

Children with Special Health Care Needs

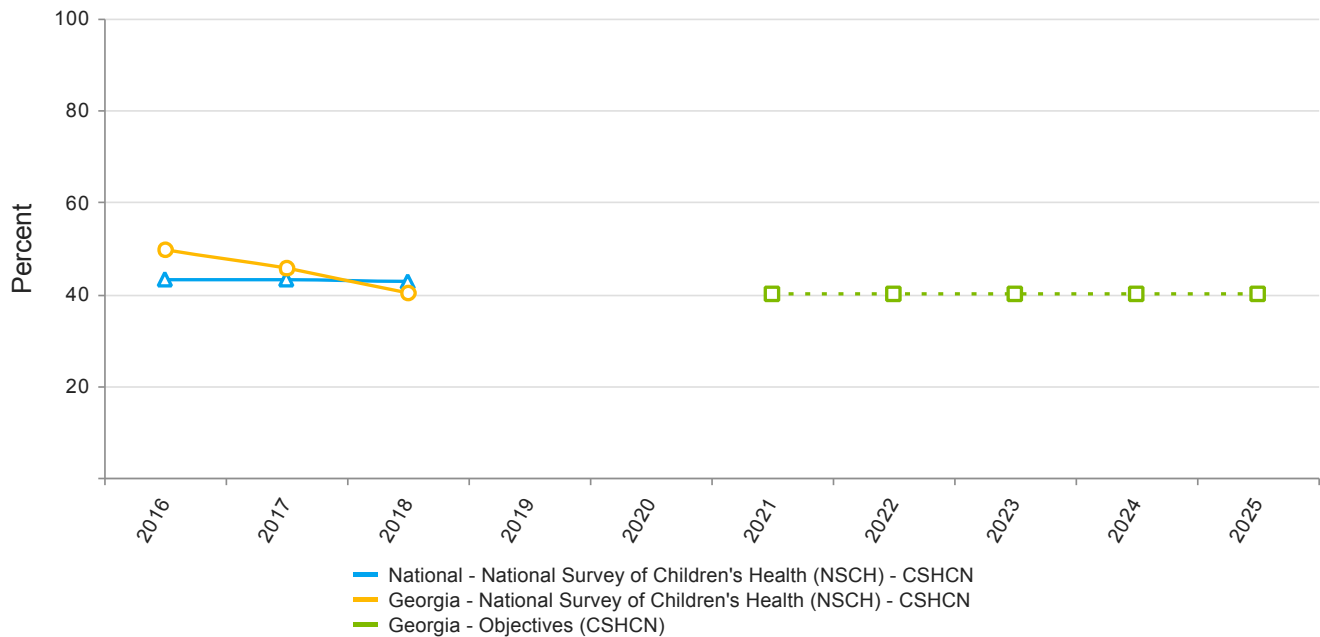
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2017_2018	15.5 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	48.9 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	88.5 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2017_2018	5.7 %	NPM 11

National Performance Measures

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

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2019
Annual Objective	
Annual Indicator	40.3
Numerator	195,620
Denominator	485,463
Data Source	NSCH-CSHCN
Data Source Year	2017_2018

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	40.0	40.0	40.0	40.0	40.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of telehealth/telemedicine patient encounters

Measure Status:		Active
State Provided Data		
		2019
Annual Objective		
Annual Indicator		767
Numerator		
Denominator		
Data Source	CYSHCN program/ DPH Office of Telehealth and Telem	
Data Source Year		SFY 2019
Provisional or Final ?		Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	767.0	805.0	843.0	881.0	919.0

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

Measure Status:		Active
State Provided Data		
		2019
Annual Objective		
Annual Indicator		10
Numerator		
Denominator		
Data Source		CYSHCN program/ DPH Office of Telehealth and Telem
Data Source Year		SFY 2019
Provisional or Final ?		Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	10.0	14.0	18.0	22.0	26.0

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

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

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	3,809.0	4,000.0	4,190.0	4,381.0	4,571.0

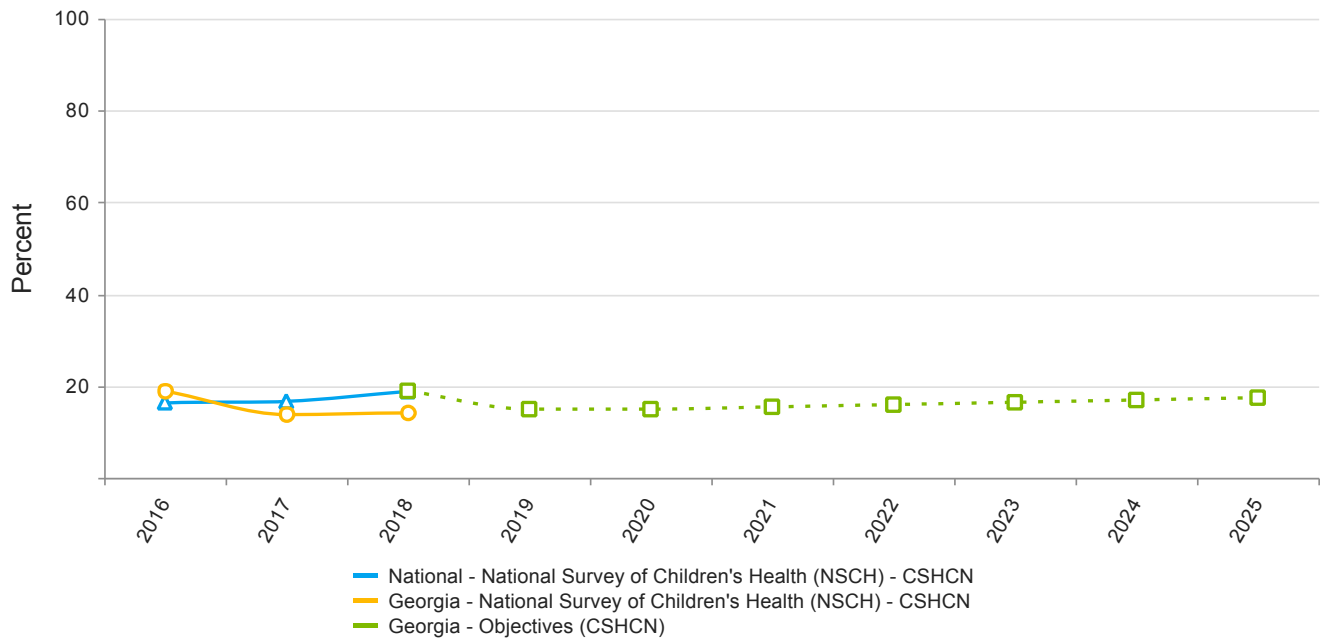
ESM 11.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs

Measure Status:		Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	0.0	0.0	0.0	0.0

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



NPM 12 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	2017	2018	2019
Annual Objective			19	15
Annual Indicator		19.0	14.0	14.2
Numerator		44,578	32,898	27,235
Denominator		234,699	234,571	192,079
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	15.0	15.5	16.0	16.5	17.0	17.5

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of youth/young adults enrolled in the Department's Title V program for Children and Youth with Special Health Care Needs (CYSHCN) that transfer to an adult provider.

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	23.0	27.0	31.0	35.0	39.0

ESM 12.2 - Number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs.

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5.0	10.0	15.0	20.0	25.0

State Action Plan Table

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

Priority Need

Improve systems of care for CYSHCN

NPM

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

Objectives

12.1 By 2025, increase the percentage of youth/young adults enrolled in the state's Title V Children and Youth with Special Health Care Needs program that report successful transfer to an adult provider by 20%

12.2 By 2025, increase the number of community stakeholders that partner with the state's Title V Children and Youth with Special Health Care Needs program to implement health care transition processes and procedures for youth/young adults with or without special health care needs by 25.

Strategies

12.1a Develop and implement a health care transition quality improvement and evaluation plan to assess the effectiveness and efficiencies of the Department's health care transition program activities that impact youth and families.

12.1b Provide technical assistance and guidance on health care transition planning for care coordinators supporting the Title V Children and Youth with Special Health Care Needs program.

12.1c Implement condition specific transition planning protocols for adolescents enrolled in the Title V Children and Youth with Special Health Care Needs program.

12.1d Provide educational opportunities for youth and families to increase their knowledge on health care transition planning services and resources.

12.2a Establish an advisory group to include youth, families, and providers to support practice improvement efforts for health care transition.

12.2b Partner with adolescent health programs within the Department to implement best practices that support health care transition planning for youth and young adults with or without special health care needs.

12.2c Develop and implement a health care transition communication plan to share targeted messaging for transitioning youth/young adults with and without special health care needs from pediatric to adult care for audiences to include youth/young adults, families, health plans, medical providers, state agencies and community partners.

12.2d Provide continuing education opportunities on the six core elements of health care transition for medical and nursing students, pediatric and adult providers.

ESMs	Status
ESM 12.1 - Percent of youth/young adults enrolled in the Department's Title V program for Children and Youth with Special Health Care Needs (CYSHCN) that transfer to an adult provider.	Active
ESM 12.2 - Number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs.	Active

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

State Action Plan Table (Georgia) - Children with Special Health Care Needs - Entry 2

Priority Need

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

NPM

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

Objectives

11.1 By 2025, increase access to pediatric specialty medical care for children and youth with special health care needs.

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

11.3 By 2025, increase the number of state agencies and community partners that collaborate to ensure families can access medical homes.

Strategies

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

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

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

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

11.2a Expand the capacity of HMG liaisons to help families navigate/ access comprehensive services.

11.2b Improve access to information and resources for CYSHCN.

11.2c Develop an outreach plan to engage partners, providers, and families in the utilization of HMG, a shared resource to assist families to navigate the early childhood system.

11.3a Engage stakeholders with a shared vision and common understanding for the need of a medical home and willingness to join into an approach to solve the problem through agreed-upon actions.

11.3b Construct an informative PowerPoint/Webinar that can be utilized to educate partners on the importance of encouraging families to seek a medical home and that will offer stakeholders innovative ideas on how to expand the concept of a medical home which ultimately will increase the number of families with a medical home.

ESMs	Status
ESM 11.1 - Number of telehealth/telemedicine patient encounters	Active
ESM 11.2 - Number of telehealth/telemedicine providers in the network	Active
ESM 11.3 - Number of callers connected to resources through Help Me Grow (HMG)	Active
ESM 11.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

2016-2020: National Performance Measures**2016-2020: State Performance Measures**

2016-2020: SPM 2 - Rate of children and youth with special health care needs that have accessed their specialty health care visit through a telehealth clinic.

Measure Status:			Active	
State Provided Data				
	2016	2017	2018	2019
Annual Objective		1.3	1.4	1.5
Annual Indicator	1.5	1.3	1.3	1.4
Numerator	704	781	784	809
Denominator	477,000	581,912	616,847	583,184
Data Source	CMS Program Data and Kids Count	CMS Program Data and NSCH	CMS Program Data and NSCH	CMS Program Data and NSCH
Data Source Year	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Children with Special Health Care Needs - Annual Report

Priority Need: Improve Systems of Care for CYSHCN

Strengthening the system of services for children and youth with special health care needs was determined as a state priority during the Title V MCH Needs Assessment conducted in 2015. Strategic partnerships with state agencies, community stakeholders, medical providers and families laid the groundwork to capture the deficits and gaps in the system of services for children and youth with special health care needs. National data and statewide assessments further illustrated performance measures for the state which underperformed national averages and highlighted areas of needed improvement for the system of services available to families.

Georgia's Title V MCH Section provides leadership and oversight, technical assistance and trainings, policy development and implementation and professional development for the Georgia Autism Initiative, Early Intervention – BCW, CYSHCN - CMS, and EHDI programs. These programs provide critical services and support for children and youth with special health care needs from infancy to young adulthood and their families. Working collaboratively across the CYSHCN programs within MCH provides enhanced opportunities to leverage resources such as subject matter expertise, funding, trainings and family participation.

The Georgia Autism Initiative, BCW, CMS and EHDI programs are family centered and community-based and ensure early screening and diagnosis, access to a medical home and adequate insurance, as well as successful transition from pediatric to adult health care services. Services are offered statewide and administered through local child health programs available in Georgia's public health districts. Competent nurses, social workers, care coordinators, service coordinators, developmental specialists, early intervention specialists, therapists and medical providers are responsible for providing direct services to children and youth with special needs and their families.

Timely and ongoing screening and access to a continuum of medical care and early intervention services are critical to achieving optimal outcomes for children and youth with special health care needs. MCH Autism, BCW, CMS and EHDI programs work together to ensure a comprehensive and seamless system of services for families caring for children and youth with special needs. In the reporting year, the CMS program served more than 8,000 children and youth through direct and enabling services and more than 29,000 families through education and awareness campaigns and outreach activities to engage families in community resources. The BCW program served 19,278 children, the Georgia Autism Initiative served more than 2,000 children and more than 200 providers. The EHDI Program served 124,829 unique children born July 1, 2018-June 30, 2019 by providing inpatient and/or outpatient hearing screenings and/or hearing diagnostic evaluations (when a hearing screening was not done).

Systems of Services Overview

Children's Medical Services

Enhancing the system of care for youth and young adults transitioning from pediatric to adult care as well as for families with CYSHCN to access timely pediatric medical care in rural areas of the state are priority areas for the CMS program. CMS partners with primary care providers, pediatric sub-specialists, healthcare vendors, state agencies and community-based resources to coordinate timely access to health care services and supports for eligible CYSHCN and their families. Children and youth ages birth to 21 years of age with an eligible chronic medical condition, and family income at or below 247 percent of the federal poverty level are served by CMS. In the reporting year, 81 percent of transition age youth, 14 to 21, and their families have partnered with their care coordinator to plan for transition from pediatric to adult centered health care. For young adults ages 18 to 21 enrolled for CMS services, 21 percent have transferred to adult model of care or to an adult provider.

CMS provides and/or arranges for comprehensive physical evaluations, diagnostic tests, inpatient and outpatient hospitalization, medications and other medical treatments, post-op therapy, durable medical equipment, hearing aids related to the child's eligible condition, and genetic counseling. CMS serves as the payer of last resort for health care and medical expenses for families that do not qualify for the State's Medicaid program SCHIP or are without insurance during the time of CMS program enrollment. In addition to filling in the gap with health care coverage, CMS will also support CYSHCN and their families by coordinating appointments, identifying resources, assisting with social supports such as transportation and support groups. Helping CYSHCN and their families feel confident about managing their health care needs and navigating through complex social issues is a very important goal for the CMS program.

CMS care coordinators ensure families have adequate insurance by assessing eligibility for the State's Medicaid and SCHIP programs and assist with the applications if clients do not have insurance or express a burden in maintaining health care. The program also assists with co-pays and deductibles and provide support to navigate health benefits requiring prior authorizations and letters of medical necessity. The CMS care coordinators also facilitate the transition process from pediatric to adult health care for adolescents ages 14 and older. Approximately 1,144 CMS program participants and their families received transition planning, support and education by care coordinators in the reporting year. The care coordinator's role in the transition process supports youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.

Pediatric specialty care clinics for children and youth living in rural counties are offered where pediatric medical specialist's services are limited. The CMS program offers specialty clinics in nine public health districts and coordinates services with more than 30 specialty providers for face to face as well as telemedicine clinic visits. During the reporting year, approximately 380 clinic days were offered, 126 of those were provided via telemedicine, and 3,603 children and youth were served via the specialty clinics. Specialty clinic types include endocrinology, nephrology, cardiac, chronic lung, genetics, hematology/sickle cell, orthopedic, hearing, neurology and cystic fibrosis.

CMS care coordinators frequently participate in a variety of outreach activities to assist with building partnerships with community stakeholders to effectively support families' wide range of medical and social needs and improving the timeliness of families accessing services.

Early Intervention

Babies Can't Wait

BCW, also known as Georgia's Part C program, provides a coordinated, comprehensive and integrated system of early intervention services for infants and toddlers with special needs, birth to age three, and their families. BCW provides early identification and screening of children with developmental delays and chronic health conditions by using a multidisciplinary evaluation and assessment to determine the scope of service needs. Services to improve the developmental potential of infants and toddlers include occupational, physical and speech language therapy, psychological services, service coordination, special instruction, and behavioral intervention which are outlined in the child's Individualized Family Service Plan (IFSP).

To continue efforts in addressing the social emotional needs and concerns of families enrolled for services, a third cohort of Pyramid trainings was delivered to Service Coordinators and Special Instructors in the five State Systematic Improvement Plan (SSIP) districts (LaGrange, Macon, Gainesville, Clayton, Rome & Waycross) to implement evidence-based practices. The Master Cadre trainers in each SSIP implementation district conducted trainings with assistance and support provided by Georgia State University staff.

BCW and DOE met regularly to discuss process improvement for the transition of children from Part C into Part B. A joint meeting with the district Early Intervention Coordinators (EIC) and DOE Regional representatives met to discuss local challenges and strengthen understanding of the transition requirements. A follow-up webinar was held with BCW Service Coordinators and local education staff to ensure understanding of transition requirements. Additional regional meetings were held across the state to develop a local transition agreement between BCW district programs and local education agencies on transition expectations, roles & responsibilities. Regular technical assistance conference calls were scheduled by the Part C Coordinator with the EIC monthly to discuss topics in need of clarification and consistent understanding.

A legislative Social/Emotional Study Committee formed to discuss current services available for infants and toddlers to address social emotional concerns. The MCH Director discussed DPH services and how MCH programs address the social/emotional needs of children birth to three enrolled in BCW.

Georgia Autism Initiative

The Georgia Autism Initiative improves access to statewide early identification and screening for Autism Spectrum Disorders (ASD) in children through an enhanced professional development infrastructure for medical providers (pediatricians, family physicians, physician's assistants, nurse practitioners, and nurse managers). Evidence-based practices, such as academic detailing, is utilized during trainings. The trainings offered to Medical providers is comprehensive and includes the following learning objectives; importance of early screening, listening to parental concerns, using screening tools during well-child visits, implementing standardized screening practices, billing for reimbursement, as well as referring children for diagnosis, early intervention, and community supports. In addition to academic detailing, outreach was conducted using a variety of strategies, such as webinars, tele-health, and practice visits.

The following priorities and respective activities were addressed during the reporting period:

- Increase the number of children aged 16 to 30 months of age screened for ASD
- Increase the number and knowledge of licensed providers trained to diagnose ASD
- Increase the number of children having a first diagnostic evaluation for ASD by 36 months of age
- Increase the number of children enrolled in early intervention for ASD by 48 months of age
- Provide technical assistance and transition planning to school systems and families of youth with ASD aged 14 to 21

Through collaboration with internal and external stakeholders, the Georgia Autism Initiative effectively increased awareness, educated professionals, trained families, conducted screenings, referred for diagnostic evaluations, developed functional behavior plans and facilitated transition assessments.

The Georgia Autism Initiative refined statewide service delivery plans for implementation within the public health districts. Updates adopted best practices from other states and emerging research. The plan included guidance for districts implementing evaluation, assessment, referral for diagnosis and behavioral health services within the natural environment. A comprehensive communication strategy was utilized, and the Georgia Autism Initiative District Plan document was finalized and distributed to district staff. To further streamline best practices and communication, a Frequently Asked Questions (FAQ) was developed. District feedback was considered to refine the FAQ as needed.

BCW program staff facilitated training to utilize modified features made in the Babies Information Billing System (BIBS), the central data management system. An Autism Billing and Training Manual was developed for internal and external providers containing information on specialties added for autism, billing codes for autism, and how to enter

screening, diagnostic and intervention information. A MCHAT-R/F Training for over 300 Public Health professionals was provided during the reporting year. Professionals received training on the MCHAT- R/F to increase the early detection of children suspected of having an ASD diagnosis.

Child Health Coordinators completed a knowledge demonstration quiz to assess their understanding of administering the MCHAT-R/F screening tool with children and families. Child Health Coordinators scored an average of 91 percent on the quiz, demonstrating a significant understanding of administering the MCHAT-R/F screening tool. MCHAT-R/F Training objectives were to:

- Discuss the prevalence of autism spectrum disorders
- Describe how to administer the Modified Checklist for Autism in Toddlers Revised with Follow-up
- Discuss techniques and strategies to discuss screening results with families

During the reporting year, a total of 2964 MCHAT-R/F screenings were conducted and/or collected at the recommended 18-month and 24-month intervals with 933 conducted at the 18-month interval and 2031 conducted at the 24-month interval.

In 2014, research indicated the average age of ASD diagnosis was four years and five months of age. Researchers believe this to be a result of limited awareness and access to skilled diagnostic evaluators. The Georgia Autism Initiative collaborated with the Emory Autism Center (EAC) to develop the Georgia Autism Assessment Collaborative (GAAC) Provider Directory, distributed in December 2018. The GAAC consists of 36 licensed community psychologists that received training on the ADOS-2, facilitated through collaboration with EAC, and remain engaged in the project through regularly scheduled webinars. The GAAC members listed accept referrals for the early evaluation (<3 years old) of children suspected of have an ASD diagnosis. A survey /questionnaire was developed and distributed to all GAAC members to collect recent data on their practice use of the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2), contact information and insurance carriers accepted. This information will be used to update and release the annual 2020 Annual GAAC Provider Directory. In addition, the program collaborated with EAC, to deepen the commitment of licensed community psychologists providing quality early diagnostic assessment through a network of five GAAC Early Identification Specialty Clinics. During the reporting year, GAAC Specialty Clinic members met to plan the development of a standardized diagnostic summary form that would help streamline referrals and reduce delays in appropriate intervention when children are identified to have an ASD. GAAC Specialty Clinic members participate in further training, serve as diagnostic referral sources for young children suspected of ASD, act as resources and conduits for information in their region and assist in the ongoing effort to further define GAAC standards and operations. Four out of five Specialty Clinics successfully completed clinical reliability testing according to diagnostic standards, with one Specialty Clinic conducting ongoing and assisted clinical reliability testing.

BCW collaborated with EAC to develop, implement and facilitate a Board-Certified Behavior Analyst (BCBA) Training and Supervision Program, providing necessary field experience up to 1500 hours for qualified trainees seeking to complete and pass the national behavior analysts exam. Seventy-five interested BCBA's attended orientation sessions with the opportunity to discuss service delivery among local EIC. Orientation sessions were held in four Public Health Districts to include: District 3-1 Cobb/Douglas, District 4 LaGrange, District 5 Macon and District 9 Coastal.

In the reporting year, the program began contracting with BCBAs with 14 enrolled BCBA providers and 11 RBT providers. By September 30, 2019 a total of 37 children were receiving autism services in seven public health districts, 39.8 percent of those with a completed diagnostic evaluation.

An Individualized Transition Assessment Plan (ITAP) Model for adolescents transitioning to young adulthood, 14 to 21 years of age was developed, and a multi-agency Advisory Board was convened quarterly with representation from local, state and higher education institutions. The advisory board provided feedback on best practices, implementation and resources needed to support youth with ASD including the development of three Healthcare Transition Workbooks for families, educators and students. Over 20 students received transition assessments using the ITAP Model, following four post-secondary trajectories:

- College Bound
- College Bound (non-traditional)
- Transition Program
- Career Pathway

The Georgia Autism Initiative customized and distributed Learn the Signs, Act Early (LTSAE) materials, originally developed by the CDC. Distribution included over 1000 Milestone Moments booklets and brochures, to Children 1st Programs and WIC clinics increase awareness of developmental delays and appropriate developmental monitoring.

Early Hearing Detection and Intervention

EHDI is a multi-partner screening and intervention system for children with hearing loss. The EHDI program maintains and supports a comprehensive, coordinated statewide screening and referral system. EHDI includes screening for hearing loss on all newborns in the birthing hospital; referral of those who do not pass the hospital screening for rescreening; referral of those who do not pass the rescreening for diagnostic audiological evaluation; and linkage to appropriate intervention for babies diagnosed with hearing loss. The most crucial period for language development is the first year of life. Without newborn hearing screening, hearing loss is typically not identified until two years of age. Screening all newborns prior to discharge from the hospital or birthing center is essential for the earliest possible identification of hearing loss, and consequently, for language, literacy, communication, and academic potential to be maximized.

The EHDI program facilitates technical assistance and training on implementing and maintaining a quality newborn hearing screening program to hospitals, primary care physicians, audiologists, early interventionists, and local child health program EHDI staff members. Each of the 18 public health districts has one full time EHDI program coordinator with the responsibility of documenting and tracking newborns that do not pass the newborn hearing screen to their outcome and responsible for partnering with birthing facilities, pediatricians, audiologists, and families to help facilitate rescreening, diagnostic evaluation and enrollment into early intervention.

Collaboration with a variety of external partners is a core feature of the EHDI program. The contracts with Georgia Hands & Voices (H&V) a family centered organization that focuses on peer-to-peer support. the EHDI program refers all families with children who are Deaf or hard of hearing to H&V. H&V offers the Advocacy Support Training and Support (ASTra) The ASTra program informs families of their rights during the IFSP and an Individualized Education Plan (IEP) process as well as other rights as it pertains to the American with Disabilities Act. In the most recent contract year, ASTra staff made 252 contact attempts to 152 unique families, and 133 of those children have complete IFSPs/IEPs. Although H&V focuses on families with children who are deaf or hard of hearing (D/HH), many professionals and families have learned about the successful outcomes of participating in the ASTra training. Several professionals and families that have children with special health care needs other than hearing loss have made requests to participate in the training.

To better incorporate the family perspective and increase service providers' engagement and knowledge of EHDI,

the state office worked collaboratively with Athens and Augusta public health districts to establish learning communities. Both communities defined and addressed specific district-level activities to improve progress towards meeting the 1-3-6 benchmarks. Each learning community actively involved parents with children who are DHH aged three and under, clinical professionals, local public health staff, hospital screening programs, and others deemed key worked with the EHDI program. The EHDI program also supports three additional districts to develop and implement learning communities in their local jurisdictions.

Birth to Literacy for Children who are Deaf or Hard of Hearing

An important amendment to existing legislation was passed in the previous year to focus on the academic landscape for children who are deaf or hard of hearing. In May 2018 the “Birth to Literacy” legislation for infants and young children identified as D/HH, was enacted in Georgia. The DOE identified that deaf or hard of hearing D/HH students were lost in the educational system and may be underserved. Within the DOE system, students are only identified as D/HH if they have an IEP or they have documentation of using assistive devices. DOE found that many children identified as D/HH are not reading on grade level. Alternatively, because D/HH children are only identified academically by an IEP, there is limited information on how many D/HH children are doing well in school and are therefore unable to design programs to replicate that success. As a result of O.C.G.A. § 30-1-5, it is easier for the EHDI and Part C programs within DPH to work more collaboratively with the DECAL and DOE to monitor and strengthen the systems that support early identification, intervention, language development academic achievement for D/HH children across the continuum of service they receive from birth to third grade. Several cross-agency collaborative meetings were held in the reporting year to better understand the landscape for D/HH children and to identify key activities and benchmarks that can be used to measure the effectiveness of the collective system established across agencies.

All participating agencies collaborated on the development of a charter to guide this important work and to establish processes to ensure there is equal opportunity for all stakeholders to develop and contribute to the development of policies and procedures to guide implementation of the legislation. All participating agencies agreed a charter was a necessary strategy in creating and implementing a comprehensive and collaborative ecosystem for D/HH children. The collaborative group also developed a Memorandum of Understanding outlining the role and scope of each stakeholder and how data will be used and shared. In compliance with the new law, all children under the age of five who are diagnosed with hearing loss will receive a unique identification number from DOE. The identification number is stored in the EHDI database from date of diagnosis, which for many children is in infancy, to date of school entry. This legislation is a foundation to better understand how early identification, early intervention, and the larger early childhood system in Georgia supports language acquisition and academic success for deaf or hard of hearing children in the state. More importantly, this unique opportunity for collaboration across state agencies will lay the foundation to better support outcomes among children and families. Agencies participating in the work have identified areas in the current D/HH landscape that can be strengthened and developed workgroups to implement strategies to address these areas. Families of children who are D/HH are engaged as partners throughout the process to ensure that the system continues to focus on family needs. DPH, DECAL and DOE will jointly publish an environmental scan of the early childhood system for D/HH children. This report will serve as a baseline report from which future progress on this legislation will be measured.

Systems Building

NPM 12: Transition to Adult Care for All Children

According to the National Children’s Survey 2017-2018, in the state of Georgia, only 14.2 percent of children and youth (12-17) received services necessary to make transitions to adult health care. The National Children’s Survey data from 2016/2017 to 2017/2018 reports increases in the following areas:

- Percent of CYSHCN, ages 12-17, whose doctors actively worked to manage his/her health and health care
- Percent of CYSHCN, ages 12-17, whose doctors worked to understand the changes in health care after age 18
- Transition Part C: Percent of CYSHCN, ages 12-17, whose doctor discussed transitioning to providers who treat adults
- Percent of CYSHCN, ages 12-17, whose doctor worked to make positive choices about his/her health
- Percent of CYSHCN, ages 12-17, who discussed how to obtain/keep health insurance coverage into adulthood

The CMS program is committed to fostering a system that provides youth with special health care needs and their families the support needed to successfully transition to adult health care. The CMS program will apply the Six Core Elements of Health Care Transition, an evidence-driven approach, to successfully transition youth and young adults from a pediatric to adult model of health care. The CMS Programs leverage existing partnerships, resources and training opportunities to improve Georgia's systems of care for improving transition services for CYSHCN.

Children's Medical Services

CMS continues to engage various partners to improve the successful transition for youth and young adults from pediatric to adult care.

Implementation of health care transition protocols and standards in public and private health care settings

The CMS program implemented new transition to adult care protocols and standards to facilitate improvements in supporting families and youth with health care transition planning. The new policies and procedures were developed using the Got Transition Six Core Elements of Health Care Transition framework and integrated into the program's care coordination practices. All care coordinators are trained on the new transition policies and procedures and will receive ongoing coaching and monitoring to ensure families and youth receive adequate preparation and support in the transition process.

Coaching support is provided to ensure implementation of the new policies and procedures. Ongoing monitoring is conducted to ensure that transition planning starts at the appropriate age, readiness assessments are completed in partnership with the families and youth, goals and action documented and appropriate follow up provided to ensure success.

The CMS program's efforts to integrate health care transition planning into care coordination practices is an intentional process that requires training, coaching and monitoring techniques to increase the number of families who successfully transition. Integrating Health Care Transition Planning into Care Coordination Practices for the Children's Medical Services Program poster was presented at the 2019 AMCHP Conference in San Antonio, Texas in March 2019.

The continued partnership with and funding for the Adult Disability Medical Healthcare (ADMH) provides a vital resource to young adults with intellectual and developmental disabilities and their families. In the reporting year, approximately 167 patients were seen by ADMH for transition services and supports. ADMH is housed within a family physician practice and transition clinics are supported by several disciplines, which includes; family physicians, behavioral analyst, clinical social worker, medical assistant and family/patient advocate.

Outreach and awareness activities geared towards youth, families and community stakeholders

In partnership with Parent to Parent of Georgia (P2P), youth and parent/caregivers have access to annual workshops on preparing for the transition from pediatric to adult model of care. The curriculum used to facilitate these

workshops are adapted from the Waisman Center and has accompanying workbooks for families and youth to document their transition goals as well as activities to help youth practice independent health care skills such as setting appointments, scheduling transportation and filling prescriptions.

To assist with efforts in educating the public on transition, the CMS program has a collection of transition materials specifically developed for families and youth. These materials are marketed at annual outreach events such as health fairs, expos, family nights and conferences. More than 18,000 transition materials have been distributed to youth, families and community partners.

In partnership with DPH's Office of Nursing, the CMS program had several opportunities to collaborate with school nurses through the Regional Educational Service Agency (RESA). RESA is comprised of 16 regional educational service agencies strategically located in service districts throughout the Georgia. RESA served 180 school systems administered by DOE.

Additional opportunities to streamline transition efforts across the state included participation in the Georgia Interagency Transition Council. State agencies and leaders shared resources, collaborated, and created synergy surrounding transition work. Georgia State University Center for Leadership in Disability facilitated the Council and other state and community agencies included DOE, Vocational Rehabilitation, Legal Aid, Colleges and Georgia's Inclusive Postsecondary education programs, Independent Living, Department of Behavioral Health and Developmental Disabilities, Assistive Technology Centers, and the Marcus Autism Center.

Training opportunities for health care professionals

Through continued partnerships with the Georgia Academy of Family Physicians and the Georgia Chapter of the American Academy of Pediatrics, the CMS program provided annual health care transition training opportunities to pediatricians, family physicians and pediatric nurse members. Trainings were offered via face to face encounters at the annual fall and summer conference meetings as well as via webinar. During this reporting period, there were eight training opportunities provided.

Georgia Autism Initiative

The Georgia Autism Initiative developed materials and resources for healthcare providers to offer services aimed at helping young people with autism spectrum disorder adopt a more independent and empowered lifestyle as they transitioned into adulthood. In collaboration with the CMS program, education was provided to pediatricians and family practice physicians on supporting young adults in transitioning to adult healthcare services through various training modalities; which included webinars, lectures presentations, and grand rounds for medical residents.

SPM 2: Improve Access to Specialty Care for CYSHCN

CYSHCN programs partner with health care providers and community-based resources to coordinate pediatric specialty and therapeutic care for CYSHCN and their families. To ensure that children and youth served in rural communities received appropriate and needed specialty medical and therapeutic services, CMS, BCW and EHDI programs offered access to specialty services.

DPH's Office of Telehealth and Telemedicine, in partnership with county health departments, oversee a robust telehealth network which encompasses Georgia's 159 counties. The telehealth and telemedicine programs aim to improve access to healthcare services, address workforce shortages, and reduce health disparities across Georgia. DPH defines 'telehealth' as the use of electronic information and telecommunications to support long-distance clinical health care, health related education and health administration. DPH defines 'telemedicine' as the use of medical information exchange from one site to another via electronic communication to improve the patient's clinical

health status. Partnering with specialists and other telehealth entities has been an important driving force for program expansion.

CMS offers specialty clinics in nine local public health district programs, which included face to face and telemedicine. CMS used telehealth and telemedicine to provide developmental and genetic services, asthma management, as well as endocrinology, nephrology, pediatric neurosurgery, pulmonology and sickle cell follow-up care. As the presentation/origination site, the CMS program can facilitate reimbursement with appropriate Medicaid telehealth billing codes. All families accessing telemedicine have access to free language assistance services. Families have freedom of choice to use informal or formal interpreters.

CMS worked with specialty clinics for over a decade through partnerships with pediatric healthcare systems, university systems and private specialty providers. With increasing provider shortages, CMS recognized the necessity for more robust telehealth services to meet the needs of children. Telehealth services through CMS were first implemented at a pulmonology clinic in Valdosta, and slowly expanded to other counties. During this reporting period, there were seven district CMS sites capable of providing telemedicine services. The CYSHCN program continues to coordinate clinics with telehealth services and onsite providers. For example, the sickle cell clinic has onsite and telemedicine clinic hours. Only follow up appointments are offered via telemedicine. Initial consultations and diagnosis are only provided when the hematologist is onsite.

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

Since 2017, there have been additional telemedicine services pilot projects that have been established to improve access to audiological and therapeutic services for infants and children with special health care needs. The tele-audiology initiative is a partnership with the state EHDI program, the audiology department at Children's Healthcare of Atlanta (CHOA), and the Waycross Health District's EHDI program. The tele-audiology clinic is held once a month and is used to perform diagnostic testing on infants four to six weeks of age that received a referral resulting from the hearing screen performed at the birthing hospital. The tele-audiology clinic will serve one to two patients per month.

The tele-intervention pilot project for physical and speech therapy is offered in the Waycross Health District's BCW program. An opportunity to connect therapy providers with their clients in their home via telemedicine is a breakthrough achievement. The Tele-intervention pilot serves five families with physical therapy and four families with Speech language therapy. This pilot is an effort to address the shortage of therapeutic providers available to many families needing early intervention services for infants and toddlers ages birth to three years of age.

Current Year: Oct 2019 – Sept 2020

Priority Need: Improve Systems of Care for CYSHCN

The Georgia Autism Initiative, BCW, CMS and EHDI programs work together to ensure a comprehensive and seamless system of services for Georgia families caring for children and youth with special needs. During the current reporting year, CYSHCN focused on workforce development, strengthening family engagement and community partnerships, expanding telehealth and telemedicine services and responding to the COVID-19 pandemic.

System of Services Overview

Please add some intro lines about all programs were impacted by COVID-19 and to assist the public health districts COOPs were developed to provide guidance on program implementation during the pandemic.

Children's Medical Services

Creating and reinforcing the system of care for youth and young adults transitioning from pediatric to adult care as well as for families with CYSHCN to access timely pediatric medical care in rural areas of the state are priority areas for the CMS program. CMS partners with primary care providers, pediatric sub-specialists, healthcare vendors, state agencies and community-based resources to coordinate timely access to health care services and supports for eligible CYSHCN and their families.

Families enrolled in CMS receive care coordination services by nurses and social workers. Beginning in February and March of 2020, the COVID-19 pandemic impacted the state, MCH workforce and families. Many CMS care coordinators became responsible for assisting with COVID-19 testing sites and local emergency call centers. The remaining CMS staff continued to provide services and supports to families and CYSHCN.

CMS implemented its continuity of operations plan to ensure families had access to essential services. The program focused on maintaining constant communication with enrolled families as well as those that may have been newly referred to the CMS program for services. Annual and six-month care planning with the family's verbal consent is conducted via the phone rather than by home or office visits. The primary focus of the care planning addresses current and immediate medical and family support needs as well as medications and medical supplies. During this time period, the program also limited the standard disenrollment, financial eligibility and cost participation procedures to ensure a continuum of services for families impacted by the state declared public health emergency. Many of the specialty care clinics are held via telemedicine or telehealth with only a few clinic providers deciding to continue to offer face to face visits for follow up care to patients.

The CMS program also worked with community partners and Georgia's Family to Family Health Information Center to provide critical information and resources to families across the state caring for CYSHCN.

Early Intervention

Babies Can't Wait

Early Intervention, primarily delivered in the child's natural environment, were impacted by the COVID-19 pandemic. The BCW program ramped up their teleintervention program capabilities to the 18 public health districts. Prior to the pandemic, BCW was only piloting teleintervention in four public health districts (Waycross, Valdosta, Dublin & Gainesville). To prepare for the expansion, BCW in partnership with the Office of Telehealth and Telemedicine, equipped and trained 1000+ BCW providers on the WebEx telehealth platform. The telehealth platform along with weekly technical assistance calls, user guides and resources allowed for an expedited process to prepare BCW providers to begin service coordination, special instruction, speech, physical and occupational therapy for families via telehealth as a viable service delivery option. Families who do not have the technology to participate in teleintervention were provided services by phone, consistent with Georgia Medicaid and OSEP guidance regarding service provision via alternative means.

Early Hearing Detection and Intervention

During the current year, the EHDI program maintains and supports a comprehensive, coordinated statewide screening and referral system. EHDI includes screening for hearing loss on all newborns in the birthing hospital; referral of those who do not pass the hospital screening for rescreening; referral of those who do not pass the rescreening for diagnostic audiological evaluation; and linkage to appropriate intervention for babies diagnosed with

hearing loss.

The COVID-19 pandemic has interrupted the system for EHDI. The impact on health care processes and the public health workforce has created challenges in ensuring that newborn babies receive an initial hearing screen by one month of age and diagnostic services by three months of age. EHDI has implemented a Continuity of Operations (COOP) plan to provide guidance to District EHDI Coordinators during the COVID-19 pandemic, outlining essential services relating to 1-3-6 benchmarks, hospital responsibilities, and the importance of tracking available services at the district level. The COOP plan also outlines follow-up and documentation recommendations and provides a framework to track cases impacted by COVID-19.

Some of Georgia's birthing facilities are screening mothers and infants for COVID-19 symptoms, and only conducting hearing screenings on non-symptomatic babies. Symptomatic families are discharged without a hearing screening and may have a future appointment scheduled at time of discharge. Other hospitals have postponed newborn hearing screening altogether, until COVID-19 subsides, placing the responsibility of follow up solely on the parents and District EHDI Coordinators. Families that are discharged from the hospital without a hearing screening, a future appointment, or proper education on the importance of newborn hearing screening are unlikely to follow-up at a later time. In addition, some families have received education on the importance of screening but are electing to postpone testing due to fear of infection.

District EHDI Coordinators are working hard to educate families on the importance of newborn hearing screening and are exploring outpatient options to refer families for testing. Many health departments have postponed in-home hearing screening and hearing screening clinics until further notice. Of Georgia's 18 public health districts, seven District EHDI Coordinators have been selected to assist with the COVID-19 response in their community, diverting their time away from EHDI responsibilities. Other District Coordinators assist with the COVID-19 response as needed but continue to focus most of their efforts on EHDI coordination and follow-up.

Audiology facilities have implemented a variety of schedules to provide care. Some audiology facilities, primarily in the metro Atlanta area, remain open and continue to provide services. Other facilities have implemented emergency only services or are offering sick/well visits during different parts of the day or implemented alternate schedules, setting a specific amount of time aside each week to conduct screenings on non-symptomatic babies at a specific age. Some facilities have postponed testing until further notice. Teletherapy services are also being provided by some facilities, however, the services that are being provided varies by location.

Two early intervention programs, Auditory Verbal Center and Georgia H&V have implemented teleservices for clients and other early intervention programs are conducting staff trainings to provide such services to families. EHDI strives to ensure that families receive the services they need during the pandemic.

During the COVID-19 pandemic, EHDI follow up services have been impacted differently across the state. Several follow up locations are currently closed for both outpatient rescreens and diagnostic services. In the metro area, the primary audiology providers continue to see infants as a priority and are pre-screening families before they come in for services. In other areas of the state, audiology and outpatient rescreen services are closed indefinitely. Care coordination services that are usually provided in the home are now provided over the telephone. There are partner agencies that are utilizing existing telehealth infrastructure, like the Auditory Verbal Center for teletherapy, and others who are investigating telehealth options for continued therapeutic services.

The ability to continue services to families and receive reimbursement for those services was made possible by the expansion of telehealth and telemedicine services policy guidelines by the Department of Community Health (DCH)/Medicaid. DCH telehealth guidance was updated on March 17, 2020 and included all qualified providers

permitted to furnish Medicaid-reimbursed telehealth services during the Public Health Emergency include physicians and certain non-physician providers such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners enrolled in Georgia Medicaid such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists and therapists may also deliver services within their scope of practice, consistent with Medicaid reimbursement rules, and in the category of service in which they are enrolled.

Related Legislation: The Coronavirus Preparedness and Response Supplemental Appropriations Act as signed into law by the President of the United States on March 6, 2020 allows states broad authority to waive limitations on settings where members are eligible to receive telehealth and where telehealth services can be delivered during the emergency. All members with access to video or telephone communication may receive services in their homes to reduce exposure to themselves and others. Under the emergency declaration and waivers, these services may be provided by professionals regardless of patient location. The services must meet established medical necessity criteria relevant to the procedure or treatment.

Qualified providers deliver services from distant sites. During the COVID-19 state of emergency, providers may deliver medically necessary services in various settings including their homes or other settings in which the privacy and confidentiality of the member can be assured. Qualified providers should continue to follow all applicable licensure rules specific to their profession. Services delivered from distant sites will be billed using the provider billing address associated with the enrolled Medicaid practice or facility. Claims must be billed using the associated procedure code, GT modifier and place of service code to indicate telehealth delivery.

Systems Building

Developing the system of services for CYSHCN through workforce development, family engagement, community partnerships and telehealth/telemedicine services are critical components of this year's efforts to better support the needs of CYSHCN and their families.

Workforce Development

The CMS program is committed to improving the partnership with families and has implemented the Family Engagement Learning Community for care coordinators supporting local district programs. The overall goal of the learning community is to shift the local public health district CMS program's level of engagement further down the continuum from direct consultation to partnership and shared leadership with families enrolled for services.

- Through an organized and facilitated learning community, the CMS workforce will gain knowledge, skills and resources to effectively prepare families to be partners in the health care decisions for their child. All 18 local public health district CMS programs participated in the twelve-month learning community. The learning community is comprised of four phases: Communication Phase: Aims to increase the number of strategies program coordinators use to share information with families and community partners.
- Family Activities Phase: Aims to establish and maintain opportunities for families to volunteer and connect with other families in the program. Advocacy/Leadership Training Phase: Aims to provide training for families on a variety of topics that promote leadership and advocacy skills for CYSHCN.
- Advisory Council Phase: Aims to establish a parent led advisory council for CMS, that will continue to enhance the program structure and quality of services.

The learning community has strengthened community partnerships and increased the number of activities provided for families which include; family appreciation, lunch and learns, miracle league baseball games, durable medical equipment fairs and conference attendance.

BCW is committed to increasing the percentage of infants and toddlers who are nearer or meet age expectations for positive social-emotional skills including social relationships. For the past several years, BCW providers including Service Coordinators and Special Instructors have received training and coaching to implement evidence-based practices for providing positive behavior supports to children identified with behavioral concerns.

Since 2015, there have been four Cohorts with more than twelve local BCW programs trained on the Pyramid Model: Promoting Social Emotional Competence. Pyramid Module One training (Family Coaching), 201 trained providers, Module two (Parents Interacting with Infants), 170 providers trained, and Module three the face-to-face Train-the-trainer, 111 providers trained. As a result of the Pyramid training, results show improved provider knowledge and confidence in using evidence-based practices. Self-Assessment survey results show the majority of trained providers use specific evidence-based practices most of the time or always to support parents and caregivers in improving their child's social emotional skills. Observation results show that most of the providers are using specific evidence-based practices in their practice. Survey results show that families have increased understanding and confidence in their capability to support their child's social-emotional development.

Related legislation: A legislative Social/Emotional study committee that was formed last session finalized its recommendations, suggesting that a multi-agency task force be formed to begin working on improving service options for young children with social-emotional needs. DCH made available as of April 1, 2020, reimbursable CPT codes for use by licensed Social Workers and Professional Counselors enabling them to provide and be reimbursed for much needed behavioral health services for young children.

Georgia Autism Initiative, in collaboration with the EAC, implemented the BCBA Training and Supervision Program which allows children with autism spectrum disorder to receive behavioral support services from supervised trainees completing their filed hours required to become BCBAs. This initiative has provided field experience for approximately 12 professionals pursuing a behavioral health national certification. Approximately 200 children have received behavioral support services through this initiative.

The EHDI program has implemented two learning communities within the Augusta and Athens health districts to educate providers about the importance of meeting the 1-3-6 EHDI benchmarks (screen for hearing loss before one month of age, diagnose hearing loss before three months of age and enroll in early intervention programs before six months of age) and promoting care coordination in their district. Learning community members include DPH staff, audiologists, family members of children who are deaf or hard of hearing, hospitals, early intervention providers, and medical home providers. Learning Communities are targeting areas for improvement of service provision specific to their district based on the feedback received from the members and from performance measures shared by the state EHDI program.

Related legislation: As a result of Act 462, it is easier for the EHDI and Part C programs to work more collaboratively with DECAL and the DOE to monitor and strengthen the systems that support early identification, intervention, language development, academic achievement for D/HH children across the continuum of service they receive from birth to third grade.

Family Engagement

The Parents as Partners project was implemented to enhance and further support the system of care for CYSHCN. The CMS and BCW programs partners with P2P, Georgia's Family to Family Health Information Center, to implement the Parents as Partners Project. Parents as Partners are parents of a child or youth who has a special health care need and provide support to other parents who have children with special health care needs as well. The Parents as Partners are paid as part-time employees of P2P and support local district child health programs and

private pediatric medical practices. Parents as Partners provide information & resources, emotional support, and coordinate free training opportunities for parents served at their site.

Since the initiation of the project, there have been 17 Parents as Partners trained and supporting families with children and youth with special health care needs. The most recent Parent Partner was hired to serve a community-based organization supporting the refugee/immigrant population in Clarkston. The partnership with the Refugee Health section provided an opportunity to discuss the early intervention needs of the population and strategies. The Parent Partner along with ongoing stakeholder engagement and training opportunities offers help to better support the refugee/immigrant population.

P2P also maintains the Statewide Central Directory database and hotline funded by the CMS and early intervention programs and houses approximately 6,000 resources. The Directory allows users to search for information and referral resources or one on one assistance over the phone for families of children ages birth to 26 with developmental delays, disabilities and chronic health care conditions.

EHDI maintains strong collaborative ties with the family to family support program, the Georgia Chapter of H&V. EHDI contracts with H&V to provide support and facilitate care coordination through two of their programs: Guide By Your Side and Advocacy and Support Training. H&V leaders are included on the EHDI stakeholders/ advisory committee at state and district levels, are invited to review educational materials prepared for families, are enlisted to encourage families to seek follow-up services when their baby does not pass the newborn hearing screening, and are funded to attend the annual EHDI meeting sponsored by federal grants.

NPM 12: Transition to Adult Care for All Children

Health Care Transition Projects

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

Outreach and awareness activities geared towards youth, families and community stakeholders

In partnership with P2P, youth and parent/caregivers have access to annual workshops on preparing for the transition from pediatric to adult model of care. The curriculum used to facilitate these workshops are adapted from the Waisman Center and has accompanying workbooks for families and youth to document their transition goals as well as activities to help youth practice independent health care skills such as setting appointments, scheduling transportation and filling prescriptions. Six workshops in English and Spanish are funded through the contract with P2P. Due to COVID-19, only two face to face workshops have been provided to families and youth, however, a contract extension was approved allowing P2P to facilitate the remaining workshops virtually.

To assist with efforts in educating the public on transition, the CMS program has revamped the DPH transition from pediatric to adult care webpage. The new webpage has material targeted towards families, youth/young adults and professionals. With questionnaires and links to feedback surveys incorporated throughout the webpage to assess transition readiness and satisfaction with the transition information presented on the site. There is also the collection of transition materials specifically developed for families and youth. These materials are marketed at annual outreach events such as health fairs, expos, family nights and conferences and are now hosted on the revamped webpage.

The CMS program has also partnered with the Adult Disability Medical Healthcare to provide annual trainings to families on how to support the transition needs for youth and young adults with intellectual and developmental

disabilities. In response to the COVID- 19 pandemic, a virtual discussion was offered to families to provide strategies on how to respond and support their children's behavioral challenges while at home and away from their normal school routines. The program was also able to provide a virtual support group discussion for young adults with developmental disabilities on tips to stay healthy, resources available, how to process thoughts and feelings related to physical distancing and relieving anxiety due to COVID-19.

Training opportunities for health care professionals

Through continued partnerships with the Georgia Academy of Family Physicians and the Georgia Chapter of the American Academy of Pediatrics, the CMS program provides annual health care transition training opportunities to pediatricians, family physicians and pediatric nurse members.

The following trainings are offered during the current year:

- Transforming Your Health Practice into an Adolescent Centered Medical Home-Family Physicians Fall Conference
- How to Break Up with Your Adolescent Patients Gently- Ground Rounds
- It's You, Not Them- Grand Rounds
- Demystifying Health Care Transition: The 6-Step Program for Family Physicians-Family Physicians Virtual Summer Conference
- Healthcare Transition for Adolescents and Young Adults with Autism-Family Physician Webinar
- Patient Privacy in Considerations in Family Practice-Family Physicians Webinar
- Achieving Successful Healthcare Transitions Despite a Pandemic-Pediatricians

Trainings are offered via face to face encounters at the annual fall and summer conference meetings as well as via webinar. During this reporting period, there will be five training opportunities provided with approximately 300 attendees.

Implementation of health care transition protocols and standards in public and private health care settings

The CMS program's efforts to enhance transition planning for enrolled families and youth has been an ongoing process. CMS utilized Got Transition's Six Core Elements of Health Care Transition principles and guidance to revamp the policies and procedures which created a roadmap for care coordinators to effectively support youth/young adults and their parent/caregivers. To ensure implementation of the new policies and procedures, the program's care coordinators receive ongoing training, coaching and monitoring to effectively work with families and youth/young adults with special health care needs.

About 74 percent of transition aged youth in the program receive ongoing transition planning and preparation.

During the current reporting period, the program has made strides to address identifying adult providers for young adults to transfer to an adult model of care. About 20 percent of the young adults 18 years of age and older enrolled for services have transferred to an adult model of care. There are not many adult providers that are available to care for young adults with special health care needs across the state. Identifying adult providers for young adults with special health care needs is a major obstacle and the program provides as many resources as possible. Resources shared include community clinics, not for profit clinics, federally qualified health centers, Medicaid services for adults, prescription assistance programs and adult services available in the health departments.

The CMS program also supports and provides funding to the Adult Disability Medical Health Care (ADMH) which is a non-profit organization that serves adults with intellectual and developmental disabilities. ADMH services are based on the patient centered medical home model that provides coordinated, comprehensive, compassionate care within a framework that focuses on the needs of the patient. The partnership with ADMH began in 2016 and during that time has increased the number of funded transition clinics from three to twelve annually. On an annual basis, more than 120 individuals are served. ADMH is housed within a family physician practice and transition clinics are supported by several disciplines, which includes; family physicians, behavioral analyst, clinical social worker, medical assistant and family/patient advocate. The number of physicians supporting the transition clinic has also grown from two to four physicians, which has made an incredible impact on the ability for the clinic to serve more patients.

CMS has worked closely with ADMH to incorporate telehealth services in their standard of care. DPH provided telehealth technology and training to ADMH. The program is using the technology for program planning and connecting with the behavioral analysts for consultation services. With the impact of COVID-19, the ADMH telehealth services ramped up and the team is providing their comprehensive transition clinic visit remotely with patients in their home. ADMH has also connected with a psychiatry provider for telehealth consultations to add to their comprehensive visit. ADMH's capacity to serve the community and individuals with developmental disabilities has grown considerably over the years and their model of care proves to be effective, compassionate and supportive.

SPM 2: Improve Access to Specialty Care for CYSHCN

In the current year, CMS partnered with health care providers and community-based resources to coordinate care for CYSHCN and their families. The CMS program used telehealth and telemedicine to provide developmental and genetic services, asthma-management, as well as endocrinology, nephrology, pediatric neurosurgery, pulmonology and sickle cell follow-up care. As the presentation/origination site, the CMS program was able to facilitate reimbursement with appropriate Medicaid telehealth billing codes.

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

The EHDI program is also working to address provider shortage issues. A large geographical area of the southern portion of the state does not have access to audiologists with the expertise and instrumentation necessary to perform hearing assessments for infants. In effort to reduce some of the health care disparities, Georgia EHDI and audiologists at CHOA have implemented a tele-audiology program at 2 facilities for providing hearing assessment services for infants under 4 months of age who referred their newborn hearing screening. Waycross and Valdosta health districts now have personnel on site trained to connect babies and their families to the skilled pediatric audiologists at CHOA on monthly schedule.

The BCW program's teleintervention pilot program began more than a year ago in the Waycross health district. Teleintervention offers an opportunity to connect therapy providers with their clients in their home via telemedicine. This pilot project is currently serving families with physical and speech therapy via telehealth. This pilot is an effort to address the shortage of therapeutic providers available to many families needing early intervention services, especially in the rural areas of Georgia. The project continues to focus not only on service delivery availability but also how to incorporate providers into the team structure remotely. With the impact of the COVID-19 pandemic, the pilot teleintervention program has expanded to all providers within the BCW network and to all 18 public health

districts. BCW has successfully trained over 1,000 providers to provide teleintervention.

Children with Special Health Care Needs - Application Year

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

NPM 11: Medical Home

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

Strategies:

- 1.1 Expand the use of telehealth technology to improve access to audiological and early intervention services for children and youth with special health care needs.
- 1.2 Facilitate efforts to educate families about telehealth as an option for care.
- 1.3 Provide ongoing evaluation of the Department's telehealth network to ensure pediatric specialty services meet the needs of families and patients.
- 1.4 Develop and implement a quality improvement plan for Title V's Children and Youth with Special Health Care Needs program to identify opportunities in which telehealth technology may be used to improve medical home access.

The CYSHCN program will continue to ensure children with chronic and complex medical needs have access to affordable, family-centered, continuous, and coordinated quality health care. In counties which are considered rural and there is limited access to pediatric subspecialty care, the CYSHCN program will utilize the DPH's robust telehealth/telemedicine infrastructure to provide access to specialty clinical care. With more than a decade of experience with partnering with pediatric healthcare systems, university systems, and private specialty providers, the CYSHCN program will coordinate pediatric sub-specialty care for seven telemedicine clinic sites and serve more than 700 families annually. Telemedicine specialty care types includes genetic testing, diagnostics and counseling, sickle cell follow up care, and endocrine, pulmonology, pediatric neurosurgery and nephrology services.

To increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home, the CYSHCN program will improve access to timely and affordable diagnostic evaluations and treatment services for children with special health care needs. The program will continue to monitor and increase the existing tele-audiology and tele-intervention pilot programs currently provided in select public health districts. CYSHCN will utilize existing partnerships with community-based organizations and physician groups to promote education and awareness of telehealth opportunities with families as well as continue to monitor and evaluate the satisfaction of telemedicine services provided to families across child serving programs. The program will partner with DPH's Office of Quality, Performance, & Accreditation to identify additional opportunities for the CYSHCN program to utilize telehealth for improved coordination of care for youth and their families, enhanced collaboration with physicians, pediatric specialists, and interventionists and develop a streamlined process for collecting and reporting statewide telehealth/telemedicine initiatives supporting children and youth with special health care needs.

Priority Need: Improve Systems of Care for CYSHCN

NPM 12: Transition to Adult Care for All Children

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

Strategies:

- 1.1 Develop and implement a health care transition quality improvement and evaluation plan to assess the effectiveness and efficiencies of the Department's health care transition program activities that impact youth and families.
- 1.2 Provide technical assistance and guidance on health care transition planning for care coordinators supporting the Title V Children and Youth with Special Health Care Needs program.
- 1.3 Implement condition specific transition planning protocols for adolescents enrolled in the Title V Children and Youth with Special Health Care Needs program.
- 1.4 Provide educational opportunities for youth and families to increase their knowledge on health care transition planning services and resources.

Children's Medical Services

Strengthening the system of care for youth and young adults transitioning from a pediatric to an adult model of care will continue to be a priority for DPH. Strategies will not only enhance transition services offered to youth and families enrolled in the state's CYSHCN program but also set the stage for statewide transition services transformation across multiple systems of services.

The CYSHCN Program will work diligently to increase the number of youth and young adults enrolled for services that transition to an adult model of care by providing ongoing technical assistance to local district CMS programs on engaging and partnering with local adult providers that serve as potential resources to link youth and young adults to continued care. Continued education to care coordinators will be provided on local community resources that will aid in youth/young adults' transition to adult services and educational opportunities to youth and families on health care transition preparation and planning will be promoted. Focus will be placed on identifying and developing additional opportunities to use technology to reach individuals in remote and rural areas. The program will continue monitoring and the evaluation of CMS health care transition program activities to ensure youth and young adults and their families are satisfied with services and their transition needs are being met. CYSHCN will utilize existing medical condition specific transition planning protocols to better prepare the youth and young adult and transferring adult provider for the move from pediatric to adult care.

The CYSHCN program will increase the number of community stakeholders that work to implement health care transition processes and procedures for youth and young adults with or without special health care needs within their respective disciplines by establishing a diverse and collaborative health care transition advisory group to direct and lead efforts to support statewide transition services transformation activities. CYSHCN will engage with and utilize subject matter experts representing various health care, community and family support arenas to assess, strategize and lead workforce development and training, communications, outreach and awareness, youth and family support and program eligibility and service delivery initiatives. The program will partner with adolescent health programs within DPH to implement best practices that support health care transition planning for youth and young adults with or without special health care needs. Continued training opportunities to medical providers and community partners on implementing the Six Core Elements of Health Care Transition will be promoted and a health care transition communications plan will be developed and implemented to share targeted messaging for transitioning youth and young adults with youth and their families, medical partners, community-based organizations and state agencies.

Priority Need: Promote Oral Health to All Populations

NPM 13: Preventive Dental Visits

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

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

Other CYSHCN Programs

Babies Can't Wait

BCW will continue to serve children birth to three with developmental delay and Category One chronic conditions. BCW will continue to focus on increasing provider capacity and is working on addressing strengths and challenges within the program. BCW is redefining the program infrastructure and identifying areas to target for the upcoming year.

BCW will continue to revise and clarify policies and procedures related to consistent implementation of the Part C program across public health districts. As policies are updated, related trainings will be developed and delivered to district staff and contractors to ensure understanding of program requirements and expectations. A BCW Training & Support Coordinator will assist the program in developing and delivering a state-wide training program for BCW District and Contract providers.

Transition between Part C and Part B will continue to be targeted effort. BCW will continue to work with Part B partners to ensure a consistent understanding of the transition requirements between programs. BCW, Part B/619, and Head Start have launched transition forums across the state, allowing opportunities for BCW Districts, LEAs and Head Start programs to come together to discuss transition expectations and local implementation plans.

BCW has implemented a data monitoring plan across the districts that will continue to ensure that districts are regularly reviewing their program data so that the APR reporting process will become more streamlined and efficient and accurate.

Georgia Autism Initiative

In the coming year, the Autism program will continue to improve and increase early identification and screening for ASD in children. Increasing early identification of autism and other developmental disabilities will help to improve outcomes for children by connecting them to early intervention services and supports. The program will implement statewide screening, evaluation and treatment for children and youth with ASD.

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

MCH will maintain its partnerships with local programs and agencies to meet goals and objectives. The following is a list of internal and external partners:

- Babies Can't Wait (Part C Early Intervention Program)
- Children's Medical Services (State Children with Special Health Care Needs Program)
- Children First (Single point of entry for child health services in public health)
- Georgia Department of Community Health (Medicaid)
- Georgia Department of Behavioral Health and Developmental Disabilities
- Georgia Department of Education
- Georgia Chapter of the American Academy of Pediatrics
- Georgia Academy of Family Physicians
- Centers for Disease Control and Prevention
- Georgia State University
- Marcus Autism Center
- Emory Autism Center

MCH will continue to utilize quantitative evaluation methods to examine the achievement of goals in relation to the medical provider's pre-knowledge and skills, as well as the effectiveness of the learning outcomes. Referrals will continue to be tracked from participating practices to Child Health programs for children who screen positive for developmental delays. Qualitative evaluation methods will also examine the process of the educational interventions.

Early Hearing Detection Intervention

The EHDI program will continue the work that was enhanced by Legislative Act 462 bringing into focus the academic landscape for children who are deaf or hard of hearing. EHDI and Part C programs will continue to work more collaboratively with DECAL and the DOE to monitor and strengthen the systems that support early identification, intervention, language development academic achievement for D/HH children across the continuum of service they receive from birth to third grade.

EHDI will continue to collaborate with key stakeholders to enhance the quality and timeliness of the EHDI system and continue to promote activities that result in access to needed resources and interventions to promote language acquisition and optimal social, emotional and cognitive development for children who are deaf or hard of hearing. To that end, EHDI will continue to engage two family support programs through Georgia Hands and Voices; Guide By Your Side and Advocacy Support and Training. Parent guides are assigned to each of the public health districts and work closely with district EHDI coordinators to identify families who may benefit from peer support. The EHDI program will also continue to support Georgia PINES Deaf Mentor program. The Deaf Mentor program provides families who have children with hearing loss with family-centered, home-based, and curriculum-led early education, focusing on visual communication, American Sign Language, and Deaf Culture.