide linkage with Medicaid and PeachCare for Kids for case management and receipt of medical services.				X
3. Collaborating with the Department of Juvenile Justice to provide services to youth. Collaborating with DCH to provide linkage with Medicaid and PeachCare for Kids for case management and				X
4. Operating family planning clinics for adolescents in health departments and non-traditional sites (e.g., night clinic, vans, jails, DFCS offices).	X			
5. Funding Southside Medical Hospital Project, working with adolescent males to encourage them to get involved in health care.		X		

6. Providing abstinence and adolescent pregnancy information and contraceptive services in teen centers.			X	
7. Participating in the development of Regional Comprehensive youth Development Systems throughout Georgia.				X
8.				
9.				
10.				

b. Current Activities
Activity 1: Increase opportunities to engage in teen pregnancy prevention activities at state and local levels.

Activity 2: Partner with external and internal stakeholders and a selected university partner to increase surveillance capacity identify gaps in teen pregnancy prevention knowledge and develop and implement a plan to resolve these gaps.

Activity3: Convene multi-state agency workgroup to identify opportunities and develop a strategic plan for teen pregnancy activities.

c. Plan for the Coming Year
Activity 1: Partner with Title X, WIC and DHS and PREP to increase opportunities to engage in teen pregnancy prevention activities at the state and local levels.

Output Measure(s): Number of programs trained to provide evidence-based pregnancy prevention curricula; the number of teens receiving evidence-based pregnancy prevention programs; the number of Teen Center programs implementing an evidence-based program/curriculum

Monitoring: Review quarterly and annual reports submitted to DHS for PREP and from districts for Centers of Excellence, Title X, and WIC.

Activity 2: Partner with external and internal stakeholders to develop a report on the state of teen pregnancy and repeat teen pregnancy in Georgia and implement a plan to reduce rates.

Output Measure(s): Development of report. Monitoring:

quarterly updates.

Activity 3: Work with the Public Private Partnership to Prevent Teen Pregnancy (P3), a multi-state agency workgroup, to identify opportunities and develop a strategic plan for teen pregnancy activities.

Output Measure(s): Partner-approved strategic plan; work plan to implement teen pregnancy prevention activities.

Monitoring: Number of meetings; strategic plan developed.

Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	17.2	24	39.8	37.6	37.6
Annual Indicator	39.0	39.0	37.4	37.4	37.4
Numerator	51170	51681	48574	50333	51064
Denominator	131206	132515	129876	134579	136536
Data Source	Basic Screening Survey	Basic Screening Survey	Basic Screening Survey	Basic Screening Survey	Basic Screening Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?		Final	Final	Final	
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	38	38.2	38.3	38.3	

Notes-2012
The denominator for 2012 was estimated by linear projection using Fall enrollments for K-12 Public Schools from 2000 to 2010 obtained from http://gaosa.org/report.aspx (Enrollment by demographics tab), and estimate of 2011 enrollments. Denominators for previous years were updated so that all denominators reflect Fall enrollments for 3rd graders for the respective years

Notes - 2011
Data Collected in Year: 2011. Children 0 to 17.
Data were updated for 2006, 2007, 2008, 2009, and 2010. New link for the Current Population Survey tables is: http://www.census.gov/cps/data/cpstablecreator.html

Denominator estimates were obtained from OASIS for the 0 to 17 year old population. We could not tell the source of the denominator for the previous years so we used OASIS and updated the denominators for 2006 to 2010. Population estimates for 2011 are not available and so were estimated by linear projection using values for 2000 to 2010.

Data have been recalculated for 2007 and 2008 as follows:

2007: numerator 311,656; denominator 2,513,356; and annual indicator 12.4

2008: numerator 286,619; denominator 2,536,452; and annual indicator 11.3

Notes - 2010
The percent of third grade children who have received a protective sealant on at least one permanent molar tooth is determined from the Basic Screening Survey. The Basic Screening Survey is a sample survey that includes an

oral examination performed by a trained professional. The most recent Basic Screening Survey is for the 2010/2011 school year.

Denominator data from K-12 Public Schools Annual Report Card (http://reportcard2010.gaosa.org/). Denominator data are from the Fall enrollment. Data are not available for 2010, so a linear projection was estimated using data from 2003 through 2009.

Given the decline from the previous Basic Screening Survey, an annual increase of 0.5% will be projected for the Annual Indicator through 2015.

Notes - 2009

The percent of third grade children who have received a protective sealant on at least one permanent molar tooth is determined from the Basic Screening Survey. The Basic Screening Survey is a sample survey that includes an oral examination performed by a trained professional. The most recent Basic Screening Survey was for the 2005/2006 school year.

Denominator data from 2005-2006 K-12 Public Schools Annual Report Card (http://reportcard2006.gaosa.org/k12/demographics.aspX?ID=ALL:ALL&TestKey=EnR&TestType =demographics). All data reflect Fall enrollment except for 2006 which reflects Spring enrollment. Data for 2007, 2008, and 2009 are estimated with a linear projection methodology using data from 2003 through 2006.

Data were updated for 2007, 2008, and 2009.

As this indicator is populated using data from the 2005/2006 Basic Screening Survey until a new survey is completed, estimating the annual performance objective is difficult. Based on the data from the 2005/2006 survey (39% with sealants), a 0.5% increase would be expected annually from 2006 through 2014.

a. Last Year's Accomplishments

A Head Start Oral Health BSS is planned for fall of 2014.

Training materials for School Nurses on dental preventive measures were developed and over 180 school nurses were trained either in local sessions or at the Georgia Association of School Nurses Annual Session.

Implementation of fluoride varnish application during routine well baby and toddler visits has been slow although training of medical providers was offered. The OHU will be working with the Georgia Chapter of the Academy of Pediatrics on tracking how many practices have implemented this preventive treatment for high risk kids.

One OHU staff member presented baby oral health to new mothers at a hospital, “New Mom” update.

The OHU Epidemiologist and staff presented a poster presentation on ER non-traumatic oral health visits for children in Georgia at the National Oral Health Conference, April 2013.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to visit schools to conduct screenings on children, place sealants when needed and provide prevention services, including education and fluoride treatments.			X	

2. Sharing best practices through quarterly Oral Health Coordinators' meetings with dental public health providers throughout the state.				X
3. Continuing to provide ongoing consultative support and technical assistance (TA) to the districts, including monitoring and evaluation.				X
4. Continuing to provide TA and monitoring to school-based sealant programs (offered in schools with high student participation in the free and reduced school lunch program).				X
5. Continuing to train school and public health nurses on oral disease prevention methods such as sealants and fluoride varnish. Providing oral screenings and emergency dental care.				X
6. Through the Oral Health Coalition, assessing strategies to improve oral health and develop and implement an oral health plan for Georgia.				X
7. Providing training to the medical and dental professional communities on infant oral health and application of fluoride varnish.				X
8.				
9.				
10.				

b. Current Activities

Activity 1: Increase the capacity to provide dental sealants through school-based programs.

In FY 2012, the oral health school based prevention program placed 7,461 dental sealants on 2,142 children.

Activity 2: Increase oral health surveillance capacity.

Activity 3: Promote the increased use of dental sealants to public health and community dental providers and educate them on evidence-based guidelines for the placement of sealants.

School nurse trainings occur year round.

Activity 4: Provide education and training for dental and non-dental health care providers on initiation of infant oral health screening and fluoride varnish application by age one year.

Staff provided training during the Head Start State Conference in May 2013.

Activity 5: Disseminate information through various public mechanisms.

Georgia Health Coalition website is developed with more to come.

c. Plan for the Coming Year

Activity 1: Increase the capacity to provide dental sealants through school-based programs.

Output Measure(s): Number of sealant events occurring in school-based or community settings per year.

Monitoring: Quarterly review of data collected in the oral health database and CDC sealant- tracking system

(SEALS).

Activity 2: Increase oral health surveillance capacity: PRAMS, BRFSS, YRBS, utilize data from Head Start Oral Health Survey

Output Measure(s): Number of questions asked about oral health on PRAMS; number of questions asked about oral health on YRBS; number of questions asked about oral health on BRFSS; data from 3rd Grade Oral Health and Nutrition/Obesity Survey and Head Start Oral Health Surveys conducted annually; full data review every 2-3 years to determine gaps in oral health services.

Monitoring: Quarterly review of surveillance instruments and survey progress.

Activity 3: Promote increased capacity to provide oral health services in Georgia through partnership with the Oral Health Coalition.

Output Measure(s): Number of publication materials developed for Oral Health Coalition (OHC) website; use of social media to increase public awareness of oral health activities; number of volunteer dentists and hygienists maintained through the OHC; number of presentations given to Public Health and community dental providers; # of people trained.

Monitoring: Quarterly monitoring reports.

Activity 4: Provide education and training for dental and non-dental health care providers on initiation of infant oral health screening and fluoride varnish application by age one year.

Output Measure(s): WIC-Oral Health pilot programs implemented in select county public health departments to provide oral health education and fluoride varnish to pregnant and new mothers, and fluoride varnish to their infant children; number of presentations to dental and non-dental providers on infant oral health care; number of dental and non-dental providers trained.

Monitoring: Yearly review of PH data to determine number of children and prenatal patients receiving at least one dental prevention service; development and implementation of training plans for non-dental providers and quarterly updates.

Activity 5: Maintain Community Water Fluoridation program.

Output Measure(s): Number of water plant operators trained; number of CDC quality awards for fluoridation.

Monitoring: Quarterly monitoring reports.

Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4	3.5	3.2	3	
Annual Indicator	3.5	2.9	4.0	3.2	2.9
Numerator	74	54	82	67	64
Denominator	2127815	2064991	2074416	2076584	2222955

Data Source	Vital Records	Vital Records	Vital Records	Vital Records	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Provisional	Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	2.8	2.7	2.7	2.7	

Notes-2012

Data are from OASIS. The population denominator for 2011 was estimated by linear projection using data for 2000 to 2010.

The numerator for 2009 to 2011 was estimated by linear projection using data from 2000 to 2008.

The Annual Indicator-number of deaths to children ages 15- to 17 years by motor vehicle crashes was calculated using the numerator and denominator and expressed per 100,000 children

Notes - 2011

Death record data is unavailable for 2009, 2010, and 2011 and population data is unavailable for 2011. The provisional estimates for the number of deaths were developed using a linear projection with data from 2000 to 2008 and for the population using a linear projection with data from 2000 through 2010.

Notes - 2010

Death record data are unavailable for 2009 and 2010. The number of deaths are developed using a linear projection with data from 2000 through 2008. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 and 2010 are estimated using a linear projection with data from 2000 through 2008.

Annual performance objective estimates are developed by applying an annual decline of 3% to the 2010 point estimate based on the annual decline between 2000 and 2010.

Notes - 2009

Death record data are unavailable for 2008 and 2009. The number of deaths are developed using a linear projection with data from 2000 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009.

Annual performance objective estimates are developed by applying the average annual percent change between 2000 through 2009 to the 2009 point estimate.

a. Last Year's Accomplishments

The COSP expanded the CPS Mini-Grant Program to include 142 counties, compared to the 135 participating the previous year. The COSP distributed 9,957 child safety seats statewide, including 53 seats for children with special needs and 20 car beds. Requests for assistance continue to increase and the referrals come from Children's Medical Services, local Child Passenger Safety Technicians, and Mini-Grantees.

The COSP received 48 TBS fax forms from health department documenting 48 children saved from serious injury and death. Injury Prevention staff participated in Southeast Georgia EMS-C Conference and the State EMS-C Advisory

Council meeting in September 2012. Injury prevention staff also exhibited at the Annual Georgia Fire Safety Symposium in July 2012.

Injury prevention staff provided technical assistance and/or training in basic child passenger safety to 15 hospitals, including 3 hospitals new to the program. A total of 12,187 pocket cards illustrating the GA CPS law, age/weight of a child guideline, and best practices were distributed to healthcare providers at various events/trainings. The COSP conducted 20 trainings, 1 conference, 8 meetings and 2 "Roadeos" for approximately 1,647 participants. The COSP conducted nine briefings at Traffic Enforcement Networks meetings with over 300 law enforcement officers in attendance. Injury prevention staff also assisted in the field with eight road checks/safety seat checkpoints or Click It Or Ticket events. Project staff co-taught five National Child Passenger Safety Certification Training Program courses. Additionally, the COSP built better relationships with the state WIC and DFCS management and provided 316 CPS posters (including 115 in Spanish) to all GA DPH WIC and DFCS offices. Injury Prevention staff led, assisted, and participated in the 2012 Traffic Injury Prevention Caravan event.

After the development of Georgia's "Transporting Georgia's Special Children Safely" last year, the COSP partnered with Children's Healthcare of Atlanta and Safe Kids East Central to provide two trainings during 2012. Classes were offered in May (Hall County) with 23 participants and August (Cobb County) with 31 participants. A total of 54 CPSTs completed this special needs training in FFY 2012.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing child passenger safety training, technical assistance and monitoring.			X	
2. Distributing car safety seats.		X		
3. Providing education child passenger safety.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Distribute conventional seats and children with special health care needs-specific child safety seats.

The COSP has distributed 37,642 pieces of PI&E materials; this includes 2,425 seats. It is estimated that 4.8 individuals have been reached. IP staff received 37 referrals for children with special health care needs through local CMS staff and 21 child restraints were provided. During CPS monthly classes, a total of 2,877 caregivers were trained and counties distributed 2,392 child safety seats in the class. OIP staff continued to work with counties on the 2013 CPS Mini-Grant guidelines and application process. Staff fielded multiple calls and emails from county representatives and continued to work with other partners to support the program.

Activity 2: Document number of children saved from serious injury or death due to program- funded child safety seats by applying Teddy Bear Stickers (TBS) to program-funded seats

Thirteen TBS forms were received documenting lives saved. Some were not using a program related car seat but the word is spreading to inform the COSP of lives saved in car seats.

Activity 3: Offer child passenger safety training and presentations to internal and external stakeholders.

Training and presentations included: local school bus trainings, exhibits at GA AAP and GA AFP conferences, 2 "Keeping Kids Safe" training sessions, providing technical assistance to counties, trainings to the EMS community, webinar trainings for DFCS staff, presentations to Head Start's Board of Directors, 4 CPST certification classes, and a video conference meeting for Mini-Grantees with 109 participants from 62 counties. Staff also taught a Special Needs Transportation class called SNAP (Special Needs Access Program) with EMS-C and local county Safe Kids staff.

Activity 4: Host and participate in statewide Transporting Children with Special Health Care Needs conference.

IP staff hosted the 2013 Specialized Child Restraint Manufacturers' Workshop on January 17, 2013 at MCCG Hospital. Seventy participants attended representing CMS, health department, certified CPSTs, Safe Kids, hospital staff, law enforcement, fire, physical and occupational therapists, etc.

Activity 5: Review report on child deaths resulting from motor vehicle crashes and develop prevention policy recommendations and activities.

IP staff have been asked to sit on the Statewide GOHS Occupant Safety Task Force in order to identify the strategic Highway Safety Plan objectives needed for 2013. Staff continue to work and strategize with GA DECAL to provide best practice recommendation for their policy/regulations regarding childcare center usage of commercial vehicles not covered in the GA CODE.

c. Plan for the Coming Year

Activity 1: Distribute conventional seats and children with special health care needs-specific child safety seats.

Output Measure(s): Number of counties where seats were distributed; number of seats distributed.

Monitoring: Quarterly monitoring of the number of seats distributed to participating organizations and the number of safety seats distributed.

Activity 2: Document the number of children saved from serious injury or death due to program- funded child safety seats by applying Teddy Bear Stickers (TBS) to program-funded seats, encourage participation in the TBS program, and processing TBS Fax Back Forms.

Output Measure(s): Number of presentations given about reporting; annual report of children saved.

Monitoring: Quarterly report on number of TBS Fax Back Forms received; develop and implement strategic plan for encouraging participation in TBS program.

Activity 3: Offer child passenger safety training and presentations to internal and external stakeholders.

Output Measure(s): Audience trained; number of reporting presentations and associated educational and equipment distribution; number of people trained; number recertified; number of recertification trainings; number of Traffic Enforcement Network briefings conducted; number attending Traffic Enforcement Network briefings.

Monitoring: Quarterly monitoring reports.

Activity 4: Host and participate in statewide Transporting Children with Special Health Care

Needs training.

Output Measure(s): Number of attendees; participant evaluation report; number of people trained to assess and respond to transportation challenges among children with special health care needs.

Monitoring: Review of notes from planning meetings.

Performance Measure 11: The percent of mothers who breastfeed their infants at 6 months of age.

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	**33**	**35**	**42**	**40.4**	**44.2**
Annual Indicator	**36.7**	**40.8**	**40.1**	**41.2**	**42.2**
Numerator	**53752**	**57663**	**53663**	**54459**	**60144**
Denominator	**14646**	**141332**	**133668**	**132239**	**142460**
Data Source	**NIS**	**NIS**	**NIS**	**NIS**	**NIS**
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Provisional	Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	42.8	44.1	45.4	46.6	

Notes - 2011
2007 data is based on the 2007 birth cohort - Final (changed from the way it was done before; we need to discuss that)
2008 data is provisional data obtained from the Breastfeeding report card for 2011

Indicator estimates for 2009 to 2011 are based on projections using 2004-2008 data

The denominator, number of births was obtained from OASIS. The births for 2011 were projected using data for 2000 to 2010.

2008 data has been recalculated as follows:

numerator: 53,752
denominator: 146,464 annual indicator:
36.7

Notes - 2010
Data accessed on July 3, 2011 at http://www.cdc.gov/breastfeeding/data/nis_data. Data are based on birth cohorts. Therefore, the data reported for the 2007 reporting year is from the 2006 birth cohort. Data from the 2008 birth cohort (2009 and 2010 reporting years) are not available. Data are estimated using a linear projection with data from reporting years 2001 through 2008. While NIS is a sample survey, the numerator is estimated by

multiplying the number of birth reported for the specific birth cohort.

Based on trends in the data, an increase of 3 percent annually is expected in the annual indicator through 2015.

Notes - 2009
The specific source for these data are http://www.cdc.gov/breastfeeding/data/nis_data accessed on May 14, 2010. Data are based on birth cohorts. As such, the measure of six month breastfeeding in the National Immunization Survey reports on activity in 2006 and 2007. Therefore, the data reported for the 2007 reporting year are from the 2006 birth cohort. Data from the 2007 and 2008 birth cohorts are not available. For the 2008 and 2009 reporting year,
data were estimated using a linear projection with data from the 2000 through 2006 birth cohorts. While NIS is a sample survey, the numerator is estimated by multiplying the number of births reported for the specific birth cohort.

Data were updated for 2008 and 2009.

Annual performance objective estimates are developed by applying the average annual percent change (3.6%) between 2000 through 2009 to the 2009 point estimate.

a. Last Year's Accomplishments
In the process of updating.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintaining breastfeeding coalitions and collaborative efforts at the state and district level.			X	
2. Assisting districts implement breastfeeding education and support plans.				X
3. Continuing monitoring and surveillance of breastfeeding initiation and duration data.				X
4. Integrating breastfeeding promotion into relevant MCH, public health and community-based programs to prevent obesity.				X
5. Continuing to implement revised data collection systems in the Office of Nutrition and WIC and monitoring new data on duration rates.				X
6. Distributing revised Peer Counselor Program Guidelines to district programs as standard of care and best practices.				X
7. Making site visits to district Peer Counselor Programs to offer technical assistance and conduct program evaluation.				X
8. Expanding outreach to Georgia businesses and corporation via "The Business Care for Breastfeeding" tool kit.			X	
9. Maintaining the lactation room at the state office building.		X		
10. Continuing contract for peer counselor training and supervisor in-service training and education.				X

b. Current Activities
Activity 1: Increase surveillance of breastfeeding rates and community attitudes to breastfeeding.

Activity 2: Standardize and improve breastfeeding messaging statewide.

Activity 3: Develop strategy implementation plan and timeline for establishing breastfeeding- friendly hospitals in Georgia.

Activity 4: Establish Baby Cafés in Georgia to support breastfeeding mothers.

Activity 5: Expand WIC Peer Counseling program to include all 18 public health districts and two contracted WIC sites.

Activity 6: Ensure implementation of a mother-friendly worksite program in Georgia.

c. Plan for the Coming Year
Activity 1: Increase surveillance of breastfeeding rates and community attitudes to breastfeeding.

Output Measure(s): Development of a biennial survey to be implemented in WIC clinics; data from state BRFSS.

Monitoring: Quarterly reports.

Activity 2. Standardize and improve breastfeeding messaging statewide.

Output Measure(s): Development and implementation of a statewide media campaign to promote breastfeeding.

Monitoring: Project plan and implementation timeline; quarterly reports.

Activity 3: Develop strategy implementation plan and timeline for establishing breastfeeding- friendly hospitals in Georgia.

Output Measure(s): Guidelines for new program; hospitals participating in Georgia adaptation of Ten Steps to Successful Breastfeeding; number of hospitals to express interest and commitment in achieving Baby Friendly Certification from Baby Friendly USA.

Monitoring: Quarterly reports.

Activity 4: Establish Baby Cafés in Georgia to support breastfeeding mothers.

Output Measure(s): Number of Baby Cafés in Georgia; number of clients served; number of families of infants/children with special health care needs served.

Monitoring: Implementation plan and timeline; contract/procurement developed.

Activity 5: Expand WIC Peer Counseling program to include all 18 public health districts and two contracted WIC sites.

Output Measure(s): Number of peer counselors; percentage of districts/contracted sites with participating in program; number of clients who receive peer counseling services.

Monitoring: Quarterly reports.

Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	2012
Annual Performance Objective	98.7	99.1	99.5	99.7	97.8
Annual Indicator	99.0	99.3	99.6	97.8	97.6
Numerator	127191	123021	118851	113042	124308
Denominator	128532	123912	119292	115617	127408
Data Source	Newborn Hearing Program Data	Newborn Hearin g Progra	Newborn Hearing Program	Newborn Heari ng Progr	Newborn Hearing Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	Provisional
	2013	**2014**	**2015**	**2016**	2017
Annual Performance Objective	99.9	99.9	99.9	99.9	99.9

Notes-2012
The denominator is the number of live births as reported by hospitals. The numerator is the number of births screened as reported by hospitals. Source: Hospital quarterly reports SENDSS retrieved 05/01.

Notes - 2011
The denominator is the number of eligible births reported by the hospital, which equals live births minus newborn deaths, minus refused screening, minus transferred out without screen, plus transferred in without screen. The numerator is the number of births screened. It is common that hospitals report that they screen more births than are eligible and then have a report of screening over 100% of their births. The data reported adjusts for over reporting screening by not allowing any hospital to go over 100%.

The annual performance objectives reflect Georgia's goal and belief that 100% of all newborns should receive a hearing screen prior to hospital discharge and progress toward this goal.

2007 and 2008 data have been recalculated as follows:

2007: numerator is 140,201; denominator 148,403; and annual indicator is 94.5

2008: numerator is 127,191; denominator 128,532; and annual indicator is 99

Notes - 2010
The denominator is the number of eligible births reported by the hospital, which equals live births minus newborn

deaths, minus refused screening, minus transferred out without screen, plus transferred in without screen. The numerator is the number of births screened. It is common that hospitals report that they screen more births than are eligible and then have a report of screening over 100% of their births. The data reported adjusts for over reporting screening by not allowing any hospital to go over 100%.

The annual performance objectives reflect Georgia's goal and belief that 100% of all newborns should receive a hearing screen prior to hospital discharge and progress toward this goal.

The data are not available for 2010. The data presented are an estimate based on data from 2008 and 2009.

Notes - 2009
The denominator is the number of eligible births reported by the hospital, which equals live births minus newborn deaths, minus refused screening, minus transferred out without screen, plus transferred in without screen. The numerator is the number of births screened. It is common that hospitals report that they screen more births than are eligible and then have a report of screening over 100% of their births. The data reported adjusts for over reporting screening by not allowing any hospital to go over 100%.

The annual performance objectives reflect Georgia's goal and belief that 100% of all newborns should receive a hearing screen prior to hospital discharge.

a. Last Year's Accomplishments

Georgia participated in the Improving Hearing Screening and Intervention Systems (IHSIS) Learning Collaborative from June 2011-September 2012. Two articles on newborn hearing screening were written and published in the GAAFP newsletter and two in the GAAAP newsletter. Chapter Champion conducted outreach activities in addressing best practices for newborn hearing screening and follow-up. UNHSI Program Staff attended GAAFP and GAAAP conferences in the fall and summer. The Georgia UNHSI Guidelines for Pediatric Medical Home Provider was completed and distributed at the GAAFP and GAAAP conferences in June 2012. “Have You Heard?” newborn screening brochure was completed and is available in English and Spanish. The brochure has been distributed to all birthing facilities, health districts, and health departments and is posted on the UNHSI website. UNHSI Program began distributing quarterly newsletters to audiologists addressing updates from DPH, education and training opportunities, reporting, and best practices procedures.

Risk Factor protocol was approved and presented at the Child Health Meeting in September 2012. Risk Factor protocol birth through 6 months has been implemented. Revised Quarterly Hospital Report Form, to improve aggregate data collection, was implemented statewide June 2012. The report has been built into the UNHSI data management system, SendSS, for online entry. Audiologist survey, initiated in 2011, was completed and used to create the Georgia UNHSI Audiology Facility Locator in September 2012 and can be assessed on the UNHSI website.

UNHSI Stakeholders Committee resumed quarterly meetings in July 2012. UNHSI Program staff presented at Georgia PINES and UNHSI District/Regional meetings.

The Georgia Hearing Aid Loaner Bank was opened in September 2012 and provides temporary hearing aids for children while they are waiting to receive their personal hearing aids.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing analysis of quarterly hearing screening data to identify hospitals with unsatisfactory screening and referral performance.			X	
2. Continuing to promote UNHSI.				X
3. Providing training and technical assistance to hospitals and other health care providers screening newborns.				X

4. Developing data system to link newborn hearing screening information with the electronic birth certificate.				X
5. Providing technical assistance to Children 1st and UNHSI Follow Up Coordinators in health districts to link with children identified through screening reports from hospitals and other healthcare providers.				X
6. Developing UNHSI module in SendSS and providing access to healthcare providers statewide.				X
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Provide professional development for pre- and postnatal families and healthcare professionals about newborn hearing screening (UNHSI) and the importance of follow-up hearing screening by disseminating information via multiple communication methods.

UNHSI Program Staff presented at UNHSI District/Regional meetings focusing on reporting, risk factors, and best practice. UNHSI Program Staff also made a presentation to HMHB educating about the UNHSI Program, goals we are working toward and information/message that should be shared with parents. "Have You Heard?" brochure to be included in HMHB packet for expectant mothers. Stakeholder Committee Meetings continue quarterly. Webinar was presented by UNHSI Program in December 2012 after completion of the NICHQ Learning Collaborative for stakeholders, UNHSI District Coordinators, hospitals, audiologists, and interested parties about the experience and direction of the UNHSI Program. The NICHQ Learning Collaborative educated program staff on quality improvement methodologies to improve timeliness of screening, audiologic diagnosis, and entry into intervention. The pediatrician survey was completed and will be posted on Survey Monkey. Parent and physician letters that have been revised/created to better educate on appropriate follow-up are now available in SendSS. Revisions on Georgia's Resource Guide for families of children with hearing loss continue with recommendations from stakeholders presently being incorporated into the guide. Presentations at GA AAP and GAFP Conferences on newborn hearing screening in November with UNHSI Program present as exhibitors.

Activity 2: Improve the UNHSI system by developing and implementing a policy and procedure manual on early detection and intervention of children with suspected or confirmed hearing loss for hospitals, audiologists, and program staff.

The draft of the Policy and Procedure Manual, after review by stakeholders, has been submitted for approval. Separate sections address relevant issues for hospitals, Audiologists, otorhinolaryngologists, and Primary Care Physicians.

Activity 3: Reduce the percentage of babies who are lost to follow-up.

SendSS enhancements continue with hearing summary report completed to better assist UNHSI District Coordinators in follow-up. "Lost to Follow" protocol is in development and being built into SendSS as follow-up actions that must be completed prior to closing a case as lost to follow-up. UNHSI District Coordinators process flow in follow-up on refers is being revised for consistency across the state.

Activity 4 Develop and pilot data entry screen in SendSS for hospitals to manual enter hearing screening results.

October 2012 – September 2013 Activity 4:

A number of hospitals were contacted regarding manually entering hearing screening results on infants born in their facility. At this time, none of the hospitals contacted have been able to assist. Plans are still in place to add hearing screening results to the state's Electronic Birth Certificate (EBC), which uploads information into SendSS. This may eliminate the need for hospitals to manually enter hearing screening results. UNHSI and MCH have been working with Vital Records to add hearing screening results and risk factor information to the new Vital Events Information System (VEIS) birth file, which is under development. Information requested from UNHSI has been provided. Tentative date for implementation is end of 2013.

c. Plan for the Coming Year

Activity 1: Provide professional development for pre- and postnatal families and healthcare professionals about newborn hearing screening (UNHSI) and the importance of follow-up hearing screening by disseminating information via multiple communication methods, including PSAs, the UNHSI brochure and web-site, social networking sites, newsletter articles, and presentations.

Output Measure(s): Type and number of materials distributed; number of newsletter articles written; number of presentations given; number of friends and networks on social networking sites.

Monitoring: Quarterly review of education activities. Bi-monthly monitoring and updates of social networking sites.

Activity 2: Improve the UNHSI system by developing and implementing a policy and procedure manual on early detection and intervention of children with suspected or confirmed hearing loss for hospitals, audiologists, and program staff.

Output Measure(s): Revised policy and procedure manual available in print and electronically on website.

Monitoring: Quarterly review and discussion regarding progress at stakeholder meeting; ensure distribution to appropriate providers and availability of UNHSI website.

Activity 3: Reduce the percentage of babies who are lost to follow-up.

Output Measure(s): Quarterly comparison of differences between the number of births reported through the hearing screening system and the number of births registered, by hospital; summary of discussions with Vital Records and the outcomes; documentation of education, TA, and training activities provided to hospitals.

Monitoring: Quarterly meetings to review hospital and vital records data and discuss outcomes of meetings with Vital Records and the education, TA, and training activities provided to hospitals.

Activity 4: Develop and pilot a data entry screen in SendSS for hospitals to manually enter hearing screening results.

Output Measure(s): Module developed; pilot sites' evaluations of the data entry screen. Monitoring: Bi-monthly

meetings to discuss progress towards completion of the module; monthly reviews of the number of hearing screen results entered into SendSS.

Performance Measure 13: Percent of children without health insurance.

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	13.2	11.7	10.8	11.2	11.2
Annual Indicator	11.5	10.2	11.9	10.0	11.2
Numerator	288837	263520	296495	248531	277753
Denominator	2516819	2583533	2491552	2493574	2490275
Data Source	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional
	2013	**2014**	**2015**	**2016**	2017
Annual Performance Objective	11.2	11.2	11.1	11.1	11.1

Notes-2012

Data collected in year 2012. Children 0 to 17. The link to the Current Population Survey table is as follows: http://www.census.gov/cps/data/cpstablecreator.html

2012 denominator estimates were obtained from OASIS for the 0 to 17 year old population. The 2011 denominator based on linear projection was updated to the final number.

Population estimates for 2012 are not available and were estimated by linear projection using values for 2000 to 2011.

Notes - 2011

Data Collected in Year: 2011. Children 0 to 17.
Data were updated for 2006, 2007, 2008, 2009, and 2010. New link for the Current Population Survey tables is: http://www.census.gov/cps/data/cpstablecreator.html

Denominator estimates were obtained from OASIS for the 0 to 17 year old population. We could not tell the source of the denominator for the previous years so we used OASIS and updated the denominators for 2006 to 2010. Population estimates for 2011 are not available and so were estimated by linear projection using values for 2000 to 2010.

2007 and 2008 data have been recalculated as follows:

2007: numerator 311,656; denominator 2,513,356; and annual indicator 12.4

2008: numerator 286,619; denominator 2,536,452; and annual indicator 11.3

Notes - 2010

Between 2003 and 2010, there has been a slight decline on average of 0.2%. This is applied to the 2010 point estimate to project the annual performance objective for 2011 through 2015.

Notes - 2009

For the FY11 submission, the data source was changed to the Current Population Survey (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html). Data for 2009 are not available. These data will be available with the release of data for the 2010 Current Population Survey. For 2009, data were estimated using a linear projection with data from 2002 through 2008.

Data were updated for 2007, 2008, and 2009.

Annual performance objective estimates are developed by applying the average annual percent change (-0.6%) between 2002 through 2009 to the 2009 point estimate.

a. Last Year's Accomplishments

In the process of being updated.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing training, technical assistance and monitoring of Grant-in-Aid (GIA) annex deliverables related to PeachCare for Kids and Medicaid outreach, referral and administrative case management.				X
2. Continuing collaborations with DFCS and the Department of Community Health to plan and coordinate "Cover the Uninsured Week" activities for adolescents throughout Georgia.				X
3. Providing training, technical assistance and monitoring of Grant-in-Aid annex deliverables related to ensuring a medical home for all children and adolescents and their families who lack insurance.				X
4. Continuing to assist families during the Children 1st Family Assessment in completing necessary forms for enrollment in Medicaid or PeachCare for Kids.		X		
5. Sharing Medicaid and PeachCare for Kids information at community health fairs, trainings, exhibits, etc.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Monitor and report percentage of children without healthcare insurance by utilizing various sources of data.

Activity 2: Screen all children participating in MCH programs for eligibility for public insurance options and make appropriate referrals.

c. Plan for the Coming Year

Activity 1: Monitor and report percentage of children without healthcare insurance by utilizing various sources of data.

Output Measure(s): Child health insurance status report. Monitoring:

Quarterly progress reports.

Activity 2: Screen all children participating in MCH programs for eligibility for public insurance options and make appropriate referrals.

Output Measure(s): Number of children screened; number of children referred. Monitoring:

Quarterly data reports.

Performance Measure 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	29	28	30.4	28.8	28.3
Annual Indicator	31.4	30.6	29.3		31.3
Numerator	25994	23650	39959		
Denominator	82782	77286	136379		
Data Source	PedNSS	PedNSS	PedNSS	PedNSS	PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final		
	2013	2014	2015	2016	2017
Annual Performance Objective	27.8	27.4	26.9		

Notes - 2010
Data from Georgia PedNSS report as provided by Georgia WIC.

The average annual percent change between 2008 and 2009 is an decrease of 3.4%. The annual performance objective is decreased by half of this increase through 2015.

Notes - 2009
Data from Georgia PedNSS report as provided by Georgia WIC.

The average annual percent change between 2000 and 2008 is an increase of 2.4%. While there was a decrease between 2008 and 2009, this was the first decrease between 2000 through 2009. The annual performance objective will be set for a 0.5% decline in each year through 2014.

a. Last Year's Accomplishments

Continued changes in leadership in the WIC program and competing priorities of addressing vendor fraud, strengthening vendor authorization, and addressing a previous management evaluation from USDA delayed progress on this performance measure during the reporting period.

1. The Georgia WIC Program established policies and procedures for utilizing the new WHO CDC Growth Charts for Infants. Revised policies require all children above two years of age to be plotted on the standard CDC Growth Chart.

2. Department of Public Health, Georgia WIC, and Children's Healthcare of Atlanta (CHOA) coordinated an obesity initiative titled Strong 4 Life. WIC Public Health Staff in the Macon and Columbus Health District received training, education materials and technical assistance.

3. Established monthly child weight reports for the WIC population. Children age 2-5 are classified as one of the following:
- High Risk Underweight <=5th Percentile
- Underweight >5 to <=10th Percentile
- Normal Weight >10 to <85th
- At Risk for Overweight >=85 to < 95th Percentile
- High Risk Overweight/Obese >=95th Percentile

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing individual counseling to WIC participants on a variety of nutrition topics addressing healthy weight (i.e., Strong-4-Life, healthy eating, stress-free feeding and physical activity).	X			
2. Providing nutrition education to WIC participants through eating and physical activity programs (i.e., Individual counseling sessions, group nutrition education classes, healthy			X	
3. Providing training to WIC staff on nutrition education best practices that result in improved behaviors, including children who are overweight or obese.				X
4. Providing via contracts Lunch and Learn sessions with private providers and sharing information about services available to children who may be eligible for WIC, Medicaid and/or PeachCare for Kids.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1:
Draft State level nutrition education reports have been prepared and discussed, but further progress has been delayed due to limited staff availability, changes in leadership, and higher priority system projects.

Draft policies and procedures have been developed to implement internet based nutrition education modules. The state anticipates piloting internet based nutrition education in three health districts (Columbus, Gwinnett, Cobb / Douglas)

Activity 2: Establish comprehensive obesity-related risk behavior data surveillance system through Georgia's WIC electronic child and adult nutrition assessment forms.

c. Plan for the Coming Year
Activity 1: Monthly, quarterly and annual reports will be available at the clinic, county, district and state levels.

Output Measure(s): Reports available. Monitoring: Monthly

and quarterly reports.

Activity 2: Review monthly and quarterly reports to identify clinics, counties or districts with improved rates in order to identify their best practices.

Output Measure(s): Clinics, counties, and districts identified with improved rates. Monitoring:

Monthly and quarterly reports.

Activity 3: Identify at least two nutrition education best practices. Outcome

Measure (s): Best practices identified,

Monitoring: Monthly and quarterly reports.

Activity 4: Implement internet based nutrition education modules.

Output Measure(s): Rate of WIC clients who received nutrition education. Monitoring:

Monthly and quarterly reports

Activity 5: Provide Strong 4 Life Obesity Training and related resources to an additional three districts.

Output Measure (s): Number of districts trained using Strong 4 Life Obesity Intervention training.

Challenges:

Note: The Georgia WIC program is working through a state level reorganization and does not have staff currently in place to complete all of the activities listed above.

Performance Measure 15: Percentage of women who smoke in the last three months of pregnancy.

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	10.1	9.2	7.4	8.7	8.4
Annual Indicator	8.1	8.5	8.3	8.8	9
Numerator	11864	12013	11094	11637	12821
Denominator	146464	141332	133668	132239	142460

Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because					
3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	8.1	7.8	7.5		

Notes-2012

While PRAMS is a sample survey, the numerator is estimated by multiplying the rate from PRAMS and the total number of pregnancies in the year. The number of births to all mothers who are GA residents (from OASIS) is used as a proxy for the total number of pregnancies for that year. PRAMS data are available through 2010, a linear projection was made for 2011 and 2012 using PRAMS data from 2007 -2010. For the total number of pregnancies (births) the estimate for 2012 was made using data from 2000-2011.

Notes - 2010

Previously, data for 2007 were not available. These data are now available and indicate a point estimate of 7.6 percent in 2007. Therefore, there were increases in this indicator in 2008 and 2009. Therefore, the projection for 2010 is based on data from 2007 through 2009 only. While PRAMS is a sample survey, the numerator is estimated by multiplying the rate from PRAMS and the total number of pregnancies in the year.

Given the trend in this indicator, the projections for the annual performance objective are done so to identify intermediate goals to achieve the same rate in 2015 that was identified in 2007.

Notes - 2009

PRAMS data are not available for 2007, 2008, or 2009. These data have been estimated using a linear projection with PRAMS data from 2004 through 2006. While PRAMS is a sample survey, the numerator is estimated by multiplying the rate from PRAMS and the total number of pregnancies in the year. Pregnancy data are available through 2007. Pregnancies for 2008 and 2009 are estimated using a linear projection.

There are insufficient data to project the annual performance objectives based on previous data. The annual performance objectives were estimated using an annual decline of 2.5%.

a. Last Year's Accomplishments

Georgia Tobacco Use Prevention Program (GTUPP) staff disseminated newly developed GTQL brochures (including the pregnant and postpartum version) to all 18 local public health districts statewide via district coordinators. Approximately 20,000 brochures were disseminated in the first quarter. GTUPP drafted Tobacco Cessation posters containing one version tailored for pregnant and postpartum women tobacco users.

GTUPP worked with national tobacco cessation vendor of the GTQL which resulted in the purchase and incorporation of pregnancy/postpartum screening module and the delivery of specialty tobacco cessation screening and 10-call counseling services effective 1/1/12. An overview of GTQL Tobacco Cessation efforts was presented and subsequently a partnership was established to focus on both Gestational Diabetes and Tobacco Cessation efforts. Georgia OB/GYN society staff acquired an intern to support collaborative efforts and mail GTQL materials. An electronic version of the current ACOG Smoking Cessation and Pregnancy toolkit was provided to the OB/GYN clinical liaison for further dissemination to physicians by mail and/or newsletter.

GTUPP staff met with Georgia Department of Community Health (DCH) Medicaid liaison resulting in dissemination of new DCH Policy Guidance: *Smoking and Tobacco Cessation Counseling Services for Pregnant*

Women-Medicaid (effective date: 10/11) applicable to pregnant women serviced in local health departments statewide. DCH policy guidance was disseminated to all public health district coordinators. The primary focus areas were reimbursement information for providing one-on-one tobacco cessation counseling and implementation of 5As practices.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducting statewide perinatal center training in 13 of 18 public health districts.				X
2. Continuing Council on Maternal and Infant Health participation in regional perinatal center activities.				X
3. Providing preconception health counseling to family planning clients.	X			
4. Continuing to provide perinatal case management training.				X
5. Continuing to promote interconceptional periods of at least 1.5 to 2 years.			X	
6. Continuing to work with regional tertiary hospitals to improve communication in the community.				X
7. Collaborating with WIC on activities to improve communication with clients receiving services from Women's Health and WIC.				X
8.				
9.				
10.				

b. Current Activities

Activity 1: Partner with health departments, women's health coordinators, youth development coordinators, family planning clinics and WIC to increase awareness of the impact of smoking in pregnancy.

GTUPP disseminated new Georgia Tobacco Quit Line brochures (including a pregnant and postpartum version) to 14 health districts statewide via district coordinators in the first quarter.

Activity 2: Collaborate with GOGS to increase providers and pregnant patient awareness of the Georgia Tobacco Quit Line.

A new Tobacco Cessation Coordinator was hired. During the first quarter, 43 pregnant tobacco users became GTQL participants. In addition, 12 female adult tobacco users who indicated that they were planning a pregnancy also became GTQL participants. A press release regarding expansion of free nicotine replacement therapy (NRT) to uninsured adults (aged 18 and older) was shared with clinician liaison at Georgia OB/GYN Society.

Activity 3: Develop and implement a health education campaign targeting pregnant women in public health districts with high rates of tobacco use.

No further updates related to this activity.

Activity 4: Implement the Tobacco Cessation Fax Back Program in 25% of local public health departments as a part of Family Planning Services tobacco use assessment intake procedures.

Development and enhancement of Tobacco Cessation Fax Back Program based on California Diabetes Program model (Do you cAARD? Program) occurred resulting in the Georgia cAARDs Program during 2nd quarter 2012. Georgia cAARDs Program pilot phase was implemented in 2 public health districts (includes 30 participating health departments) during the 3rd quarter 2012.

Pilot sites received Georgia cAARDs Program lobby signage during September 2012 and October 2012.

GTUPP staff worked with vendor during 4th quarter 2013 to request customized reports on a monthly basis for participating public health districts to assess impact associated with GTQL utilization.

During the first quarter, the local health department staff accounted for 8% of the referrals to the GTQL and were the primary referral source for 126 GTQL adult participants. There were 1,405 calls to the GTQL and 14 web-based enrollments to the GTQL. There were 144 faxes to the GTBL.

c. Plan for the Coming Year

Activity 1: Partner with health departments, women's health coordinators, youth development coordinators, family planning clinics and WIC to increase awareness of the impact of smoking in pregnancy.

Output Measure(s): Number of women of childbearing age; number of pregnancy women referred to and enrolled in the smoking cessation program.

Monitoring: Quarterly reports.

Activity 2: Collaborate with the Georgia Obstetrical and Gynecological Society to increase providers and pregnant patient awareness and utilization of the Georgia Tobacco Quit Line.

Output Measure(s): Number of calls to Quit Line; number of providers trained; number of referrals to Quit Line; number of pregnant women enrolled; number of women of childbearing age enrolled; number of hits to the Georgia Tobacco Quit Line website.

Monitoring: Quarterly reports.

Activity 3: Develop and implement a health education campaign targeting pregnant women in clusters of high infant mortality rates.

Output Measure(s): Number of PSAs developed; number of calls to the Quit Line based on PSA. Monitoring:

Quarterly reports

Activity 4: Implement the Tobacco Cessation Fax Back Program in 25% of local public health departments as a part of Family Planning Services tobacco use assessment intake procedures.

Output Measure(s): Number of local public health departments that implement the fax back program; number of calls to the Georgia Tobacco Quit Line; number of faxes to Georgia Tobacco Quit Line.

Monitoring: Quarterly reports.

Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	5.4	4.5	4.2	4.6	4.6
Annual Indicator	6.0	6.0	6.1	5.7	5.2
Numerator	41	43	43	40	38
Denominator	687846	712243	707249	700944	732313
Data Source	Vital Record	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because					
Is the Data Provisional or Final?			Provisional	Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	4.5	4.5	4.5	4.5	

Notes - 2011
Death record data are unavailable for 2009, 2010, and 2011 and population are unavailable for 2011. The provisional estimates for the number of deaths were developed using a linear

projection with data from 2000 through 2008, and for the population, using a linear projection with data from 2000 through 2010.

Notes - 2010
Data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear projection with data from 2000 through 2008. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 and 2010 are estimated using a linear projection with data from 2000 through 2008.

Given the increase in 2008, the last year for which there are final data, the annual performance indictor will use a 0.5% reduction to determine estimates from 2011 through 2015.

Notes - 2009
Data were updated for 2007, 2008, and 2009.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

The average annual percent change is -2.3%. This is applied to the 2009 projected rate of 4.3 to project the annual performance indicator for 2010 through 2014.

a. Last Year's Accomplishments

Suicide Prevention Coalitions have been built on a local level bringing awareness, education, resources, support and trainings out into communities across GA. There are now 11 active community coalitions. Broad training in gatekeeper programs, QPR (Question, Persuade, Refer) and Mental Health First Aid has occurred.

Three Statewide Stakeholders Conferences were organized and executed with one having more than 400 attendees from all over the state. Additionally, three Statewide College Conferences to introduce program and resources were held. Also, conferences were hosted and/or supported for the aging population, military, and

veterans.

Training, assistance and ongoing support in leading Survivors of Suicide Support Groups was provided. There are now 26 groups in GA with 5 more in progress. As an extension of this work, we have been able to offer families that have lost a loved one to suicide an annual family grief support camp-Camp SOS.

Thousands of “Purple Packets” were developed, printed and distributed to deliver comfort and resource information to survivors statewide. A GA model for SOS Groups for Children and teens are in development and a “train-the-trainer” training was held in May. A statewide suicide prevention information network, www.GSPIN.org with a broadcast network, was built and maintained to connect all stakeholders.

We are partnering with NAMI GA to train First Responders in Crisis Intervention Team Training, arming officers and EMS with skills to work with suicide attempters and survivors of suicide loss. We are also rolling out CSSRS (Columbia Suicide Severity Rating Scale) and safety planning to the provider network statewide.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Providing training, technical assistance and monitoring of district activities and progress related to suicide prevention plans and objectives.				X
2. Continuing collaborations with the Department of Behavioral Health and Developmental Disabilities, Office of Injury Prevention and other agency staff to develop a statewide suicide prevention plan that includes staff development.				X
3. Continuing development of MCH referral, intake and assessment processes to identify adolescents "at risk" and to assure timely receipt of appropriate mental health resources.				X
4. Continuing to develop outcome and contract requirements, performance expectations/indicators and policies and procedures for contracts and Grant-in-Aid annexes related to adolescent mental health resources.				X
5. Continuing to fund and implement youth development programs and activities that provide adult-supervised activities, caring adult mentors and peer educators for targeted youth.			X	
6. Providing training and technical assistance to the Georgia Association of School Nurses and other school health professionals related to suicide prevention.				X
7. Providing information to CMS staff on identification and referral of at-risk clients.				X
8.				
9.				
10.				

b. Current Activities

Activity 1: Work with GVDRS to produce an age range specific fact sheet and map with overlay of high schools for distribution to the school systems.

Fact Sheet and Map were created and distributed statewide.

Activity 2: Activity 2: Follow up on survey of existing protocols in high schools regarding suicide ideation and

attempts.

Work within the Suicide Prevention Action Network has included implementing Suicide Prevention, Help Seeking and Resiliency Building programs for the middle and high schools, and bringing prevention and post-vention programs to schools to give them a model for building teams within the school and community to help them respond appropriately at the moment of a crisis.

Activity 3: Review report on child deaths resulting from suicide completions through Child Fatality Review and develop policy recommendations and activities aimed at reducing such deaths.

Partnership between child fatality review and the Georgia Violent Death Reporting system was developed for data collection and reporting.

Activity 4: Track DBHDD policy to utilize the Columbia Suicide Severity Risk Scale for all providers.

Staff position was vacant as of December 2012 and is currently being filled. All work within suicide prevention has been done by the Georgia Suicide Action Network and the Georgia Suicide Prevention Information Network.

c. Plan for the Coming Year

Activity 1: Work with the GVDRS to produce an age range (age 8 -- 19) specific fact sheet and map with overlay of high schools for distribution to the school systems every two years.

Output Measure(s): Number of suicide attempts by age group; number of suicide completions by age group; production of fact sheets; distribution of reports to school systems; number of health districts receiving fact sheets.

Monitoring: Quarterly progress reports; draft fact sheets.

Activity 2: Follow up on school-based Postvention training and survey of protocols in high schools regarding suicide ideation, attempts, and school response.

Output Measure(s): Survey designed; survey distributed; report of survey results;

Monitoring: Survey validation report; plan for survey implementation.

Activity 3: Review report on child deaths resulting from suicide completions through Child Fatality Review, in combination with other data sets, and develop policy recommendations and activities aimed at reducing such deaths.

Output Measure(s): Annual Child Fatality Review Team Report across multiple sources of data on child deaths that includes suicide deaths and policy recommendations.

Monitoring: Quarterly reports.

Activity 4: Track DBHDD policy to utilize the Columbia Suicide Severity Risk Scale for all providers.

Output Measure(s): Policy developed; percent of providers utilizing tool. Monitoring:

Quarterly reports.

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	77.5	70	73.4	73.3	73.6
Annual Indicator	74.6	74.9	73.0	77.8	77.1
Numerator	2013	1945	1846	1868	1785
Denominator	2697	2596	2529	2400	2316
Data Source	Vital Recor	Vital Records	Vital Records	Vital Records	Vital Records
Check this box if you cannot report the numerator because					
Is the Data Provisional or Final?		Final	Final	Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	74	74.4	74.7	74.7	74.7

Notes-2012
Birth record data are unavailable for 2012. The provisional estimates are developed using a linear projection with data from 2008 through 2011. The facility table that was used to obtain estimates for 2000 to 2007 was recently updated with 6 new level 3 (former level 2) facilities. The exact date these facilities became level 3s is unknown but they were included in the analysis for 2008 to 2011 as level 3s.

Notes - 2011
Birth record and population data are unavailable for 2011. The provisional estimates were developed using a linear projection with data from 2008 through 2010. The facility table that was used to obtain estimates for 2000 to 2007 was recently updated with six new level 3 (formerly level 2) facilities. The exact date these because level 3's is unknown, but they were included in the analysis for 2008 to 2010 as level 2s.

The 2007 data was recalculated as follows:

2007: numerator 1931; denominator 2682; and annual indicator 69.5.

Notes - 2010
Georgia has five perinatal levels. Level 0 has no delivery capacity. Level I is basic care. Level II is specialty care. Level III is subspecialty care. Level IV is the state designated perinatal centers. Level I through III are self-designated at the time of application for Certificate of Need. Facilities for high-risk deliveries and neonates are defined as Level III and IV facilities.

Data are unavailable for 2009 and 2010. The provisional estimates are developed using a linear projection with data from 2000 through 2008.

The average annual percent change for this indicator is declining. With an expectation to improve this indicator, the

annual performance objective reflects a 0.5% increase.

Notes - 2009
Georgia has five perinatal levels. Level 0 has no delivery capacity. Level I is basic care. Level II is specialty care. Level III is subspecialty care. Level IV is the state designated perinatal centers. Level I through III are self-designated at the time of application for Certificate of Need. Facilities for high-risk deliveries and neonates are defined as Level III and IV facilities.

Data were updated for 2007, 2008, and 2009.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007.

The average annual percent change for this indicator is -0.7%. With an expectation to improve this indicator, the annual performance objective reflects a 0.5% increase in the 2009 percent.

a. Last Year's Accomplishments

Regional Perinatal Centers (RPCs) were reconvened. A Training Needs Assessment was conducted targeting the RPCs. The MCHS revised the Core Requirements and Recommended Guidelines and developed draft Administrative and Financial Screening Tools. The MCHS submitted FY 2013 amendments and FY 2014 contracts to the Contracts Unit.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducting annual performance audits at each regional perinatal center.				X
2. Working on outreach education plans at all regional perinatal centers.				X
3. Focusing on perinatal case management training on preterm delivery prevention.				X
4. Continuing to work with the Georgia Obstetrical Gynecological Society (GOGS) on increasing the number of very low birthweight facilities for high risk deliveries and neonates.				X
5. Conducting bi-annual regional perinatal center clinical peer reviews.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Conduct a perinatal capacity survey of designated Level II and Level III facilities in the state.

The survey instrument is in draft form.

Activity 2: Meet with Georgia Obstetrical and Gynecological Society, neonatologists, perinatologists, leadership from the Regional Perinatal Centers, and other appropriate stakeholders to share research findings and develop a strategic plan to improve the percent of deliveries performed at appropriate sites.

Work was initiated on development of a perinatal plan as part of the HRSA Infant Mortality Collaborative efforts. Two face-to-face meetings were conducted in October 2012 and May 2013 with over 40 participants.

c. Plan for the Coming Year
Activity 1: Conduct a perinatal capacity survey of all birthing hospitals.

Output Measure(s): Number of completed surveys; analyses of surveys; development and dissemination recommendations from analysis.

Monitoring: Survey response and completion rates; Completion of analyses; Engagement of stakeholders.

Activity 2: In collaboration with stakeholders, develop and implement a Public Health perinatal plan with measurable outcomes.

Output Measure(s): Draft perinatal plan; number of measurable outcomes; number of partners collaborating.

Monitoring: Quarterly reports.

Activity 3: Strengthen the Regional Perinatal Center Program.

Output Measure(s): Number and type of technical assistance/training provided; number of policies and procedures revised.

Monitoring: Quarterly reports.

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	87	64.5	70	81.8	82.6
Annual Indicator	80.7	80.8	71.4	70.3	67.2
Numerator	64096	73160	70188	74810	77856
Denominator	79445	90491	98343	106350	115799
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	**Final**	**Final**	**Final**	**Final**	**Provisional**
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	**83.5**	**84.3**	**85.1**		

Notes - 2010
In 2007, Georgia adopted the 2003, Revised Birth Certificate part way through the year. This had two impacts on NPM18. First, it changed how the entry into prenatal care question was asked from asking for month of entry into prenatal care to asking for date of entry into prenatal care. Second, the vitals reporting system changed. The impact of the first change is well described by NCHS. The impact of the second change was that the percent of women with unknown entry into prenatal care increased beyond what would be expected to happen from the wording change alone.

Data for 2008 and 2009 are actual final data. 2010 is a projection based on these two data points. The denominator differs here from other measures because we did not include the missing values. In 2008, 45.8 percent of the data were missing. In 2009, 36.0 percent of the data were missing.

The annual performance objective is projected using a 1 percent increase to indicate the desire on the part of the state to increase this rate. There are no data that allow for an accurate projection.

Notes - 2009
In 2007, Georgia adopted the 2003 Revised Birth Certificate part way through the year. This had two impacts on NPM18. First, it changed how the entry into prenatal care question was asked from asking for month of entry into prenatal care to asking for date of entry into prenatal care. Second, the vitals reporting system changed. The impact of the first change is well described by National Center for Health Statistics. The impact of the second change was that the percent of women with unknown entry into prenatal care increased beyond what would be expected to happen from the wording change alone. In 2007, 22.5% of women were missing information necessary for calculating trimester of entry into prenatal care. The denominator is all births. If the denominator was limited to only those who had valid data, the rate in 2007 (the last year for which actual data exist) would be 82.7% (96,662/116,941).

Data from 2007, 2008, and 2009 were updated.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Given the changes in this measure, the linear projections may be less reliable than in other measures.

Given the current volatility of this measure, projecting the annual performance measure is challenging. Based on the projected rate in 2009, the annual performance measure reflects a 0.5% increase in this measure annually.

a. Last Year's Accomplishments
In the process of being updated.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to provide referrals to private OB providers, WIC and Medicaid for all clients enrolled in Perinatal Case Management (PCM).			X	
2. Providing Family Planning staff with opportunities to attend PCM training to learn about the importance of early entry into prenatal care.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1. Convene meeting with Georgia Obstetrical and Gynecological Society, Georgia Academy of Family Physicians, Georgia Chapter of American College of Nurse Midwives, and Care Management Organizations to discuss barriers to prenatal care beginning in first trimester.

Activity 2. Partner with stakeholders to fund CenteringPregnancy Projects.

c. Plan for the Coming Year

Activity 1: Partner with stakeholders to strategically expand CenteringPregnancy Projects. Output

Measure(s): Number of sites; number of patients served; evaluation report. Monitoring: Monthly reports of

number of clients enrolled; submission of data forms.

D. State Performance Measures

State Performance Measure 1: Percent of high school students who are obese (BMI > or = 95th percentile)

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				12.3	
Annual Indicator	13.8	12.4	12.4	15.0	15.0
Numerator	62543	56528	57026	694502	70007
Denominator	453210	455871	459886	462998	466712
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?			Final	Final	
	2013	**2014**	**2015**	**2016**	2017
Annual Performance Objective	12	11.9	11.8	11.8	

Notes – 2012

The 2012 population denominator was estimated by linear projection and the numerator was obtained, as in other years, by applying the indicator to the denominator.

Notes - 2011
Data are from Georgia YRBS. Actual surveys were conducted in 2007, 2009, 2011. For the intervening years when the survey is not conducted, the same estimate is maintained.

Previous notes state that the denominator and numerator were updated using current population estimates. We have searched census.gov and OASIS and cannot locate the actual source for the denominator. It is not also clear which age range was used for high schoolers (14-18 years OR
14-17 years OR 15-18 years OR 15-17 years) to enable exact calculation of the population.

The 2011 population denominator was estimated by linear projection and the numerator was obtained as in other years, by applying the indicator to the denominator.

Notes - 2010
Data are from the Georgia YRBS. These data are available every other year. In even numbered years, when data are not collected, the indicator from the previous year is repeated. While the YRBS provides a point estimate based on a sample survey, the numerator and denominator are updated using current population estimates. The annual performance objective is based on a 1 percent annual decline.

a. Last Year's Accomplishments
In the process of being updated.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Leading development and implementation of Georgia's Childhood Obesity Initiative.				X
2. Serving on Fitness Testing Steering Committee.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Support policy and practice change to reduce childhood obesity rates.

Activity 2: Participate in a public/private partnership with the Department of Education (DOE) to implement statewide fitness assessments.

Activity 3: Identify key projects to support obesity prevention.

Activity 4: In collaboration with other organization stakeholders regarding childhood obesity prevention, provide data and technical assistance to support selected communities in designing a nutrition and physical activity strategies tailored to local target population needs; partner to support evaluation design and implementation.

c. Plan for the Coming Year
Activity 1: Support policy and practice change in childcare centers and public school systems to reduce childhood

obesity rates.

Output Measure(s): Number of partnerships created; number of mini-grants offered to schools/childcare centers for nutrition and physical activity standards; number of practice changes; number of policy changes.

Monitoring: Quarterly reports.

Activity 2: Participate in a public/private partnership with the Department of Education to implement statewide fitness assessments in schools with a goal of reaching all school systems in Georgia.

Output Measure(s): number of school systems implementing fitness assessments; number of individual data records entered.

Monitoring: Quarterly reports.

Activity 3: Implement statewide social media campaign to promote childhood nutrition and physical activity.

Output Measure(s): Number of public service announcements (PSAs); number of website hits; number of click-throughs on interactive geo-coded on-line resource directory.

Monitoring: Quarterly reports.

Activity 4: In collaboration with other organization stakeholders regarding childhood obesity prevention, provide data and technical assistance to support selected communities in designing a nutrition and physical activity strategies tailored to local target population needs; partner to support evaluation design and implementation.

Output Measure(s): DPH points of contact to support strategy design and provide TA identified; initial review and summary of a variety of public health data sources to inform strategy development completed; number of local strategies developed; evaluation plan developed.

Monitoring: Quarterly reports.

State Performance Measure 2: Infant mortality rate among infants born weighing 1,500 grams or more who survive past the first 27 days of life

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				**1.8**	**1.9**
Annual Indicator	**1.9**	**1.9**	**1.7**	**1.8**	**1.8**
Numerator	**270**	**257**	**226**	**257**	**254**
Denominator	**143559**	**138542**	**131004**	**143046**	**144084**

Data Source	Linked Birth-Death Record	Linked Birth-Death Record	Linked Birth-Death Record	Linked Birth-Deaths	Linked Birth-Deaths
Is the Data Provisional or Final?	Final	Final	Final	Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	1.9	1.8	1.8	1.8	1.8

Notes - 2011
Source is the Linked Birth-Death Record. Linked birth and death records are only available through 2007. Data (Numerator and Denominator) for 2008 through 2011 were projected using linear estimation based on data from 2000 to 2007

Notes - 2010
Linked birth and death records were only available through 2007. Data for 2008, 2009, and 2010 were projected using a linear estimation based on data from 2000 through 2007. Based on trends in this indicator, a decline of 0.2 percent is expected for 2011 through 2015.

TVIS rounds to the tenths place, but this is a measure more accurately expressed to the hundredths place.

a. Last Year's Accomplishments
In the process of being updated.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participating in HRSA's Regions IV and VI Infant Mortality Collaborative.				X
2. Developing an infant morality strategic plan.				X
3. Establishing a statewide perinatal quality collaborative.				X
4. Strengthening Georgia's 1115 Family Planning Waiver.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Implement a targeted infant mortality reduction initiative aligned with the Department of Public Health's Strategic Initiative.

Activity 2: Work with GOGS to implement perinatal collaborative to reduce non-medically indicated elective inductions and Cesarean sections.

c. Plan for the Coming Year

Activity 1: Implement a targeted infant mortality reduction initiative aligned with the Department of Public Health's strategic initiative.

Output Measure(s): Implementation milestones met as projected. Monitoring:

Quarterly reports.

Activity 2: Implement Georgia's Public Health Perinatal Plan.

Output Measure(s): number of partners in perinatal quality collaborative; percent of non-medically indicated elective deliveries prior to 39 weeks; number of linked data sets.

Monitoring: Quarterly reports.

State Performance Measure 3: Number of abstracts submitted, reports prepared, presentations made, and publications submitted for peer review where MCHP staff are authors or coauthors

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

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					5
Annual Indicator				0	
Numerator					8
Denominator					1
Data Source				Office of MCH Epi	Office of MCH Epi
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	7	10	12	15	15

Notes - 2011
This performance measure provides the number of abstracts and reports completed for the project year. Although an annaul objective can be established, an annual indicator cannot be determined because there is no denominator for this measure.

Notes - 2010
Data collection for this measure did not initiate until October 1, 2010. Therefore, for calendar year 2010, there were no events that satisfied this measure. Events have occurred during 2011 and will be reported in subsequent years.

a. Last Year's Accomplishments

Two papers were published during the reporting period:

1. **Ogbuanu CA,** Goodman D, Kahn K, Long C, Noggle B, Bagchi S, Barradas D, Castrucci BC. (2012) Timely Access to Quality Health Care Among Georgia children Ages 4-17 Years. *Maternal and Child Health Journal, 16*(S2), 307-319.
2. **Ogbuanu CA,** Goodman D, Kahn K, Noggle B, Long C, Bagchi S, Barradas D, Castrucci BC. (2012). Factors associated with parent report of access to care and the quality of care received by children 4 to 17 years of age in Georgia. *Maternal and Child Health Journal, 16*(S1), 129-142.

Five presentations were made during the reporting period:

1. Certification as a Mother-friendly worksite, 83rd Georgia Public Health Association Annual Meeting, April 2012
2. WIC Breastfeeding Initiation and Duration Rates, Georgia District Nutrition Services Directors' Meeting, January 2012
3. WIC Breastfeeding Initiation and Duration Rates, Georgia WIC Breastfeeding Advisory Committee Meeting, December 2011
4. The Determinants of Timely Access to Quality Health Care among Georgia Children 4-17 years of age, 17th Annual Maternal and Child Health Epidemiology Conference, December 2011
5. Factors Associated with Parent Report of Access to Care and the Quality of Care Received by Children 4-17 years of age – How do they differ in Georgia?, 139th APHA Annual meeting and Exposition – Poster, October-November 2011

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintaining Perinatal Research Collaborative with Emory University.				X
2. Continuing to identify opportunities to present at the local, state, and national level.				X
3. Continuing to prepare reports and publications.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activity 1: Develop a collaborative research agenda for the MCH Program.

Activity 2: Implement studies and disseminate results to address knowledge gaps and inform policy/program activities.

c. Plan for the Coming Year
Activity 1: Develop a collaborative annual research agenda for the MCH Program.

Output Measure(s): Number of external collaborators; number of studies identified; number of studies initiated; number of studies completed

Monitoring: Quarterly reports.

Activity 2: Implement studies and disseminate results to address knowledge gaps and inform policy/program activities.

Output Measure(s): Number of policy/program changes; number of presentations; number of publications; number of reports issued.

Monitoring: Quarterly reports.

State Performance Measure 4: Deaths to children ages 15 to 17 years caused by motor vehicle crashes

per 100,000 children

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	2012
Annual Performance Objective				14.5	14.3
Annual Indicator	12.0	9.2	10.7	9.6	8.0
Numerator	49	39	45	40	35
Denominator	408637	423461	420430	416990	439208
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records/OAS
Is the Data Provisional or Final?	Final	Final	Final	Provisional	Provisional
	2013	**2014**	**2015**	**2016**	
Annual Performance Objective	14.2	14	13.9	13.9	

Notes-2012
Data are from OASIS. The population denominator for 2012 was estimated by linear projection using data for 2002-2011.
The numerators for 2011 and 2012 were estimated using 2001 to 2010 data. The numerators for 2009 and 2010 were updated with final data.
The Annual indicator – number of deaths to children ages 15 to 17 years by motor vehicle crashes was calculated using the numerator and denominator and expressed per 100,000 children.

Notes - 2011
Data are from OASIS. The Population denominator for 2011 was estimated by linear projection using data for 2000 to 2010

The numerator for 2009 to 2011 was estimated by linear projection using data from 2000 to 2008
.

The Annual indicator -number of deaths to children ages 15 to 17 years by motor vehicle crashes was calculated using the numerator and denominator and expressed per 100,000 children.

2008 was recalculated as follows: Annual indicator:

12.1
Numerator: 289
Denominator: 148,501

Notes - 2010
Data for 2008 are final. Data for 2009 and 2010 are not availabe. Data are projected using a linear estimate derived from data from 2000 through 2008. The average change in this indcator between 2000 and 2010 is positive. Therefore, a 1 percent decline is applied to estimate the annual performance objective.

a. Last Year's Accomplishments

By the end of the fiscal year there were Community Mobilization groups functioning in 26 counties.

There were a total of 74 activities conducted during the year, including teen traffic safety events, seat belt surveys, and child safety seat classes.

Crash data from the hospital inpatient discharge data base on crash injuries were provided to local injury

prevention groups. Two hundred thirty data variable maps were provided to NE GA RRI and their enforcement networks.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establishing/maintaining Community Mobilization Groups.				X
2. Hosting traffic safety events.		X		
3. Providing car seat classes and other injury prevention education.		X		
4. Providing survey and crash data sets.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Establish or maintain rural Community Mobilization Groups (CMGs).

Twenty-six community mobilization groups were maintained.

Activity 2: Host at least ten traffic safety evens or projects, carried out within the Southeast Rural Road Initiative region during the program year.

The project provides technical assistance visits to locations to support the development of community groups which carry on traffic safety events. Fifty-four safety projects were conducted October 2012-March 2013.

Activity 3: Provide survey and crash data charts and maps from at least six counties detailing at least four risk factors to Regional Traffic Enforcement Networks and the Northeast Georgia Rural Roads Initiative groups for use in planning.

Four crash data charts have been provided so far this year.

c. Plan for the Coming Year

Activity 1: Establish or maintain at least 16 rural Community Mobilization Groups (CMGs).

Output Measure(s): Number of functioning CMGs.

Monitoring: Quarterly reports.

Activity 2: Support the development of at least thirty safety events, projects or surveys carried out within the Southeast Rural Road initiative region during the program year.

Output Measure(s): Number of projects or events conducted

Monitoring: Quarterly reports.

Activity 3 Provide motor vehicle crash related data, charts and/or maps from at least six counties detailing risk factors for community mobilization groups and Regional Traffic Enforcement Networks and other interested groups

Output Measure(s): Number of data reports, charts and maps provided to CMGs or other networks

Monitoring: Quarterly reports.

Activity 4: Provide at least 60 on-site technical assistance visits to counties to develop and support highway safety community mobilization groups, needs assessment, evaluation, safety resources and projects.

Output Measure(s): # of technical assistance visits provided

Monitoring: Quarterly reports

State Performance Measure 5: Among children five years of age and younger who received services through the MCH Program, the percent who received a developmental screen

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				35	35
Annual Indicator				38.6	38.6%
Numerator				7490	7490
Denominator				19382	19382
Data Source				Children 1st quarterly reports	Children 1st Quarterly report
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	35	35	35	35	35

Notes - 2011
This is a new measure. The 2011 data was compiled using the Children 1st Quarterly Report Item I1 for fiscal quarters 2 and 3. Collection of this item began in the second quarter of Fiscal year 2012. It is anticipated that the annual performance objective should be estimated at approximately 35 percent but this will likely change as more data become available.

Notes - 2010

This is a new measure. The MCH Program is currently working to develop measurement processes to adequately capture the data. It is difficult to project the annual performance objective without baseline data. However, through discussions with staff, it is anticipated that this performance objective should be estimated at approximately 35 percent. This will likely change as more data become available.

a. Last Year's Accomplishments

All of the local boards of health utilize the Ages and Stages Questionnaire-3 (ASQ) and the Ages and Stages Questionnaire for Social Emotional for developmental screening including Children 1st, Health Check and Babies Can't Wait. Through the Early Childhood Comprehensive Systems grant and the Third Grade Reading

Campaign, efforts were made to increase the numbers of developmental screenings outside of public health and develop a process for making referrals into MCH programs, as appropriate. A joint training between the DPH Children 1st and Babies Can't Wait program staff and the DFCS staff was conducted across the state. A statewide, web-based system was rolled out to all 18 public health districts. This data will eventually have the ability to track ASQ:3 and ASQ:SE scores on children referred to Children 1st or Babies Can't Wait.

Children 1st worked on requirements gathering to add the scores of the ASQ:3 to the web-based Children 1st data system that is being rolled out to the health districts. The Children 1st screening and referral form was revised and use of the form began 10/1/12. The ability to attach developmental screening results to referrals into Children 1st or Babies Can't Wait is a part of this revised form. Additionally, the Children 1st web-based data system is being enhanced to include these scores from either public health or non-public health providers.

Funding to support developmental screening specialists in WIC clinics ended in September 2011. The recommendation was made to continue providing developmental screening to those children referred through Child Abuse Prevention and Treatment Act (CAPTA) and those referred to Children 1st with suspected developmental delay. Through a contract with the Governor's Office for Children and Families (GOCF) Children 1st will begin work as the Central Intake provider to support the Maternal Infant Early Childhood Home Visiting Grant (MIECHV). As the Central Intake provider, DPH in the seven MIECHV counties will provide a Comprehensive Core Screening to determine the needs of the families of expectant mothers or children birth to age five. If it is determined that the child is at-risk for developmental delay, Central Intake will also conduct an ASQ:3.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Utilizing the Ages and Stages Questionnaire-3 (ASQ-3) and Ages and Stages Questionnaire - Social Emotional (ASQ-SE) at the local level.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Identify a standard tool and protocol for developmental screening to be used in all MCH programs.

The local boards of health continue to utilize the ASQ:3 for developmental screening in several child health programs, including Children 1st, Health Check, and Babies Can't Wait. Through grants within MCH, efforts are being made to survey developmental screening throughout the state and increase the numbers of community providers conducting screens and linking the results back to public health programs.

Activity 2: Develop a reporting and measurement strategy that can be applied throughout all MCH programs.

The Children 1st online screening and referral form will be rolled out in the next quarter. It will include the ability to

attach developmental screening results to referrals into Children 1st or Babies Can't Wait. Additionally, the Children 1st web-based data system is also being enhanced to include these scores from either public health or non-public health providers.

Activity 3: Develop a strategic plan and pilot sites to implement developmental screens for all WIC clients.

Through the contract with the GOCF, Children 1st and Central Intake staff continue to provide developmental screens to those children identified as at-risk to developmental delays via the Central Intake referral. Many of the families screened as part of the Central Intake process are identified in the WIC clinics.

c. Plan for the Coming Year

Activity 1:Implement a reporting and measurement strategy that can be applied throughout all MCH programs.

Output Measure(s): Inclusion of the ASQ scores in the Children 1st module of SendSS Newborn

Monitoring: Quarterly reports.

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

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

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

Notes-2012

As a result of delays in implementing a survey to measure pediatrician and family physician attitudes toward treating children with special health care needs, Georgia is currently unable to report this measure.

Notes - 2010

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

a. Last Year's Accomplishments

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

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

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

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

Table 4b, State Performance Measures Summary Sheet

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

b. Current Activities

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

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

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

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

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

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

c. Plan for the Coming Year

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

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

Monitoring: Implementation plan and timeline.

State Performance Measure 7: Percent of very low birth weight infants (<1,500 grams at birth) enrolled in First Care

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	35	35	35	35	35
Annual Indicator			14.4	21.5%	19.2%
Numerator			364	516	445
Denominator	2697	2596	2529	2400	2322
Data Source			Children 1st quarterly	Children 1st quarterly reports	Children 1st quarterly reports
Is the Data Provisional or Final?			Final	Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	25	25	25	25	25

Notes - 2011
The 2011 numerator data is from FY2011 enrollment numbers from First Care. Denominator data on the number of very low birthweight births in 2011 was estimated from 2006 to 2010 data from OASIS.

Notes - 2010
The numberator data are 0 because the MCH Program continues to develop the First Care program for implementation. Implementation is targeted for October 1, 2011.

Denominator data are projected as data for 2010 are not yet available. Actual data from 2000 through 2008 are used to estimate the number of very low birth weight births in 2010.

As there are no data on which to project the annual performance indictor, the goal in year one is to engage at least 25 percent of all very low birth weight infants. This will change as more data become available.

a. Last Year's Accomplishments

The Children 1st program coordinated three Task Force meetings to discuss the core functions of the program and what services would be delivered to the at-risk population, including the very low birth weight infants receiving care in 1st Care. The group decided to continue providing services to this population and the program reviewed the Task

Force recommendations for planning for 2013. Twelve of the eighteen public health districts opted to continue providing 1st Care services to the very low birth weight and medically fragile. Work began on developing a 1st Care Standard Operating Procedures manual and 1st Care nurses' training program to standardize services across the providing health districts.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Working to identify and implement evidence-based interventions.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1. Implement a protocol and standard operating procedures to provide home visits to infants delivered weighing less than 1,500 grams.

DPH hired a Pediatric Nurse Practitioner with neonatal experience to assist in developing a training program for 1st Care nurses who provide home visits for very low and low birth weight infants through 1st Care. The nurse is also assisting in drafting a Standard Operating Procedures manual and developing a Plan of Care from to standardize the 1st Care service delivery model. The 1st Care Nurses training was completed in all 12 of the 18 districts participating in this service.

Activity 2. As part of a larger report, infants weighing less than 1,500 grams at birth will be analyzed.

Implementation of this activity has been delayed.

c. Plan for the Coming Year

Activity 1: Monitor implementation of districts providing home visiting to infants weighing less than 1,500 grams.

Output Measure(s): Number of clients (infants receiving home visiting services) served; number of clients surviving past 28 days of life.

Monitoring: Quarterly monitoring.

E. Health Status Indicators

Introduction

The 12 MCH health status indicators direct the work of the MCH Program and Division of Public Health in the following ways:

•Program development: The indicators inform and assist in directing MCH efforts such as the MCH Program's preconception health initiative, consumer and provider education, health promotion materials, web site

development, contracts with provider organizations, and newsletter articles.

•Program assessment and enhancement: Examples include updating of tertiary center core requirements, focusing on enhancement and improvement of outreach education and developmental follow-up of newborns.

•Resource allocation: Acquisition and distribution of resources such as child safety kits through Children 1st have been informed by the health status indicators. Initiatives such as FOCUS, a data-driven community approach to addressing infant mortality in selected counties, have also been guided by health status indicator data.

•Monitoring, technical assistance, and quality assurance: Key performance indicators of measures of program process performance and are linked to health status indicators through logic models and program plans. These measures are used as triggers for technical assistance and quality assurance.

HSI 1A: The percent of live births weighing less than 2,500 grams.
In 2007, the rate of low birth weight in Georgia was approximately double the Healthy People 2010 objectives. The rate infants born weighting less than 2,500 grams increased by 10.5 percent between 1998 and 2007. Women who had more than a high school education had a lower rate of low birth weight than women with a high school degree or less. Rates of low birth weight were elevated among Black infants. The rate of low birth weight among Black infants was nearly three times the Healthy People 2010 objective. Hispanic infants had the lowest rate of low birth weight. Among Georgia's 18 public health districts, there were seven public health districts with rates of low birth weight in excess of 10.5 percent. Of these seven public health districts, four had rates of low birth weight in excess of 11.0 percent.

This indicator is used for surveillance and monitoring of poor birth outcomes in Georgia. The Office of Health Information and Policy (OHIP) has developed an online web tool for querying Vital Statistics and Hospital Discharge data. Low birth weight is one of the indicators contained within these data. The MCH Epidemiology Section produces the Reproductive Health Indicators Report that provides trend data by race/ethnicity, public health district and perinatal region to monitor key indicators of reproductive health, including low birth weight. In addition, the prevalence of low birth weight is calculated for geographical and population subgroups to provide information that is used to target resources and to develop interventions addressed at increasing birth weight. Low birth weight has also been used as an outcome in the evaluation of public health programs, including WIC, Medicaid Perinatal Case management, and Babies Born Healthy.

The Division of Medical Assistance has been leading an effort to understand the impact of strategies to reduce low birth weight on the rate of low birth weight. Included in the justification for the Family Planning Waiver submitted by the Division of Medical Assistance is to reduce subsequent poor birth outcomes including low birth weight.

/2012/In January 2011, the Planning for Healthy Babies, the Medicaid Family Planning Waiver in Georgia, was implemented. Title V collaborated with the Division of Medical Assistance to support outreach and marketing efforts to increase enrollment.//2012//
/2013/The implementation of "auto-enrollment" on December 1, 2011 has increased the number of enrollees in the Family Planning Waiver. Auto-enrollment includes women currently eligible but rolling off Medicaid at 60 days post-partum; females aging out of Medicaid or CHIP at age 19; Medicaid women who have had a very low birthweight (VLBW) baby based upon their diagnosis code in Medicaid claims history. As of May 2012, there are 28,891 family planning waiver participants, 27 of whom had a VLBW baby and are also in the interpregnancy care program.
/2014/There are no updates for this indicator.//2014//

HSI 1B: The percent of live singleton births weighing less than 2,500 grams.

Data from 2000 through 2007 indicate little change in the proportion of all low birth weight births attributed to multiple births. In this time period, the average percent of all low birth weight deliveries that were attributed to singleton births was 78.5 percent with a standard deviation of 0.3 percentage points.

/2012/This rate continues to be stagnant with minimal change over time.//2012// **/2014/There are no updates for this**

indicator.//2014//

HSI 2A: The percent of live births weighing less than 1,500 grams.

In 2007, the rate of very low birth weight in Georgia was approximately double the Healthy People 2010 objectives. Though double the Healthy People 2010 objective of 0.9 percent, the rate of infants born weighing less than 1,500 grams remained consistent from 1998 through 2007. Women who had more than a high school education had a lower rate of very low birth weight than women with a high school degree or less. The rate of very low birth weight was elevated among Black infants. The rate of very low birth weight among Black infants was nearly four times the Healthy People 2010 objective. Hispanic infants had the lowest rate of very low birth weight. Among Georgia's 18 public health districts, four had rates of very low birth weight in excess of 2.0 percent.

This indicator is used for surveillance and monitoring of poor birth outcomes in Georgia. The Office of Health Information and Policy (OHIP) has developed an online web tool for querying Vital Statistics and Hospital Discharge data. Very low birth weight is one of the indicators contained within these data. The MCH Epidemiology Section produces the Reproductive Health Indicators Report that provides trend data by race/ethnicity, public health district and perinatal region to monitor key indicators of reproductive health, including very low birth weight. In addition, the prevalence of very low birth weight is calculated for geographical and population subgroups to provide information that is used to target resources and to develop interventions addressed at increasing birth weight. In support of National Performance Measure 17, the MCH Epidemiology Section analyzes the level of care of hospitals where babies weighing less than 1,500 grams are born to monitor the effectiveness of the regional perinatal system in ensuring that all women are receiving the appropriate level of care.

/2012/Continued and expanded work with NPM 17 and the Georgia Obstetrical and Gynecological Society may help reduce this rate.//2012//2013/ Georgia is developing a perinatal quality collaborative to further address this issue. 2010 VLBW rate was 1.9, above the Healthy People 2020 baseline of 1.5 in 2007 and target of 1.4.//2013// **/2014/There are no updates for this indicator.//2014//**

HSI 2B: The percent of live singleton births weighing less than 1,500 grams.

Data from 2000 through 2007 indicate little change in the proportion of all very low birth weight births attributed to multiple births. In this time period, the average percent of all very low birth weight deliveries that were attributed to singleton births was 77.3 percent with a standard deviation of 1.3 percentage points.

/2012/There has been minimal change in this indicator over time.//2012// **/2014/There are no updates for this indicator.//2014//**

HSI 3A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Among children 1 to 5 years of age, three of the top five causes of death were unintentional injuries. Among children 6 to 9 years of age, four of the top ten causes of death were unintentional injuries. Among children 10 to 14 years of age, three of the top ten causes of death were unintentional injuries. Among these causes of death alone, there was a total of 7,780.5 years of potential life lost.

This indicator is used for surveillance and monitoring of years of potential life lost in children due to injury. OHIP has developed an online web tool containing Vital Statistics and Hospital Discharge data. OASIS is a flexible tool that allows for querying of several variables including cause of death, cause of hospitalization, and age. Several MCH Program partners including the Injury Prevention Program and Georgia Poison Center contribute to efforts to reduce the unintentional injury mortality rate.

/2012/With funding from the CDC, the Office of Injury Prevention (OIP) has been able to work with local fire departments to target high-risk housing, install appropriate types and numbers of smoke alarms, educate occupants and report out on potential lives saved.

The OIP offers an incentive program that matches county or district level expenditures for safety equipment purchased from 7/1/09 to 12/31/10. The funding source can be state funding, discretionary funding used by health department/district offices for safety equipment or public/private funding -- donations received from local businesses, community service organizations used toward the purchase of safety equipment. We match expenditures for safety equipment such as approved child safety seats, including special needs child safety seats, bicycle helmets, smoke alarms, etc. The match is returned in equipment.

See HSI #03B for information specific to motor vehicle crashes.

Safe Kids Georgia coordinates 36 coalitions in Georgia and is the primary partner to the Department of Public Health for unintentional injury prevention at the local level. Their program areas include choking and poisoning prevention, drowning prevention, hyperthermia prevention and burn (scalding) prevention.

Georgia Family Connection Partnership is a new communication partner in supporting injury prevention messages to their local collaboratives. They are a full partner in the statewide Give Kids a Boost campaign and encourage their local member participants to support the local events associated with this statewide initiative.

The Infant Safe Sleep Coalition is convened quarterly by the Georgia Child Fatality Review Panel. Sleep related deaths are significant for babies 0-1. The Coalition has been successful in convening a wide range of partners to educate them on the issue and discuss potential solutions.//2012// /2013/ Due to funding constraints, matching program has not occurred.//2013// **/2014/There are no updates for this indicator.//2014//**

HSI 3B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

This indicator is used for surveillance and monitoring of years of potential life lost in children due to injury. Motor vehicle crashes are the leading cause of death among children ages 14 years and younger. In 2007, motor vehicle deaths result in 4,750 years of potential life lost. The MCH Program and its partners work to reduce motor vehicle crash mortality through education and by providing car safety seats to children in need throughout Georgia.

/2012/The OIP purchased 28,000 child safety seats with MCH funding for distribution through local programs in 136 Georgia counties. This equipment supplements that which is provided by the Governor's Office of Highway Safety (GOHS).

MCH funding is supporting an initiative in which DFCS staff participate in a district CPS education training, and will receive 16 car seats to each county for transporting children in state care.

The OIP is providing technical assistance, education and 50 booster seats to each Head Start facility working with a local CPS coalition. The seats are intended for Head Start families as part of an evidence based program of equipment distribution, education and enforcement.

The OIP is providing funds for the certification of 600 Georgia State Troopers. This training was mandated by Georgia State Patrol leadership. It offers a unique partnership between Public Health and Public Safety and establishes sustainable support of local injury prevention programs.

The GOHS, a strong partner with DPH, supports child passenger safety technician training which is a national certification for professionals in child safety seats.

A new booster seat law which extends the required age for a child to use a booster seat from under six years of age to under eight years of age was passed during the 2011 Legislative session. The strengthening of this law (effective July 1, 2011) has prompted additional staff efforts in booster seat education, technician training and equipment distribution.//2102//
/2013/Due to funding constraints, projects with DFCS and Headstart have not occurred.//2013// **/2014/There are no updates for this indicator.//2014//**

HSI 3C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

This indicator is used for surveillance and monitoring of years of potential life lost in children due to injury. Motor vehicle crashes are the leading cause of death among children/young adults between the ages of 15 to 24 years. In 2007, motor vehicle deaths result in 23,366 years of potential life lost. The MCH Program and its partners work to reduce motor vehicle crash mortality through education and policy initiatives to reduce the risk of motor vehicle crashes in this age group. Legislation enacted on July 1, 2010 that limits cell phone use for adolescent drivers and texting for all drivers may lead to a decrease in this indicator.

/2012/The Rural Roads Initiative has initiated and maintains 21 community mobilization groups, worked with communities to conduct at least twenty occupant safety projects, conducted at least 10 seat belt surveys of high risk teen drivers and helped to develop at least six new resources for occupant safety efforts.

The Teenage and Adult Driver Responsibility Act (TADRA), Georgia's version of graduated drivers license legislation, is being rigorously evaluated through the Emory Center for Injury Control and the Emory Rollins School of Public Health.//2012// /2013/Activities from 2012 will continue in 2013.//2013// **/2014/ There are no updates for this indicator.//2014//**

HSI 4A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger used for

surveillance and monitoring of years of potential life lost in children due to injury. OHIP has developed an online web tool containing Vital Statistics and Hospital Discharge data. OASIS is a flexible tool that allows for querying of several variables including cause of hospitalization and age. Several MCH Program partners including the Injury Prevention Program and Georgia Poison Center contribute to efforts to reduce the unintentional injury morbidity rate.

/2012/With funding from the CDC, the Office of Injury Prevention (OIP) has been able to work with local fire departments to target high-risk housing, install appropriate types and numbers of smoke alarms, educate occupants and report out on potential lives saved.

The OIP offers an incentive program that matches county or district level expenditures for safety equipment purchased from 7/1/09 to 12/31/10. The funding source can be state, discretionary funding used by health department/district offices for safety equipment, or public/private donations received from local businesses, community service organizations used toward the purchase of safety equipment. The OIP matches expenditures for safety equipment such as approved child safety seats, including special needs child safety seats, bicycle helmets, smoke alarms, etc. The match is provided in equipment.

See HSI #03B for information specific to motor vehicle crashes.

Safe Kids Georgia coordinates 36 coalitions in Georgia and is the primary partner to the Department of Public Health for unintentional injury prevention at the local level. Their program areas include choking and poisoning prevention, drowning prevention, hyperthermia prevention and burn (scalding) prevention.

Georgia Family Connection Partnership is a new communication partner in supporting injury prevention messages to their local collaboratives. They are a full partner in the statewide Give Kids a Boost campaign and encourage their local member participants to support the local events associated with this statewide initiative.

The Infant Safe Sleep Coalition is convened quarterly by the Georgia Child Fatality Review Panel. Sleep related deaths are significant for babies 0-1. The Coalition has been successful in convening a wide range of partners to educate them on the issue and discuss potential solutions.

The OIP provided Dogbite Prevention guidance and materials to Children's Healthcare of Atlanta, Emergency Department.

Bike helmet distribution is being included in the Matching Grant to local Safe Kids coalitions and health departments.//2012// /2013/Activities from 2012 will continue in 2013.//2013//
/2014/Activities from 2013 will continue in 2014.//2014//

HSI 4B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

Motor vehicle crashes are among the top ten causes of emergency room visits and hospitalizations in Georgia among children 14 years of age and younger. In 2007, approximately
10,000 emergency room visits and 600 hospitalizations were attributed to motor vehicle crashes. The MCH Program and its partners work to reduce motor vehicle crash mortality through education and by providing car safety seats to children in need throughout Georgia.

/2012/The OIP purchased 28,000 child safety seats with MCH funding for distribution through local programs in 136 Georgia counties. This equipment supplements that which is provided by the Governor's Office of Highway Safety (GOHS).

MCH funding is supporting an initiative in which DFCS staff participate in a district CPS education training, and will receive 16 car seats to each county for transporting children in state care.

The OIP is providing technical assistance, education and 50 booster seats to each Head Start facility working with a local CPS coalition. The seats are intended for Head Start families as part of an evidence based program of equipment distribution, education and enforcement.

The OIP is providing funds for the certification of 600 Georgia State Troopers. This training was mandated by Georgia State Patrol leadership. It offers a unique partnership between Public Health and Public Safety and establishes sustainable support of local injury prevention programs.

The GOHS, a strong partner with DPH, supports child passenger safety technician training which is a national certification for professionals in child safety seats.

A new booster seat law which extends the required age for a child to use a booster seat from under six years of age to under eight years of age was passed during the 2011 Legislative session. The strengthening of this law (effective July 1, 2011) has prompted additional staff efforts in booster seat education, technician training and equipment distribution.//2102//
/2013/Due to funding constraints, projects with DFCS and Headstart have not occurred.//2013// **/2014/Activities from 2013 will continue in 2014.//2014//**

HSI 4C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged
15 through 24 years.

Among children ages 15 to 24 years, motor vehicle crashes are within the top two leading causes of hospitalizations and emergency room visits. In 2007, more than 20,000 emergency room visits and 1,500 hospitalizations were attributed to motor vehicle crashes. The MCH Program and its partners work to reduce motor vehicle crash morbidity through education and policy initiatives to reduce the risk of motor vehicle crashes in this age group. Legislation enacted on July 1, 2010 that limits cell phone use for adolescent drivers and texting for all drivers may lead to a

decrease in this indicator.

/2012/The Rural Roads Initiative has initiated and maintains 21 community mobilization groups, worked with communities to conduct at least twenty occupant safety projects, conducted at least
10 seat belt surveys of high risk teen drivers and helped to develop at least six new resources for occupant safety efforts.

The Teenage and Adult Driver Responsibility Act (TADRA), Georgia's version of graduated drivers license legislation, is being rigorously evaluated through the Emory Center for Injury Control and the Emory Rollins School of Public Health.//2012// /2013/Activities from 2012 will continue in 2013.//2013// **/2014/Activities from 2013 will continue in 2014.//2014//**

HSI 5A:
The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

Between 1999 and 2008, the rate of newly diagnosed cases of Chlamydia among adolescents exceeded 2,000 cases per 100,000 adolescents in every year except 2005. The greatest the rates of newly diagnosed cases of Chlamydia were found in 2007 and 2008. Comparing 1999 to
2008, the rate of newly diagnosed cases of Chlamydia among adolescents increased 14.6 percent. There were approximately double the numbers of newly diagnosed cases among adolescents 18 to 21 years of age as there were among adolescents 15 to 17 years of age. While adolescents 18 to 21 years of age account for the majority of newly diagnosed Chlamydia cases among adolescents, the rate of newly diagnosed cases of Chlamydia among adolescents 15 to
17 years of age exceeds 1,500 cases per 100,000 adolescents and the rate of newly diagnosed cases of gonorrhea exceeds 500 cases per 100,000 adolescents. Black adolescents had the greatest rates of newly diagnosed cases of Chlamydia. For the rates of newly diagnosed cases of Chlamydia\, the ratio of rates among Black adolescents to White adolescents was ten to one. The ratio of rates among Black adolescents to Hispanic adolescents was seven to one for newly diagnosed cases of Chlamydia. Female adolescents had significantly greater rates of newly diagnosed cases of Chlamydia compared to male adolescents. The ratio of the rate of newly diagnosed cases of Chlamydia among female adolescents to male adolescents was four to one. There were four newly diagnosed cases of Chlamydia among adolescent females for every one newly diagnosed case among male adolescents.

This indicator is used for surveillance and monitoring of STDs and women's health. Chlamydia is
a reportable disease and these data have been available on the Public Health website for several years. The OASIS web query tool includes STD data. Data can be queried by disease and age of the case. The STD Epidemiology Section conducts surveillance and produces reports on the prevalence and incidence of Chlamydia in Georgia.

/2012/Rates of Chlamydia remained constant over time. There are no updates to provide in this application.//2012///2013/Rates continue to remain constant over time.//2013// **/2014/There are no updates for this indicator.//2014//**

HSI 5B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia. Between 1999 and

2008, the rate of newly diagnosed Chlamydia cases for women 18 to 44 years
of age increased in all but three years. During this ten-year period, there was a 23 percent
increase in the rate of newly diagnosed Chlamydia cases. Rates of newly diagnosed cases of Chlamydia were greatest among younger women and Black women. The ratio of the newly diagnosed case rate among women 18 to 19 years of age and 25 to 34 years of age was six to one. The newly diagnosed case rate ratio was four to one when comparing women ages 20 to 24 years of age to women 25 to 34 years of age. Black women have the greatest rates of newly diagnosed cases of Chlamydia. For rates of newly diagnosed cases of Chlamydia, the newly diagnosed case rate ratio of Black women to White women was nine to one and fifteen to one. The newly diagnosed case rate ratio of Black women to Hispanic women was four to one for Chlamydia. Among Georgia's 18 public health districts, the Southwest Health District and the West Central Health District had the greatest rates of newly diagnosed cases of Chlamydia. These were the only two public health districts with rates of newly diagnosed cases of Chlamydia in excess of 2,000 cases per 100,000 women 18 to 44 years of age. There were eight other public health districts with

rates of newly diagnosed cases of Chlamydia in excess of 1,500 cases per 100,000 women 18 to 44 years of age.

This indicator is used for surveillance and monitoring of STDs and women's health. Chlamydia is a reportable disease and these data have been available on the Public Health website for several years. The OASIS web query tool includes STD data. Data can be queried by disease and age of the case. The STD Epidemiology Section conducts surveillance and produces reports on the prevalence and incidence of Chlamydia in Georgia.

/2012/Rates of Chlamydia remained constant over time. There are no updates to provide in this application.//2012///2013/Rates continue to remain constant over time.//2013// **/2014/There are no updates for this indicator.//2014//**

HSI 6A: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)

The race of nearly 95 percent of all children in Georgia is either White or Black/African American. The ratio of White to Black/African American children in Georgia is 1.8 to 1. This indicator is used to monitor population trends to understand demographic changes in Georgia and best target resources.

/2012/There are no significant demographic shifts to report.//2012/////2013/Rates continue to remain constant over time.//2013// **/2014/The population trends remain constant.//2014//**

HSI 6B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)

Among children under the age of 10 years, 14.2 percent are Hispanic or Latino compared to 8.1 percent among children between the ages of 10 and 24 years. Nearly one-fifth of all infants born in Georgia are Hispanic or Latino. This indicator is used to monitor population trends to understand demographic changes in Georgia and best target resources.

/2012/There are no significant demographic shifts to report.//2012/////2013/Rates continue to remain constant over time.//2013**// /2014/The population trends remains constant.//2014//**

HSI 7A: Live births to women (of all ages) enumerated by maternal age and race. (Demographics)

Births to women under the age of 20 years accounted for a greater proportion of births to Black/African American (16.5 percent) women than White women (10.3 percent). Women age 35 years and older accounted for a greater percent of births to White women than Black/African American women. This indicator is used to monitor the trends in births and understand demographic changes in Georgia and best target resources.

/2012/There are no significant demographic shifts to report.//2012// /2013/There are no significant demographic shifts to report.//2013// **/2014/There are no significant demographic shifts to report.//2014//**

HSI 7B: Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)

The distribution of maternal age by ethnicity is similar between Hispanic and non-Hispanic women. Births to women 35 years and older accounted for a greater percent of all births among Hispanic women compared to non-Hispanic women, but the percent of all births attributed to women age 20 years and older was identical between the groups. This indicator is used to monitor the trends in births and understand demographic changes in Georgia and best target resources.

/2012/There are no significant demographic shifts to report.//2012///2013/There are no significant demographic shifts to report.//2013//**/2014/There are no significant demographic shifts to report.//2014//**

HSI 8A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

While the ratio of the number of White children to Black/African American children is 1.8 to 1, the ratio for child death is 1.1 to 1. This indicates that Black/African American children are overrepresented in the mortality data compared to the population. This indicator is used to monitor the burden of death in children and variation by subpopulations to target resources. MCH Epidemiology conducts analyses of infant deaths to identify groups at highest risk and to identify risk factors that may be potentially modifiable. Results from these analyses are being used to target intervention efforts and to focus efforts on effective interventions.

/2012/There are no significant demographic shifts to report.//2012// /2013/There are no significant demographic shifts to report.//2013// **/2014/There are no significant demographic shifts to report.//2014//**

HSI 8B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

The distribution of childhood mortality by age is similar between Hispanic and non-Hispanic children. This indicator is used to monitor the burden of death in children and variation by subpopulations to target resources. MCH Epidemiology conducts analyses of infant deaths to identify groups at highest risk and to identify risk factors that may be potentially modifiable. Results from these analyses are being used to target intervention efforts and to focus efforts on effective interventions.

/2012/There are no significant demographic shifts to report.//2012// /2013/There are no significant demographic shifts to report.//2013// **/2014/There are no significant demographic shifts to report.//2014//**

HSI 9A: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)

Black/African American children are overrepresented in public programs based on the population distribution. The percent of Black/African children who did not complete high school and the rate of juvenile crime arrests among this population of children are greater than among White children. Understanding shifts in utilization of public programs for MCH populations is useful in determining other MCH programmatic needs and the effect on MCH health status.

/2012/There are no major changes to discuss for this year. Some data points are difficult to update based on the source. Greater effort will be given to improving relationships with the agencies providing these data to ensure more recent data in future submissions.//2012// /2013/ It is still difficult to gather all data points for all state programs. However, the 2012 Georgia Child Fatality Review Report indicates of the 594 reviewed deaths of children age 0 -- 18, 48% of the decedent and his/her family had contact with a public agency. //2013//
/2014/There are no updates for this indicator.//2014//

HSI 9B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)

Less than 5 percent of Hispanic children report being in a household headed by a single parent compared to more than 30 percent among non-Hispanic children. Participation data for Medicaid and SCHIP are difficult to interpret given the large number participants with unknown ethnicity. While the percent of Hispanic children who do not complete high school is greater than among non-Hispanic children, the rate of juvenile crime arrests among non-Hispanic children is double that of Hispanic children.

/2012/There are no major changes to discuss for this year. Some data points are difficult to update based on the source. Greater effort will be given to improving relationships with the agencies providing these data to ensure more recent data in future submissions.//2012//
/2013/There are no major changes to report this year.//2013// **/2014/There are no updates for this indicator.//2014//**

HSI 10: Geographic living area for all children aged 0 through 19 years.

Georgia has undergone a shift from a largely rural state with urban clusters to a primarily urban state with rural areas. During the previous 25 years, Georgia has been described in terms to "two Georgias" -- economically strong urban and less economically advantaged rural. However, over the previous decade, the state's population has become segmented into four distinct groupings among Georgia's 159 counties. These are:

•Urban -- 14 counties that form the core centers for Georgia's 15 metropolitan statistical areas (MSAs)
•Suburban -- 56 counties located in the 15 Georgia MSAs
•Rural growth -- 30 rural counties with small core urban areas that serve as a stimulus for supporting the local economy
•Rural decline -- 30 counties, almost all located in south Georgia, experiencing population declines

Monitoring of shifts in population in rural and urban areas is helpful in targeting MCH programs and planning interventions and strategy.

/2012/The number of people living in urban areas increased by approximately 50,000 people compared to only 6,000 in rural areas. This trend is consistent with the previously noted trends in Georgia.//2012// /2013/There are no significant changes to report.//2013// **/2014/There are no updates for this indicator.//2014//**

HSI 11: Percent of the State population at various levels of the federal poverty level. Childhood poverty is an

important indicator of child health and MCH programmatic needs.
Monitoring child poverty allows the MCH Program to determine possible demand for services.

/2012/For each poverty group, there were slight increases from the previous year's reporting. This likely reflects that overall state of the US and Georgia economy.//2012// /2013/ The rate persons living below the poverty level continues to increase in Georgia and is higher than the national rate.//2013// **/2014/There are no updates for this indicator.//2014//**

HSI 12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.

Childhood poverty is an important indicator of child health and MCH programmatic needs. Monitoring child poverty allows the MCH Program to determine possible demand for services.

/2012/For each poverty group, there was an increase of at least two percentage points. This likely reflects that overall state of the US and Georgia economy. As childhood poverty increases, outreach for WIC and Medicaid become increasingly important.//2012// //2013/There are no significant demographic shifts to report.//2013// **/2014/There are no updates for this indicator.//2014//**

F. Other Program Activities

Toll-free Hotlines: Georgia's Title V toll-free hotline, PowerLine, is run by Healthy Mothers, Healthy Babies Coalition of Georgia (HMHB) under a MCH contract. PowerLine assists women, pregnant women, parents, health care providers, social service agencies, community organizations, and any other individual or agency experiencing difficulties in obtaining information about health care and/or health care services. The bilingual toll-free number (statewide 1-800-822-2539; Metro Atlanta 770-481-5501) is available Monday-Friday 8:00 A.M. through 6:00 P.M., staffed with Information and Referral Specialists that provide callers with information on local general practitioners and medical specialists; dentists; prenatal healthcare services; low cost healthcare resources for the uninsured; HIV testing sites; dental, vision, and hearing screening facilities; breastfeeding information resources; plus other healthcare and public health referrals. PowerLine also answers the state WIC customer service toll-free telephone line, referring callers to the appropriate WIC Clinic and recording complaints or fraud reports. PowerLine also provides referrals for DPH's Perinatal HIV Prevention Project, Women's Health, Newborn Screening, Babies Can't Wait, Women's Right to Know, PeachCare for Kids, and Children 1st. PowerLine maintains Georgia's most comprehensive database of physicians and clinics that accept Medicaid and PeachCare, reduced fees, and/or low cost fees. Annually, PowerLine assists over 25,000 individuals experiencing difficulties or delays in accessing healthcare services, providing over 50,000 referrals to services. /2013/ HMHB is enhancing PowerLine's breastfeeding support by obtaining Certified Lactation Counselor certification for all Information and Referral Specialists. Access has also been enhanced with the addition of online referrals.//2013//

Babies Can't Wait (Part C, IDEA) supports a separate toll-free number (1-800-229-2038) for individuals with disabilities, families of children with special needs, and professionals that provides a special needs database/directory of over 5,000 public and private early intervention services, research and demonstration projects, professional groups, parent support groups and advocate associations available in the state for children with or at-risk for developmental delays or disabilities. There are over 150 searchable categories, including advocacy, early intervention, diagnostic, physical therapy, speech therapy, occupational therapy, child care centers, respite care, Medicaid, education, counseling, support groups, camps, vocational services, and many others. A unique hotline feature is that a parent of a child with a disability answers the phone. The BCW central directory is operated by Parent to Parent of Georgia, a statewide parent-run organization. Hotline callers can be matched with supporting parents whose children have similar disabilities. The Parent to Parent of Georgia website allows users to search the special needs database online (http://p2pga.org). Other website content includes a parent designed graphic roadmap to services that walks parents through what they need to know to navigate Georgia's disability, health, and education systems; information on reading materials, health and education training courses, and family leadership and community opportunities; and a parent blog. Users can sign up for an email list, FaceBook updates, and twitter notices and news.

The toll-free Georgia Tobacco Quit Line (1-877-270-7867), funded by the tobacco Master Settlement Agreement and implemented through DPH in collaboration with the Georgia Cancer Coalition, connects callers 13 years of age or older to a trained counselor who can help them develop a personal plan to stop smoking. The Quit Line is also available to the parents of youth who use tobacco products. Trained counselors offer counseling tailored to the caller's needs, self-

help materials, and referral to other resources. The Quit Line is available 8:00 A.M. to 12:00 A.M. daily. A line (1-877-266-3863) is dedicated for Spanish-speaking callers. /2013/ Third party counseling in over 140 languages is offered by AT&T Translation Services and services are available for the deaf/hard of hearing. In 2010, there were 9,100 direct calls to the Quit Line; 2,295 tobacco users received services; and 1,362 users registered for web-based services.//2013//

The Georgia Crisis and Access Line (GCAL) serves as the central access point to connect the state's youth and adults to local services for mental health and addictive diseases services. Individuals can call the hotline (1-800-715-4225) 24 hours/seven days a week and be connected to clinical staff that assist callers with information and brief screening and evaluation services. In addition, a website (www.mygcal.com) offers users a list of Behavioral Health and Developmental Disabilities providers and services by county. /2013/ On 12/15/11, Behavioral Health Link, the GCAL contractor, was one of 10 crisis centers to receive funding from the National Suicide Prevention Lifeline (NSPL) to collaborate in the development of IM/Chat based services to increase community access to online crisis services to each center's community.//2013//

Internet Resources: In 2008, DCH launched georgiahealthinfo.gov, a consumer-focused, one-stop resource for information on health education, health care providers, health care facilities, and health care comparison/planning information in Georgia. Website content includes health education materials, wellness and prevention information, local health care provider profiles, quality and cost comparison data, a long-term care decision support tool, and health plan comparison. Georgiahealthinfo.gov is now available on twitter (gahi.gov) and Facebook.

MCH's Early Childhood Comprehensive Systems (ECCS) initiative is developing an online early childhood clearinghouse for consumers, child care providers, health care providers, early childhood advocates, and others. Clearinghouse resources are grouped in seven main information categories (child development, children with special needs, community advocacy and policy, early learning and child care, family support, health and dental care, and parenting information). The clearinghouse (www.eccsga.org) is live and currently includes summaries and links to over 400 early childhood web-based resources.

/2102/MCH's Office of Title V and Integration is the state coordinator to expand partners and promote enrollment in the National HMHB text4baby campaign. Title V funds will used to purchase the customized text4baby option. MCH is also exploring ways to track father enrollment in this service.//2012// /2013/ Georgia customized various Text4Baby messages and currently has2,502 enrollees in the program. //2013//

/2012/MCH is partnering with the Georgia campaign for grade level reading which aims to increase the percentage of children reading at or above grade level by the end of 3rd grade from 30% to 60% by 2015. Title V funds support this effort in four health districts to increase the number of referrals from primary care providers to child health programs and the number of ASQ trainings by ASQ certified trainers for staff, community partners and parents.//2012//

Other Activities: Outside of Title V funded activities, there are a number of other program activities comprising the MCH system that significantly impact the state's Title V population. These programs include Health Check (EPSDT), Right from the Start Medicaid, Family Planning, and Immunization, as well as activities focused on CSHCN, such as the Governor's Council on Developmental Disabilities and Social Security determination. The relationship between the MCHP and these activities is described in III. State Overview, Sections C (Organizational Structure) and D (Other Capacity) of this application. Family leadership and support activities are discussed in Section D.

G. Technical Assistance

The MCH Services Block Grant and Medicaid, known as Title V and Title XIX respectively, were created by the Social Security Act and are mandated to collaborate by a 1989 amendment to the act. Together these programs ensure that low-income families receive the health services they need. Georgia Title V seeks technical assistance to enhance the current relationship between Title V and Title XIX. Through the development of the FY11 Title V MCH Services Block Grant application, Medicaid was a topic of several public comments. These comments ranged from the selection of a care management organization and coordination of services for children with special health care needs through a medical home to the role that improved collaboration could have in treating obesity or supporting breastfeeding. One of Georgia's top priority needs also addresses the provider supply available through Medicaid to treat children with special health care needs. While the Division of Public Health and the Division of Medical Assistance are confronting significant funding challenges, a possible solution may lie in improved coordination, consolidation, and support of priorities shared by Title V and Title XIX.

The most recent agreement between Title V and Title XIX was effective July 1, 2003. This agreement was developed when Title V and Title XIX were in different state agencies. Following the reorganization of the Division of Public Health, Title V and Title XIX are now co-located in the Department of Community Health. With changes in leadership in the Divisions of Medical Assistance and Public Health and the MCH Program, there is an opportunity to review the previous agreement and develop and implement an updated agreement. To develop and implement an updated agreement, each program must understand the limitations and priorities of the other to reach a consensus of what can be done to ensure optimal service for the Georgia MCH population. In addition to an updated agreement, improved understanding of the intersection between MCH programs, for example, WIC, Children's Medical Services, and Babies Can't Wait, and Medicaid is needed to ensure that Georgia maximizes each funding source. Another area of needed collaboration between the MCH Program and Medicaid will be the implementation of a planned Medicaid Women's Health Waiver. Given the funding for family planning in Georgia, successful implementation of this waiver will require coordination between Titles V, X, XIX, and XX.

Form 15 reflects the desire of Georgia Title V to work with an outside contractor that can identify education needs about each program and implement necessary training and/or prepare and distribute necessary documents and serve as an intermediary through the development of an updated agreement.

Given the many intersection points between Medicaid and Title V as well as other MCH Programs including WIC, Babies Can't Wait, and the Family Planning program, strengthening the
partnership between Titles V and XIX is vital to the health of maternal and child health populations throughout Georgia. While Georgia may have other technical assistance needs, this is the only technical assistance need requested in the FY11 application to ensure that this need will be a priority and focal point for the upcoming year.

/2012/Through a contract with Georgia Family Connection Partnership, Title V is embarking on an opportunity analysis to identify opportunities related to the preferred relationship with Title V and Medicaid. A report is expected by December 2011 at which time a strategic direction will be determined.

For FY12, Georgia seeks technical assistance in the best use of the existing birth certificate data to populate prenatal care measures including calculating the Kotelchuck Index. With the switch to the 2003 Certificate of Live Birth, there has been a significant increase in missing data rendering these variables unreliable and unavailable for use. There are several measures throughout the Title V Block Grant that require the use of prenatal care data derived from the birth certificate. Georgia seeks technical assistance to aid in addressing this challenge.//2012//

/2013/A preliminary report has been completed that identified opportunities related to the preferred relationship with Title V and Medicaid. Additional analysis is currently being

conducted and a more comprehensive report will be developed based on analysis findings.

For FY13, Georgia seeks technical assistance to improve performance related to three National Performance Measures:

NPM 3: Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

NPM 4: The percent of children with special health care needs age 0 to 19 whose families have adequate private and/or public insurance to pay for the services they need.

NPM 6: The percentage of youth with special health care needs who receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Technical assistance is requested on how other states, especially in states in Georgia's region, are meeting NPMs 3 and 6. For NPM 4, technical assistance is needed on how other states partner with state Medicaid and private insurance companies.//2013//

/2014/Technical assistance is requested on how to adjust the section's current work in light of the Affordable Care Act.//2014//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

A. EXPENDITURES

State and federal funds are allocated based on priority needs identified through the MCHBG development process. This process includes reviewing health status and outcomes for women and children, projecting future needs and assessing current capacity/infrastructure. The MCH Program, in concert with the Division of Public Health, makes recommendations for funding levels for services to women and children. These funding requests are then processed through the Georgia General Assembly's Annual Appropriations Bill.

The state required match on our FFY 2013 MCHBG Budget of $15,882,994 is $11,912,246. Using Georgia's Office of Financial Services MCH Block Grant Expenditure Report, the FFY 2013 state match is $24,725,138 (as of 6/28/13). Georgia's maintenance of effort (MOE) level is $36,079,622. Our current MOE level is $41,325,936 for the FFY 2013 grant as of 6/28/12.

B. BUDGET

The Department of Public Health has a system of accountability to monitor the allocation and expenditures of funds provided to local health districts. The department utilizes the computer program, Uniform Accounting System (UAS), where the local health districts' administrative personnel input budget (funds that are allocated by programs such as Children with Special Health Care Needs) and expenditures. The Office of Planning and Budget Services approves all allocations to the local health districts. Reconciliations are made on a quarterly basis. In addition to the department staff, staff the MCH Program and Division of Public Health monitor programs quarterly and provide technical assistance where needed.

The FFY 2014 Budget for the Federal-State block grant partnership totals $310,702,695. Of this amount, $15,882,904 is Title V funds. The remaining amounts represent State Funds totaling $126,369,205 and $150,133,658 in Other Funds, and $18,316,838 in Program Income. Other Federal funds that support Maternal and Child Health (MCH) activities in Georgia are estimated at $291,898,196. This represents a variety of Federal Programs including three (3) Healthy Start Projects; Emergency Medical Services for Children (EMSC); Women, Infants, and Children (WIC), State Systems Development Initiative (SSDI), Universal Hearing Screening, and Healthy Child Care 2000. This brings the grand total for the State MCH Budget to $602,600,891 (see line 11 of Form 2).

For FFY 2014, $133,777,925 is budgeted for Direct Medical Care Services, $24,593,837 for Enabling Services, $128,009,184 for Population-Based Services, and $24,321,749 for Infrastructure Building Services.

The total Federal-State Block Grant Partnership for FFY 2014 includes approximately $18,316,838 in Program Income (See Form 2, line 6). This income is derived from Medicaid earnings for services provided to pregnant and post partum women, preventive health care services to children, and reproductive health services to women.

Of the Title V requested allocation ($15,882,994), $7,656,756 or 48.21% is earmarked for preventive and primary care for children. Infants less than one year old - The block grant funds ($252,896) are used to support the positions and administration of High Risk Infant Follow-up - home visits for medically fragile infants and newborns. Title V-leveraged services for this population include: Pregnancy Related Services - Medicaid post partum home and clinic visits through 1st year of life, Neonatal Intensive Care Unit (NICU) Benefits and Administration - 6 tertiary centers statewide which provide clinical care and education services for high risk newborns, education to prevent Sudden

Infant Death Syndrome (SIDS), single point of entry - Children 1st , MCH Drugs, and staffing for Local Health Districts; Children 1-22 years old: Title V funds ($7,200,199) are used in this area for, Lead Based Poisoning, Oral Health (contract with Richmond County Board of Health to provide dental services to mothers, infants, and children in the Augusta health district and to provide training opportunities for pediatric dental residents in a mobile clinic environment), and Vaccines for Children. The Title V-leveraged services for this population include EPSDT Health Check - quality assurance, Children 1st, Family Connection - help partners strengthen families in Georgia by building their capacity to develop relationships and implement community-driven plans, linking community priorities and efforts to state decision makers and promote "what works" using research and evaluation, and connecting partners to each other and to the statewide network of 159 Family Connection county collaborative, and the MATCH Program - a system that supports services for children with severe behavior and/or health problems. Approximately 45.33% or ($7,200,199), is earmarked for Children with Special Health Care Needs to support Genetic/Sickle, Children Medical Services and Pediatric AIDS. There is 4.41% or $699,732, earmarked for Title V administrative costs, used to support positions and administration. These positions provide data, quality assurance, technical assistance, policy, planning, and operational services that support and enhance the State's MCH system. These percentages are in keeping with the 30/30 required by Title V. The remaining $326,307 is used to support comprehensive health services for (pregnant) women. The Title V leveraged services are: Six Tertiary Care Centers - high risk maternal services and MCH Drugs.

We do not anticipate any budget issues relative to MCH Block Grant Match requirements for the FFY 2014 budget.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state- specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.