Maternal and Child Health Services Title V Block Grant

Georgia

FY 2021 Application/ FY 2019 Annual Report

Created on 9/15/2020 at 12:50 PM

Table of Contents

I. General Requirements

I.A. Letter of Transmittal

GEORGIA DEPARTMENT OF PUBLIC HEALTH

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

2 Peachtree Street, NW, 15th Floor
Atlanta, Georgia 30303-3142

dph.ga.gov

September 15, 2020

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

Grantee Name:	Georgia Department of Public Health
Grant Name:	Maternal and Child Health Services Title V Block Grant
Funding Opportunity Number:	HRSA-20-001

Dear Dr. Warren,

This is a letter of transmittal informing you that a grant application requesting funding for the FY 2021 Maternal and Child Health Services Title V Block Grant has been submitted from the Georgia Department of Public Health.

For questions related to the grant, please contact Jeannine Galloway, Maternal and Child Health Director. Ms. Galloway can be reached at 470-303-0236 or Jeannine.Galloway@dph.ga.gov.

Sincerely,

Jeannine Galloway, MPH
Maternal and Child Health Director
Title V Program Director
Georgia Department of Public Health

Lee Wright
Chief Financial Officer
Georgia Department of Public Health

We protect lives.

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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

The 2021 Application/2019 Annual Report provides an overview of MCH's recent successes and achievements, as well as a summary of the Five-Year Needs Assessment. The needs assessment resulted in identifying priority areas and a five-year plan with objectives and strategies designed to meet those needs. MCH activities will continue to be coordinated across funding sources, state agencies, and local providers relying on partnerships, shared measurement, and data to track the impact and effectiveness of services, activities, and strategies. MCH will continue to address the goal of establishing a foundation of health early in life by investing in and fulfilling its commitment to improve the health of women, infants, and children, including those with special health care needs. In addition, DPH will continue to address social determinants of health and improve health equity.

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

MCH Advisory Council

During the reporting year, MCH assembled the MCH Advisory Council to provide support and guidance to the Title V program for the purpose of promoting and improving maternal and child health in Georgia. The Council convenes quarterly and brings together several organizations and groups with a broad range of expertise to address and improve health outcomes for women, infants, children, and families. The Council serves as a conduit for the exchange of information and advises on progress, facilitates private and public sector support for improving health outcomes and helps focus efforts among partners, recommends collaborative initiatives, and reviews existing and proposed Title V projects. Council members include representatives from state, local, non-profit, academic, health care, and professional organizations who have expertise in areas related to MCH, such as nursing, nutrition, parenting, pediatrics, family practice, child protection, family development, district and state health departments, and a parent/family member representative.

COVID-19

With the emergence of the COVID-19 pandemic, DPH is working closely with the Center for Disease Control (CDC) and state partners to respond to the outbreak. The goal is to quickly identify cases of COVID-19 and take the appropriate public health action to reduce its spread and protect the general public. MCH programs have developed responses to ensure continued and appropriate services.

Population needs and priorities

Across all MCH programs, implementation efforts include activities specific to health equity, community engagement, performance management, quality improvement and evaluation. Title V efforts are focused on health equity and are integral in assuring that populations experiencing the greatest health disparities receive equitable and needed services. Progress on each priority is outlined below:

Women/Maternal Health: Due to the critical need to reduce maternal mortality, MCH focused on efforts to impact this need. In 2011, the maternal mortality rate (MMR) was 28.7, which on average was four times higher in Black, non-Hispanic women (39.1 deaths per 100,000 live births) than White, non-Hispanic women (9.6 deaths per 100,000 live births). These staggering rates and the underlying racial and ethnic disparities served as the impetus for the creation of a statewide Maternal Mortality Review Committee (MMRC) in 2012. Coordinated by the Georgia Obstetrical and Gynecology Society (GaOBGYN) with funding provided by MCH, the committee reviews cases to determine causes of death, and provides recommendations for maternal mortality reduction. As of 2019, the MMRC has reviewed 349 maternal deaths in Georgia from 2012 to 2015. Of the 349 maternal deaths reviewed, 145 were determined to be pregnancy-related deaths. There were 28 pregnancy-related deaths per 100,000 live births. Two-thirds of pregnancy related deaths were determined to be preventable.

Perinatal/Infant Health: Infant mortality is the single leading indicator of the overall health and well-being of a population. In 2018, Georgia's infant mortality rate (IMR), per 1,000 live births, was 7.1, compared to the national rate of 5.8. In the 2015 needs assessment, stakeholders identified infant mortality and the need to reduce maternal substance use as a state priority. The major evidence-based strategies recommended nationally for addressing infant mortality were regionalized perinatal care, safe sleep initiatives, and improving breastfeeding rates. In 2018, DPH launched an initiative to designate hospitals according to the appropriate level of maternal and neonatal care provided. DPH continues to develop strong partnerships around the coordination of Regional Perinatal Centers (RPC) by providing information and education to delivering facilities, staff, and women to ensure they deliver at the appropriate facility in instances where mother and baby may require specialized care. In 2018, the Neonatal Subcommittee of the Georgia Perinatal Quality Collaborative (GaPQC) developed a baseline survey for birthing hospitals to determine current practices around Neonatal Abstinence Syndrome (NAS) diagnosis and treatment and to explore gaps and opportunities for maternal interventions. Increasing breastfeeding rates and eliminating Sudden Unexplained Infant Deaths (SUID) are ongoing MCH initiatives which are integral parts of Georgia's strategic plan to reduce infant mortality. Georgia has 16 baby-friendly designated birthing hospitals commited to creating a culture of breastfeeding. The Georgia Safe to Sleep initiative has 100 percent of the 77 birthing hospitals providing parents with safe infant sleep education prior to hospital discharge and 100 percent of hospitals reported having a safe infant sleep policy in place or in progress. To strengthen community awareness and involvement in reducing infant mortality, MCH developed the Improving Birth Outcomes Initiative to develop strategies to reduce premature births and infant mortality among all infants, and specifically black infants, by addressing the correlations between race, equity, infant mortality and pre-term birth.

Child Health: Promoting developmental screenings and physical activity were priorities for Child Health in the 2015 needs assessment. The Children 1st program facilitated trainings for the Ages and Stages Questionnaire (ASQ) developmental screening tool, developmental milestones, and Child Health Referral System to more than 2,300 staff from hospitals, public health programs, community organizations, daycare centers, head start programs and primary care offices. Addressing obesity requires a multi-level approach, involving both policies and activities in schools. In a partnership with the Georgia Department of Education (DOE), MCH works intensively on obesity prevention in elementary and early learning school settings. These efforts include the Georgia School Health and Physical Education (SHAPE) Network, which provides trainings and resources for school district staff and administrators on incorporating physical activity into daily school activities.

Adolescent Health: The Adolescent Health program addresses risk and protective factors for children ages 8-17 at the local, regional, and state levels and provides evidence-based and informed interventions and strategies to impact health outcomes. The Adolescent Health and Youth Development (AHYD) program aims to empower youth with the knowledge and skills to strengthen relationships, increase community awareness and engagement to solve adolescent related issues. SHAPE implements the Power Up for 30 (PU30) program in middle schools to increase physical activity.

Children and Youth with Special Health Care Needs (CYSHCN): CYSHCN priorities are to improve systems of care for CYSHCN with an emphasis on educating providers, families, and adolescents on the health care transition from pediatric to the adult care process as well as the expansion of DPH's Telehealth infrastructure to support specialty clinic services. The Children's Medical Services (CMS) Program partners with health care providers, state agencies, and community organizations to coordinate health care service and supports for eligible CYSHCN and their families. During the reporting period, 74% of transition aged youth in the program receive ongoing transition planning and preparation.

Cross-Cutting/Life Course: Oral health is a priority for MCH and a strategic focus to improving health outcomes for women, infants and children. The Oral Health program provides training to organizational stakeholders and provides services including fluoride varnish, dental sealants, prevention education and comprehensive restorative treatment. School-based prevention programs targeting high-risk children, teledentistry, and tobacco prevention programs to pregnant women are provided. Oral Health conducts training and presentations on best practices and the importance of oral health in all MCH domains at the local, state, and national levels.

Needs Assessment Summary

In accordance with MCHB guidance requiring states to conduct a needs assessment every five years, Georgia conducted a comprehensive needs assessment that included a thorough review of available quantitative data and collection of qualitative data among members of the community and key leaders in MCH. The needs assessment provided an opportunity to report on health status, identify priority health needs, adopt measures to monitor improvement, enhance partnerships and engage new partners for MCH programs across the state. Eight priority needs were identified:

Prevent Maternal Mortality

Maternal Mortality will be continued as a priority in the 2020 needs assessment. The MMRC has provided the state with rich data on factors leading to maternal death. The strategies implemented over the next five years to address this need will center around continuing MMRC activities to ensure that all maternal deaths are identified accurately. Promoting well-women visits and the use of Long Acting Reversable Contraceptives (LARC) for women of reproductive age will improve the overall health status of women before they enter pregnancy and prevent maternal death.

Prevent Infant Mortality

Preventing infant mortality will be continued as a priority in the 2020 needs assessment as Georgia's infants continue to experience a higher rate of mortality than the national average. Efforts to strengthen appropriate perinatal care, breastfeeding and safe sleep practices will continue as new opportunities to create partnerships through a statewide infant mortality prevention group, improve community education and awareness, and expand qualitative and quantitative data collection efforts will be developed.

Promote Developmental Screenings Among Children

Developmental screenings will be continued as a priority in the 2020 needs assessment due to the continued need in Georgia. The assessment identified the importance of continuing the priority area to ensure continued access and design creative service delivery approaches that include online screening opportunities to improve access and expand reach.

Increase Bullying and Suicide Prevention

Bullying is an emerging need identified as a new priority in the 2020 needs assessment. Suicide is the second-leading cause of death behind unintentional injury for children ages 10-17 in Georgia. MCH will expand partnerships and fill an important gap in public health work being done to address this issue.

Increase the Number of Children With and Without Special Health Care Needs Who Have a Medical Home

The 2020 needs assessment identified the need to create the medical home priority due to the importance of a patient-centered medical home to provide accessible, comprehensive, family-centered, coordinated, and culturally effective medical care. It is advantageous for CSHCN as they require coordination of care between providers and this priority will help ensure continuity of care.

Improve Systems of Care for CYSHCN

Georgia will continue working on the priority to improve the overall system of care for CYSHCN to ensure system navigation and service delivery. MCH will address all aspects of a well-functioning system for CYSHCN, with a focus on health care transition to adult care. MCH will focus on ensuring that all children in CMS, the state program for CYSHCN, have a satisfactory transition plan and are linked with a medical home prior to discharge from the program.

Promote Oral Health Among All Populations

Oral health continues to be identified as a priority affecting all populations. Increasing oral health care utilization during pregnancy can impact the likelihood that the child will receive appropriate oral health care. MCH will continue to promote oral health among all populations by continually supporting the community water fluoridation program and specifically focusing on outreach to pregnant women and children as well as providing oral health care and education to children and adolescents.

Increase Father Involvement Among All Populations

The 2020 needs assessment identified the need to create a priority to increase father involvement among all populations. Research shows that father involvement is important during the prenatal period and every stage in the growth and development of a child. Targeting approaches to best engage fathers can improve maternal and birth outcomes and provide a valuable contribution in helping children and families to thrive. Identifying this strategy as a priority will help ensure enhanced MCH involvement throughout this area.

III.A.2. How Federal Title V Funds Support State MCH Efforts

Title V MCH Block Grant funds provide critical infrastructure, support, and resources to the state's overall MCH efforts. Federal funding supports analytic capacity to monitor and describe health and wellbeing, guide programs, and inform evidence-based practices to promote optimal health. Preventive services, policy, educational initiatives and partnerships with communities, government, and academia work to advance common goals and improve access to medical and supportive services to improve health. Federal funds complement MCH efforts supported by the state and creates partnerships that support access to quality health care for mothers and children and CYSHCN.

Title V funds support diverse initiatives such as breastfeeding education for health care providers, newborn screening, and increased access to medical and dental care services. Federal funds coupled with the state flexibility under the block grant have provided Georgia the opportunity to support a wide range of strategies to reduce morbidity and mortality such as reviewing maternal deaths to learn more about causes and prevention and launch initiatives through telehealth expansion and increased access to evidence-based home visiting and early intervention programs. The federal-state partnership allows for linkages and collaboration with local agencies to provide statewide coverage and assurance of access to women's health care services, preventive and primary child health care services, and services to CYSHCN.

III.A.3. MCH Success Story

MCH created the Fatherhood Initiative (FI) as a resource to increase access and capacity of fatherhood programs in Georgia, develop messaging for fathers and create a "Father-Friendly" referral system that improves fathers' access to services. Through a partnership with the National Fatherhood Initiative (NFI), MCH implemented the Father Readiness Network Assessment (FRNA) for staff across 21 Home Visiting Local Implementing Agencies (LIA) to assess the readiness of each LIA to engage fathers in programs and services. Results from the FRNA were evaluated in four areas: Leadership, Organizational, Program Development, and Community Outreach. As a result, the FI is leading efforts that advise sites in creating action plans to increase father readiness in the four areas. The LIAs are creating spaces for fathers that are welcoming, display appropriate messaging, and make available male-focused literature. LIA's are increasing staff's ability to engage fathers, hiring males for service delivery, and hosting targeted activities such as safe sleep education, early learning literacy, and nutrition. MCH was awarded the Morehouse School of Medicine T^x funding to support efforts in identifying the strengths and gaps in fatherhood services. The project involves two Healthy Start sites, WIC, and Grady Hospital's Centering Pregnancy Program and will use community-based participatory approaches to assess the needs and challenges of African American fathers when accessing MCH services.

III.B. Overview of the State

Georgia, known as the “Peach State”, has a diverse and growing population, robust political landscape, and a slow growing health care environment. The distinct health care environments in rural Georgia and the urban metropolitan area are a unique challenge for the Title V MCH Program. The growing population amplifies challenges that arise from the political landscape, health care environment, economy and/or sociocultural context.

Geographic Description

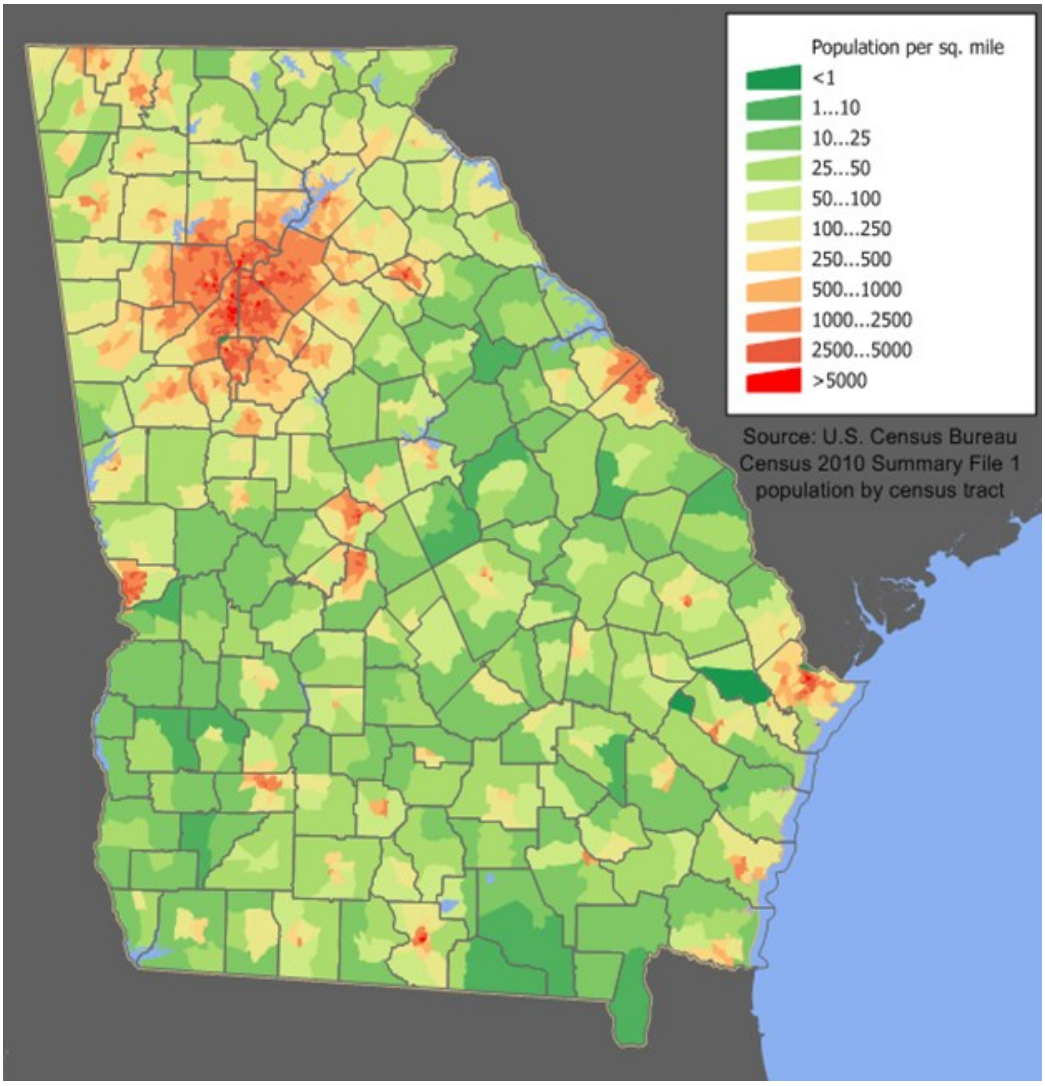
Georgia is located on the southeastern Atlantic coast of the United States whose terrain spans coastal beaches, farmland, and mountains. It is bordered on the south by Florida; on the east by the Atlantic Ocean and South Carolina; on the west by Alabama; and on the north by Tennessee and North Carolina. The highest point in Georgia is 4,784 feet; the lowest point is sea level. Georgia is ranked 24th in terms of land size and is the largest state geographically east of the Mississippi River.

Urban and Rural Counties

Of Georgia’s 159 counties, there are both urban and rural located throughout the state. The Census Bureau defines two types of urban areas: urbanized areas of 50,000 people or more, and urban clusters between 2,500 people and 50,000 people. All other counties are considered rural. Of the 159 counties in Georgia, 124 are designated as rural by the Georgia Rural Development Council. There are 20 smaller cities and urban areas with populations above 50,000. Most the state’s rural counties are in the southern half of the state.

According to the 2010 census, the most recent census available, there are 15 Metropolitan Statistical Areas in Georgia: Albany, Athens-Clarke County, Atlanta-Sandy Springs-Roswell, Augusta-Richmond County (GA-SC), Brunswick, Chattanooga (TN-GA), Columbus (GA-AL), Dalton, Gainesville, Hinesville, Macon, Rome, Savannah, Valdosta and Warner-Robins. [4] The largely rural makeup of the state provides many challenges, and opportunities, to offering adequate health and social services to all Georgia residents. Due to the large number of counties being designated as rural, access to health care services is challenging, and as such it is essential for DPH to accommodate the needs of the rural population. DPH provides an alternative approach in meeting the needs of Georgia’s rural citizens through innovative strategies such as telehealth services that increase access to health care providers and services. The following map generated by the US Census Bureau based on population data for 2010 depicts the urbanized and non-urbanized areas in Georgia.

Figure 1: Urbanized areas in Georgia



Population

According to July 2019 population estimates from the US Census Bureau, Georgia is the eighth most populous state in the nation with an estimated population of 10,617,423.[38] Since 2000, Georgia's population has increased 25 percent with the population first surpassing 10 million residents in 2013. This growth has resulted in a fundamental shift in Georgia's population changing the state from a largely rural area with urban centers to an urban state with rural areas. Rural Georgians have health experiences that contrast their urban counterparts including, travelling longer distances to seek medical care and higher rates of chronic health conditions.[18] Georgia is the 14th fastest growing state in the nation and is the 7th highest among states with the largest numeric population increase.[17] It is estimated that Georgia's population will increase to 11.8 million by 2030.[10] As with any population growth, there are increasing demands on state and local governments to provide necessary services, including health and social services.

Atlanta, the state capitol, is the economic, cultural and demographic center of Georgia. The Atlanta metropolitan area, which includes 29 counties, had the nation's fourth highest population growth from 2017 to 2018 with an estimated population of more than 5.9 million. Metro-Atlanta contains about 57 percent of Georgia's entire population.[39] Approximately 6.2 percent of residents are under age five, 23.8 percent are under the age of 18 and 13.9 percent are over age 65. Females comprise 51.4 percent of Georgia's population. Georgia has the second-

highest LGBTQ percentage in the South with a population of roughly 4.5 percent and ranks 17th nationwide. An estimated 4.2 percent of Atlanta's metropolitan population is gay, lesbian, or bisexual.[40]

Georgia has shown dramatic increases in minority groups, which account for approximately 47 percent of the overall state's population. This trend in the demographic shift is expected to be sustained in the coming years and Georgia is projected to become a majority-minority state by 2028.[53] Currently, Black or African American is approximately one-third of the state's overall population and the largest minority group; this is approximately 2.5 times higher than the national average of 13 percent. Hispanic or Latino is the most rapidly growing minority group, comprising almost 10 percent of all Georgians. Persons of Asian descent are an additional four percent of the state's population.

Race/Ethnicity

In 2019, the US Census Quick Facts illustrated that 60.2 percent of Georgians were White, 32.6 percent were Black or African American, 9.9 percent were Hispanic or Latino, and 4.4 percent were Asian.[42] The number of Hispanics in Georgia doubled between 2000 and 2010, according to the most recent U.S. Census. The number of Asians nearly doubled, with the highest increases seen among Asian Indian, Korean and Vietnamese populations. Such a growth in diversity and population necessitates the availability of culturally competent health care, education and human services.[18]

Age and Gender

According to the US Census Bureau estimates in 2019, Georgia's population is younger compared to the U.S., with the 8th largest percent of population under 18 years old (23.6 percent). The median age in Georgia is 36.2 years of age, with a gender difference of 51.3 percent females and 48.7 percent males across the state. There are approximately 2.1 million Georgian women of reproductive ages (15-44 years old). In 2019, there were 126,250 births in Georgia.[42]

Immigration

Georgia's population is continually evolving with the immigration of foreign-born individuals that add to the racially and ethnically diverse population of Georgia. In 2019, it was estimated that one in ten Georgia residents is an immigrant, while seven percent of residents are native-born U.S. citizens with at least one immigrant parent. However, there has been an increase in naturalized citizens from 33.8 percent in 2010 to 43.6 percent in 2018.[19] In 2018, 1.1 million immigrants (foreign-born individuals) comprised 10 percent of the population. Georgia was home to 502,347 women, 493,737 men, and 67,989 children who were immigrants. The top countries of origin for immigrants were Mexico (22 percent), India (nine percent), Jamaica (four percent), Korea (four percent), and Guatemala (four percent).[19]

Immigrants in Georgia are concentrated at either end of the educational spectrum. More than a third (35 percent) of adult immigrants had a college degree or more education in 2019, while one-quarter (25 percent) had less than a high school diploma. In 2019, 23.2 percent of foreign-born residents had a high school diploma or GED with 16.9 percent attaining some college or their associate degree.[19] In 2019, 38.2 percent of foreign-born residents fell below 200 percent of the poverty level and 31.3 percent had no health insurance coverage.[19]

Language Proficiency

Over 13 percent of Georgia residents speak a language other than English.[19] Of the other languages spoken; Spanish is the most commonly spoken language at approximately 8 percent. Both other Indo-European languages, Asian and Pacific Island languages, account for approximately 2.5 percent, and the remaining 1 percent of residents speaks another language. Of those that speak a language other than English, 43 percent speak English less than very well.[19] These factors can have implications on the services offered to residents and may necessitate investment

in interpretation and culturally competent approaches to health care delivery.

Family Household Type

Children growing up in single-parent families typically do not have the same economic or human resources available as those growing up in two-parent families. Compared with children in married-couple families, children raised in single-parent households are more likely to drop out of school, to have or cause a teen pregnancy and to experience a divorce in adulthood. In 2017, according to the 2019 Kids Count data, 38 percent of Georgia's children lived in single-parent families. Children living in high-poverty areas decreased from 14 percent in 2012 to 13 percent in 2017.[45] The average household size was 2.6 and the average family size was 3.2.[16]

Educational Attainment

Public schools are the primary source of education in Georgia. In 2017, 64.6 percent of children attended a public nursery school and/or preschool while 35.4 percent attended a private nursery school and/or preschool. In 2017, 90.5 percent of students in Kindergarten to 12th grade were in public school and 9.5 percent were in private school.[19] According to the 2019 Kids Count Data, young children, ages three and four, not in a preschool program has remained at 50 percent over the past ten years. Fourth graders proficient in reading improved from 29 percent in 2009 to 35 percent in 2017. Eighth graders not proficient in math improved from 73 percent in 2009 to 69 percent in 2017 and high school students not graduating on time reduced to 19 percent in 2017 from 33 percent in 2011.[55]

Georgia's graduation rate continues to rise. The rate has increased by 12 percentage points since 2012. In 2019, Georgia's high school graduation rate increased, rising to 82 percent, an all-time high since the state began using the adjusted cohort calculation now required by federal law.[55]

Large racial and ethnic difference exist in postsecondary educational attainment in Georgia. About four in ten Georgians older than 25 have an associate or bachelor's degree. The share is closer to two in ten for Latino Georgians and three in 10 for African Americans. About six in ten Asian American and Pacific Islanders have an associate degree or above, the highest rate of attainment of any racial or ethnic group.[56]

According to the American Community Survey (ACS) of the U.S. Census Bureau, the median household income for Georgia was $55,679 in 2018, the latest figures available. Compared to the median U.S. household income, Georgia's median household income is $4,614 lower.[18]

Table 2. Median Household Income in Georgia and the US, 2008-2018

Year	Georgia	United States
2018	$55,679	$60,293
2017	$52,977	$57,652
2016	$51,037	$55,322
2015	$49,620	$53,889
2014	$49,342	$53,482
2013	$47,829	$52,250
2012	$47,895	$52,117
2011	$47,650	$52,306
2010	$49,605	$53,469
2009	$51,684	$54,541
2008	$55,027	$56,290

Poverty

Poverty is more prevalent in Georgia than in many states across the nation. According to the latest available data, in 2018, 14.3 percent of Georgians were living below the poverty line, compared with 11.8 percent for the U.S. overall. Over eight percent were below 50 percent of the federal poverty level (FPL) and 22.9 percent were living at less than 125 percent of the FPL. As of 2018, twenty-one percent of children in Georgia under the age of 18 live in poverty, which is an improvement from 25 percent in 2010. Poverty disproportionately affects race and ethnicity in Georgia. The poverty of Georgians living below the FPL based on race and ethnicity in 2018 was 20 percent, with 11 percent White, 29 percent African American or Black, 8 percent Asian and Pacific Islander, and 30 percent Hispanic or Latino.[19]

Health Equity and Social Determinates of Health (SDoH) Disparities

According to the 2019 Kids Count Data Book, Georgia ranked 39th in overall child well-being, 37th in economic well-being, 39th in health, 40th in family and community, and 34th in education. The annual Kids Count Data Book uses 16 indicators to rank each state across four domains – health, education, economic well-being and family and community – that represent what children need the most to thrive. Though Georgia's children and families still face many challenges, there are some promising trends for the state. When looking at outcomes such as maternal mortality, infant mortality, low birth weight, and preterm birth we see consistent trends based on race/ethnicity. Georgia's maternal mortality rate illustrates that Black, non-Hispanic women are three times more likely to die of pregnancy-related complications than White, non-Hispanic women. In 2018, racial disparities were also seen in infant mortality rates with a rate of 11.8 in Black, non-Hispanic or Latino infant deaths compared to a rate of 5.0 in White, non-Hispanic or Latino infant deaths under one year of age. The percent for Black, non-Hispanic or Latino low birth weight infants was 14.7 percent compared to 7.2 percent for low birth weight White, non-Hispanic infants. Premature births in 2019 occurred at 14.7 percent in Black, non-Hispanic women compared to 10.0 percent in White, non-Hispanic women.[57]

Economy

A vital component to Georgia's economy is the transportation system including the interstate highway system, Hartsfield-Jackson Atlanta International Airport, and the deep-water ports of Savannah and Brunswick.

Georgia has over 1200 miles of interstate highways which connect Georgia to neighboring states and the rest of the nation and help move workers from their homes to places of employment in the major cities. Three of the interstate

highways converge in Atlanta, making it, along with Hartsfield-Jackson Atlanta International Airport, the transportation hub of the southeast. Atlanta is one of only five cities in the nation to be served by three separate interstate highways. The construction of these interstate highways was instrumental in the booming growth of Atlanta in the latter part of the 20th century. The highways helped attract business, industry, and more transportation facilities to the Atlanta area.[39] These advantages have led to many global headquarters establishing headquarters in Atlanta including 16 Fortune 500 companies, 26 Fortune 1000 businesses and more than 450 Fortune 500 companies having a presence in the state.[42]

Georgia economic products can now reach approximately 80 percent of Americans overnight using the interstate highway system, while products coming into Georgia can reach Georgians in every part of the state just as quickly.

Two of the interstate highways- I-85 and I-285- are near Hartsfield-Jackson Atlanta International Airport. Hartfield-Jackson is one of the busiest airports in the nation. Business travelers and those visiting Georgia add enormous impact to Georgia's economy. Hartfield-Jackson also hosts the only Perishables Complex in the southeast- allowing for rapid movement of agricultural products. In addition, Hartsfield-Jackson is home to the Georgia Foreign Trade Zone, where Georgia companies can produce products at reduced cost, facilitating trade and increasing the overall competitiveness of companies doing business in Georgia. Combining all aspects of Hartfield-Jackson's effect on the regional economy of Atlanta, Georgia, and the southeast, it generates $23.5 billion on an annual basis. The deep-water seaports of Savannah and Brunswick are integral to Georgia's economy as they allow products to be sent via ship to all parts of the world, while allowing foreign products to come into Georgia. The port of Savannah handles approximately 80 percent of the material entering Georgia via ship and is one of the fastest growing ports in the nation. [39]

The film and television industry are other major industries adding to Georgia's economy. Georgia offers lucrative tax incentives for television and movies making the state a popular site for filming and production stimulating further growth. A little more than a decade ago, the state passed a tax credit that allowed productions to collect a credit of up to 30 percent of its budget, enabling studios to save money or increase their budgets. Producers also prefer the state's generally lower prices compared with California or New York, as well as the geographic diversity with cities such as Atlanta and many rural locations which offer a variety of settings. Georgia's film industry has continued to grow with 399 productions from July 1, 2018 to June 30, 20198 filmed in Georgia resulting in a record $2.9 billion invested in the state.[63] Film and television production in Georgia support more than 92,000 jobs and brings significant economic benefits to communities and families. Georgia had 455 qualified television and film production in 2018.[48]

Georgia has a rich, varied, and ongoing tradition of producing quality sports teams that enhance the economy. Atlanta is home to six professional sports franchises- the Braves (Major League Baseball), Hawks (National Basketball Association), Falcons (National Football League), Dream (Women's National Basketball Association), Atlanta United (Major League Soccer) and the recently added Big Peach (Major League Rugby).[47] Atlanta was home to NFL Superbowl LIII with more than 500,000 attending and more than 150,000 out-of-state visitors.[47] In addition to Atlanta's major league sports teams, minor league franchises are hosted by several Georgia cities. Augusta, Georgia is home to the Masters, professional golf's most famous and prestigious event. Atlanta Motor Speedway hosts one of NASCAR's biggest races each Labor Day weekend. Sports provide an economic boost for the city and remain a key revenue-generator within the tourism industry.[41]

Homelessness

In 2019 a total of 4,183 people in 152 counties (not including Atlanta), covering 96 percent of Georgia's geography, met the Housing and Urban Development's (HUD) definition for homelessness, a 13 percent increase from 2017. Fifty-four percent were unsheltered; the other 46 percent were in emergency or transitional housing. A larger

percentage of homeless families were sheltered, 92 percent, than unsheltered, and a larger proportion of individuals without children were unsheltered,73 percent, than sheltered. Child Only households represented less than one percent of the homeless population. Six percent of the estimated homeless population identified as veterans and seven percent identified as chronically homeless, defined as having a disability and length of homelessness of at least one year or experienced homelessness four times in the past three years. Domestic violence victims, mental illness, and substance abuse disorder were among the greatest populations represented.[58]

The homeless youth population, youth under the age of 24 with or without a child under the age of 18, represented eight percent of the total homeless population.[59] Also, in 2019, the city of Atlanta reported 3,217 homeless, a 4.5 percent overall increase from 2017. A total of 84.3 percent were over the age of 24.[60]

Insurance Status

Georgia's uninsured population rate rose slightly in 2019 to 13.7 percent giving Georgia the third-highest percentage of uninsured in the U.S. In 2018, there were 19.4 percent of women ages 15-44 uninsured in Georgia.[61] Six percent of Georgia's children are uninsured, making it the state with the 9th highest rate of uninsured children. The most recent data available show that among Georgians between 19 to 64, 19 percent are uninsured, ranking it the fourth highest in the nation.[11] Those that identify as Black and White have the highest percentage of being uninsured, 40 percent and 34 percent, respectively. Twenty-one percent of Hispanics are uninsured.[11] This is yet another disparity that further contributes to the delay in seeking health care, increased visits to the emergency room and poor health outcomes.

Medicaid provides nearly two million Georgians with vital health services, 92 percent of whom are children, elderly or disabled. Medicaid covers 1.3 million Georgia children and Georgians who live with disabilities. [62]

Health Reform

The Affordable Care Act, signed in 2010, went into effect in 2014. It is a state decision to participate in the Medicaid expansion or not, and as of 2019 Georgia will not expand. More than 460,000 people enrolled in plans for 2019 during open enrollment, a drop of more than 20,000 from 2018.[3] Four insurers offer coverage in 2019 through Healthcare.gov. Average rate increases for plans in Georgia's individual market are less than four percent for 2019.[3] DPH will continue to adapt to the changing health care landscape to promote the health of women and children.

Title V Priorities

Considering the geographic and demographic landscape in Georgia, this is a critical time for the Title V program to set priorities. The process used by the Title V Director, MCH Staff, partners and stakeholders for determining the needs and priorities of the program is multifactorial. The five-year needs assessment is used to evaluate priorities and efforts are made to align with priorities of the Governor, Commissioner and Executive Leadership representing the MCH section within the agency. Title V priorities are also chosen to the extent that they address needs that are not otherwise met through other grants, programs and partnering organizations.

The mission of the Department of Public Health is to prevent disease, injury and disability; promote health and wellbeing; and prepare for and respond to disasters. DPH's workforce is guided by the following core values in carrying out our public health work:

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

Excellence – Commitment, accountability, and transparency for optimal efficient, effective, and responsive

performance.

Partnership – Internal and external teamwork to solve problems, make decisions, and achieve common goals.

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

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

DPH COVID-19 Response

DPH is working closely with the CDC, and state partners to respond to the COVID-19 pandemic. The goal is to quickly identify cases of COVID-19 and take the appropriate public health action to reduce its spread and protect the general public.

DPH Emergency Preparedness and Response (EPR) is providing CDC information and guidance about COVID-19 to all health care and hospital facilities throughout Georgia and holding weekly calls with the entire public health and hospital/health care community to update information and answer questions. DPH serves as the clearinghouse for coordination between state agencies, health care providers and medical facilities and has created communication strategies for presenting CDC messages such as billboards, Public Service Announcements (PSA), flyers and videos. DPH is poised to provide infrastructural and leadership support to improve the health of mothers, children, and families. MCH Title V programs have continued to implement evidence-based approaches to address COVID-19. MCH programs share COVID-19 messaging with district staff, partners and families and have adapted policies, procedures, and ensured continuity of care for home visiting programs, early intervention, child health services, and CYSHCN services. MCH programs have developed innovative strategies utilizing telehealth that have enabled continuity of care in providing home visiting and early intervention services. Expanding telehealth services to traditional in person service delivery programs have allowed for an opportunity to ensure that families receive vital support while following COVID-19 prevention guidelines.

DPH epidemiologists are on-call to help health care providers evaluate individuals presenting with symptoms of COVID-19 to ensure that possible cases are managed safely, support laboratory testing and implement recommendations from the CDC. In the event of COVID-19 in Georgia, epidemiologists would also be monitoring outbreaks and recommending control strategies, including guidance regarding testing and isolation.
Should it become necessary, DPH may recommend appropriate community mitigation measures for affected communities, such as temporary closure of childcare facilities and schools/colleges and universities, school and workplace social distancing measures, and postponement or cancellation of mass gatherings. Additionally, businesses should consider ways to implement strategies to reduce the impact of a potential COVID-19 outbreak on their workforce, including teleworking and cross-training employees on essential job functions.

COVID-19 is rapidly evolving, and guidance is subject to change. The preparations currently underway in Georgia are based on the best scientific information and data from the CDC. DPH continues to monitor the COVID-19 situation, and work with state partners and health care communities to incorporate the most up to date guidance in our planning and preparation efforts.

Healthy Georgia Collaborative

Healthy Georgia Collaborative is Georgia's COVID-19 contact tracing initiative executed by DPH. Contact tracing is the process of quickly identifying, assessing, and managing people who have been exposed to a disease to prevent additional transmission. When used with other public health measures like widespread testing and social distancing, contact tracing is a key strategy for preventing further spread of COVID-19. DPH has trained a large contact tracing

workforce exceeding 1,450 employees to stop the transmission of COVID-19. DPH maintains long-standing relationships with many of Georgia's colleges and universities, and these relationships are more important than ever in the fight against COVID-19. Leveraging our existing partnerships, DPH's University Relations/ Applied Learning Program screened over 2,000 internship applications and recruited 284 interns from Georgia schools for the Summer 2020 Contact Tracing internship. In addition to actively recruiting students for Fall 2020 internships, University Relations is also working to expand our partnership network to additional Georgia universities and technical colleges, particularly those in the state's rural regions.

III.C. Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Goals, Framework and Methodology

Georgia's Title V Five-Year Needs Assessment was implemented through the lens of the Maternal and Child Health (MCH) program's core values of prevention and wellness, social determinants of health, life course perspective, and health equity. The needs assessment was conducted by the MCH Section within the Georgia Department of Public Health (DPH), Division of Health Promotion (HP). MCH currently uses the following mission and vision to guide all programmatic efforts, including the Title V Needs Assessment.

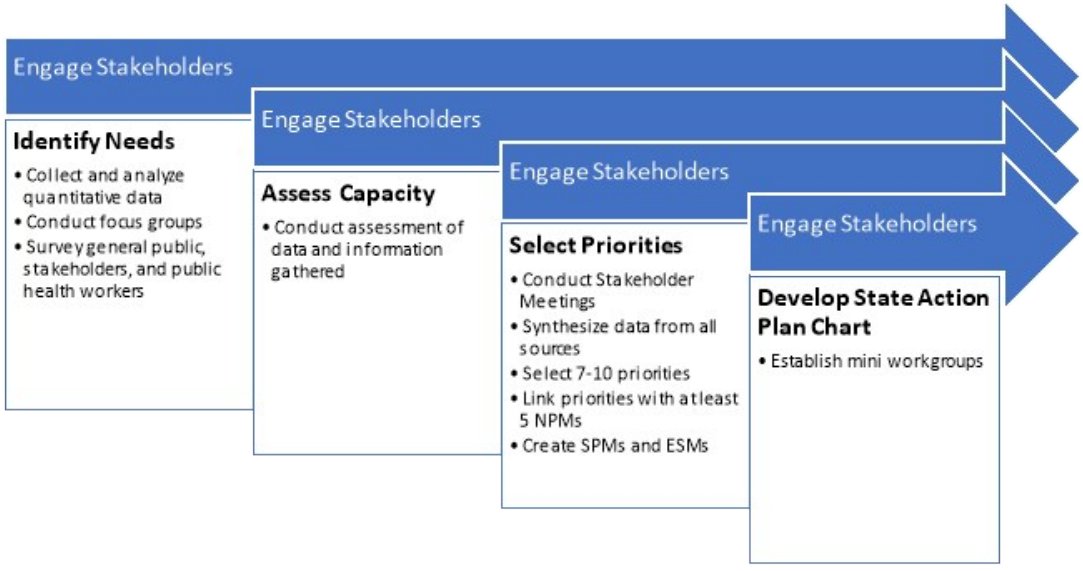
Mission: To implement measurable and accountable services and programs that improve the health of women, infants, children, including children and youth with special health care needs, fathers, and families in Georgia.

Vision: Through the implementation of evidence-based strategies and the use of program and surveillance data, identify and deliver public health information and population-based interventions that have an impact on the health status of women, infants, children, including children and youth with special health care needs, fathers, and families in Georgia.

The Needs Assessment Workgroup (NAW) was established to complete the needs assessment. The group, under the leadership of the Title V Director and Deputy Director, consisted of directors and managers from all MCH programs, MCH Epidemiology, Program Evaluation and Performance Improvement, Adolescent Health, Chronic Disease, Office of Sexually Transmitted Disease (STD), and Injury Prevention.

The Needs Assessment was organized by six population health domains: Maternal/Women's Health, Perinatal Health, Children's Health, Adolescent Health, Children and Youth with Special Health Care Needs (CYSHCN), and Cross-Cutting. Key steps for the needs assessment process are outlined in Figure 1.

Figure 1: Georgia Title V Needs Assessment Process



Methodology

Quantitative and qualitative methods were used to assess strengths and needs of the MCH population, program

capacity, and core partnerships and collaborations that support program efforts. Upon presentation to MCH stakeholders, the qualitative data provided support and meaning to the quantitative data being reviewed for a cohesive landscape of maternal and child health needs within the state of Georgia.

Quantitative Methods

A thorough examination of the health status of women and children was conducted by analyzing the most current information available by population domain. Trends over time were presented for all data where possible and information was stratified by relevant variables including age, race/ethnicity, education, income, gender, health insurance coverage, and CYSHCN status. Comparisons with national averages and Healthy People 2020 objectives were made when possible to provide better context for the data provided. The following data sources were used:

- Behavioral Risk Factor Surveillance System (BRFSS)
- Emergency Department Data (EDD)
- Georgia Adolescent Immunization Survey (GAIS)
- Georgia Immunization Survey (GIS)
- Georgia Violent Death Reporting System (GA-VDRS)
- Hospital Discharge Data (HDD)
- Maternal Mortality Review Committee (MMRC)
- National Immunization Survey (NIS)
- National Survey of Children's Health (NSCH)
- Neonatal Abstinence Syndrome (NAS) Module
- Newborn Screening (NBS)
- Online Analytical Statistical Information System (OASIS)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Third Grade Basic Screening Survey (BSS)
- Vital Records: Birth Certificates (BC), Death Certificates (DC), and Fetal Death Certificates (FDC)
- Youth Risk Behavior Survey (YRBS)
- Youth Tobacco Survey (YTS)

Qualitative Methods

Focus Groups

Qualitative data were gathered throughout Georgia to gain further insight into the needs of MCH populations and areas to improve the delivery of public health services. Data were gathered through 10 focus groups with 82 participants throughout the state. The focus groups included three groups of pregnant women/mothers, two groups of men/fathers, three groups of teenager/youth, one group of parents of CYSHCN, and one group of refugee mothers and fathers. Focus group participants were asked to describe their knowledge and understanding of the services offered through Title V, their experiences seeking such services, any unmet health care needs for them or their families, and their perceptions about the needs of their communities. Participants were also encouraged to discuss their experiences seeking health care through telehealth as well as any recommendations for improving Title V programs and services. MCH population and focus group location are outlined in Figure 2.

Figure 2: MCH Population and Location

Pregnant Women/ Mothers	Parents of CYSHCN	Adolescents	Fathers	Refugees
Albany	Dalton	Cordele	Atlanta	Dekalb
Dublin		Norcross	Dublin	
		Rome		

Surveys

Three surveys were created to collect information from the public, public health workforce, and partners and stakeholders across the state to identify needs and opportunities to address health needs. The responses to the General Public, Workforce, and Stakeholder Surveys were collected through snowball and convenience sampling. The Workforce Survey was taken by state employees and electronically sent to district staff. The Stakeholder Survey was distributed to partners and stakeholders via the MCH listserv. The General Public Survey was posted on the DPH website as well as shared with MCH partners and stakeholders. Partners and stakeholders were asked to send the General Public Survey out via email, newsletter, social media, and/or post on their agency/organization website. There were 213 responses to the General Public Survey, 144 responses to the Workforce Survey, and 213 responses to the Stakeholder Survey.

Interface Between Needs Assessment Data, Priority Needs and State Action Plan Chart

The MCH program, NAW, and Program Evaluation and Performance Improvement team members reviewed data from the quantitative and qualitative analysis in order to select the potential priority needs for the state for the population domains relevant to their work. Staff were asked to primarily consider whether the data indicated an area of need, whether it was measurable, and whether MCH had the capacity and authority to address the need. A total of 34 priorities were selected and brought to stakeholders for prioritization.

Stakeholder prioritization was completed in two different methods. First, a meeting was held in Atlanta to encourage the participation of stakeholders in North Georgia. A total of 25 stakeholders representing 25 organizations attended. During the meeting, following prioritization activities and group discussions, each stakeholder individually completed a prioritization tool. The tool was designed to rate each need on a scale of 1 to 5 based on the following criteria: seriousness of the issue, health equity, economic impact, trend, magnitude of the problem, and importance. Stakeholders contributed key activities and strategies within each area of need to inform the development of the State Action Plan Table.

The second prioritization meeting was scheduled in Dublin for the stakeholders in South Georgia. The meeting was cancelled due to travel restrictions in response to COVID-19. The prioritization tool was replicated in SurveyMonkey and sent to the South Georgia stakeholders via email. Stakeholders were given a week to rate each priority need and submit the survey.

The individual rating tools were analyzed to determine the highest rated priority needs in each domain. When determining priorities, the needs with the highest rating in each domain were considered first. The data and results from the survey rankings were reviewed to assess consistency and confirm an area of need. Needs were then aligned with a NPM when possible.

Figure 3: Linkage between Priority Needs and National Performance Measures (NPM)

Population Domain	Priority Need	National Performance Measure(s)	State Performance Measure(s)
Maternal/Women's Health	Prevent maternal mortality	Well-women visit	
Perinatal/Infant Health	Prevent infant mortality	Breastfeeding Perinatal regionalization Safe sleep	Congenital syphilis Infant mortality in the black population
Child Health	Promote developmental screenings among children	Developmental screening	
	Increase the number of children, with and without special health care needs, who have a medical home	Medical home	
Adolescent Health	Increase bullying and suicide prevention	Bullying	
Children and Youth with Special Health Care Needs	Increase the number of children, with and without special health care needs, who have a medical home	Medical home	
	Improve systems of care for CYSHCN	Transition	
Cross-Cutting	Promote oral health among MCH populations	Preventive dental visit	
	Increase fatherhood involvement among MCH populations	None	Fatherhood Involvement

The State Action Plan Table was developed by the work groups for each domain. Strategies were identified based on suggestions from the stakeholder meeting, focus group findings, MCH Advisory Council meetings, and a review of the evidence-based or -informed strategies for each NPM.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

The following summary provides an overview of the quantitative findings related to the identified priority needs and qualitative findings from focus group and survey responses. Each domain includes a summary of strengths and needs related to the identified priority need and national priority areas.

MCH Population Needs

Maternal/ Women's Health

Maternal Mortality

From 2012-2015, the maternal mortality ratio was 67 deaths per 100,000 live births; the pregnancy-related mortality ratio was 28 deaths per 100,000 live births. Approximately 66% of the pregnancy-related deaths were preventable. Overall, the five leading causes of pregnancy-related deaths are Cardiomyopathy, Cardiovascular/Coronary, Hemorrhage, Embolism, and Preeclampsia and Eclampsia. Medicaid was the primary payor at the time of delivery for the majority (66%) of maternal deaths occurring at the time of delivery up to a year postpartum. Non-Hispanic (NH) Black women are 2.7 times more likely to die from pregnancy-related causes than NH White women. As maternal age increases, the pregnancy-related maternal mortality ratio increases. Women 35 years and older have a pregnancy-related mortality ratio 2.5 times greater than women ages 25-29.

Well-Women Visits

Women's health consistently was voiced as a priority. Access to care is a need that was expressed as overarching not only for a specific community, but providers, programs, and families throughout the state. Among women of reproductive age (WRA), 69% had seen a doctor in the past 12 months. By race/ethnicity and health coverage, respectively, the percentage of WRA reporting seeing a doctor in the past 12 months was highest among NH Black women and women with health insurance coverage. Among women with a recent live birth in 2017-2018, just over 60% reported a health care visit (HCV) of any type in the 12 months before their pregnancy. Younger women, NH Black and Hispanic women, and women whose payor at delivery was Medicaid were less likely to report a HCV in the year before pregnancy. From 2013-2018, the percent of women with no insurance in the month before pregnancy decreased from 38% to 26%. Hispanic women and women with Medicaid or other insurance at delivery were more likely to report no insurance coverage before pregnancy than women of other racial/ethnic groups or with private insurance at delivery.

Family Planning

From 2013-2018, the percentage of women with a recent live birth who reported an unintended pregnancy increased from 5% to 10%. Intended pregnancies were more common among older, White NH and Hispanic women, and those with a private payor at delivery. Among women who were not trying to get pregnant when they became pregnant, use of low-efficacy birth control methods (condoms and withdrawal) was most reported, followed by medium-efficacy methods (the pill, patch or injectables). Use of high-efficacy birth control methods was least commonly reported among women who were trying not to get pregnant when they conceived.

Early Prenatal Care

The percent of women who have a live birth that receive prenatal care in the first trimester steadily increased from 51.8% in 2009 to 67.8% in 2018. While progress is being made towards the Healthy People 2020 goal of 84.8%, the goal has not been achieved. First trimester prenatal care entry was less common among Black, non-Hispanic and Hispanic women, teen mothers (ages <20 years), and self-pay women.

Postpartum Visit

From 2013-2018, the percent of women who received a postpartum visit with a health care provider remained relatively constant around 90%. From 2017-2018, postpartum care was less commonly reported by Hispanic women and those whose payor at delivery was Medicaid or other insurance compared to NH White and women with a private payor at delivery, respectively. Among women who did receive a postpartum visit, the most commonly reported topics discussed with a health care provider were birth control methods for use after birth (89%), mental health screening (81%), healthy habits (diet and exercise, 62%) and smoking cigarettes (62%).

Strengths and Needs

The data indicates areas where Georgia's maternal population are achieving acceptable outcomes. The percent of women's first trimester prenatal care visits have steadily increased. The percent of women who received a postpartum visit with a health care provider remained relatively constant. There is a need to reduce the maternal mortality ratio. Not only has the rate increased but there is a stark racial-ethic disparity in pregnancy-related maternal deaths. The rate of unintended pregnancy doubled from 2013-2018 and early prenatal and postpartum care is less common in NH, Black and Hispanic women.

Programmatic Efforts to be Continued

- The MMRC provided the state with important findings on the prevalence and causes of maternal mortality
- Perinatal Levels of Care has created a mechanism for levels of care designation and ongoing site verification of birthing hospitals
- Family Planning has developed a provision of resources that increase access to family planning services to women

- The Georgia Perinatal Quality Collaborative (GaPQC) implemented quality improvement activities within participating hospitals assuring resources such as protocol, policies and procedures and staff are readily available

Areas of Opportunity

- Continue to implement data to action activities to improve maternal health and well-being and decrease maternal mortality based on findings and causes
- Promote well-women-visits and pre- or interconnection care
- Promote family planning services available through health department

Perinatal Health

Infant Mortality

The infant mortality rate was 7.1 in 2018. Disparities exist by race, with the rate of death for NH Black infants being twice that of NH Whites. The number one cause of infant mortality are disorders related to preterm birth and low birth weight, while deaths attributable to birth defects are second. From 2008-2017, the percent of live births occurring before 37 weeks (preterm) slightly decreased from 11.9% to 11.4%, making little progress towards the Healthy People 2020 target of 9.4%. From 2015-2017, preterm births occurred most frequently among NH Black (14.0%) than other racial/ethnic groups; women 40 years or older (16.4%) than any other maternal age groups, and deliveries paid by Medicaid (12.3%) than other payors. The percent of live births with a low infant birthweight (<2,500 grams) has remained relatively stable from 9.6% in 2008 to 9.9% 2017.

Breastfeeding

Among women with a recent live birth, 84% reported ever breastfeeding or pumping breastmilk to feed their infant. Younger women ,20 years of age or younger, and those with Medicaid or other non-private insurance at delivery were less likely to report ever breastfeeding. Current breastfeeding was less commonly reported by younger women, NH Black and Hispanic women, and those with Medicaid or other non-private insurance coverage at the time of infant delivery. Among Georgia infants born in 2015, under half (44%) were exclusively breastfed through three months of age and one in five (22%) were exclusively breastfed through six months of age. Just over one in three (35%) were breastfeeding at 12 months of age. Approximately one in five (21%) received formula before two 2 days of age.

Safe Sleep Practices

From 2013-2018, the percent of women who reported most often placing their infant to sleep on their back increased from 44% to 74%. Among women with a recent live birth in 2017-2018, placing their infant to sleep on their back was less commonly reported among NH Black and Hispanic women and those whose payor at delivery was Medicaid. Just under 90% of women reported placing their infant to sleep in a crib, bassinet or pack and play. Some women reported their infant slept with a blanket (45%), bumper pads (18%) or toys, cushions or pillows (7%).

Evidence-Based Home Visiting Programs

Among Georgia women with a recent live birth from 2017-2018, 7% reported receiving a home visit from a health care worker since their infant was born to learn how to care for themselves and/or their new baby. There were no significant differences in reported receipt of a home visit by demographic. Among women who reported a home visit, the most common type of visitor was a nurse or nurse's aide (38%), followed by someone else (30%), and a doula or midwife (22%). A teacher or health educator (11%) was the least commonly reported type of home visitor.

Strengths and Needs

Certain population sub-groups in Georgia are meeting or exceeding national standards. Breastfeeding is being initiated at acceptable rates. Safe Sleep rates have increased. There is a clear need to reduce racial disparities leading to higher infant mortality rates in the Black population in Georgia. Racial disparities are evident in preterm

births, breastfeeding rates and safe sleep practices resulting in high infant mortality rates. Breastfeeding initiation and exclusivity have lower rates among younger mothers and with Medicaid as a payor source.

Programmatic Efforts to be Continued

- The Georgia 5-STAR initiative has been highly successful in motivating hospitals to take steps toward becoming breastfeeding-friendly
- The Safe to Sleep campaign continues to be promoted to change community norms regarding safe sleep environments
- Evidence -based home visiting programs promote breast feeding and safe sleep practices and is effective in reducing infant mortality and racial disparities
- Risk appropriate perinatal care are being implemented in birthing hospitals
- throughout the state

Areas of Opportunity

- Promote the perinatal levels of care designation program and recruit all Georgia birthing hospitals to participate in measuring compliance with the level of care designation
- Implement a referral WIC Peer Counseling referral process
- Build internal capacity and infrastructure to develop strategic plans to advance health equity and reduce disparities in the Black population
- Foster strategic community partnerships to build collaborations and engage in health equity practices

Child Health

Developmental Screening

In 2016, only two in five (37%) of children aged 9 to 35 months received a developmental screening using a parent-completed screening tool. Substantially fewer NH Black and Hispanic children were reported to receive this screening than NH White children in 2016. From 2017-2018, approximately half of children age 9 to 35 months received a developmental screening using a parent-completed screening tool in the past year; and the disparity in receipt of screening by race and ethnicity persisted as substantially fewer Hispanic and Black NH children were reported to have received a parent-completed developmental screening than White NH students.

Medical Home

In 2016, approximately half of non-CYSHCN 0 to 17 years of age received care that met the criteria for having a medical home. NH Black (31%) and Hispanic (40%) children were less likely to report having care that met the criteria for having a medical home than NH White (64%) children. In 2017, just under half (47%) of non-CYSHCN had a medical home, while a greater percentage of NH White children (56%) reported having a medical home than NH Black (40%) and Hispanic (39%) children.

Childhood Immunization Rates

Statewide, vaccination coverage at 24 months of age was 84%. Children with a maternal race of Asian, older maternal age, and a private health care provider had the highest coverage. Statewide, the 2018 vaccination coverage for 7th grade students was 93.9%. Statewide, the 2018 vaccination rate for 1 HPV was significantly higher than the 2017 rate, whereas the vaccination rates for Tdap and MCV4 were significantly lower. The statewide vaccination rates for 1 HPV was significantly higher for female students than male students. Statewide coverage rates for all vaccines were significantly higher for students enrolled in public schools than students enrolled in private schools.

Physical Activity

In 2016, two out of five (42%) of children aged 6 to 11 years engaged in vigorous physical activity 0-3 days a week

and just over a third (36%) engaged in physical activity daily. Hispanic and NH Black children were more likely to have 0-3 days of physical activity per week than NH White children. Hispanic children were less likely to be physically active daily compared to other racial and ethnic groups in 2016 (although this estimate should be interpreted with caution). In 2017, 44% of children age 6 to 11 were physically active at least 60 minutes per day for 1-3 days per week, 27% were physically active for 60 minutes every day, and approximately 5% of children had zero days per week with at least 60 minutes of physical activity. In 2017, almost 60% of NH Black children reported at least 60 minutes of physical activity 1-3 days per week; about 25% NH White and 15% of NH Black children reported this level of physical activity daily.

Non-Fatal Injury

From 2009 to 2018, “Other” unintentional injury was the leading cause of emergency department visits for adolescents 1 to 9 years of age, followed by falls and motor vehicle crashes. Motor vehicle crashes were the leading cause of death for children, while accidental drowning and submersion, accidental exposure to smoke, fire and flames, and all “other” unintentional injury followed, respectively. Overall, hospitalization, emergency department visit rate, and mortality rate for unintentional injury among children has decreased over time.

Strengths and Needs

A decline has been seen in the rate of hospitalizations due to non-fatal injury among children. Despite the successes seen around developmental screenings, less than half of Georgia’s children receive screening. Additionally, there are disparities in Georgia related to race and insurance status.

Programmatic Efforts to be Continued

- Promote developmental screenings by engaging physicians and community-based organizations to increase screening practices
- Promote car seat distribution to prevent injury and death due to motor vehicle crashes

Areas of Opportunity

- Improve medical home access through Help Me Grow® (HMG) and telehealth.

Adolescent Health

Bullying

In 2013, about one in five public high school students reported having been bullied in the twelve months before taking the survey. NH Black high school students were less likely to report being bullied on school property than their NH White and Hispanic peers. Twelfth grade students were less likely to report having been bullied on school property than ninth or tenth grade students. In 2013, over one in ten public high school students reported having been electronically bullied, including through texting, Instagram, Facebook, or other social media, during the twelve months before taking the survey. Female students were more likely than male students to report having been electronically bullied. NH White students were more likely than NH Black students to have been electronically bullied, while twelfth grade students were less likely to report having been electronically bullied than ninth grade students.

Suicide

In 2013, about one in ten Georgia high school students reported attempting suicide in the twelve months before taking the survey. Over one in ten high school students reported that in the twelve months before taking the survey, they (1) seriously considered attempting suicide and (2) planned about how they would attempt suicide. Differences by demographic were generally insignificant. From 2011-2017, male adolescents 10 to 17 years of age were over twice as likely to commit suicide than females. Male adolescents 18 to 21 years of age were more than five times as likely to commit suicide than females. For both age groups and sexes, NH White adolescents were more likely to commit suicide than NH Black and Hispanic (males only) adolescents.

Transitions to Adult Health Care

In 2016 and 2017-2018, about 15% of non-CYSHCN adolescents 12 to 17 years of age received services necessary to make transition to adult health care.

Non-Fatal Injuries Requiring Hospitalization

From 2014 to 2018, “Other” unintentional injury was the leading cause of emergency department visits for adolescents 10 to 19 years of age, while falls and motor vehicle crashes were the fourth and fifth leading cause, respectively. Motor vehicle crashes were the leading cause of death for adolescents, while accidental drowning and submersion, accidental poisoning, and all “other” unintentional injury were fifth, sixth, and eighth, respectively. Though the hospitalization and emergency department visit rate decreased over time, the mortality rate for unintentional injury among adolescents remained stable. In 2013, approximately one in five (21.4%) of high school students had been in a physical fight within the previous twelve months. Of those, male students were twice as likely as female students to have been in a fight (28.1% and 14.3% respectively). Male students were also five times more likely to have carried a weapon in the previous thirty days (30.2%) than their female counterparts (6.4%). Despite this variance, 12% of both male and female students experience physical violence during dating in the twelve months before taking the survey.

Physical Activity

In 2016, two out of five (41%) adolescents 12 to 17 years of age engaged in vigorous physical activity 1-3 days a week, one in five (20%) engaged in physical activity daily, and about one in five (17%) did not engage in vigorous physical activity on any days per week. Hispanic (28%) and NH Black (20%) adolescents were more likely to report zero days per week of vigorous physical activity than NH White (12%) adolescents in 2016. In 2017, 35% of adolescents 12 to 17 years of age were physically active at least 60 minutes per day for 1-3 days per week, 35% were physically active for 60 minutes 4-6 days per week, 14% every day, and approximately 15% of adolescents had zero days per week with at least 60 minutes of physical activity. In 2017, zero days with at least 60 minutes of physical activity per week was more commonly reported among NH Black and Hispanic adolescents and 60 minutes of physical activity everyday was most reported by NH White adolescents.

Strengths and Needs

Hospitalization and emergency department visit rates have decreased. The prevalence of bullying and the increase in the suicide death rate indicates a need to address suicide, violence and bullying among adolescents. The overall percentages of adolescents transitioning to adult care remains low.

Programmatic Efforts to Continue

- Collaboration with Injury Prevention to provide Sources of Strength program to middle and high school students

Areas of Opportunity

- Initiate bullying prevention initiatives

Children and Youth with Special Health Care Needs

Medical Home

In 2016, approximately half of CYSHCN age 0 to 17 years received care that met the criteria for having a medical home. A smaller percentage NH Black CYSHCN (36%) were reported to have care that met the criteria for having a medical home than Hispanic (50%) and NH White (51%) CYSHCN. In 2017, two out of five (42%) CYSHCN had a medical home, with NH White CYSHCN having the highest prevalence of a medical home (49%) and NH Black CYSHCN having the lowest (28%).

Transition

In 2016 and 2017, a similar percentage of CYSHCN 12 to 17 years of age received services necessary to make the transition to adult health care – 19% and 14%, respectively.

Access to Specialty Care

In 2016, just over two in five (43%) of CYSHCN and 6% of non-CYSHCN 0-17 years of age received care from a specialist doctor (other than mental health professional) during the past 12 months. Just under one in ten (8%) of CYSHCN needed to see a specialist but did not in 2016. During 2017-2018, 40% of CYSHCN and 7% of non-CYSHCN received care from a specialist doctor (other than a mental health professional). In 2017-2018, among CYSHCN, approximately 3% needed, but did not receive care from a specialist doctor; among non-CYSHCN, 2% needed, but did not receive care from a specialist doctor.

Care Coordination Services

During 2016 and 2017, more CYSHCN 0 to 17 years of age received needed medical home care coordination during the past 12 months than non-CYSHCN. In 2016, about three in ten CYSHCN needed, but did not receive this care coordination. In 2017, nearly four in ten (37%) CYSHCN needed, but did not receive care coordination. For both years, more CYSHCN did not receive needed care coordination than non-CYSHCN.

Strengths and Needs

HMG® Liaisons help families navigate and access services to improve access to information and resources. An effort to ensure that more CYSHCN are receiving the transition to adulthood services is needed as well as initiatives to reduce racial disparities. Half of CYSHCN 12 through17 receive the services necessary to make transition to adult care.

Programmatic Efforts to be Continued:

- Family Partnership groups have successfully helped parents navigate the health care system
- Care Coordination Services facilitate CYSHCN in obtaining necessary services
- The system of care from pediatric to adult care, especially in rural areas of the state have been strengthened

Areas of Opportunity

Expand the use of telehealth technology to improve access to specialty care services

Cross-Cutting

Dental Visits During Pregnancy

Approximately one-third of women with a recent live birth from 2017-2018 had their teeth cleaned by a dentist or dental hygienist in the 12 months before pregnancy. Under 40% of women reported having their teeth cleaned during their pregnancy. About nine in ten women reported they knew it was important to care for their teeth and gums during pregnancy, while 75% reported having insurance to cover dental care during their pregnancy.

Childhood Dental Visits

In 2016, 88% of CYSHCN and 81% of non-CYSHCN received a preventative dental visit in the past year. In 2017, more than 4 out of 5 children received a preventative dental visit, with slightly more CYSHCN receiving one or more preventative dental visits in the past year (91%) than non-CYSHCN (82%).

Smoking During Pregnancy

From 2017-2018, 5% of women reported smoking cigarettes and over 1% reported using electronic nicotine delivery systems (ENDS) during the last three months of pregnancy. Smoking cigarettes during pregnancy was more common among women 20-29 years of age, NH White women, and women with Medicaid at delivery. Among women who reported smoking during the three months before pregnancy, the most common reasons that made quitting difficult were cravings for a cigarette (67%), loss of a way to handle stress (56%), others smoking around

them (55%), and worsening anxiety (39%). During pregnancy, women who smoked in the past two years were more likely to report allowing smoking inside their home than non-smokers.

Tobacco, or nicotine, use among children and adolescents

One in four Georgia high school students reported ever trying cigarette smoking. NH White high school students (34%) were more likely to report ever trying cigarette smoking than NH Black students (14%). In 2017, 8% of high school students reported current cigarette use, 13% reported current electronic cigarette use, 8% reported use of smokeless tobacco products, and 14% reported cigar use. Cigarette use was slightly more common among rural than urban high school students. Over one in four high school students ever used electronic cigarettes; use of electronic cigarettes (ever and current) was slightly more common in urban areas than rural areas. Use of electronic cigarettes (ever) was more likely to be reported by males (30%) than females (21%). NH White students reported the highest prevalence of ever using electronic cigarettes (36%), followed by Hispanic (28%) and Black (13%) students.

Mental Health Evidence-Based Screening

During the three months before pregnancy, 10% of women with a recent live birth from 2017-2018 reported having depression. Depression prior to pregnancy was more commonly reported by women in their twenties, NH White women, and those with a Medicaid payor at delivery. Among women who reported having depression during the three months before pregnancy from 2017-2018, 38% reported having a HCV for depression or anxiety in the 12 months before getting pregnant. As compared to 2013, in 2018, a greater percentage of women reported feeling down, depressed, or hopeless since their new baby was born increased. Among women whose baby was alive and living with them, 4.4% reported using counseling services for depression or anxiety since their new baby was born.

Strengths and Needs

Georgia has shown improvements in access to dental services for pregnant women and children. Additionally, the percentage of women smoking during pregnancy in Georgia remained below the national average of 10.7%, however the use of ENDS has increased in both pregnant women and adolescents.

Programmatic Efforts to be Continued

- Oral Health education and services to pregnant women through family practice physicians
- Tobacco cessation education for pregnant women during preventive dental visits
- School-based sealant programs
- Community water fluoridation

Areas of Opportunity

- Expand education to reach parents, women, and children through home visits, outreach, and education

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

DPH is the lead agency in preventing disease, injury and disability; promoting health and wellbeing; and preparing for and responding to disasters from a public health perspective. The agency's Commissioner reports directly to the Governor. HP contains the MCH Section, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Oral Health, MCH Epidemiology, and the Program Evaluation and Performance Improvement sections. The MCH section contains the following programs: Title V, Child Health, CYSHCN, and Family and Community Supports programs. DPH recently restructured and added the Clinical and Medical Services Division which includes Chronic Disease, Immunization, Infectious Disease, Nursing, Public Health Pharmacy, the Public Health Laboratory, Refugee Health and the Office of Women's Health. MCH has primary responsibility for the administration of the Title V Block Grant. The MCH Director serves as the Title V Director. The Title V MCH program sets program policy and monitors compliance with state and federal laws and rules and offers technical assistance to staff in district public health

departments regarding Title V programs. The following list provides a description of Title V funded programs.

Title V Funded Programs:

Babies Can't Wait (BCW) provides a coordinated, comprehensive and integrated system of early intervention services for infants and toddlers birth to three as outlined by IDEA Part C.
Children First serves as the "Single Point of Entry" to a statewide collaborative system of public health prevention-based programs and services for children with poor health or developmental delays.
Children's Medical Services (CMS) ensures a community-based, coordinated, family focuses, culturally appropriate, comprehensive system of quality specialty health care services available for Georgia's children with chronic medical conditions from birth to 21 years of age who live in a low-income household.
Family Planning improves the health of women and infants by enabling family to plan and space pregnancies and preventing unplanned pregnancy.
Injury Prevention provides general support to local coalitions in helping promote safe and injury free lifestyles and behaviors.
MCH Epidemiology (MCH EPI) supports data collection and analysis of all MCH programs and administers the State Systems Development Initiative (SSDI), Early Hearing and Detection Intervention (EHDI) and Pregnancy Risk Assessment Monitoring System (PRAMS).
Newborn Screening (NBS) ensures that every newborn in Georgia has a specimen collected to screen for 35 inherited disorders that would otherwise cause significant morbidity or death.
Oral Health provides community water fluoridation, school-linked fluoride supplement programs for high-risk children, dental sealants and dental health education.
Perinatal Health assures pregnant women in Georgia have every opportunity to access comprehensive perinatal health care services appropriate to meet their individual needs and supports outreach efforts. Perinatal Health addresses infant mortality, maternal mortality and breastfeeding.

III.C.2.b.ii.b. Agency Capacity

MCH currently has the capacity through structural resources, data systems, partnerships and competencies to promote the health of all MCH populations. In each domain, MCH initiates partnerships with external organizations to ensure a statewide system of services that are comprehensive community-based, coordinated and family centered. The Title V program serves all 159 Georgia counties. Title V program managers monitor all aspects of program administration in order to ensure a statewide system of services, which reflect the principles of comprehensive, community-based, coordinated and family-centered care.

Maternal/ Women's Health
MCH uses Title V funds to provide services for women of reproductive age. Family planning clinics supported by Title V provide contraceptive counseling and preventive services. Cancer screenings and HPV vaccines are provided in the family planning clinics. MCH actively supports the MMRC and engages in various initiatives to promote maternal health. MCH has epidemiology staff to support programmatic efforts. Data sources used are PRAMS, Vital Records, BRFSS, and Family Planning program data. Women's Health houses the data for the MMRC and identifies cases for review. MCH and Women's Health have active partnerships with hospitals, private practice physicians, academic institutes, cancer and HIV screening agencies, the Chronic Disease Prevention Section, HMHB, Georgia Obstetrical and Gynecological Society (GOGS) and March of Dimes (MoD) to ensure a comprehensive system of services for women of reproductive age in Georgia.

Perinatal Health
Title V staff supports newborn screening, breastfeeding initiatives, preterm birth initiatives, perinatal regionalization and the Safe to Sleep campaign to promote perinatal health. MCH also participates in the Georgia Perinatal Quality

Collaborative (GaPQC) to implement quality improvement projects in participating hospitals. Title V supports epidemiology staff to collect and analyze data on perinatal health. The primary data source used are PRAMS and Vital Records. MCH and Women's Health has active partnerships with the RPC's, birthing facilities, private practice physicians, Association of State and Territorial Health Officials (ASTHO), GOGS, HMHB, MoD, WIC, and Worksite Wellness.

Child Health

MCH promotes child health through promoting developmental screenings among children, preventing injury and promoting oral health. MCH state, district and local level staff are well-versed in developmental screening and the various tools used to assess developmental screening. The Child Occupant Safety Project (COSP) aims to prevent motor vehicle accident deaths among children. MCH utilizes the State Electronic Notifiable Disease Surveillance System (SendSS) and Babies Information and Billing System (BIBS) to assess developmental screening data. To ensure comprehensive system of services among children, MCH has active partnerships with the Chronic Disease Prevention Section Department of Early Care and Learning (DECAL), Department of Education (DOE), academic institutes, GA Chapter of the American Academy of Pediatrics (GA-AAP), GA Academy of Family Physicians (GA-AFP), Marcus Autism and Emory Autism Centers.

Adolescent Health

The Adolescent Health program sits within the Chronic Disease Prevention Section and promotes adolescent health through programs targeting tobacco prevention, sexual violence prevention, teen pregnancy prevention and positive youth development. Title V will partner with the Injury Prevention Program to identify the prevalence and existing prevention programs and legislation on bullying and facilitate improvements in bullying prevention efforts by schools that service the target population.

CYSHCN

MCH supports several programs to provide services to Georgia's CYSHCN. Children 1st acts as the access point for children with an identified special need. BCW provides services for children from birth to three. CMS is established and continues to provide on-going, comprehensive medical care for CYSHCN that are not eligible for state funded Medicaid and SCHIP programs. CMS promotes access to specialty care, care coordination, transition to adulthood and medical homes for CYSHCN. Epidemiologists support data collections for CMS.

Cross-cutting

MCH has Title V, CDC, state and private-donated funds to support oral health initiatives. MCH has access to oral health data through PRAMS, NSCH, CMS, and 3rd Grade and Head Start Basic Screening Surveys. The Oral Health program has an Oral Health Epidemiologist. To ensure a comprehensive oral health system of services, MCH has active partnerships with WIC, private practices, dental hygiene programs, academic institutes, schools, the Oral Health Coalition and CDC.

III.C.2.b.ii.c. MCH Workforce Capacity

Recognizing the importance of investing in an adequately sized, skilled workforce, Title V has built capacity to better monitor and track changing MCH needs, evaluate progress to program goals, and enhance state-local partnerships to advance MCH. HP Administration is responsible for MCH workforce development strategies that ensure recruitment and retention of qualified staff, training and professional development for employees and creative staffing structures that maximize funding resources. MCH, with 47 FTE's, has 100% of positions filled including all program director and manager positions.

Title V Leadership	
Director, Division of Health Promotion	LaToya Osmani, MPH
Director, Title V and MCH Section	Jeannine Galloway, MPH
Director, Oral Health Program	Adam Barefoot, DMD, MPH
Director, Administration, Division of Health Promotion	Valerie Newton-Lamb, MSHA
Director, Fiscal, Division of Health Promotion	Debra Chapman
Director, CYSHCN Program	Sharifa Peart, MPH
Chief Nurse, Office of Nursing	Diane Durrence, MPH, MSN, APRN
Deputy Director, Title V	Paige Jones
Deputy Director, Early Intervention	Lisa Pennington MS, MA, LPC
Deputy Director, Child Health Services	Judith Kerr, MPH
Deputy Director, Family and Community Supports	Twanna Nelson

Cultural Competency

Several methods are used to ensure that culturally competent approaches are used in service delivery across all programs. MCH EPI routinely collects and analyzes data by race, ethnicity and income to assess health equity and inform program activities. A bilingual interviewer is on PRAMS staff to ensure sufficient response rates from the Hispanic population. MCH works closely with community leaders to plan service delivery programs, collaborate on grants and implement culturally competent services that meet the unique needs of populations. In all MCH programs, services and/or educational materials are provided in English and Spanish and include images representative of the target community. The Oral Health program has bilingual staff that will provide outreach education targeted to Hispanic children. The CMS program will arrange for the provision of oral language assistance, from language interpreter and translation services, in response to the needs of Limited English Proficiency (LEP) and Sensory Impaired (SI) individuals in both face-to-face and telephone encounters with CMS. The Child Health program addresses cultural competency through partnering with the state Refugee Health Program and its case managers to address cultures and languages, such as Arabic, Somali, and Swahili. In addition, on our various councils and committees MCH strives to involve individuals representing the diversity of the community and encourages cross-cultural dialogue.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Title V is heavily focused on collaborative partnerships and demonstrate strong commitment to coordinating with others to address emerging and ongoing needs of MCH populations. Both formal and informal collaborative relationships exist that support Title V work. Georgia maintains partnerships to build the capacity of MCH services in the state.

MCHB Investments: Title V works collaboratively with other MCHB investments, including but not limited to: State System Development Initiative (SSDI), Maternal, Infant, and Early Childhood Home Visiting (MIECHV), and Healthy Start.
Other Federal Investments: Title V receives other federal investments through CDC funding which includes PRAMS, Oral Health and perinatal quality improvement, as well as USDA funded WIC and Health and Human Services funded Head Start. Title V also works closely with Part C of IDEA and Early Hearing Detection and Intervention (EHDI)
Other HRSA Programs: District coordinators partner with Federally Qualified Health Centers.
State and Local MCH Programs: The state Title V program coordinates regularly with community organizations and local health departments to implement activities.

Other programs within the State Department of Health: MCH partners with several other sections in DPH. MCH partners with the Office of Women's Health, Adolescent Health, Chronic Disease Prevention, Immunizations, Injury Prevention, STD, and Vital Records.
Other governmental agencies: MCH has strong relationships with the Department of Community Health, Department of Behavioral Health and Developmental Disabilities, the Division of Family and Children Services, Department of Early Care and Learning and the Department of Education.
Public health and health professional educational programs and universities: MCH frequently partners with Emory University, Rollins School of Public Health, Georgia State, University of Georgia, Morehouse School of Medicine, Mercer University, Valdosta State University and Augusta University.
Others: MCH has a contractual relationship with RPC's to meet the needs of the perinatal regionalization system. GOGS is contracted to administer the MMRC. Relationships with Children's Health Care of Atlanta and Augusta University will be critical to addressing transition, as these sites have transition clinics that DPH has assisted in establishing and promoting. Parent to Parent and GA-AAP are contracted to support services for CYSHCN. Emory University conducts follow-ups for the Newborn Screening program.
Title V Stakeholder Council: The MCH Advisory Council serves in an advisory capacity to MCH Title V Program; monitors progress; and addresses specific MCH population needs for MCH populations. The MCH Section serves as the lead agency for the Council. The Title V needs assessment and state action plan is the guiding document as it relates to the ongoing work of the Council. The Council is comprised of a multidisciplinary team of professionals with expertise in MCH.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Interface Between Needs Assessment Data, Priority Needs and National Performance Measures

Title V, NAW, and Promotion Evaluation and Performance staff reviewed all data from the quantitative and qualitative analysis in order to select the potential priority needs for the state in the six population domains. Staff individually indicated their top needs based on the data reports and then a consensus was developed across all members. They were asked to primarily consider whether the data indicated an area of need, whether MCH had the capacity and authority to address the need and if the need was measurable.

The individual rating tools were analyzed across the two groups to determine the highest rated priority needs in each domain. The data and results from survey rankings were reviewed to assess consistency and confirm an area of need. Needs were then aligned with a NPM when possible. The State Action Plan Chart was developed, and the strategies were identified based on suggestions from the Stakeholder meetings, focus group findings and a review of the evidence base for each NPM.

Eight priorities were developed with at least one priority for each population domain. Development of objectives and strategies, alignment with NPMs, adoption of new state performance measures (SPMs), and the creation of evidence-based strategy measures (ESMs) followed. During this process,10 NPMs and 3 SPM's were selected to address state needs. The final draft of the MCH Priorities and Associated Measures of the 2021-2025 State Action Plan was developed and presented to the MCH Advisory Council.

With similarities to priorities from the 2016-2020 plan, these new priorities expand on previous work or focus on new and emerging issues. Georgia adopted a stronger focus on innovative approaches, improving health equity, and reducing social determinates of health. The table that follows compares the most common themes across all three needs assessment data sources.

Relationship Between Priority Needs and Measures
The Georgia Title V Needs Assessment process focused on identifying and addressing issues at the state and local

levels. The top state priority issues that most closely aligned with the national priorities and NPMs were selected.

Figure 4: Priority Needs and Associated Measures

Prevent Maternal Mortality (Domain: Women's Health)
NPM: 1: Well Women Visit (Percent of women, ages 18-44, with a preventive medical visit in the past year)
Prevent Infant Mortality (Domain: Perinatal/Infant Health)
NPM 3: Risk Appropriate Perinatal Care (Percent of VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit) NPM 4: Breastfeeding ((A) Percent of infants who are ever breastfed (B) Percent of infants breastfed exclusively through 6 months) NPM 5: Safe Sleep (Percent of infants placed to sleep; (A) n their backs; (B) on separate sleep surface; and (C) without soft objects and loose bedding) SPM 1: Reduce the rate of Congenital Syphilis SPM 2: Reduce Infant Mortality in the Black Population
Promote Developmental Screenings Among Children (Domain: Child Health)
NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Increase Bullying and Suicide Prevention
NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others
Increase the number of children, Both With and Without Special Health Care Needs, Who Have a Medical Home (Domain: CYSHCN)
NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Improve Systems of Care for CYSHCN
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
Promote Oral Health Among All Populations (Domain: Cross-Cutting)
NPM 13.1: Percent of women who had a preventive dental visit during pregnancy NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Increase Father Involvement Among All MCH Populations (Domain: Cross-Cutting)
SPM 3: Percent of Fathers who reported increase in knowledge using 24/7 Dads® curriculum in Georgia Home Visiting Program sites

III.D. Financial Narrative

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$17,267,095	$16,870,802	$16,966,578	$16,928,422
State Funds	$114,351,317	$110,765,452	$111,754,674	$113,240,452
Local Funds	$0	$0	$0	$0
Other Funds	$147,350,720	$149,036,298	$167,447,415	$155,458,036
Program Funds	$9,133,503	$6,662,232	$8,425,409	$5,824,514
SubTotal	$288,102,635	$283,334,784	$304,594,076	$291,451,424
Other Federal Funds	$33,098,697	$36,589,422	$34,857,870	$33,367,812
Total	$321,201,332	$319,924,206	$339,451,946	$324,819,236

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$17,154,058	$17,153,951	$17,412,396	
State Funds	$112,090,944	$114,368,375	$113,196,297	
Local Funds	$0	$0	$0	
Other Funds	$164,161,576	$158,710,749	$165,676,651	
Program Funds	$6,857,920	$7,378,500	$6,087,139	
SubTotal	$300,264,498	$297,611,575	$302,372,483	
Other Federal Funds	$33,901,215	$34,776,278	$35,139,766	
Total	$334,165,713	$332,387,853	$337,512,249	

	2021	
	Budgeted	Expended
Federal Allocation	$19,811,036	
State Funds	$109,975,740	
Local Funds	$0	
Other Funds	$165,826,555	
Program Funds	$6,578,000	
SubTotal	$302,191,331	
Other Federal Funds	$35,533,337	
Total	$337,724,668	

III.D.1. Expenditures

FY 2019 Annual Report Expenditures

Georgia's Maternal and Child Health State and Federal funds are allocated based on priority needs to be identified through the Maternal Child Health Block Grant (MCHBG) development process. This process includes reviewing health status and outcomes for women and children, projecting future needs and assessing current capacity/infrastructure. As part of the Georgia Department of Public Health's budget process, recommendations are made for funding levels for services to women, infant and children.

The MCH Block Grant funding and expenditures for FY 2019 is based on actual expenditures and supported data. Expenditures are reported out of PeopleSoft Financials and Uniform Accounting System (UAS), **to ensure compliance requirements are met such as**:

- MCH Program staff meets with local public health districts, to conduct monthly, quarterly calls, and site visits to ensure local public health districts are spending funds accordingly, to federal, other, or state requirements.
- Funds are allocated to the local public health districts based on Performance Measures, Data and Allocation Formula Methods to ensure compliance requirements are met.
- Local Public Health Districts are required to submit monthly and quarterly reports to State Program Managers to ensure oversight of expenditures such as:
  Referral Log, Outreach Log, Patient Benefit Log, Specialty Clinic report, Preventive Participant Report, Data Report, Statistical Reporting, Programmatic Report and Satisfaction Survey for all patients receiving telemedicine services.

The total FY 2019 Federal-State Title V Block Grant Partnership Annual Report expended $297,611,575 and the Georgia Maintenance of Effort (MOE) sustained the level of $36,079,622. The FY 2019 State MCH Budget /Expenditure Grand total is 332,387,853. (See Form 2 line 11)

The Federal MCH Block Grant funding supports the activities within Division of Health Promotion, which administers the MCH Services Title V Block Grant: MCH, Women's Health, and Oral Health Programs. Program Partnership with Division of Health Protection: Injury Prevention, Adolescent Health, Epidemiology programs.

Federal MCH Block Grant Annual Report: The Title V funding focused on the priority need of the following programs:

- **Women's/Maternal Health:** The program continued to focus on improving access to health care, including access to the most effective forms of contraceptives; and preconception health to promote women's health prior to pregnancy and strategies to reduce maternal mortality. MMRC direct and lead initiatives to impact maternal birth outcomes. Centering Pregnancy empowers patients, strengthens patient/provider relationships, and builds communities through health assessment, interactive learning, and community building. Improve birth outcomes and decrease preterm birth rates through the implementation of a Centering Pregnancy Model Program. Women's Health provided oversight and management of the NAS surveillance process in close collaboration with MCH EPI and birthing hospital staff.
- **Infant Mortality:** The program aims to assure pregnant women in Georgia every opportunity to access comprehensive perinatal health care services appropriate to meet their individual needs.
- **Oral Health:** The program participated in a work groups and campaign promotion to improve oral health access and care for pregnant women in Georgia through the HMHB.
- **Injury Prevention/Safe Sleep:** The program developed and implemented the "Safe Infant Sleep to support hospitals in their efforts to educate families about safe sleep practices and provide education materials throughout

the state. Injury prevention provision of general support to local coalition in helping promote safe and injury free lifestyles and behaviors.

- **Family and Community Support -Home Visiting:** The program strengths-based, family-centered support strategies that give pregnant women and at-risk families with children from birth until kindergarten entry the resources and skills they need to raise children who are physically, socially, and emotionally healthy and ready to learn.
- **Refugee Health:** The program promotes the physical, mental, and social well-being of all newly arriving refugees in the state of Georgia, which helps to ensure that refugees receive adequate healthcare.
- **Child Health:** Children 1st serves as the single point of entry to child health services through DPH connecting children and families with public health and other prevention-based programs and services. Children 1st aims to identify all children ages birth to five who are at risk for poor health and development. The EDHI program maintains and support a comprehensive, coordinated, statewide screening and referral system promoting hearing screening and appropriate follow-up for all newborns through education, technical assistance and training regarding implementing and maintaining a quality newborn hearing screening program.
- **MCH Epidemiology:** The section carries out several activities to identify diseases and describe health conditions, assess the health of Georgians, and develop recommendations to control diseases and improve the overall health status in the state. conduct data analyses and disseminate information from surveillance systems, monitor and investigate reports of unusual health conditions and conduct active and passive surveillance to detect diseases and adverse health conditions.
- **Georgia Shape/Child Health and Wellness:** The program has served statewide coalitions, and annual events as the agency's child health and wellness program. Also, provides technical assistance and funding through various partnerships.
- **Fatherhood Initiative:** The program developed the initiative with the goal to create strategies that increase awareness and advocacy across intra and inter-agency partners, creating a culture of inclusion for fathers across the state. The program continues to increase father engagement and involvement in MCH programs through capacity building, collaboration, coordination, and providing resources to encourage father inclusion.
- **Suicide Prevention:** The program contracted with SPAN-GA to implement the Sources of Strength wellness program within several of Georgia's middle and high schools. The program address awareness and education surrounding mental health and suicide also took place through the engagement of community and family members.
- **Children with Special Health Care Needs:** 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. CYSHCN programs partner with health care providers and community-based resources to coordinate pediatric specialty and therapeutic care for CYSHCN and their families.

FY19 Title V 30/30/10 requirement expended $17,153,951. Of this amount follows: (See Form 2 lines 1A-1C):

- Preventive and Primary Care for Children 30%: $5,411,961 (31.5%)
- Children with Special Health Care Needs 30%: $6,618,805 (38.5%)
- Title V Administrative Costs 10%: $988,015 (5.8%)

Types of Service Federal: (Form 3b Federal)

- Direct Services: $5,882,219
- Enabling Services: $4,782,747
- Public Health Services and System: $6,488,985

Types of Service Non-Federal: (Form 3b Non-Federal)

- Direct Services: $34,531,346
- Enabling Services: $71,786,687
- Public Health Services and System: $174,139,591

The **State MCH Funds** expended $114,368,375 exceeding the State required match of $12,865,463 for FY 2019 MCH Federal Allocation of $17,153,951. In addition to the required match for the MCH Block Grant - additional State Funds are used to support MCH programs and partnership activities in the MCH Population Domains: Women/Maternal Health, Child Health, Children 1st, Adolescent Health, Immunizations, GA Shape, Oral Health, Early Brain Development, Refugee Health and Children with Special Health Care Needs. (See Form 2 line 3)

The **Other Funds** expended $158,710,749; funds were used to support: (See Form 2 line 5)

- Six Regional Perinatal Centers (RPC), to provide advanced care for high risk mothers and infants.
- AMCHP Developmental Data Monitoring Within the State System.
- Reimbursement of Babies Can't Wait Special Instruction Services: support the need of Part C Early Intervention to provide coordination, comprehensive and integrated system of services for infants and toddlers with special needs, birth to 3 and their families.
- Georgia Newborn Screening: The program comprised of six major components to ensure every newborn receives adequate screening for these 35 conditions and infants that screen positive for a condition receive appropriate and timely follow up such as: Education, Screening, Follow-up, Medical Diagnosis, Management and Evaluation.
- Partnership with Immunization Vaccines for Children (VFC) program, which is used to fund infants less than 1 and children 1-22.

The **Program Income** expended $7,378,500, this income is derived from Medicaid Perinatal Case Management, Medicaid DSPS earnings, Family Planning Fees, Private Insurance, Health Check earnings and Outpatient Client Fees, for services provided to Pregnant and Postpartum Women, Preventive and Primary Care for Children and Reproductive Health Services to Women. The expenditures are tracked and monitored through the Uniform Accounting System (UAS) monthly/quarterly. The UAS data reports are reviewed quarterly for annual reporting. (See Form 2 line 6)

The **Other Federal Funds** expended $34,776,278 this amount represents the variation of federal funds managed under the Title V Administrator. These funds are used to support the need of preventing, promoting, and improving children and youth with special health care needs and pregnant women, mothers, and infants.

Other Federal Funds consist of:

- Temporary Assistance for Needy Families (TANF)
- Maternal, Infant and Early Childhood Home Visiting Program (Innovation)
- Maternal, Infant and Early Childhood Home Visiting Program (Formula)
- Georgia Perinatal Quality Collaborative Grant (GaPQC)
- Universal Newborn Hearing Screening (UNHS)
- Georgia Early Hearing Detection and Intervention (EHDI)
- Preventive Health Services Block Grant (PHHS)
- Georgia's Project LAUNCH
- Infants and Toddlers with Disabilities (Part C)
- Georgia Oral Health Prevention Program
- Integrated Food OMH

III.D.2. Budget

FY 2021 Application Budget

The Georgia 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 systems such as: PeopleSoft Financials and Uniform Accounting System (UAS), where state and local health districts' administrative personnel input budgets (funds that are allocated by programs such as Children with Special Health Care Needs) and expenditures. The Maternal and Child Health Section of the Georgia Department of Public Health administers audits, monitor programs monthly/quarterly and provides technical assistance when needed.

The Federal-State Title V Block Grant Partnership total for FY 2021 is $302,191,331. Of this amount, MCH expects to fund the FY 2021 budget from 6% Federal MCH Block Grant, 36% from State MCH Funds, 55% from Other Funds and 2% from Program Income. Georgia's total Maintenance of Effort (MOE) from 1989 is $36,079,622. As shown on Form 2, MCH effort far exceeds the Match and MOE requirements. The total FY 2021 State MCH Budget Grand Total is $337,724,668 (including the Other Federal Funds in the total budget).

The FY2021 Federal Application request amount is $19,811,036. The required State Match for Georgia is $14,858,277, which includes federal earmarked for Preventive and Primary Care for Children and Children with Special Health Care Needs.

FY 2021 Federal MCH Block Grant 30%-30%-10% requirement:

- Preventive and Primary Care for Children is budgeted for: $6,575,638 (33.1%)
- Children with Special Health Care Needs is budgeted for $7,512,066 (37.9%)
- Title V Administrative Cost is budgeted for $1,561,557 (7.9%)
- All Others is budgeted for $4,161,775

MCH Populations:

Pregnant Women: Title V is used in this area for Women's/Maternal Health Services providing access to high-quality perinatal care to Georgians as we recognize that there is a direct relationship between perinatal birth outcomes and the quality of health care services.

Centering Pregnancy program will continue to support public health districts in their goal to provide Centering Pregnancy services to women in the community.

Maternal Mortality Review Committee (GA MMRC) to reduce the Maternal Mortality rate and identify pregnancy-associated deaths (deaths during or within a year of pregnancy).

Neonatal Abstinence Syndrome (NAS) and Centering Pregnancy services to decrease the rate of preterm and low weight babies, increase breastfeeding rates to lead to better pregnancy spacing in Georgia.

Family and Community Support -Home Visiting the program gives pregnant women and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.

Infants Less Than 1 Year Old: Title V-leveraged services for this population include: Infant Mortality, Maternal Mortality, Neonatal Intensive Care Unit (NICU) Benefits and Administration - 6 tertiary centers statewide which provide clinical care and education services for high risk newborns, education and the prevention of Sudden Infant Death Syndrome (SIDS) and Other Infants Deaths (OID). Georgia Newborn Screening (NBS) Program and Epidemiology provides data and surveillance for MCH programs.

Children 1-22 Years Old: Children1st facilitates early identification of at-risk children and links them with early interventions services, as well as other public health services and community-based resources. The Oral Health Program contract with Richmond County Board of Health to provide dental services to mothers and children in the Augusta Health District and to provide training opportunities for pediatric dental residents in a mobile clinic environment.

The Injury Prevention program is committed to define the problem, identify risk and protective factors, develop and test prevention strategies, and assure widespread adoption of proven injury prevention principles and strategies as it relates to areas: Suicide Prevention Program SPAN-GA and Safe to Sleep programs.

Child Occupancy Safety Program (COSP) Motor vehicle related injuries continue to be a leading cause of death for children under 14 years of age. The Child Occupant Safety Project, utilizing local partners, conducted monthly education classes to train caregivers on proper use and installation of child safety seats.

Children with Special Health Care Needs (CSHCN): Children Medical Services provides care coordination, early and continuous screening for children with special health care needs and other needed medical/health services for eligible children and their families.

Federal MCH Block Grant Budget:

Federal Allocation Application Budget: MCH Program Measures	Budget Amount
Perinatal /Maternal Health	$1,925,184
Infant Mortality	$322,844
MCH Epidemiology	$432,060
Family & Community Support	$1,922,146
First Care	$160,000
Suicide Prevention	$75,000
Child Health	$1,040,050
Newborn Screening	$3,295,175
Injury Prevention/Safe Sleep	$580,509
Infant and Child Oral Health	$984,445
Children with Special Needs Care Needs	$7,512,066
Adminsitration Cost	$1,561,557
Total Federal Allocation Budget	**$19,811,036**

Other Federal Funds Budget:

Other Federal Grants: MCH Program Federal Grants	Grant Amount
Infants and Toddlers with Disabilities	$14,932,168
Georgia's State Actions to Improve Oral Health Outcomes	$370,000
Preventive Health Services Block Grant (PHHS)	$1,106,289
Temporary Assistance for Needy Families (TANF)	$10,404,529
Healthy Start Initiative Eliminating Racial/Ethnic Disparities	$1,092,899
Universal Newborn Hearing Screening	$235,000
Maternal, Infant and Early Childhood Home Visiting Program (formula)	$7,008,414
Georgia Early Hearing Detection and Intervention (EHDI)	$160,000
Georgia's State-based Perinatal Quality Collaborative Project	$200,000
State Partnership Grant Program To Improve Minority Health	$24,038
Total Other Federal Budget	**$35,533,337**

Other Funds Budget:

Program Name	Other Funds	Budget Amount
Regional Perinatal Care Centers	Federal Medical Assistance Percentages Match	$14,990,492
Women/ Maternal Health	American College of Obstetricians and Gynecologists AIM	$9,000
Genetics/Sickle Cell	Federal Medical Assistance Percentages Match	$963,981
Babies Can't Wait	Babies Can't Wait Medicaid Reimbursement	$1,100,000
Children's Medical Services	Children Elderly Trust Funds	$62,103
Immunization	Children's Health Insurance Program (CHIP)	$148,539,222
Genetics/Sickle Cell	Newborn Screening System QI Projects APHL	$161,757
	Total Other Funds	**$165,826,555**

III.E. Five-Year State Action Plan

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

State: Georgia

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

The Title V MCH program is committed to providing a foundation for family and community health across the state and in improving quality health care services for Georgia's families. Georgia utilizes multiple resources to design the state's Title V MCH program to address the nine priority needs which includes a variety of evidence-based and evidence-informed strategies. The life course perspective is used as a framework to conceptualize health and health disparities and guide improvements with emphasis on early determinants of health and the need for integration within structural, social, and cultural contexts. All activities within Georgia's Title V program connect to selected NPMs, SPMs, and ESMs.

Title V MCH program's success to improve health outcomes relies on leveraging extensive statewide partnerships. The Title V program staff lead multiple stakeholder groups that address both internal and external MCH programming. A Title V MCH Advisory Council was formed to contribute to the development of Title V plans, assist with assessment of needs, prioritization of services, and establishment of objectives for MCH programs. In addition to maintaining close relationships with public health districts, MCH partners with over 100 external stakeholders including Georgia's Hospital Association, Georgia's American Academy of Pediatrics, Georgia's Academy of Family Physicians, and Georgia's Obstetrics and Gynecological Society. These advisory councils, workgroups, and consumer engagement opportunities provide stakeholder perspective on policy issues and approaches for defining problems and possible solutions.

Title V implements the core public health functions of assessment, assurance, and policy development. The five-year needs assessment was conducted utilizing a life course perspective intentionally engaging with MCH partners and stakeholders. Title V addresses national and state performance measures through strategic coordination of efforts with partners and stakeholders to improve health outcomes for all MCH populations.

Family centered care is a priority and families and consumers are recognized as valued partners in making significant change in performance measures. The Title V Children's Medical Services (CMS) program identified areas of opportunity to strengthen the core principles of family centered care with an emphasis on engagement and leadership for families. A Family Engagement Learning Community (FELC) was developed with care coordinators serving families across the state with the goal of building a sustainable model for ensuring family partnerships in the CMS program. The FELC is providing a greater understanding of the importance for families as partners and providing the skills to establish and maintain authentic engagement with families. Title V aims to assess MCH programmatic support of family engagement activities. To illustrate the value of family engagement, Title V and CYSHCN program staff presented posters at the 2019 Annual AMCHP Conference on *Family Engagement in Georgia's Maternal and Child Health Title V Programs* and *Strengthening Family Engagement Through Workforce Development: Utilizing Communities and Quality Improvement Strategies for the Children's Medical Services Program*. Title V continues to assess the measures MCH programs utilize to support family engagement at state and district levels illustrating the level of engagement for each part of the family engagement framework.

To engage fathers and strengthen family partnerships, Georgia continues to participate in a pilot study of the first Pregnancy Risk Assessment Monitoring System (PRAMS) for Dads during the perinatal period. The study is the first surveillance system of new fathers, developing and piloting questions for PRAMS for fathers in Georgia. Title V recognizes that improved outcomes in infants and children are related to father involvement and has focused efforts to improve fatherhood involvement within the public health districts and home visiting sites.

Title V MCH programs develop and implement programs and initiatives that address the core functions of

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

III.E.2.b. Supportive Administrative Systems and Processes

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

The Health Promotion Administration Unit is responsible for DPH MCH workforce development strategies that ensure recruitment and retention of qualified staff, training and professional development for employees and strategic staffing structures that maximize funding resources. DPH MCH acknowledges the candidate driven job market and continues to utilize the latest recruiting strategies including social recruiting, employer branding and candidate experience. DPH MCH has 97% of positions filled including all program director and manager positions. The MCH leadership staff is comprised of the following individuals:

LaToya Osmani, MPH serves as the Director of the Division of Health Promotion. She is a member of the DPH Executive Leadership Team and is responsible for providing leadership to the MCH Section, Supplemental Nutrition Program for Women, Infants, and Children (WIC), and cross cutting programs: Oral Health, Early Brain Development, and Georgia SHAPE. She has over twenty years of experience in public health ranging from the federal, local, non-profit, private and global arenas. In addition to her public health administrative experience, she is skilled in informatics, business analysis and has taught public health. Leveraging her knowledge of public health enterprise, Ms. Osmani has supported and aligned teams to streamline processes and increase efficiency to strengthen public health programs and services.

Jeannine Galloway, MPH is the MCH Director overseeing programs and services related to early intervention, children and youth with special health care needs, fatherhood and maternal and infant health. In addition, she serves as the Director for the Title V Block Grant. Ms. Galloway has over 15 years of experience in public health increasing funding, partnerships, and programs with federal, state and non-profit organizations. Her experience includes creating, disseminating and evaluating national and state interventions.

Paige Jones is a Deputy Director managing the Title V block grant. She has over 27 years of MCH experience developing, managing and directing both public health, Medicaid and non-profit care coordination programs. Ms. Jones is responsible for the coordination of the Title V Block Grant, Five-year Needs Assessment, and the Improving Birth Outcomes Initiative. Ms. Jones also directed evidence-based home visitation programs, developed a fatherhood initiative and led collective impact efforts.

Diane Durrence, MPH, MSN, APRN is the Chief Nurse and lead over the DPH Nursing Program. Ms. Durrence provides leadership to the Women's Health Program, with responsibility for programs and initiatives that impact maternal health outcomes, as well as other women's health initiatives. She has over 25 years of public health experience in clinical services and program management.

Lisa Pennington MS, MA, LPC is a Deputy Director managing the Early Intervention unit. She has over 27 years of Part C experience, conducting assessments and providing administrative guidance and oversight. Ms. Pennington also has direct service experience working in private practice providing behavioral health treatment services to children, adolescents and adults. She responsible for overseeing child health programs and initiatives including: Babies Can't Wait Program, Children's Medical Services, the Georgia Autism Initiative and Children's Medical Services.

Sharifa Peart, MPH is the Children and Youth with Special Health Care Needs (CYSHCN) Program Director and supervises the Children Medical Services Program, Health Check and the Autism Initiative. She has been with the DPH MCH Section since 2012 and has experience in health care transition, telemedicine expansion, care coordination, physician engagement, family satisfaction, and child health referral systems. Ms. Peart was accepted into the 2019-2020 Georgia Leadership & Education in Neurodevelopmental Disabilities (GaLEND) interdisciplinary

training program for future professionals, disability advocates, and family members.

Judith Kerr, MPH, is a Deputy Director managing the Child Health Services unit that includes Newborn Screening, Early Hearing Detection and Intervention, Children First and 1st Care programs, as well as the Help Me Grow initiative. She has worked with DPH screening programs since 2015, increasing hospital and physician engagement with child health screening programs and revising referral policies and protocols. Prior to this role, Ms. Kerr served as a program manager for a charitable clinic where she led the expansion of pediatric vision clinics for underserved populations.

Twanna Nelson is a Deputy Director managing the Family and Community Supports unit that includes the Maternal Infant and Early Child Home Visiting (MIECHV) activities for the agency, the Fatherhood Initiative aimed at ensuring public health programs and external partnering agencies are intentionally involving fathers in programs and services; and the Healthy Start initiative funded by HRSA with the purpose of lowering risk factors associated with preterm birth, low birth weight, infant mortality and poor developmental outcomes.

Adam Barefoot DMD MPH, is the Director of Oral Health managing the State Oral Health Program including grants, contracts, budgeting, staffing, partnerships, and strategic programmatic objectives and activities. He helps facilitate oral health literacy awareness, education, school based oral health prevention programs, community fluoridation systems, oral health surveillance, and direct provision of clinical services throughout the state public health districts.

Valerie Newton-Lamb, MSHA is the Director of Administration for the Division of Health Promotion. She has over 20 years of experience in public health and healthcare administration managing complex, large scale operations. Ms. Newton-Lamb is responsible for Workforce Management, QI/Process Improvement and Communications, Planning and Partnerships within the Health Promotion Division.

Debra Chapman is the Fiscal Director for the Division of Health Promotion. She has over 20 years of experience in public health managing budgets. Her areas of responsibility are financial services, monitoring budget expenditures, preparing district budget and financial reports and grants and contracts. Ms. Chapman provides information and serves as a resource to others; achieving defined objectives by planning, developing, implementing and maintaining services in compliance with established guidelines; and serving as a member of the leadership team.

The MCH Family Support Coordinator, a CYSHCN parent, provides support and guidance to state and local district BCW and CMS staff by developing and promoting opportunities to engage families, establish partnerships with community stakeholders, and facilitate resolutions to family concerns. Title V programs would not function without the support of a dedicated team of epidemiologists (Epi) data analysts and program evaluators for data supports and program evaluation.

Ongoing workforce development for staff includes formal professional development, leadership training, cultural competency and family engagement training. Several months before the COVID-19 pandemic, DPH rolled out Brainstorm Quick Help, a new learning platform. The platform surveys staff and customizes learning based on job title, work style, skill level, and interests. It also outlines a personalized skill path based on survey feedback. The coursework in Quick Help was pivotal in preparing staff for efficient telework and virtual team operations.

The Division of Health Promotion promotes horizontal/lattice approach development opportunities to provide a non-linear path for professional growth, acquisition of new skills rather than hierarchical job titles, create value for staff by increasing knowledge and provide multi-directional career opportunities with wider prospects for job opportunities. The horizontal approach for career development contributes to a well-skilled, diversified team, well-rounded senior leaders who have more insight into several different business units across an organization, greater opportunity to

explore interests within the organization and across different departments and encourage employee retention across organizations.

The Division of Health Promotion continued workforce initiatives that focused on workforce training that supports MCH strategies in home visiting and early brain development.

The Family and Community Supports program completed the following efforts:

- Ninth annual Georgia Home Visiting Institute day of training for 277 home visitors; DPH sponsored the training in partnership with United Way of Greater Atlanta and planned by the Home Visiting Professional Development Work Group.
- Worked with MCH Communications to finalize development of home visiting career kit consisting of home visiting brochures and postcards, pens, first aid kits, cell phone card holders, bookmarks and lip balm.
- Spoke to over 256 college and technical school students about home visiting through nine in-class presentations, five career fairs, and visited 60 colleges and technical schools
- Awarded eight additional Child Development Associate scholarships to home visitors
- University of Georgia J.W. Fanning Institute has conducted two *Home Visiting Leadership Academy* webinar sessions, two leadership webinars for home visitors and First Steps Coordinators and two in-person Home Visiting Leadership professional development workshops
- Developed and distributed a professional development survey to all home visitors and program managers to better assess training needs and priorities

The Early Brain Development and Learning Acquisition program facilitated several initiatives on Early Brain Development. Talk With Me Baby™ is a partnership of organizations that are committed to ensuring that every newborn in Georgia receives essential language nutrition and has the opportunity to reach their full potential. Together, these partners targeted the large-scale workforces that already interacted with new and expectant parents (nurses, WIC nutritionists, early learning educators, obstetricians, pediatricians, foster parents, home visitors, etc.). The focus is on preparing these employees to coach families on how and why they should provide their babies with the “language nutrition” they need to support early brain development. Over 8,000 people across various workforces have been trained in the Talk With Me Baby curriculum.

DPH’s Applied Learning Program’s efforts to bolster the future of the public health workforce includes ongoing student internships. The DPH Health Promotion Division was chosen to serve as a Public Health Associate Program (PHAP) host site as an additional effort to build the next generation of public health professionals. DPH will host PHAP associates for a two-year training program which will include a rotation through MCH, WIC and cross cutting programs within the agency. DPH will continue to foster a learning environment and culture to support the efforts of DPH to build a workforce capable for accomplishing the mission of public health as well as meet the mission of the Title V MCH Block Grant.

Several methods are used to ensure culturally competent approaches are used in service delivery across all programs. MCH EPI routinely collects and analyzes data by race/ethnicity and income to assess health equity and inform program activities
MCH works closely with community leaders to plan service delivery programs, collaborate on grants and implement culturally competent services that meet the unique needs of populations.

As the MCH Section Chair of the Georgia Public Health Association (GPHA), the MCH Director provides learning opportunities for MCH professionals and students through quarterly webinars and newsletters. Webinars were

provided on Georgia's Cross-Agency Child Data System housed in the Department of Early Learning and Care and the Georgia System of Care Plan to Help Address Mental and Behavioral Challenges of Children hosted by the Georgia Health Policy Center. The importance of Stakeholder Engagement in the Title V Five-year Needs Assessment was presented at the 2019 GPHA Conference. Future webinars will be presented focusing on MCH data and other MCH topics of interest.

To strengthen and enhance leadership skills, the MCH Director participated in AMCHP's New Directors Leadership Lab. The MCH Director participated in a ten-month program providing an opportunity to increase knowledge related to key MCH and leadership topics.

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

Families and consumers provide knowledge and insight to state programs and staff, as well as suggestions on how to make positive changes for the MCH populations. The Title V program provides opportunities for meaningful engagement at varying levels of involvement and intensity to fit the needs of consumers and families.

MCH has an understanding and appreciation of the benefits that come from collaboration with families and program participants. Promoting and strengthening family partnerships remains a key priority and area of focus. Families bring valuable input and perspective including the knowledge of their family strengths and individual needs to inform program development and priorities. Promoting a holistic, culturally relevant approach to health and wellness for all families and children, including those with special health care needs, keep families at the center of public health care practice, policy, and research.
MCH fosters a "Culture of Family Engagement" in all aspects of program planning, implementation and evaluation and adheres to the Multidimensional Framework for Patient and Family Engagement in Health and Health Care (Carmen et al. (2013)) to measure, monitor and evaluate MCH's levels of family engagement across a continuum. Families, interns, and community partners are included alongside MCH staff in training, quality improvement initiatives, block grant development and review, workforce development, and policymaking. Families and partners also serve on the MCH Advisory Council, and as part-time and full-time staff.

MCH programs focus on activities engaging families to participate in special projects to increase engagement at the organizational design and governance level of the Family Engagement Framework. MCH programs are dedicated and engage with families through the following activities:

Fatherhood Initiative: The Family and Community Support Team's Strong Fathers Strong Families Initiative engages fathers to improve health outcomes for children.

CYSHCN Family Engagement Learning Collaborative (FELC): The CYSHCN Director and Family Support Coordinator lead a FELC to assist district level CYSHCN coordinators to intentionally and effectively increase family engagement at the local level.

Early Hearing Detection and Intervention Learning Community (EHDI): The EDHI Learning Community trains providers on 1-3-6 follow-up, care coordination and provider and family engagement. The community consists of a parent of a child identified as deaf or deaf and hard of hearing, a family physician, an early interventionist, a state early care and learning program representative, and an audiologist.

Atlanta Healthy Start Initiative Community Action Network (CAN): Title V and Women's Health Staff participate in the Atlanta Healthy Start CAN with other community partners, family and healthcare organizations to conduct a community learning collaborative focusing on Maternal Mental Illness.

Georgia Perinatal Quality Collaborative (GaPQC): Family Leaders participate in the GaPQC Health Equity Subcommittee.

Centering Pregnancy: Pregnant women of diverse backgrounds and ages act as peer mentors during facilitated discussions by a medical professional at prenatal visits.

Adolescent Health: Youth are invited to participate in a development program that consists of leadership development, teen-dating violence prevention, team building, and building self-esteem and self-confidence.

Oral Health: The Oral Health program partners with the community for oral health events including churches, Special Olympics, Head Start, Easter Seals, CYSHCN (BCW, CMS), daycares and preschools.

Newborn Screening (NBS)
NBS Family representatives attend the semi-annual Newborn Screening and Genetics Advisory Committee (NBSAC) meetings to present and testify the impact of newborn screening on saving lives and changing outcomes for children with heritable conditions. The NBSAC is composed of parent representative organizations, Parent to Parent of Georgia, Hands and Voices, PKU Alliance and the Sickle Cell Foundation of Georgia. A Family Leader led the review work group during the year.

Family and Community Supports
Family and Community Supports lead the Continuous Quality Improvement (CQI) project which focuses on family engagement. The mission of the CQI plan is to facilitate the provision of high-quality, evidence-based family support services to at-risk families and children, prenatally up to age five.

Babies Can't Wait
Local BCW Programs participate in outreach activities and partner with local organizations to share educational materials. Some districts participate in the CMS FELC whose activities include play groups, CYSCHN sports events, Special Needs Prom, P2P Health and Education Trainings and Workshops, Family Fun Days, Community Lunch & Learns. Families participate in quarterly State Interagency Coordinating Council (SICC) and Local Interagency Coordinating Council (LICC) meetings. Karen Lewis is the current SICC chairperson. Ms. Lewis is a longtime MCH family leader whose child was a participant in MCH's BCW early intervention program. Through continued engagement, training and support, Ms. Lewis has increased in leadership capacity and effectively serves in the highest leadership role for the council.

Children's Medical Services (CMS)
CMS expands family engagement through workforce development and community partnerships. Opportunities include the FELC that provides a platform for local district CMS programs to engage with and develop parent leaders.

Input from families and youth is essential for improving outcomes in all MCH populations. Efforts to increase capacity within MCH to implement, support, scale-up and sustain quality family engagement will continue. Additionally, MCH continues to work with partners and stakeholders to identify opportunities for family partnerships, improve systems to reduce barriers to family engagement, encourage capacity in the workforce to encourage meaningful family participation, and identify outcomes for successful family professional partnerships in all systems. New initiatives will target increasing engagement on the policy level and continue to intentionally plan activities to include family and partner engagement and evaluate activities for effectiveness.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

DPH is a Tier Two site for the States Systems Development Insurance Initiative (SSDI) project period, December 1, 2017 through November 30, 2022. Georgia proposed to build and expand state data capacity, develop and use data linkages among key MCH datasets and enhance DPH surveillance systems that address the data needs related to emerging MCH issues; particularly infant health (e.g., NAS and Zika-related birth defects). Achieving the proposed objectives will enable Georgia to better measure multiple Title V Minimum/Core Indicators. Anticipated outputs of the proposed activities address most of the HRSA-identified Tier Two program outcomes. Through collaborative efforts the MCH program and the MCH Epidemiology program developed analysis plans and disseminated the subsequent data analyses, aiming to use SSDI funds to better guide policy and programmatic direction within MCH.

DPH activities align with the primary purpose of SSDI to develop, enhance, and expand state and jurisdictional data capacity for needs assessment and performance measure reporting. MCH Epidemiologist (EPI) worked closely with the Women's Health team to include family planning data in the State Electronic Notifiable Disease Surveillance System (SendSS) to allow accessible and timely data to MCH EPI and program staff. MCH staff will be able to improve program evaluation activities as automated reports will be created within SendSS. An Infant Health EPI was hired to support MCH EPI's capacity to conduct analyses specific to relevant Title V indicators. Through routine and ongoing meetings with MCH, analytic plans are developed to serve as a foundation that informs programmatic direction with data linkages established to better guide programs and also provide information that increases the ability of the program to assess, plan, implement, and/or evaluate efforts. Analytic plans will be developed to serve as a foundation to inform programmatic direction. This will increase the ability to assess, plan, implement, and/or evaluate program efforts. MCH EPI staff responsible for implementing data linkages will also increase their capacity to perform data linkages through trainings. By establishing and maintaining surveillance systems relevant to emerging MCH issues and performing data analyses for the corresponding programs, MCH EPI can enhance MCH's understanding of the burden and underlying dynamics of emerging MCH issues.

Prior to being awarded the current SSDI grant, DPH had ongoing surveillance efforts for NAS and birth defects related to the Zika virus. Improving both surveillance systems will enable MCH EPI to effectively identify cases and guide programmatic decision making around each health area. Infants with a Zika-related birth defect will be linked to relevant medical and early intervention services. Data related to this surveillance effort will inform state and national level recommendations for this population.

To meet the goal of building and expanding state data capacity to support Title V Block Grant activities, the SSDI current fiscal year funds are being used to: 1) facilitate direct access to women's health data, 2) fund an epidemiologist focused on infant-related morbidity and mortality, and 3) to create an analysis plan to meet Title V data needs. To date, the Infant EPI has been performing infant health-related analyses that MCH EPI did not have the capacity to previously perform. MCH EPI successfully developed the centralized information system to store DPH Family Planning data that is easily downloaded for analysis and has several analyses available for MCHP staff to use to evaluate performance. This Family Planning Portal has allowed for more timely access to the data, while also making basic analyses available more quickly for the non-epidemiology staff. Over the current fiscal year, this centralized information system will be maintained and modified to increase the capacity to produce ad hoc reports (e.g., quarterly and annual TANF reports, Long Acting Reversible Contraceptive reports, health district level services). The periodicity of the data has already been increased to monthly availability or requisite data, while the lag time for accessing and analyzing the Georgia Hospital Discharge Data (GHDD) - a core MCH dataset - has decreased. GHDD is now able to be received quarterly, a quarter after the last month in a quarter. MCH EPI processes the quarterly data to perform surveillance on severe maternal morbidity for participating hospital facilities. This effort supports GaPQC, which aims to reduce the burden of obstetric hemorrhage and severe hypertension among delivering women in Georgia. To date, facility-specific quarterly data reports have been provided to hospitals

participating in each Alliance for Innovation on Maternal Health bundle for the last six quarters.

To meet the goal of advancing the development and utilization of linked information systems among MCH datasets, the SSDI current fiscal year funds are being used to: 1) develop a plan to implement annual data linkages that fill existing gaps in the ability to assess indicators from the Minimum/Core dataset and 2) perform the annual data linkage. To date, enhanced data linkages have assisted in improving the quality of data reported as part of Newborn Screening and Early Hearing Detection and Intervention. As required by the SSDI grant, MCH EPI will also report on the SSDI performance measure related to data access, periodicity, and lag time. The Newborn Screening EPI has successfully linked electronic birth certificate data with screening data to improve the quality of data submitted to the APHL New Steps data repository.

To meet the goal of supporting surveillance systems development that addresses the needs of emerging MCH issues, the SSDI current fiscal year funds are being used to: 1) enhance NAS surveillance and 2) expand Georgia's surveillance of emerging threats to women and infants via ongoing development of the congenital infections registry and geo-enabling of surveillance data. MCH EPI was one of four sites awarded a contract from the Council for State and Territorial Epidemiologists (CSTE) to pilot the new NAS case definition approved at the CSTE Annual Conference. MCH EPI has been working with several external laboratories to expand the use of electronic lab reporting (ELR) to include neonatal toxicology results, which can be linked to existing NAS case reports or used to create new case reports. Edits to the existing NAS reporting module to capture information of interest per the new NAS case definition are in progress. MCH EPI has completed multiple data requests for internal and external stakeholders related to NAS. Regarding the development of the Georgia Birth Defects Registry, multiple datasets have been linked together (e.g., Birth Certificate, Georgia Birth Defects Reporting and Information System). Confirmed cases of birth defects have been connected into Georgia's early intervention referral program, Children 1st. During the current budget year, the capacity to link confirmed cases of birth defects into early intervention services will be integrated into the electronic information system development.
Throughout the remainder of the current fiscal year, the ongoing development of the Georgia Birth Defects Registry will result in multiple data linkages yet to be established in Georgia. The Georgia Birth Defects Registry now contains Vital Records data (e.g., birth certificates, death certificates, and fetal death certificates), and healthcare provider reported cases (e.g., facility-level line lists of suspected cases and direct reports). A strategy for linking internal screening and surveillance systems (e.g., Newborn Screening (Pulse Oximetry), Early Hearing Detection and Intervention, NAS), referral and medical services (e.g., Children 1st and Children Medical Services), electronic medical records, and data from the CDC's Metropolitan Atlanta Congenital Birth Defects Program. SSDI funds assist in the ongoing development of this electronic information system. The Congenital Infection Registry and related surveillance efforts to monitor the impact of in-utero exposures on infants currently is not geo-enabled. For the remainder of the current year, MCH EPI intends to enlist the support of an ESRI contractor to assist in expediting the geo-enabling of this critical data.

To further the goal of building and expanding state data capacity, modifications to the centralized information system housing Georgia Family Planning data will be compiled and executed to better assist data-driven decision making in Title V-related MCH programs. In the third year of the project period, the focus will be on using the information system to better evaluate relevant women's health indicators. This will include modifications to the reporting capacity of the information system, code to produce the desired results for performance indicators at different geographic extents, and dissemination of results to inform policy and programmatic decision making.

In the coming year, the Infant EPI funded through SSDI will continue to work with MCH to assist in deepening the understanding of the burden of NAS in Georgia. Upon completion of the modifications to the existing NAS reporting module, the new case definition will be introduced to existing reporters, and efforts to onboard non-reporting facilities and external laboratories to begin reporting will continue. Suspected NAS cases identified through the Birth Defects

Registry will be linked to the NAS reporting module. As part of the case definition pilot project, medical records will be requested and reviewed for NAS case confirmation to improve data quality and completeness and provide recommended modifications to the case definition based on our findings. MCH EPI will work with MCH to establish a path forward in automating the process to refer confirmed cases to early intervention services.

The Georgia Birth Defects Registry will complete the development stage of the Birth Defect Registry and enter the implementation phase. Ongoing modifications will be made to the Registry to ensure it is operating as expected. Efforts will also be made to ensure that identified infants and children with birth defects will be connected to early intervention services. Once the Registry is validated in its entirety, initial efforts to produce broad estimates of the incidence and prevalence of birth defects in Georgia will be made. The Congenital Infections Registry will continue to enhance the geo-enabling of surveillance data to better monitor the threat of emerging threats to women and infants.

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

The MCH Title V program works collaboratively with state agencies, professional organizations, and community based nonprofits to ensure access to quality health care and needed health services for women, children and CYSHCN. Statewide efforts are coordinated within the MCH section to provide and promote quality driven, comprehensive, family-centered and community based systems of care for Georgia's diverse and growing populations.

Georgia's Title XIX Medicaid program provides support to pregnant women, children, retirees age 65 and older, and individuals who are legally blind or disabled. Since 2006, Georgia Medicaid has contracted with managed care organizations to manage more than 1.3 million Medicaid and State Children's Health Insurance Program (SCHIP) low income adults and children. Georgia ranks 42nd in the nation with nine percent of adults one to 64 covered by Medicaid. Children, youth, and young adults in foster care, those receiving Adoption Assistance, and a select group of children with Department of Juvenile Justice involvement are covered for their medical, dental and behavioral health needs through a single managed care organization. A small carve-out of the Aged, Blind and Disabled population is served through a fee-for-service arrangement. MCH Title V works closely with Medicaid to ensure individuals across the state have access to these programs and services.

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

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

Close partnership between Medicaid and MCH Title V also assists with providing timely access to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits for children and adolescents in areas where there are shortages in pediatricians. The Title V MCH program and the DPH Medicaid Liaison collaborate to ensure an understanding of MCH programs and ensuring DPH representation with CMOs. Together MCH and Medicaid have the capacity to reduce morbidity and mortality among women, infants, children and adolescents, and to improve the health status of women
and children in Georgia. Local health departments, including rural areas, provide EPSDT services to low income children and adolescents. Many children birth to five with identified developmental delay and risk factors are connected to the C1st program for assessment, monitoring and linkages to the early intervention services.

Georgia's early intervention services program, BCW, expanded its scope of services in 2018 to include the provision of autism related services. This expansion was due to Medicaid's expansion of covered services to include adaptive behavioral services (ABS) for individuals under the age of 21 with ASD. ASD coverage is provided for assessment and treatment services according to severity and is based on medical necessity. To ensure adequately trained professionals to provide quality diagnostic assessments, the Georgia Autism Assessment Collaborative

(GAAC) was formed. GAAC is funded by MCH Title V and implemented by the Emory Autism Center (EAC), with cooperation from the Georgia Psychological Association. Babies Can't Wait (BCW) is enrolling board certified behavioral analysts to provide ABS to eligible children as well as working with the Children 1st program to expand access to Modified Checklist for Autism in Toddlers (MCHAT) screenings for infants and toddlers.

MCH Title V program also works with professional organizations to strengthen the public/private partnership with physician members and dental providers to ensure access to quality medical services for women, children and CYSHCN. Partners include the Georgia Chapter of the American Academy of Pediatrics, Georgia Academy of Family Physicians, Georgia Perinatal Association, Georgia Dental Hygienists, Georgia Dental Society, Georgia Hospital Association, and Georgia Obstetrical and Gynecological Society. Working with professional organizations extends the reach of public health initiatives and strengthens access to pediatric medical home, developmental screenings, early intervention services, oral health care for pregnant women and CYSHCN, breastfeeding education and countless other initiatives. MCH Title V works closely with the GaOBGYN to initiate and administer the GaPQC initiative to implement the use of Alliance for Innovation on Maternal Health (AIM) hemorrhage and hypertension patient safety bundles in the state's birthing hospitals. Physicians also play an instrumental role in supporting the CMS program's specialty clinics. CMS partners with more than 30 medical providers to improve access to pediatric specialty care for children, living in rural counties across Georgia, and their families. The CMS program works closely with DPH's Office of Telehealth and Telemedicine to utilize telemedicine technology within seven specialty clinic sites.

Along with professional organizations, the MCH Title V program works with many community-based nonprofits that supports the delivery of services to low-income women and children. Two of those nonprofit organizations include Parent to Parent (P2P) of Georgia and Healthy Mothers Healthy Babies (HMHB). These organizations receive funds to provide outreach, referrals, and support to Georgia families. P2P connects families by using volunteer families who are willing to assist other families through virtual support, support groups, and one-on-one matches to supporting parents. They also educate families by providing a Special Needs group trainings across the state, and one-on-one assistance. P2P operates and maintains the Special Needs Database, trains volunteer parents across the state to become and participate as family leaders, conducts transition from pediatric to adult care workshops for parents and youth as well as administers the Parent as Partners project at seven site locations across the state. HMHB manages the C1st information and referral line receiving and making approximately 41,000 calls annually. HMHB partners with the Georgia Association for Primary Health Care, to provide education to families on health insurance, Affordable Care Act (ACA) plans, eligibility and directly enroll families in ACA plans through the Federal Healthcare Marketplace and P4HB.

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

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

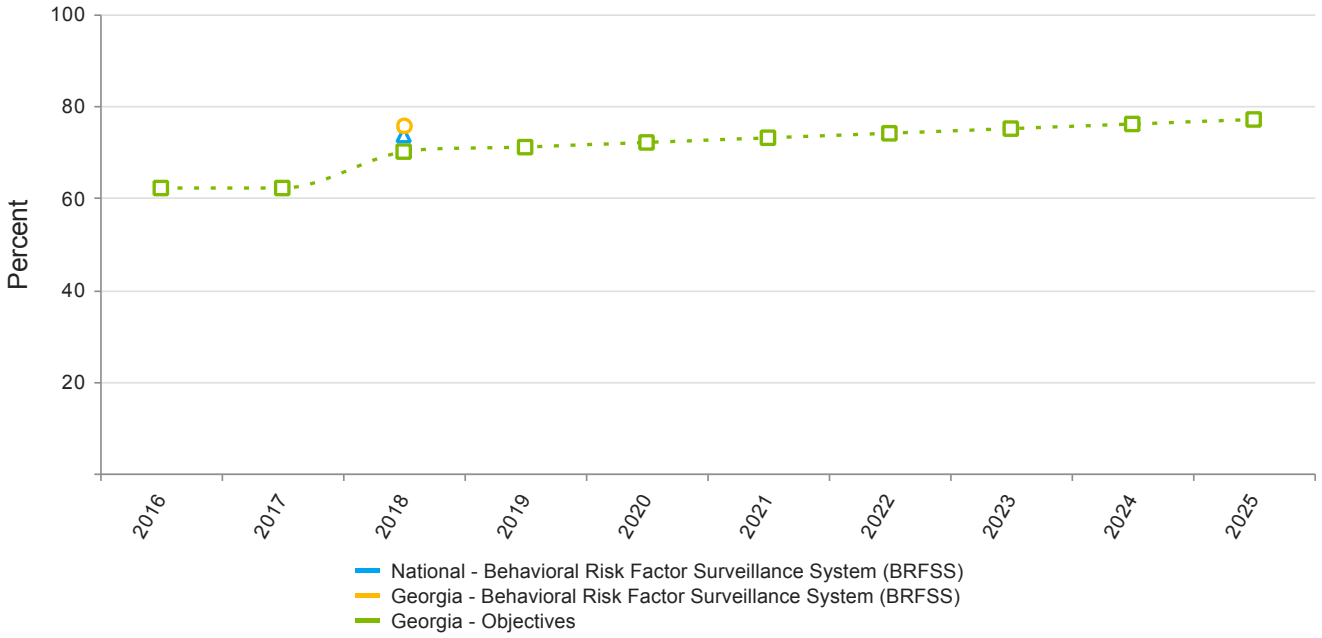
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2017	72.6	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	32.9	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	10.1 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	11.5 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	28.3 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	7.2	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	7.2	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.6	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.5	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	251.5	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2018	6.3 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2017	3.4	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	12.8 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	88.5 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	20.6	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2018	13.6 %	NPM 1

National Performance Measures

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



Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	62.1	62.1	70	71
Annual Indicator	67.7	69.7	70.4	75.5
Numerator	1,258,025	1,321,663	1,335,604	1,443,474
Denominator	1,857,538	1,895,900	1,898,399	1,912,418
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	72.0	73.0	74.0	75.0	76.0	77.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of initial program cervical screening tests that are conducted among women who have never been screened or not screened within the last 10 years

Measure Status:	Active

Baseline data was not available/provided.

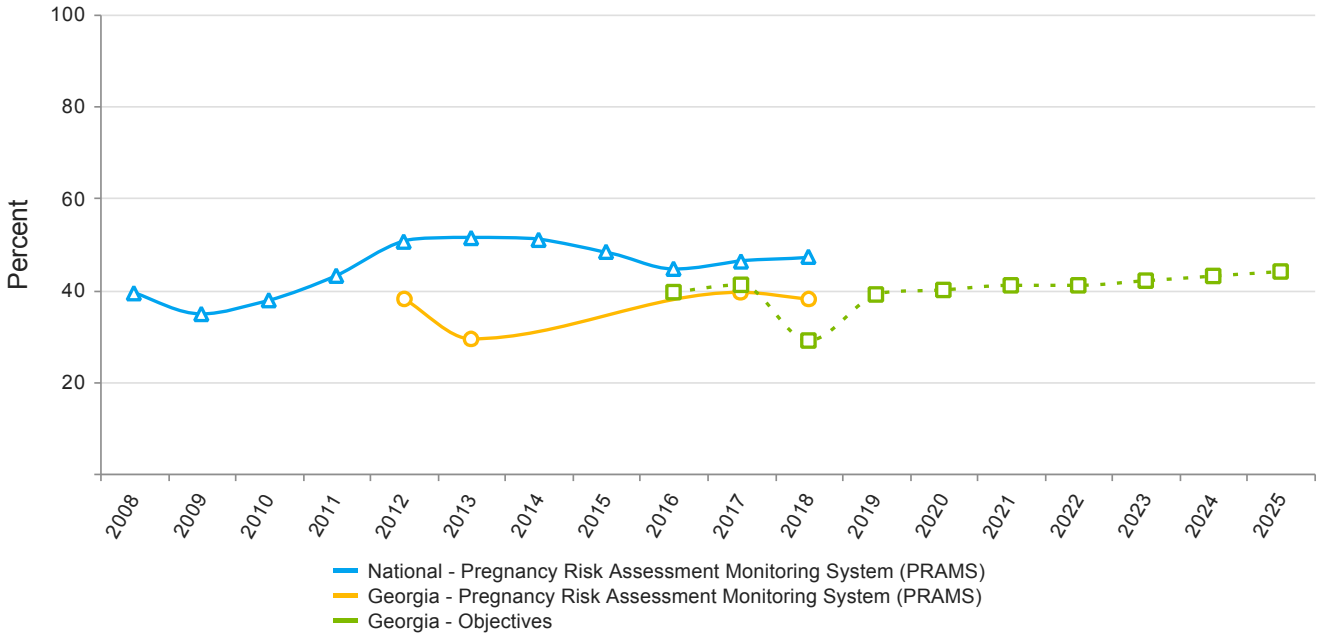
Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	20.0	20.0	20.0	20.0

ESM 1.2 - Number of LARCs utilized among women of reproductive age (15-44 years) served in local Public Health Departments

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	6,960
Numerator	
Denominator	
Data Source	SENDSS
Data Source Year	CY 2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7,169.0	7,378.0	7,587.0	7,796.0	8,005.0

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



Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	39.5	41.1	29	39
Annual Indicator	29.3	29.3	39.3	37.9
Numerator	18,443	18,443	48,597	45,805
Denominator	63,060	63,060	123,575	120,710
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2013	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	40.0	41.0	41.0	42.0	43.0	44.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

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

Measure Status:	Active

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

ESM 13.1.3 - Number of views of the oral health videos and social media clips

Measure Status:	Active

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

State Action Plan Table

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

Priority Need

Prevent Maternal Mortality

NPM

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

Objectives

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

1.2 Increase overall number of LARCs (IUDs and implants) provided to eligible women of reproductive age (15-44) when served by the Georgia Family Planning Program in local Public Health Departments by 3% annually.

Strategies

1.1.a Meet or exceed the CDC guideline of providing ≥75% of federally funded screening mammograms to women over 50 years of age.

1.1.b Meet or exceed the CDC guideline of providing ≥20% of initial pap tests to individuals who have never or rarely been screened for cervical cancer.

1.2 Increase the number of LARCs utilized among women of reproductive age (15-44 years) served in local Public Health Departments.

ESMs	Status
ESM 1.1 - Percent of initial program cervical screening tests that are conducted among women who have never been screened or not screened within the last 10 years	Active
ESM 1.2 - Number of LARCs utilized among women of reproductive age (15-44 years) served in local Public Health Departments	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

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

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

Promote oral health among MCH populations

NPM

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

Objectives

13.1.1 Develop, maintain, and update a state oral health surveillance system that helps capture data, and identify gaps in data related to oral health information pertaining to pregnant woman.

13.1.2 Increase perinatal providers educated on the impact of oral health and pregnancy.

13.1.3 Increase number of Home Visiting workers throughout the state educated on oral health in pregnancy so they will be able to increase oral health literacy in pregnant patients and new moms within the families they serve.

13.1.4 Improve oral health literacy through awareness campaigns geared towards pregnant women.

13.1.5 Maintain a high level of access for all Georgians, including pregnant women, to community water with the recommended level of fluoride as a means of reducing dental decay.

Strategies

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

13.1.2 Partner with Georgia OBGYN Society, Healthy Mothers Healthy Babies, and Georgia Academy of Family Physicians to coordinate trainings on oral health and the medical provider role.

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

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

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

ESMs	Status
ESM 13.1.1 - Percent of medical providers who reported an increase of oral health knowledge from trainings and presentations	Active
ESM 13.1.2 - Number of oral health resource bags distributed to pregnant women and caregivers of young children through internal and external partners	Active
ESM 13.1.3 - Number of views of the oral health videos and social media clips	Active

NOMs
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

2016-2020: National Performance Measures

2016-2020: State Performance Measures

2016-2020: SPM 1 - Percent of women (ages 15-44) served in the Georgia Family Planning Program (GFPP) who use long-acting reversible contraceptives (LARC).

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		11	16.5	15
Annual Indicator	16.6	15.6	17	18.1
Numerator	9,714	9,175	10,348	10,613
Denominator	58,434	58,675	60,860	58,568
Data Source	GFPP	GFPP	GFPP	GFPP
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Priority Need: Prevent Maternal Mortality

NPM 1: Well-Woman Visits

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

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

Maternal mortality was identified as a priority need for Georgia in 2015 with a strategic focus on increasing the percentage of women who receive a preventive health care visit. Due to the critical need to reduce maternal mortality in Georgia, the Title V Program focused on strategies that reduce maternal mortality. Understanding those factors associated with maternal mortality and morbidity is essential for improving maternal health outcomes.

During the reporting year, MCH hosted the Third Annual MCH Conference at the University of Georgia to provide professional development, dialogue and networking to Georgia's MCH workforce with 400 people in attendance. The conference's keynote address presented by Dr. Fleda Mask Jackson, leader and creator of Save 100 Babies, focused on maternal mortality prevention highlighting social determinants and asset-based approaches for eliminating racial disparities in birth outcomes. A Pre-Conference session was held to provide an opportunity for MCH workforce, stakeholders and partners to learn about current trends, state and national initiatives, and how Georgia can improve maternal mortality outcomes. Two nationally recognized speakers, Mr. Charles Johnson and Dr. Joia Crear-Perry presented. Mr. Johnson shared his personal experience with maternal mortality and his mission to advocate for improved maternal health policies and regulations through his nonprofit 4Kira4Moms. Dr. Crear-Perry, the Founder and President of the National Birth Equity Collaborative, presented opportunities to reduce black maternal and infant mortality through research, family-centered collaboration and advocacy.

Maternal Mortality Review Committee

The support of the Governor and the Georgia Legislature with the passage of SB 273 in 2017, laid the foundation for the ability for the MMRC to identify pregnancy-associated deaths, review those caused by pregnancy complications and other selected deaths, and identify problems contributing to the deaths and interventions that may reduce these deaths. The bill provides legal protections for committee members and the review process, ensuring confidentiality of the review process and providing the committee with the necessary authority to collect data for case review. During the reporting year, the analysis of 2014 case review findings and draft report were completed. The final report has been published and disseminated statewide. During the review of 2014 maternal deaths in Georgia, the MMRC adopted the CDC-developed Committee Decision Form which was critical and necessary to collect additional data about factors related to the maternal death. The MMRC findings help direct and

lead initiatives to impact maternal birth outcomes. Contracts were established with 16 rural birthing facilities to provide funding for participation in perinatal quality improvement initiatives.

Priority Need: Prevent Maternal Mortality

NPM 3: Risk-appropriate Perinatal Care

Maternal and Neonatal Levels of Care

Perinatal Levels of Care Legislation became effective July 1, 2018 to create a mechanism for levels of care designation and ongoing site verification of Georgia birthing hospitals. DPH launched an initiative to designate hospitals according to the level of maternal and neonatal care the facility can provide. The purpose of a hospital designation is to encourage risk-appropriate care for Georgia's women and infants and to more accurately assess the capabilities of Georgia's hospitals. In Georgia, hospitals receive a certificate of need authorizing them to provide a level of perinatal care through the Georgia Department of Community Health. However, there has not been a mechanism to verify that hospitals are meeting the requirements for the level of care they have been authorized to provide through their license. According to the Levels of Care Assessment Tool (LOCATe) survey conducted by the CDC, nearly half of Georgia hospitals that completed the survey were assessed at a lower level of care than their self-assessed level. Through this program, hospitals may voluntarily apply for a designation from DPH. To achieve a designation, hospitals must demonstrate through document submission and an onsite review that they meet the requirements for their license, as well as additional requirements based on the recommendation from the American Academy of Pediatrics (AAP), the American College of Gynecology and Obstetrics and the Society for Maternal-Fetal Medicine. A Neonatal Subcommittee and a Maternal Subcommittee were established to assist the Maternal and Neonatal Advisory Council on the designation requirements. These subcommittees are comprised of physicians, nurses and hospital administrators from hospital systems throughout the state and represent a variety of specialties.

In the reporting year, the Neonatal Subcommittee and the Maternal Subcommittee completed their recommendations on the criteria for Levels I-III. The subcommittees used the recommendations from the American Academy of Pediatrics, the American College of Obstetrics and Gynecology and the Society for Maternal Fetal Medicine as a model. They also considered additional requirements of other states. Women's Health leadership met with several states who have implemented levels of care verification programs and national organizations promoting levels of care to learn about best practices and lessons learned.

Perinatal Regionalization

The MCH Regional Perinatal Center (RPC) program promotes access to risk appropriate perinatal care to pregnant women and their infants through regional quality improvement activities. Program activities include: 1) facilitating local perinatal advisory councils to provide regional planning, coordination, and recommendations to ensure appropriate levels of care; 2) performing regional and statewide hospital surveys and perinatal assessments; 3) developing communication networks among agencies, providers, and individuals; 4) disseminating educational materials and producing a statewide summary of findings; 5) assisting hospitals with quality improvement activities, data collection protocols, and quality assurance policies and procedures.

During the reporting year, annual site visits were completed, and RPC contract amendments were sent to contractors. Outreach Educator meetings were held and representatives from the BCW, Children's 1st and CMS. Educators updated the Hospital Assessment Checklist that is completed by Outreach Educators when they conduct site visits with birthing hospitals within their region to ensure compliance with the standard of care as defined by their level of care designation.

Alliance for Innovation on Maternal Health (AIM) Bundles

In response to the MMRC reports, Georgia applied to the AIM program and was accepted as an AIM state in October 2017 to lead the Georgia Perinatal Quality Collaborative's (GaPQC) initiative to implement the use of AIM hemorrhage and hypertension patient safety bundles in the state's birthing hospitals. The two-maternal safety bundles that were selected for implementation were the AIM Obstetric Hemorrhage Bundle and the AIM Severe Hypertension in Pregnancy Bundle. Under the leadership of DPH and in collaboration with the GaPQC, hospitals were enrolled to participate in the AIM Obstetric Hemorrhage Bundle over two enrollment periods, resulting in over half (42) of the state's delivering hospitals enrolled by the end of the reporting year. Hospitals identified their respective implementation teams and were provided structure and process measures to implement. GaPQC provides support to hospitals including monthly collaboration webinars, individualized technical calls, and data collection, analysis and reporting. In 2018 the Georgia General Assembly provided two million dollars to implement quality improvement projects in rural birthing hospitals. Sixteen hospitals received funding and are among the birthing hospitals working to implement the AIM hemorrhage bundle initiative. In the reporting year, continued outreach efforts to increase awareness of GaPQC and availability of the maternal safety bundle initiatives continued as well as hospital support for implementation of the Obstetric Hemorrhage Bundle.

Maternal Mental Health

In the reporting year, state funding was received to begin a perinatal psychiatry access program. The perinatal psychiatry access program will connect providers treating pregnant and postpartum women with training on managing perinatal mood and anxiety disorders with real-time consultations from a perinatal psychiatrist. Women's Health worked to establish contracts with the HMHB and the Emory Clinic to operate the program. Postpartum Support International, Georgia Chapter will be conducting training to increase the number of mental health providers who have a Certification in Perinatal Mental Health. Lifeline4Moms collaborated with Women's Health to provide consultation services on program development and monthly webinars and program manager conference calls.

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

During the reporting year, the state Oral Health Program participated in a work group to improve oral health access and care for pregnant women in Georgia through the HMHB. Oral Health Program team members attended quarterly meetings and the Director of Oral Health participated in bimonthly conference calls. Three key priority areas were developed which included improving oral health literacy through awareness efforts for pregnant women, increasing oral health literacy through awareness efforts geared towards perinatal providers, and reducing administrative burden for participating as a provider in state Medicaid. The Director of Oral Health participated in subcommittees dedicated to both oral health awareness efforts for perinatal providers and pregnant women.

The Oral Health Program participated in the annual MCH Conference and coordinated two days of presentations to district oral health staff and other MCH program staff. Topics included school sealant programs and mobile dentistry, child abuse, xylitol-based products as an oral health prevention strategy, and HIPPA.

The Oral Health Program worked with the MCH Epidemiology section to add three additional state supplemental questions related to oral health to the PRAMS survey. Questions were reviewed by subject matter experts from the MCH Epidemiology section as well as the Oral Health section to determine Georgia's gaps related to oral health surveillance of pregnant women.

With support of a CDC grant, the Oral Health Program developed an oral health awareness media campaign. The

campaign had two primary target groups of focus; pregnant women and caregivers of very young children and provided concise key messages to increase oral health literacy and implement positive behavior across multiple media platforms. The first phase involved 30 second radio ads airing in six public health districts. Oral Health resource bags were also developed which included two infant tooth brushes, an adult toothbrush, floss, toothpaste, a children's book about the importance of oral health, a pack of wipes to use after nursing or bottle feeding to wipe out the oral cavity, and a brochure on helpful oral health tips. The plan for distribution included utilizing oral health district staff, home visitors, DPH district nursing staff, DPH perinatal case managers, and strategic partner organizations such as Georgia OBYGN Society and HMHB. The last phase that will roll out in early 2020 will be short (under 1 minute) video clips featuring the Oral Health Director providing the same key messages which will be promoted on the DPH Facebook, YouTube, and Twitter pages as well as sponsored boosting geotargeted ads on Facebook.

Priority Need: Increase Access to Family Planning Services

SPM 1: Family Planning

Georgia's Family Planning Program provided leadership, guidance, and resources to Georgia's health districts in the development and provision of resources that increase the access of family planning services to women. Comprehensive health care provided women the support to plan the birth of their children, reduce unintended pregnancies, determine effective birth control methods and improve the well-being of families statewide. Because of the proven effectiveness of LARCs more women are planning their pregnancy which helps to insure healthier birth outcomes. Processes and procedures have been streamlined and training systems that support access to family planning and LARCs have been improved. Family Planning funds were used to purchase additional pharmaceuticals and provide support to districts to hire Advanced Practice Registered Nurses (APRN) to provide LARC related services.

The Family Planning Marketing Campaign continued with Phase II targeted to reach the Northern districts of the state. Phase II included specific messages geared towards the population.

Other Women/Maternal Health Programs

Centering Pregnancy

Centering Pregnancy is an evidenced-based model of group prenatal care combining health assessment, interactive learning and community building to help support positive health behaviors. Centering Pregnancy empowers patients, strengthens patient/provider relationships, and builds communities through health assessment, interactive learning and community building.

During the reporting period, Women's Health collaborated with external stakeholder, Harris Solution CCS, to review the prenatal care process and streamline the data collection and flow chart design. Monthly meetings continued among County Health Departments providing Centering Pregnancy in their clinics to increase awareness and share ideas for improvement and sustainability. Discussions were underway with the Macon-Bibb County Health Department to start Centering Pregnancy later in the year.

Additional activities completed included Centering Pregnancy monthly meetings, a DCH pilot in collaboration with Children 1st to improve awareness of available resources to assist mothers in detecting problems in newborns, and collaboration with the Fatherhood Initiative to ensure that father's needs are addressed. The Oral Health Program also provided dental kits and webinars educating participants on the importance of oral health care during pregnancy.

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

During the reporting year, 111 county health departments provided PCM services.
To encourage participation in PCM trainings via telehealth services, continuing education credits were offered. Thirteen districts, 39 County Health Departments and 79 staff attended the PCM training. Post survey results revealed that 95 to 96 percent of participants agree with the presentation and the material, 82 percent of participants prefer telehealth as the mode of delivery, and 91percent of participants believed telehealth was conducive to dialogue.

Planning for Healthy Babies
Planning for Health Babies (P4HB) is a family planning demonstration waiver program issued by DCH to assist DPH in reducing the number of low birth weight (LBW) and very low birth weight (VLBW) infants in Georgia. Women who meet Medicaid eligibility criteria and/or have had a VLBW baby may be eligible under the expansion policy to receive family planning services, Inter-pregnancy Care (IPC), Case Management, and/or Resource Mother program services. The program is intended to bridge health care for underinsured and uninsured women of high need. Efforts to increase enrollment into P4HB were continued with DCH and other partners.

Maternal and Child Health Information and Resource Center
In the reporting year, the Women's Health Program worked with the existing Maternal and Child Health Information and Resource Center that operates the MCH resource hotline and website to include resources and referrals to resources that identify and treat chronic illnesses such as hypertension, heart disease, obesity, and diabetes.

Current Year: Oct 2019-Sept 2020

Priority Need: Prevent Maternal Mortality

NPM 1: Well-Woman Visits

Maternal Mortality Review Committee
During the current year, the MMRC completed review of 2015 cases in September 2019. The MMRC is working towards reviewing cases within two years of the date of death. In order to meet this goal, processes and capacity have been improved. DPH received $200,000 in state funding to fund two additional case abstractors through the Georgia Obstetrical and Gynecological Society Seven MMRC meetings were scheduled for 2020 and plans made to review 2016 and 2017 cases in one year.

The MMRC worked to improve processes and ultimately improve the quality of the recommendations that are made and implemented. The committee membership was updated to ensure that needed perspectives were represented and members who had met or exceeded the three-year term limit were released. A non-clinical Co-Chair position was developed to assist with guiding the discussion on preventability, contributing factors, and recommendations. Members were added to ensure the committee includes clinical and non-clinical disciplines and is diverse with respect to race, geographic location, and specialty. The MMRC began reviewing 2016 cases and completing the entire Committee Decisions Form for pregnancy-related and pregnancy-associated, but not related cases. In December 2019, an orientation with all MMRC members was conducted to ensure they have been trained on how

to fully complete the Committee Decisions Form. A recusal policy and conflict of interest policy was also developed and implemented.

The MMRC has implemented several changes planned to increase the timeliness and quality of the review. The primary goal of the committee has been to become current on case review. While the goal is to review cases within two years of the date of death, the MMRC is currently reviewing cases approximately four years after the date of death. Two additional abstractors have been oriented to the review process and are abstracting cases with the goal of reviewing two years of cases in one year. The MMRC met to review 2016 cases. Meetings scheduled for March were postponed due to concerns over COVID-19, and future meetings have gone to a web-based format. The goal is still to complete review of 2016 cases by June 2020.

The quality of the MMRC review has been enhanced with the addition of a co-chair to facilitate the discussion on social determinants of health. Additional members have been added to include more individuals with expertise in mental health, substance use, and non-clinical disciplines, and to ensure racial diversity and representation from rural areas of the state. Previously, members were required to be physically present during the review however, video participation was offered to members not living in the metro Atlanta area to facilitate participation using Project ECHO (Extension for Community Healthcare Outcomes). This has been successful and allowed four to five members to participate remotely at each meeting.

In January, DPH published a 2012-2015 Fact Sheet that included data on pregnancy-associated, but not -related, and pregnancy-related cases. This fact sheet was used by maternal health advocates in the 2020 legislative session to advocate for maternal health, including the extension of Medicaid coverage up to one year postpartum. DPH plans to publish another fact sheet to include 2016 findings after the review is completed in fall 2020.

Efforts continue to enhance case identification and abstraction. MCH Epidemiology linked hospital discharge data with 2016 death certificates to strengthen case identification and provide further information on known cases. The effort identified eight potential cases from 2016 and will be included as a regular part of the case identification process moving forward. DPH is also working with Medicaid to develop a data sharing process to receive Medicaid information for known cases, including dates of coverage and providers seen. Knowing the providers seen will help abstractors know where to request records and expand the abstraction beyond obstetric providers.

In the current year, the Women's Health Program added a Key Informant Interviewer to the review process. The Key Informant Interviewer will interview friends, family members, and other individuals who were close to the woman's life. Having qualitative information will provide rich contextual information on the woman's life, pregnancy, and events surrounding her death, which will help the committee better identify contributing factors and recommendations for prevention. MCH Epidemiology has completed the case identification for 2017 and abstractors have begun requesting records. The MMRC is scheduled to complete 2017 cases by the end of the calendar year in 2020.

Center for Black Women's Wellness Health Equity Lab
In the current year, the MCH Director participated in the Center for Black Women's Wellness Health Equity Lab to work with design teams to develop tangible ways to support efforts to change birth outcome experiences. The Action Lab provided opportunities to collaborate with subject matter experts to explore the contribution of racism on adverse outcomes for black women and leverage findings to strategize solutions and identify the most high-leverage work to improve the system for black women. Opportunities were also provided to share and celebrate work done to-date creating shared learning across design teams. A Respectful Care Survey was developed to access care provided by organizations for women to ensure care is provided in a manner that maintains dignity, privacy and confidentiality, freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth.

Challenges: Two birthing hospitals in rural Georgia closed - Dorminy Medical Center in Fitzgerald, GA and Taylor Regional Hospital in Hawkinsville, GA.

Related legislation: GA Code § 31-2A-16 became effective July 1, 2014 authorizing DPH to conduct case review of maternal deaths. The legislation provides protection for the case review process and authorizing access to case information.

HB 684 included $2,000,000 in annual funding under DPH's Adolescent and Adult Health Promotion Program to implement perinatal quality improvement initiatives in rural birthing hospitals to improve maternal outcomes. The funding became effective July 1, 2018 and provides needed infrastructure for smaller, rural facilities to participate in perinatal improvement initiatives.

In June 2020, HB 1114 passed allowing the DCH to apply for an 1115 Waiver to extend Pregnancy Medicaid to six months after delivery.

NPM 3: Risk-appropriate Perinatal Care

Perinatal Regionalization
To strengthen the system of Regionalization, there has been continued work on increasing communication with RPC stakeholders to include meetings with RPC medical directors and outreach educators as well as conference calls with finance staff and data coordinators. Work with the six RPCs located in Albany, Atlanta, Augusta, Columbus, Macon, and Savannah continues.

The Maternal and Neonatal Center Designation program planning continued during this reporting period. The rules outlining the requirements for designated centers became effective in November 2019. A contract was established with the AAP to use the AAP Verification Program for the application and site survey process for Level II and Level III Neonatal Center Designations. The online application for Level I Maternal and Neonatal Center Designations was finalized and opened in February 2020.

Related legislation: HB1114 Pregnancy Medicaid Coverage to Six Months Postpartum was passed by the Georgia General Assembly to allow Medicaid to extend to six months post-delivery.

In 2018, the Georgia General Assembly passed HB909 which authorizes DPH to designate hospitals for maternal and neonatal care. The legislation was signed into law and became effective July 1, 2018.

Alliance for Innovation on Maternal Health Bundles
GaPQC has continued to implement the obstetric hemorrhage (HMG) and severe hypertension (HTN) in pregnancy AIM patient safety bundles. Currently, 44 hospitals are participating in HMG initiative and 41 hospitals are participating in HTN. Forty-four out of 54 (81 %) of AIM hospitals are submitting data for structure/process measures. During the reporting year, 100% (54) AIM hospitals quarterly outcome Severe Maternal Morbidity (SMM) measures were collected/analyzed, uploaded into the AIM data portal and sent to participating hospitals. Sixteen of the 44 hospitals participating in the AIM hemorrhage initiative are rural hospitals and receive state funding to support perinatal quality improvement in rural facilities. Ten rural hospitals participate in the HTN bundles. Women's Health works closely with the remaining six hospitals to recruit them into the Hypertension bundle.

A statewide needs assessment was conducted to identify priority needs of our HMG and HTN maternal teams.

Training for simulation drills and debriefs were identified as a priority among respondents. To meet this need, five regional clinical simulation drill and debrief trainings were scheduled. Due to the COVID-19 pandemic, only one training was conducted. Each were planned in collaboration with the six maternal Regional Perinatal Center Outreach Educators who would have served as trainers for the trainings in the southeast, southwest, middle, northwest and northeast regions of the state. All birthing facilities in the state were invited to participate. In total over 100 participants were registered to attend the sessions. The sessions will be rescheduled once schedules and operations return to normal. Teams enrolled in the HTN initiative will begin reporting on new process measures which involve case identification and time to treatment. Hospitals have requested assistance and the Collaborative adapted an existing tool and distributed to hospitals to help with the process. The March webinar was dedicated to engaging other states who are further along in the reporting process for these measures and in the initiatives overall. The Illinois Perinatal Quality Collaborative presented. Future webinars will be rescheduled in order to focus on supporting teams during the COVID-19 response.

Additional measures have been added to implement from the Reducing Peripartum Disparities Bundle. The requirement for implicit bias training for hospital providers and nurses is added to HMG and HTN process measures. All hospitals will report on the number of providers and staff that receive implicit bias training. Race will also be included in chart review data collected and reported in the HNT bundle. Hospitals will report on progress for implementing implicit bias training in quarterly reports. A speaker was scheduled to present on Implicit Bias and Disparities at the annual GaPQC meeting in April and two Implicit Bias trainings are tentatively planned during July/August 2020 through the Institute of Perinatal Quality Improvement, however, due to COVID-19 the meeting was posted and will be rescheduled when operations return to normal. In the meantime, efforts are focused on monthly webinars on supporting hospitals in identifying and collecting these data elements and plans are being made to offer virtual implicit bias training.

Priority Need: Promote Oral Health to All Populations

NPM 13: Preventive Dental Visit

During the current year, the Oral Health program served 1,245 pregnant women to reduce some of the contributing factors to low birth weight (LBW) infants. Education was provided to women of childbearing age about NAS and the need for good nutrition, prenatal care and dental care. The Oral Health Director also recorded a series of six short public service announcement videos focused on key messages on oral health geared towards pregnant women and caregivers of young children: https://www.youtube.com/watch?v=0Nfk_-JwaiQ&list=PLHp0_39Iqo2f5gBr-zgPISf8m5O9mCNnj . Currently the videos are on the DPH YouTube page and being shared with partners for cross promotion. The Oral Health Program continues collaboration and outreach through the following activities and initiatives:

Disseminates the message of drinking fluoridated water at all ages to pregnant and parenting women through the Georgia Oral Health Collation, Healthy Mothers and Health Babies, and Home Visiting.
Collaborates with the Tobacco Program in the Chronic Disease section to distribute toolkits geared to dental providers focused on patient tobacco cessation strategies and tips. While the recommendations can be adapted to almost all patients, the primary patient focus for tobacco cessation is pregnant women.
Presents to OBGYN residency groups on oral health and pregnancy.
Distributes Oral Health Pregnancy Resource Bags to pregnant and new mothers through partnerships with district oral health staff, district WIC nurses, other district DPH nurses, home visitors, DPH perinatal case managers, and others. Approximately 1900 bags were distributed during the reporting period.
Presents to OBGYN residents twice a year as well as disseminates a monthly newsletter to GOGS members on oral

health.
Participates on a HMHB pregnancy oral health work group to improve the number of pregnant women in Georgia receiving oral health care by focusing in three priority areas: educating pregnant women, educating perinatal providers, and reducing administrative burden in the Medicaid process.

Priority Need: Increase Access to Family Planning Services

SPM 1: Family Planning
In the current year, the Family Planning Program completed site visits which provided unique insight into the successes and challenges of each public health district. Site visits provided information concerning daily operations and provided billing, clinical and administrative technical assistance. Best practices including billing third party payers to maximize reimbursement thus generating income and the implementation of a health educator/navigator model to promote access to family planning services continue to be explored.

The Family Planning Program conducted nine weeklong women's health courses for new public health registered nurses to provide the training required to practice in an expanded roll according to nurse protocol. The expanded role skills are needed for family planning service delivery in local health departments. The program plans to partner with University of California, San Francisco, Bixby Center for Global Reproductive Health to provide the standard long acting reversible contraceptive (LARC) course and in-depth special courses to train family planning staff on best practices to increase access to LARCs as a form of family planning as well as skills training for providing breast and pelvic exams and sexually transmitted disease education. Through site visits, weeklong courses, and LARC trainings the program provides needed support and assistance to enhance quality of care and capacity to meet the family planning needs of reproductive aged women in Georgia. Over 110 new nurses completed the expanded role training during the previous two fiscal years and indications are approximately the same number will be on-boarded during the current reporting year.

Challenges and barriers: The COVID-19 pandemic has resulted in clinic closures and reduced availability of face-to-face visits. Prior to the pandemic, all family planning encounters were conducted in clinic settings. Decreased availability of staff and safety concerns related to face-to-face encounters can have an impact on contraceptive continuity and lead to an increase in unintended pregnancies. The program developed guidance for clinics in providing remote interviews for the continuation of oral contraceptives and much of the Depo Provera visit. The pandemic also required the program to postpone the remaining program site visits to Athens, Gainesville, Clayton, and Dalton health districts, the weeklong women's health trainings and LARC training courses due to concerns over COVID-19.

Other Women/Maternal Health Programs

Centering Pregnancy
During the current year, Women's Health continued to collaborate with partners to provide education and resources to Centering Pregnancy participants. In collaboration with the Oral Health Program, dental kits and an Oral Health During Pregnancy webinar were provided to Centering Pregnancy participants. Albany Area Primary Health Care, a Federally Qualified Health Center, provided staff support to the Centering Pregnancy Program in Albany and is interested in adopting the program. The program is collaborating with United Way to provide the next Basic Facilitator's training the Albany district to ensure training of replacement staff and ensure continuity of care in the district.

Augusta's Centering Pregnancy Program hosted a reunion for delivered participants. Previous program

participants shared their experiences and expressed their appreciation of the Centering Pregnancy program. Discussions centered around the individual birthing experience, contraceptives and birth spacing. Activities included playing games, winning prizes and a certificate of completion for the program was given.

Monthly meetings were scheduled to continue among County Health Districts 6 and 8-2 providing Centering Pregnancy in their clinic, however, due to District and State employees working the frontlines to help mitigate the spread of COVID-19, previously scheduled monthly meetings have not occurred. Microsoft Teams have been utilized to provide Centering Pregnancy meetings during the pandemic.

Challenges/barriers: Sustainability and staffing continue to be a challenge.
Due to COVID -19 site visits were not conducted. Some Centering Pregnancy staff assisted in supporting the needs in the community and working specimen point of collection (SPOC) locations. Some clinics suffered staffing shortages due to positive testing of COVID-19.

Perinatal Case Management
In the current year, there continues to be 111 county health departments providing PCM services in the state of Georgia. Some limited services are being provided by some districts due to COVID-19. The PCM objective by 2022 is to increase the number of County Health Departments providing PCM services to 115.

PCM trainings were conducted throughout the current year via telehealth. PCM training via face-to-face mode was cancelled during the summer months due to constraints with COVID-19. COVID -19 has placed the production of the PCM post card and pamphlet on hold. Once a timeline can be determined for distribution, literature will be distributed to all public health districts for use by the PCM Case Managers and the pregnant women enrolling in PCM.

PCM collaborated with the Child Occupant Safety Program to increase participation in the car seat program for all counties. PCM also collaborated with the Oral Health Program to provide dental kits to the pregnant women entering the county health department for PCM enrollment and a webinar educating the Perinatal Case Managers on the importance of oral health during pregnancy. Collaboration continues with the HIV Prevention Project with internal partners of the HIV program. Education was developed and is provided to women on the importance of early treatment in the pregnancy and lowering the incidence of congenital syphilis and HIV occurrence. The project is currently on hold due to the COVID-19 pandemic although discussion continues concerning opportunities following the pandemic.

Planning for Healthy Babies
In the current year, P4HB convened a working group with the purpose of increasing utilization and participation in P4HB. The MCH Director and Title V Deputy Director participate in the working group to create a statewide marketing and communications plan in collaboration with the four Care Management Organizations (CMOs), provider organizations and community-based organizations that serve the MCH population eligible for P4HB in Georgia. The goal is to amplify current efforts by the Department of Community Health (DCH) and CMOs toward increasing the knowledge, understanding and utilization of P4HB services toward reducing Georgia's LBW and VLBW rates, unintended pregnancies, and lowering Medicaid costs. HMHB is dedicated to continuing support of the program by convening community partners and provider groups toward increasing awareness of the program's benefits for greater utilization by both participants and providers statewide.

Working groups were held in December 2019, February, June, and August 2020. The mutual goal to increase the awareness and utilization of the P4HB Waiver program services for eligible women was drafted. Barriers around patient awareness were identified and marketing materials development was discussed.

Maternal and Child Health Information and Resource Center

In the current year, the Women's Health Program works with the existing Maternal and Child Health Information and Resource Center that operates the MCH resource hotline and website to include resources and referrals to resources that identify and treat chronic illnesses such as hypertension, heart disease, obesity, and diabetes.

Women/Maternal Health - Application Year

Priority Need: Prevent Maternal Mortality

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

NPM 1 Strategies:

1.1.a Meet or exceed the CDC guideline of providing ≥75% of federally funded screening mammograms to women over 50 years of age.

1.1.b Meet or exceed the CDC guideline of providing ≥20% of initial pap tests to individuals who have never or rarely been screened for cervical cancer.

1.2.a Increase the number of LARCs utilized among women of reproductive age (15-44 years) served in local Public Health Departments by 5% annually.

Preventive Medical Visit
A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of diseases to optimize the health of women before, between, and beyond potential pregnancies. A key component of a well-woman visit for a reproductive-aged woman is the development and discussion of her reproductive life plan to align with her current and future plans. Prevention, screening, and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, will be advanced with a well-woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The Women's Health program will continue to support activities to meet or exceed the CDC guideline for the percent of initial cervical screening tests that are conducted among women who have never been screened or not screened within the last 10 years.

Family Planning
Women's Health will continue to promote and increase access to family planning service particularly LARCs. Family Planning plans to launch Phase III of the marketing campaign. Site visits will be conducted with public health districts to garner insight on district level implementation of family planning. Staff will also provide an eight-week series of women's health courses for new nurses. DPH will partner with Bixby to provide the standard LARC CME course and in-depth special courses to train family planning staff on best practice in increasing access to family planning.

Maternal Mortality Review Committee
Women's Health will continue work with the MMRC to complete case reviews for 2017 and 2018. By the end of calendar year 2021, the MMRC will complete case reviews for 2019 and meet the goal of reviewing cases within two years of the date of death which will bring the case review current and provide much needed information to the GaPQC and other groups working to impact maternal mortality. In accordance with CDC recommendations a Key Informant Interviewer was hired in June 2020. The Key Informant Interviewer will be conducting interviews with friends, family members, or other close contacts of the deceased mother to provide information for the review committee beyond what is listed in the medical record, including information on social determinants of health. DPH will be implementing a data sharing process with Medicaid to obtain information on dates of coverage for each case and to provide abstractors with information on providers seen. DPH also plans to expand dissemination of report findings and recommendations by posting the information on the DPH website, and disseminating information to medical providers, community-based organizations, advocacy organizations, and other perinatal care workers.

Alliance for Innovation on Maternal Health Bundles
GaPQC will continue to support the AIM Patient Safety Bundles by providing support for birthing hospitals across the state to implement the Obstetric Hemorrhage and Severe Hypertension in Pregnancy Initiatives. Outreach efforts will continue to recruit new hospitals to join the 55 of the 73 birthing hospitals participating in one or both initiatives. To support hospital teams, monthly webinars will be hosted to provide expertise related to implementing the specific bundle interventions and provide one on one hospital support and technical assistance. Focus will be placed on incorporating elements of the Reduction of Peripartum Racial/Ethnic Disparities into each AIM bundle. In the fall of 2020, Women's Health will host a Health Equity Learning Series and Training to build capacity and create a culture of equity including systems for reporting, response, and learning. Partnerships with organizations will support improving population level outcomes for mothers and infants including March of Dimes in the health equity work and HMHB as partners on the policy and clinical implementation workgroups. Building on the foundational work of AIM, we will participate in AIM Clinical Community Integration to address preventable maternal mortality and severe maternal morbidity among pregnant and postpartum women outside of hospital and birthing facility settings.

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit
Percent of women who had a preventive dental visit during pregnancy

NPM Strategy 13.1: Provide oral health trainings and presentations to medical providers to increase knowledge.

The Oral Health program will continue to promote oral health among all populations, with a special emphasis on promoting oral health care services among pregnant women. The Oral Health Annex contract with the health districts in FY2020 included a recommendation to include perinatal oral health services for WIC and other public health patients. A newly developed and simplified oral health reporting tool will also reduce administrative burden on districts and allow for more time for patient care, education, and prevention services. With this tool, districts will provide monthly tracking of total clinical visits broken down by age categories, total number of prevention services (dental sealants, fluoride varnish applications, oral health screenings, and oral health education), as well as total number of pregnant women seen by district oral health program staff (either for services, screenings, or referrals). District program staff are continuously provided updates and resources that help empower them to provide care, services, and education for MCH populations including but not limited to, free continuing education opportunities, toolkits, guidelines, best practices, and recommendations from national oral health and MCH organizations.

The Oral Health program will continue to promote an oral health awareness campaign and will be boosting social media videos offering short key messages on oral health geared towards pregnant women and caregivers of young children. Public Service Announcement videos will be converted to fit social media platforms like Facebook, Twitter and Instagram and will target social media pages of individuals likely to be pregnant, recently pregnant, or caregivers of young children. The videos are slated to begin in August 2020. Pregnancy Oral Health Resource Bags that contain an adult toothbrush, two types of infant toothbrushes, floss, toothpaste, intraoral wipes for cleaning after nursing or bottle feeding, a brochure on health oral habits/behaviors, and a baby book on oral health will be distributed through district oral health program staff, district public health nurses, perinatal coordinators, home visitation workers, and external partners such as Healthy Mothers Healthy Babies Coalition of Georgia.

The Oral Health program will continue to create a more robust state oral health surveillance system by identifying gaps in data, researching data sources to fill gaps, and dedicating resources to incorporating sources. Due to funding received in 2020 the Oral Health program funded three additional state supplemental oral health questions to the Georgia PRAMS survey. In addition to the two standard core oral health questions and one supplemental state

oral health question. With a combined six questions related to oral health in PRAMS, future data will give a more complete picture of burden of disease, specific challenges and barriers, and strategize on best solutions. This data is expected to be available mid-2021. The Oral Health program will add a full time Oral Health Epidemiologist to help support ongoing surveillance, oral health surveillance plan implementation, and data analysis.

Other Women/Maternal Health Programs

Centering Pregnancy

The Women's Health program will continue to support public health districts in their goal to provide Centering Pregnancy services to women in the community. The Women's Health program will collaborate with Federally Qualified Health Centers (FQIC) and evaluate the data retrieved to improve the services provided in Centering Pregnancy sites in Albany. The Women's Health program will work with other public health districts that desire to host a Centering Pregnancy program in their community and form an alliance between the districts for support of one another. Efforts to collaborate and build communication and relationships between internal and external partners will continue. Women's Health will collaborate with external partners to gather information on the next Basic Facilitators training for district staff in need.

Perinatal Case Management (PCM)

Women's Health plans to increase the number of county health departments providing PCM services from 107 to 115 by 2022. The developed post cards and brochures to promote PCM benefits will be distributed to all public health districts for use by the PCM Case Managers and the pregnant women enrolling in PCM. The PCM program will collaborate with the child occupant safety program to increase participation in the car seat program for all counties and provide education to pregnant mothers on safely transporting their child. DPH will continue providing technical assistance on the PCM module, education, training and updates of the PCM program to all district PCM Case Managers on the health outcomes for at risk women. PCM will continue collaborating with the Oral Health program to distribute dental kits to pregnant women in the public health districts that enroll in the PCM program to promote good oral health during pregnancy.

Planning for Healthy Babies (P4HB)

The P4HB working group will continue activities to create a statewide marketing and communications plan in collaboration with the four Care Management Organizations, provider organizations and community-based organizations that serve populations eligible for P4HB. The working group will continue to develop plans that amplify increasing the knowledge, understanding and utilization of P4HB services toward reducing low birth weight and very low birth weight rates, unintended pregnancies, and lowering Medicaid costs. MCH is dedicated to continuing support of P4HB by participating with community partners and provider groups toward increasing awareness of the program's benefits for greater utilization by both participants and providers statewide.

Maternal and Child Health Information and Resource Center

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

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	7.2	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	7.2	NPM 3 NPM 4 NPM 5
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	4.6	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.5	NPM 4 NPM 5
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	251.5	NPM 3
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	132.3	NPM 4 NPM 5

National Performance Measures

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

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

State Provided Data				
	2016	2017	2018	2019
Annual Objective	81.8	80	83	84
Annual Indicator	80.9	83	83.9	84.6
Numerator	1,950	1,947	1,951	1,947
Denominator	2,409	2,347	2,326	2,302
Data Source	State Statistical File	State Statistical File	State Statistical File	State Statistical File
Data Source Year	2016	CY 2017	CY 2018	CY 2019
Provisional or Final ?	Final	Final	Provisional	Provisional

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	85.0	86.0	87.0	88.0	89.0	90.0

Evidence-Based or –Informed Strategy Measures

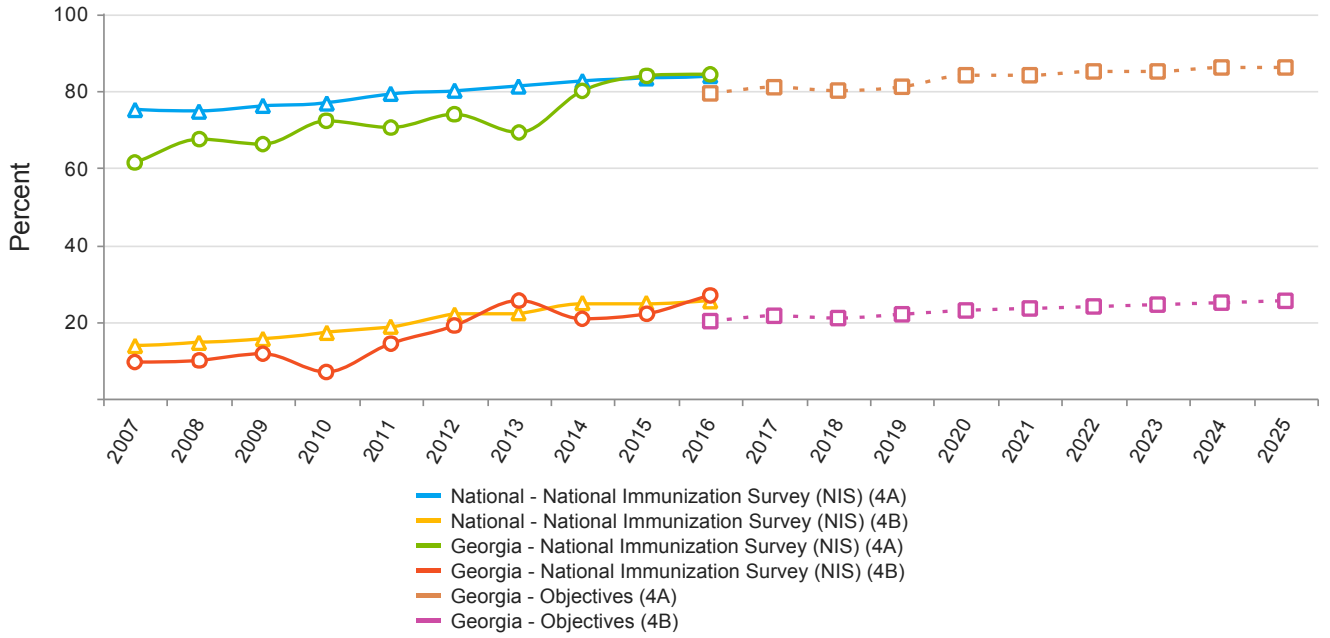
ESM 3.1 - Number of hospitals verified annually through the Neonatal Center Designation Program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	10.0	10.0	10.0	10.0

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	79.3	80.9	80	81
Annual Indicator	69.2	79.9	84.0	84.1
Numerator	80,818	100,061	106,087	109,903
Denominator	116,817	125,213	126,348	130,643
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	84.0	84.0	85.0	85.0	86.0	86.0

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

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	20.2	21.6	21	22
Annual Indicator	25.4	20.7	22.1	27.0
Numerator	29,130	25,611	26,140	33,943
Denominator	114,622	123,723	118,097	125,804
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	23.0	23.5	24.0	24.5	25.0	25.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	0.0	0.0	0.0	85.0

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

Measure Status:	Active

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

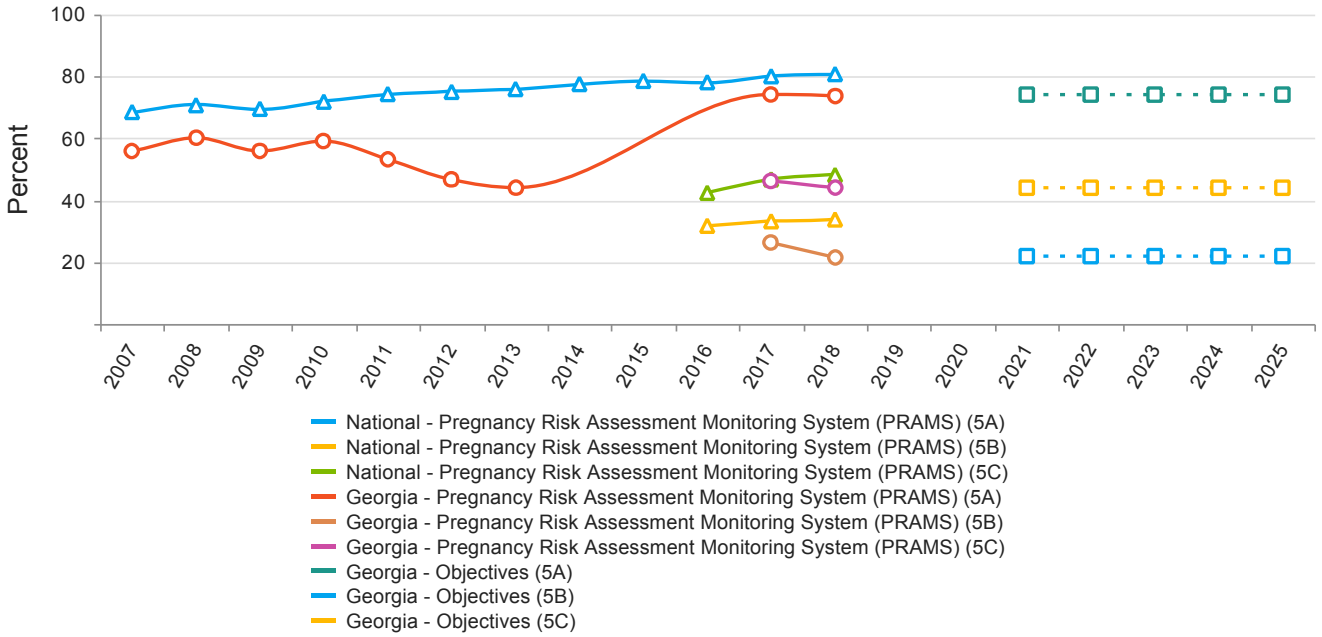
ESM 4.3 - Number of MIECHV and Healthy Start women who are referred to WIC services

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	65
Numerator	
Denominator	
Data Source	GHVP Data
Data Source Year	CY 2018
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	65.0	70.0	75.0	80.0	85.0

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



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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	73.7
Numerator	87,074
Denominator	118,209
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	74.0	74.0	74.0	74.0	74.0

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	21.7
Numerator	25,317
Denominator	116,405
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	22.0	22.0	22.0	22.0	22.0

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	44.0
Numerator	50,752
Denominator	115,426
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	44.0	44.0	44.0	44.0	44.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	60.3
Numerator	85
Denominator	141
Data Source	Georgia Safe to Sleep Program Data
Data Source Year	FFY 2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	64.0	67.0	71.0	74.0	78.0

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

Measure Status:	Active

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

State Performance Measures

SPM 1 - Percent of congenital syphilis cases averted

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	80.3
Numerator	
Denominator	
Data Source	SendSS
Data Source Year	CY 2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	81.0	81.6	82.3	83.0	83.7

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

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	10.7
Numerator	
Denominator	
Data Source	Vital Records- Birth and Death Certificates
Data Source Year	CY 2019
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	9.5	9.0	8.6	8.2	7.7

State Action Plan Table

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

Priority Need

Prevent Infant Mortality

NPM

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

Objectives

3.1 Develop a designation program in Georgia to verify hospitals are operating at the level of care authorized through the DCH Certification of Need program.

3.2 Promote the designation program and recruit all Georgia birthing hospitals to participate in measuring compliance with the level of care designation authorized through the DCH Certification of Need program.

Strategies

3.1 Complete a Neonatal Center Designation for at least 10 hospitals annually.

3.2 Conduct one site visit annually at each RPC to verify PRC compliance with Level III Care in neonatal care.

ESMs	Status
ESM 3.1 - Number of hospitals verified annually through the Neonatal Center Designation Program	Active

NOMs

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

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

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

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

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

Priority Need

Prevent Infant Mortality

NPM

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

Objectives

4.1 By the end of 2025, certify 85% of the 330 available 10-Steps to Successful Breastfeeding training slots are utilized annually by staff and providers from the state's birthing hospitals.

4.2 Increase knowledge of breastfeeding best practices among home visitors.

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

Strategies

4.1 Provide ongoing virtual 10-Steps to Successful Breastfeeding training/certification and technical assistance for providers, nurses, and other vital L&D, Mother/Baby, and NICU staff from Georgia's birthing facilities to achieve 85% utilization of training slots annually.

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

4.3 Increase the number of MIECHV and Healthy Start women who are referred to WIC.

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

NOMs

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

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

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

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

Priority Need

Prevent Infant Mortality

NPM

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

Objectives

5.1 Improve parental education regarding the sleep safety of their infants to reduce infant sleep-related deaths.

Strategies

5.1a Work with hospitals and birthing facilities to provide consistent and accurate parent/caregiver education, conduct crib audits, update policy as needed and actively endorse, and model safe infant sleep practices.

5.1b Provide training on safe infant sleep practices to community members and professionals.

5.1c Provide education materials to professionals, educators, and organizations that serve families with infants.

ESMs	Status
ESM 5.1 - Percent of hospitals and birthing facilities providing education and modeling safe infant sleep to parents with newborns or infants	Active
ESM 5.2 - Number of professionals trained to education on, identify, and model safe infant sleep environments	Active

NOMs

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

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

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

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

Priority Need

Prevent Infant Mortality

SPM

SPM 1 - Percent of congenital syphilis cases averted

Objectives

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

Strategies

1.1a Ensure investigations prioritized for females of reproductive age 0-49 and reactive serology, including provider follow-up to confirm age, treatment and pregnancy status.

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

1.1c Ensure interviews are conducted on all syphilis cases for females of reproductive age 0-49.

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

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

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

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

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

Priority Need

Prevent Infant Mortality

SPM

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

Objectives

2.1 By 2025, reduce the rate of infant mortality (per 1,000 live births) in the Black population.

Strategies

2.1a Conduct an environmental scan and needs assessment to identify gaps and needs of rural communities with high infant mortality rates.

2.1b Provide a Community Engagement Toolkit to promote collective impact and health equity to communities with high infant mortality rates.

2.1c Provide Health Promotion trainings, intra-departmental workgroups, and peer-learning opportunities to discuss equity-related content.

2.1d Build core competencies and capacities of staff to successfully achieve health equity.

2016-2020: National Performance Measures

2016-2020: State Performance Measures

2016-2020: SPM 1 - Percent of women (ages 15-44) served in the Georgia Family Planning Program (GFPP) who use long-acting reversible contraceptives (LARC).

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		11	16.5	15
Annual Indicator	16.6	15.6	17	18.1
Numerator	9,714	9,175	10,348	10,613
Denominator	58,434	58,675	60,860	58,568
Data Source	GFPP	GFPP	GFPP	GFPP
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: SPM 3 - Rate of congenital syphilis.

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		13	12.7	12.4
Annual Indicator	16.2	17.8	24.6	29.3
Numerator	21	23	31	37
Denominator	129,940	129,158	126,051	126,250
Data Source	STD Program Data and OASIS	STD Program Data and OASIS	STD Program Data	STD Program Data and OASIS
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Provisional

2016-2020: SPM 4 - Rate of infants diagnosed with Neonatal Abstinence Syndrome (NAS).

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		6.1	13.2	13.1
Annual Indicator	10.9	12	12.4	8.2
Numerator	1,310	1,438	1,430	962
Denominator	120,005	119,901	115,716	117,214
Data Source	Hospital Discharge Data, Vital Records	Hospital Discharge Data, Vital Records	Hospital Discharge Data, Vital Records	Hospital Discharge Data
Data Source Year	FY 2016	FY 2017	FY 2018	FY 2019
Provisional or Final ?	Final	Final	Final	Provisional

2016-2020: SPM 5 - Percent of birthing hospitals, NICUs, and Pediatric Departments with policies and education that adhere to the American Academy of Pediatrics (AAP) Safe Sleep guidelines

Measure Status:		Active	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			51.1
Annual Indicator		49.6	60.3
Numerator		70	85
Denominator		141	141
Data Source		GA Safe to Sleep Program Data	Georgia Safe to Sleep Program Data
Data Source Year		FFY 2018	FFY 2019
Provisional or Final ?		Final	Final

Priority Need: Prevent Infant Mortality

Perinatal services are focused on the health of women and babies before, during and after birth. The Georgia Perinatal-Infant Health program aims to assure pregnant women in Georgia every opportunity to access comprehensive perinatal health care services appropriate to meet their individual needs. DPH is committed to providing access to high-quality perinatal care to Georgians and recognize that there is a direct relationship between perinatal birth outcomes and the quality of health care services.

The number one cause of infant mortality in Georgia are disorders related to preterm birth and low birth weight. In 2018, the Infant Mortality Rate for Georgia was 7.1, per 1,000 live births, with the infant mortality rate among Black, non-Hispanic infants two times higher than White, non-Hispanic or Hispanic infants. Research indicates that maternal and infant morbidity and mortality can be reduced if high-risk pregnant women and newborns receive risk-appropriate care, health equity is ensured, and social determinants of health are addressed.

NPM 3: Risk-appropriate Perinatal Care

Perinatal Regionalization
Perinatal Regionalization is a collaborative system of hospitals & providers striving to assure that deliveries happen in the hospital with the appropriate level of care for the mother and infant. The purpose of the RPC's is to coordinate access to optimal and appropriate maternal and infant health care. Regionalized systems assign hospitals risk-appropriate levels and ensure high-risk infants are born in facilities with appropriate technology and specialized health providers. The impact of appropriate level of care on maternal/perinatal health outcomes is great as low birth weight or premature infants born in risk-appropriate facilities are more likely to survive.

Basic perinatal services include comprehensive obstetric care through neonatal newborn services. There are six RPC's, specially qualified hospitals, which are designated to specific geographic regions that provide the most advanced care for high-risk mothers and infants.

Maternal and Neonatal Levels of Care
In the reporting year, the Maternal and Neonatal Center Designation program developed rules outlining the requirements for designated centers effective November 2019. A contract with the American Academy of Pediatrics (AAP) was initiated to use the AAP Verification Program for the application and site survey process for Level II and Level III Neonatal Center Designations. The planning process for Level II and Level III Maternal Center Designations continued.

SPM 4: Breastfeeding

Breastfeeding
Georgia's 5-STAR Hospital Initiative was developed to recognize hospitals that have taken steps to promote, protect and support breastfeeding in their hospital. A five-star system was developed to encourage maternity centers to promote and support breastfeeding one step at a time. Georgia 5-STAR will award one star for every two steps implemented of the Ten Steps to Successful Breastfeeding, as defined by the World Health Organization (WHO) and Baby-Friendly® USA. In the reporting year, the Georgia 5-STAR program worked to review the current Georgia 5-STAR program offerings and past support provided to hospitals. Women's Health developed additional support materials to assist hospitals in evaluating their progress on the Ten Steps to Successful Breastfeeding-Georgia 5-STAR journey and revised the training programs as suggested by the review.

In the reporting year, Women's Health provided technical assistance by phone, emails, and in person visits. Individualized Technical Support Workshops were provided to hospitals that submitted applications to the program. The workshops were used as a platform to provide a more individualized approach to aid hospitals in overcoming their specific barriers to implementing the Ten Steps to Successful Breastfeeding in their facility.

In collaboration with the AAP, DPH delivered the Educating Physicians In Their Communities (EPIC) breastfeeding program, a physician peer-to peer training program that provides breastfeeding education to physician's offices, hospitals and residency programs, distributes information on how to access lactation support services in the community, and offers free resources for patient education. During this reporting period, fourteen EPIC breastfeeding programs were administered. MCH partnered with WIC to provide breastfeeding educational trainings to all DPH staff including nurses, peer counselors, breastfeeding coordinators, nutritionists, and administrative staff.

SPM 3: Rate of Congenital Syphilis

Congenital Syphilis

The Sexually Transmitted Diseases (STD) Office's mission is to prevent STDs by providing quality intervention strategies, programmatic support and education to all throughout the state of Georgia. With a focus on Congenital Syphilis, the STD team works to promote first and third trimester testing for HIV and Syphilis, as well as improve the data quality of Congenital Syphilis. The STD Office works to improve the identification of pregnant females with syphilis to ensure timely and appropriate treatment. During the reporting year, Syphilis During Pregnancy was added to the Notifiable Disease List. The promotion of first and third trimester testing for HIV and syphilis continued. Efforts to provide education through trainings, community outreach, provider outreach, and district STD staff continue to be a priority.

In the reporting period, a total of 1,643 cases of primary and secondary Syphilis were reported in Georgia. This is a 130-case increase from the previous year. When compared to other states in the U.S. Georgia ranked fourth in reported primary and secondary syphilis and tenth in reported Congenital Syphilis cases. In the current year, there were 31 Congenital Syphilis cases out of 126,051 Georgia resident births. In 2017, there were 23 Congenital Syphilis cases out of 129,158 Georgia resident births. From 2017- 2018, there has been a 35% increase in Congenital Syphilis cases.

SPM 4: Neonatal Substance Abuse

Neonatal Abstinence Syndrome

Neonatal Abstinence Syndrome (NAS) is a Notifiable Condition in Georgia as of January 1, 2016. DPH requires notice and reporting of incidents of NAS by a health care provider, coroner, medical examiner, or any other person who has knowledge of diagnosis or health outcomes related, directly or indirectly, to NAS.

In the reporting year, Women's Health provided oversight and management of the NAS surveillance process in close collaboration with MCH EPI and birthing hospital staff. Cases were verified by MCH EPI staff through review and confirmation of case indicators. Georgia's case criteria for a confirmed case of NAS is: (1) presence of one or more clinical symptoms of NAS and/or (2) a positive infant substance test result.

In January 2018, the Neonatal Subcommittee of the GaPQC began working on a quality initiative to impact the growing incidence of NAS. The committee developed a baseline survey for birthing hospitals to determine current practices around NAS diagnosis and treatment. The survey was piloted in four hospitals during March 2018 and

was provided to all birthing hospitals in April 2018.

GaPQC continued to implement the NAS initiative with 48 birthing hospitals. GaPQC hosted monthly webinars on recovery language, breastfeeding infants with NAS, and substance use treatment during pregnancy. There were approximately 60 participants on each call. Additionally, two Quality Improvement (QI) Technical Assistance calls were hosted with participating hospitals to provide further training on developing and implementing key driver diagrams and creating run charts. Hospitals continued to receive their monthly Vermont Oxford Network (VON) Microlesson Completion Reports and received their first quarterly length of stay report containing data calculated from hospital discharge data. The reports outlined their average length of stay compared to other GaPQC hospitals. The program was also approved for Part Four Maintenance of Certification Credit from the American Board of Pediatrics for all pediatricians participating in the collaborative to further encourage physician participation.

Other Perinatal/Infant Health Programs

Newborn Screening
Georgia Newborn Screening (NBS) is a six-part preventative health care system designed to identify and provide early treatment for 35 inherited disorders that would otherwise cause significant morbidity or death, including 29 disorders detectible through blood, hearing loss, and critical Congenital Heart Disease (CCHD). The NBS systems is comprised of six major components to ensure every newborn receives adequate screening for these 35 conditions and infants that screen positive for a condition receive appropriate and timely follow up. The six components of the system are:

- Education: of parents and health care providers
- Screening: universal testing of all newborns
- Follow-up: rapid retrieval and referral of the screen-positive newborn
- Medical Diagnosis: confirmation of a normal or abnormal screening test result by a private physician or tertiary treatment center
- Management: rapid implementation and long-term planning of therapy
- Evaluation: validation of testing procedures, efficiency of follow-up and intervention, and benefit to the patient, family, and society. This includes consideration of adding other tests to the system as indicated by appropriate research and scientific evidence.

In the previous fiscal year, the Commissioner of Public Health added three new conditions, Pompe Disease, Mucopolysaccharidosis Type I (MPS I), X-linked Adrenoleukodystrophy (X-ALD) to the state newborn screening panel. In December 2018 of the reporting year, the DPH Commissioner included an additional condition, Spinal Muscular Atrophy, to the state universal screening panel based on the rigorous review of the condition by the Newborn Screening and Genetic Advisory Committee (NBSAC) and subsequent recommendation to include the condition on the state panel. During the legislative session, DPH requested and was allocated funds to support the implementation of universal screening for four new conditions early in the next fiscal year. To educate hospitals and pediatricians about the new conditions, the newborn screening program hosted a webinar through AAP on the new conditions included on the state panel. The program issued memos to hospitals, pediatric providers and public health staff.

In November 2018, The NBSAC held ad hoc meeting during which Congenital Cytomegalovirus (cCMV) Screening was nominated to the state newborn screening panel. The NBSAC established a workgroup to review the condition and the implications of adding cCMV to the state panel. The work group included the parent of a child with a condition identified through newborn screening, a pediatric infectious disease physician, a pediatric neurologist, a

cCMV laboratory expert, the Georgia newborn screening laboratory director, clinical coordinator, and lead follow-up nurse. The work group met monthly for a six-month period and reviewed cCMV based on standard criteria outlined in Rules and Regulations that guide the addition to new conditions to the state panel and criteria used by the Advisory Committee on Heritable Disorders in Newborns and Children within the Health Resources and Services Administration.

In February 2019, the NBSAC held a regularly scheduled semi-annual meeting in which the Guanidinoacetate Methyltransferase (GAMT Deficiency) work group presented the outcomes of an extensive review conducted regarding adding GAMT to the state newborn screening panel. The work group concluded that GAMT meets many of the criteria required for inclusion on the newborn screening panel including a clear benefit to detection and treatment in the newborn period. However, the work group noted that further inquiry into the best method to detect GAMT through blood spot screening and the implications for the newborn screening follow-up process is needed. The work group recommended a pilot study be conducted to further investigate the implications GAMT screening. The NBSAC voted in favor of this recommendation pending the availability of funding to support a pilot study.

Quality Improvement

NBS continued to develop and implement strategies to consistently engage birthing centers and hospitals around the importance of newborn screening and the impact of high-quality specimen collection. In the reporting year, NBS developed and disseminated a brief instructional video reviewing necessary techniques for quality newborn screening specimen collection. The video is posted on the newborn screening website and all newborn screening specimen collectors were made aware of the video. During the reporting year, newborn screening specimen quality for all birthing facilities was monitored by the newborn screening program. Each quarter, birthing facilities that submitted newborn screening samples with zero errors received a letter from the MCH Director, recognizing the facilities' success. Facilities with consecutive quarters of zero errors in their newborn screening samples received a certificate of achievement. To further bring awareness to techniques that resulted in proper newborn screening specimen collection, the newborn screening program created posters with quick tips for collecting newborn screening samples. The program also developed pocket guides with images of quality newborn screening samples to be used as a quick reference. The video, posters and pocket guides were all on-demand resources birthing facilities used to improve the quality of their newborn screening samples. The Newborn Screening Clinic Coordinator continued to monitor the overall rate of quality newborn screening samples and provided in-person technical assistance when needed.

Sickle Cell Foundation Community Health Workers

In the reporting year, DPH partnered with the Sickle Cell Foundation of Georgia, Inc. (SCFGa) to provide Community Health Worker (CHW) services for individuals of all ages with Sickle Cell Disease (SCD) in Georgia. CHWs aim to improve overall health outcomes for SCD by providing local families with resources to increase self-care management, self-efficacy, and successful transition from pediatric to adult care. Patient education and strategic partnerships are incorporated into the program to address issues. The overall program provides several benefits to those living with sickle cell disease. CHWs serve clients by linking them to medical homes, community-based programs and resources, public health services and healthcare transition planning with adolescents. Many primary care physicians that do not have specialized training in caring for patients with SCD are uncomfortable treating adults with SCD. Individuals with SCD sometimes do not understand the need for a medical provider other than a hematologist to manage their care. As a result, fewer than half of adults with SCD have access to primary care. The partnership between DPH and SCFGa is an innovative approach to strengthen the system of care for people with SCD by better linking social support services, medical care and public health services. This partnership signifies a 'whole person approach' to supporting individuals with SCD. The SCFGa has ongoing collaboration with renowned hematologist in the state to promote the benefit of the whole person approach. They have held joint presentations in Bibb, Emanuel and Chatham Counties and have presented this approach during a webinar hosted

by the AAP.

Outreach and Education
The Newborn screening program employs various education and outreach strategies to families and providers. The program engaged directly with physicians and nurses at the Georgia Academy of Family Physician's meeting in October 2018 as well as the Georgia Chapter of American Academy of Pediatrics meeting in November 2018. These meetings provided the program opportunities to interface directly with physicians and discuss the importance of newborn screening and newborn screening results with families during the newborn visit.

ZIKA
As of May 2018, 686 cases have been identified with suspected Zika-associated birth defects and have been dispositioned into one of three categories: confirmed Zika-associated birth defects (32%), confirmed general birth defects (31%), or non-case (36%).

Potential cases were identified from three sources, including the Zika Active Monitoring System (ZAMS) and the Zika Pregnancy Registry (ZPR). Electronic birth certificates (eBCs) constituted the largest (73%) reporting source. However, birth defects reported on eBCs require confirmation through medical record review, per guidelines from CDC Zika Birth Defects Surveillance (CDC-ZBDS) and the National Birth Defects Prevention Network (NBDPN). Through this effort, MCH EPI fostered relationships with medical facilities, as well as drew attention to the need for birth defects reporting and established a protocol for tracking records from initial requests through confirmation, referral to early intervention services, and CDC reporting.

An Infant EPI focused on the surveillance of birth defects and NAS and a Medical Record Liaison assisted in the requesting of medical records. The Infant EPI and Medical Record Liaison collaborated to initiate medical record requests, review records for confirmation of reported birth defects, and abstract confirmed records. Once received, reviewed, and confirmed, the abstracted records were linked with confirmed cases from the Metropolitan Atlanta Congenital Defects Project (CDC-MACDP) and reported to CDC-ZBDS on a monthly basis.

Zika birth defects surveillance gave DPH the opportunity to develop a Birth Defects Registry that integrated data from 13 reporting sources, including eBCs and ZAMS/ZPR; expedited referral of affected infants and their families to early intervention services; and facilitated standardized, timely, reporting and confirmation of birth defects statewide. Funding for Zika-specific projects was discontinued at the end of the reporting year and Zika surveillance has been integrated into the ongoing activities of acute arboviral disease surveillance.

Safe Sleep
The Safe Infant Sleep program plans and promotes the Georgia Safe to Sleep Campaign. The campaign provides tools and resources that strengthen policy, provide consistent education and change infant sleep environments to prevent infant sleep-related deaths, empower professionals to educate parents, empower families to make informed decisions about infant sleep, and increase access to resources that support behaviors that protect infants from sleep-related deaths.

The Georgia Safe to Sleep Hospital Initiative, as part of the Georgia Safe to Sleep Campaign, is a statewide initiative designed to raise awareness about sleep-related infant deaths and evidence-based sleep practices to prevent infant mortality. The hospital initiative was launched in May 2016 to prevent infant sleep-related deaths in Georgia, empower professionals in multiple disciplines to educate parents about safe sleep environments and ensure they see proper sleeping practices modeled in hospitals. MCH continued to work with participating birthing hospitals to meet the goals of the program.

In the reporting year, all 79 Georgia birthing hospitals participated in the Safe Sleep Hospital Initiative. To support hospitals in their efforts to educate families about safe sleep practices, education materials were distributed throughout the state, including safe infant sleep educational flipcharts for educators, one-page handouts on the safe sleep environments, safe sleep brochures, crib cards, Spanish language materials and safe sleep books. Children's Healthcare of Atlanta quality improvement project expanded to all three campuses to improve modeling of safe infant sleep and "floor talkers" were designed, developed and implemented in areas with the highest sleep related death rate. The Safe Sleep Program designed, developed and implemented the "Safe Infant Sleep Education and Crib Distribution" program and study. Currently more than 30 sites are hosting safe infant sleep educational classes and distributing a play yard with bassinet to expectant mothers in or near their third trimester. A pre-and post-education survey was administered. A train the trainer education course was developed to increase the number of safe infant sleep trainings that occur with consistent and accurate education.

Published Article and Poster Presentation:

As Easy as ABC: Evaluation of Safe Sleep Initiative on Safe Sleep Compliance in a Freestanding Pediatric Hospital, S. Lazarus; T. McFadden; T. Miller

Family and Community Support Services

Evidence-Based Home Visiting (EBHV) programs are an effective early-intervention strategy to improve the health and well-being of children and parents. Home visiting is a strengths-based, family-centered support strategy that gives pregnant women and at-risk families with children from birth until kindergarten entry the resources and skills they need to raise children who are physically, socially, and emotionally healthy and ready to learn.

MCH continues its commitment to implement comprehensive, community-based maternal and early childhood programs to include evidence-based home visiting (EBHV) programs in nineteen counties (Bartow, Brooks, Catoosa, Chatham, Clarke, Clayton, Crisp, DeKalb, Dooly, Echols, Fulton, Flynn, Houston, Liberty, Lowndes, Muscogee, Richmond, Rockdale, and Whitfield). Since 2010, Georgia has instituted a comprehensive, high quality, community-based maternal and early childhood system, with EBHV as the major service strategy for improving child and family well-being. The framework seeks to assure the well-being of families with young children by identifying all expectant parents, children birth to five and their families, offering a comprehensive screening to determine strengths and needs, and linking families to community services and supports, including EBHV.

EBHV programs available in Georgia are as follows: Early Head Start - Home Based Option (EHS-HBO), Healthy Families Georgia (HFG), Nurse-Family Partnership (NFP) and Parents as Teachers (PAT). EBHV program models are proven to improve outcomes in several domains including (1) maternal and child health, (2) positive parenting practices, (3) child development and school readiness, (4) reductions in child maltreatment, (5) family economic self-sufficiency and (6) linkages and referrals to community resources and supports.

During the reporting period:

- 24,042 home visits were completed
- 2,016 families were served
- 984 new families were enrolled into Georgia Home Visiting
- 2,459 children completed the child development screening Ages and Stages Questionnaire (ASQ)
- 8,291 First Step screens were completed
- 5,946 community referrals were made for services
- 824 maternal depression screenings were completed-181 screened positive (22%) and of those,155 were receiving services or a referral was made

Maternal Infant Childhood Home Visiting (MIECHV):
The Georgia Home Visiting Institute, Accelerating Your Success with Families, was held September 10, 2019. The event featured a plenary session speaker, EJ Carrion, and provided nine breakout sessions and exhibitors. Mr. Carrion, a motivational speaker and founder and CEO of the Student Success Agency, shared his personal story with a focus on how home visitors can engage and build relationships with young parents to help unlock their true potential. There were 277people in attendance.

The Georgia Home Visiting Institute provided high quality training for Georgia home visitors and supervisors, community outreach staff, and family support staff to develop and enhance core competencies critical to their work. Trainings addressed strategies to improve the quality and effectiveness of home visiting services, with an emphasis on supporting healthy infant/toddler development and parent-child relationships to develop the skills necessary for establishing, building and enhancing relationships with families.

With the oversight of Georgia MIECHV under DPH, partnerships with other MCH initiatives strengthen program infrastructure and enhance service delivery to families.
MCH Partnership Examples include:

- Oral Health – Georgia MIECHV partnered with the DPH Oral Health section to provide education to home visitors. In December 9, 2019, the State Oral Health Director conducted a webinar for home visitors and provided a flip chart that home visitors can utilize with families. Home Visiting and Oral Health also developed an oral health survey for the home visitors to gauge their knowledge and needs.
- Children 1st /BCW -Georgia MIECHV partnered with BCW and Children 1st to develop standard operating procedures for districts with both home visiting and the Part C programs to use when collaborating. A Memorandum of Agreement template was developed, Technical Assistance (TA) provided, and a pilot was planned to test procedures.

Georgia Innovation Award Activities
The Innovation Award allowed the Home Visiting Program to implement the first multi-tiered model for professional development. This model included a workforce needs assessment that was administered to home visitors and home visiting leadership, workforce development through partnerships, and workforce sustainability. Key collaborations were made with local colleges and technical schools, Georgia Department of Early Care and Learning (DECAL), the Council for Professional Recognition, the University of Georgia (UGA) J.W. Fanning Institute for Leadership and Development and the UGA School of Public Health.

Family and Community Supports worked directly with the Institute for the Advancement of Family Support Professionals (IAFSP) to complete a customized training platform for Georgia's home visiting workforce. IAFSP offered all home visitors the opportunity to learn new skills and advance careers. Through engaging, online modules and a personalized learning map feature, professionals led professional growth and advancement with the National Family Support Competency Framework as a foundation. The Institute developed through a MIECHV Innovation Award built upon previous work of project partners to enhance professional development across the field. Iowa Department of Public Health and Virginia Department of Health were co-leads on this project.

Georgia Home Visiting sites participated in an Emergenetics training on September 9, 2019. Emergenetics is an assessment tool that allows individuals to assess his/her personality and use assessment results to provide guidance on optimal ways to interact with others in a professional or personal setting with minimal conflict. The session was attended by over 50 home visiting leaders with positive feedback. The session had 39 participants.

Lemonade for Life training was offered on August 28, 2019 to address the need for additional training in the area of toxic stress/Adverse Childhood Effects (ACEs). Lemonade for Life trained home visitors on how to use the ACEs Questionnaire and help families translate the results. The goal of this training was to provide home visitors with the tools to help promote resiliency within the families they serve and prevent future exposure to ACEs. Twenty-five home visitors participated in this training.

MCH developed a Home Visiting Career Toolkit that included Home Visiting Career brochures, postcards and other items to be distributed to students. The Home Visiting Career Toolkits were shipped to ninety-nine colleges and technical schools throughout Georgia and informed students about home visiting as a possible career. Each MIECHV site also received a career toolkit to share with students that may be interested in the field of home visiting as a viable career choice.

Collaborative efforts between the Home Visiting Program, colleges, and several home visiting sites resulted in the development of home visiting internships. The internship program was piloted with four students at two MIECHV sites. The MIECHV site in Columbus hosted three Health Promotion major students from Columbus State University. The MIECHV site in Watkinsville hosted one student from Athens Technical College that majored in Early Child Care Education. In 2019 the internship program expanded to12 students that completed internships at nine home visiting sites. Two students completed an internship with the Georgia Home Visiting Program at DPH. All participating sites were asked to have interns shadow at least three home visitors and assist in planning one group connection activity. Each student was asked to write weekly summaries during the internship and submit to the Innovation Coordinator at the end of the internship. One intern provided feedback of their experience stating, “The role of a home visitor can have an extremely positive impact on child development and the family unit. Home Visiting is something I could see myself doing in the future if I am to stick with general public health, but I can also apply the tactics if I continue on to become a pediatrician.” Many of the interns provided positive feedback and were appreciative for the opportunity.

The Home Visiting Program established scholarships that provided support for home visitors striving to earn the Home Visiting Child Development Associate (CDA) Credential. The CDA is one of the most widely recognized credentials in early childhood education and integral in the advancement of early childhood education professionals. The Home Visiting CDA Credential was developed using competency standards that focus on increasing family resiliency and increasing safer environments for children. The CDA scholarship included support to complete all prerequisite education needed to apply for the CDA, as well as the cost to complete the CDA application. The Georgia DPH Home Visiting Program awarded 30 CDA scholarships and four scholarship recipients successfully obtained the Home Visiting CDA Credential. The other home visitors continue to work towards completion with the support of the Home Visiting staff.

The Healthy Start Federal Grant, administered by HRSA's Maternal and Child Health Bureau, was awarded to MCH on April 1, 2019. Healthy Start aims to improve health outcomes before, during, and after pregnancy and, to reduce racial and ethnic disparities in rates of infant death as well as negative health outcomes in the first 18 months of life. Healthy Start funds supported the Georgia Strong Families Program (GSFP) implemented in the West Central Health District - Columbus and South Health District - Valdosta.

Current Year: Oct 2019 – Sept 2020

Priority Need: Prevent Infant Mortality

NPM 3: Risk Appropriate Perinatal Care

Maternal and Neonatal Levels of Care

A contract with the American Academy of Pediatrics (AAp) was established to use the AAP Verification Program for the application and site survey process for Level II and Level III Neonatal Center Designations. This contract was executed in January 2020. The online application for Level I Maternal and Neonatal Center Designations opened in February 2020.

Perinatal Regionalization

To strengthen the system of regionalization, there has been continued work on increasing communication with RPC stakeholders to include meetings with RPC medical directors and outreach educators as well as conference calls with finance staff and data coordinators.

The RPC's in the six birthing regions in Georgia are actively responding to the current COVID-19 pandemic in addition to continuing to provide transport and high-risk care to mothers and babies across the state. Two perinatal regions, Albany in the rural southwest, and Atlanta, have been significantly impacted by the pandemic. Maternal and Neonatal Outreach educators from these two RPCs are supporting clinical needs within their facility in addition to providing support for their regions' birthing centers.

A joint quarterly RPC Outreach Educator and Women's Health meeting was held during January 2020 to plan regional training for the state's birthing hospitals. A survey completed by all birthing hospitals identified a need for training for hospital staff to implement clinical simulation drills in their individual facilities. Clinical simulation drill implementation is required to implement maternal quality improvements for hemorrhage and hypertension emergencies. The curriculum was developed, and meeting invitations were sent to obstetrical unit staff in all birthing facilities in the state to attend one of five regional trainings scheduled in March through May. Due to the COVID-19 pandemic, the trainings were canceled. The trainings will be rescheduled when operations return to normal.

NPM 4: Breastfeeding

Breastfeeding

In the current year, the Georgia 5-STAR Hospital Initiative continued to provide technical assistance by phone, emails, and in person visits. In collaboration with the American Academy of Pediatrics- Georgia Chapter, DPH continued to deliver the EPIC breastfeeding program. In collaboration with WIC, Women's Health provided breastfeeding educational trainings to all DPH staff including nurses, peer counselors, breastfeeding coordinators, nutritionists, and administrative staff. The team hosted a breastfeeding training, "Breastfeeding: Why are We So Squeamish About It?". EPIC breastfeeding programs were also administered to hospital staff. A Mock Site Visit was conducted and designed to mimic the Baby Friendly USA designation assessment, allowing hospitals the opportunity to strategically approach continued areas of improvement and plan for a successful BFUSA designation, if desired. Clinical Competency Skills Lab Trainings were conducted to aid hospital staff in completing the five-hours of knowledge and skills competency verification as required by Baby Friendly-USA. To support virtual training opportunities, the Lactation Education Resource online training module was purchased.

SPM 3: Rate of Congenital Syphilis

Congenital Syphilis

The STD Office worked to prevent STDs by providing quality intervention strategies, programmatic support and education to all throughout the state. With a focus on Congenital Syphilis, the STD team works to promote first and third trimester testing for HIV and Congenital Syphilis, as well as to improve the data quality of Congenital Syphilis.

In the current year, district and provider education continued. The following site visits and trainings were provided:

District Education

- Rome/Dalton Site Visit (October 1, 2019)
- Gainesville Site Visit (October 9, 2019)
- Congenital Syphilis Review Board Meeting (October 29, 2019)
- District Online Meeting (December 10, 2019)
- District Online Meeting (March 10, 2020)
- District Online Meeting (June 9, 2020)
- District Online Meeting (September 8, 2020)
- Statewide STD Update Meeting (May 27, 2020)

Provider Outreach

- Georgia Academy of Family Physicians Fall Conference (Nov. 14-16, 2019)

Challenges/barriers:
COVID-19 has limited the ability to plan or implement community outreach events in 2020.

Priority Need: Prevent Maternal Substance Use

SPM 4: Neonatal Substance Abuse

Neonatal Abstinence Syndrome
In the current year, GaPQC has continued to implement the NAS initiative with 46 (63%) of birthing hospitals in the state participating in the initiative. GaPQC supports the neonatal teams by hosting the monthly webinar series to facilitate education and collaboration. The didactic presentations are designed to guide hospitals through implementing interventions listed in the key driver diagram. We have included a QI focus as part of each webinar which follows the stages of the Model for Improvement from the Institute for Healthcare Improvement.

In March 2020 the neonatal subcommittee developed a survey for all hospitals participating in the NAS initiative. The purpose was to assess interventions implemented and where additional support could be offered. Preliminary survey results show the area of need to be on IT tools and using the Plan, Do, Check, Act (PDCA) cycle for rapid quality improvement. Based on the recent survey, the focus will be placed on increasing the frequency of QI technical calls, led by the neonatal physician champion.

Hospitals continue to receive their monthly VON Microlesson Completion Reports and received their first quarterly length of stay report containing data calculated from hospital discharge data. The reports outlined the average length of stay compared to other GaPQC hospitals. Revisions were made to the SMART Aim to decrease length of stay among newborns diagnosed with NAS in participating GaPQC hospitals from 16.3 days to 14.7 days by September 9, 2020, to reflect national recommendations with a 10% decrease. GaPQC received approval for Part Four Maintenance of Certification Credit from the American Board of Pediatrics for all pediatricians participating in the collaborative to further encourage physician participation.

GaPQC, along with all hospital teams and partners, are actively responding to the current COVID-19 pandemic and preparing for how GaPQC can support hospital systems to continue to improve maternal and neonatal outcomes without further taxing the system. Women's Health will continue to use resources to support communities and continue to offer technical assistance as requested during these unprecedented times.

The Microsoft Teams platform has been utilized to maximize data sharing and create a webinar platform that is user-friendly and robust enough for recording and posting webinars for on-demand viewing. GaPQC supports the maternal and neonatal teams by hosting a monthly webinar series to facilitate education, collaboration, and support the process and structure measures for both AIM bundles and interventions for the NAS initiative. Webinars feature subject matter experts and hospital teams from Georgia and other states to share experience implementing the interventions.

A one-hour webinar to support hospital teams who are on the front lines caring for pregnant and birthing women and their infants during the COVID-19 pandemic was presented and led by a panel of experts in obstetrics and neonatal care, including our physician champions for NAS and the AIM bundles. Participants were given the opportunity to ask questions, share resources, and learn from one another. In-person trainings were changed to virtual when possible. The implicit bias training for hospital teams included a four day in-person train-the-trainer style training and the clinical simulation and debrief trainings included hands-on simulation and demonstration.

Challenges/barriers: At this time, decisions are based on the consideration of safety for staff and partners on the front lines of the COVID-19 pandemic. GaPQC is being proactive to minimize engagement by actively strategizing to build relationships that do not involve travel or meeting in person for the foreseeable future. Options continue to be explored to provide hospitals with rapid access to data in order to inform their QI initiatives and plans.

Rural hospital challenges: Even with funding provided for some, several of the rural facilities struggle with dedicating resources to the AIM project.

Related legislation: O.C.G.A. §31-12-2 (2017) statutory reporting requirement for NAS

Other Perinatal/Infant Health Programs

Newborn Screening
NBS is a life-saving public health service offered universally to infants born in Georgia. At the federal level, the Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) conducts thorough evidence reviews to determine if a condition should be added to the Federally Recommended Uniform Screening Panel (RUSP). Georgia's condition review process is similar to that at the federal level and Georgia typically adheres to RUSP. Recently, Georgia added and successfully implemented four new conditions to the NBS panel (Pompe Disease, Mucopolysaccharidosis Type I, X-linked Adrenoleukodystrophy and Spinal Muscular Atrophy). The implementation process included targeted communication to families via the NBS brochure and targeted information sent directly to hospitals and physicians who routinely submit NBS specimen, and general updates on the process shared during stakeholder meetings and Board of Health meetings. Staffing for short-term follow-up services was also expanded to meet the anticipated increase in infants that screen positive for a condition on the NBS panel. The Georgia Public Health Laboratory successfully purchased and calibrated new equipment, validated new testing methods, and completed updates to the IT systems that support efficient screening and follow-up.

DPH completed a NBSAC recruitment cycle and engaged more family representatives and more representatives from areas outside the metro-Atlanta area. In February 2020, the NBSAC held a regularly scheduled semi-annual meeting during which a nomination to add Krabbe disease to the state NBS panel was presented. The NBSAC established a workgroup to review the condition and implications of adding Krabbe to the state panel. The work group members include the co-chair of the NBSAC, a physician skilled in pediatric transplantation and gene therapy, a family member of a child with Krabbe, a genetic counselor and board member of KrabbeConnect, a clinical, biochemical, and molecular geneticist, the Director of the NBS short-term follow-up program, a pediatric

neurologist and the parent of a child with a condition identified through newborn screening. The work group met monthly for a six-month period, conducting independent research and discussing the evidence based on standard criteria. The workgroup will have an opportunity to present a summary of findings and recommendations to the NBSAC during the next semi-annual meeting.

The NBS program designed and implemented a quality improvement project to improve the quality of specimen collection and decrease the number of days the specimens are in transit to the DPH Laboratory. The project was designed for small cohorts of hospitals to be engaged over a six-month period. In December 2019, the NBS Team successfully conducted an initial training for the project, which welcomed 23 nursing staff from ten birthing facilities in metro-Atlanta. All ten hospitals identified two NBS Champions per facility and agreed to participate in the six-month QI project. During the training, participants learned about NBS specimen collection, data collection and the principles of quality improvement and small acts of change. At the close of the kickoff training, the ten QI hospitals staff received posters and “badge buddies” that display instructions for specimen collection, and illustrations on acceptable versus unacceptable specimens to share amongst fellow staff who routinely collect NBS specimen. Following the initial in-person meeting, the NBS team held monthly cohort calls with NBS champions to discuss strategies they implemented during the month and the impact of the strategies on specimen quality or transit time.

To truly realize the benefits of NBS, the NBS program supports comprehensive strategies to enable the development of infants identified with a condition via NBS. For example, In the previous funding year, the sickle cell short-term follow-up and hematology program through Augusta University added a social worker to the team to help better coordinate care for infants and children with sickle cell, or other significant hemoglobinopathy. This program services children in Augusta and conducts outreach clinics in South Georgia. Children and families who attend these clinics have access to medical care and to case management services coordinated by the social worker. The social worker most often helps families address needs for transportation, social security appeals, school 504 plans, family leave request, and community resources. The social worker also conducts developmental screens on children who have not had one conducted by their primary care physician or for who the hematologist has concerns. Any child that that showed signs of developmental delay is referred to their primary care provider for further follow up.

In the current year, the Medical Nutrition Therapy for Prevention (MNT4P) Program provides ongoing services to individuals with conditions identified through NBS. Medical nutrition therapy is the primary and lifelong treatment for most of the inherited metabolic disorders (IMD) diagnosed through NBS. The MNT4P is working to improve health outcomes and the quality of life for individuals with IMDs by increasing access to medical nutrition therapies necessary for treatment and maintenance of these metabolic disorders.

NBS and NBS follow-up has been sustained during the COVID-19 pandemic. Adjustments have been made to protocols to maintain the urgency of follow-up while minimizing risk of exposer to the virus. NBS follow-up teams conduct conference calls with subspecialists to whom they typically refer infants that require further testing or are diagnosed with an NBS condition. During the calls, the teams discuss processes specialty clinics have put in place to keep children safe during appointments and under what circumstances a child’s follow-up appointment may be postponed avoiding unnecessary exposure to the coronavirus. The follow up teams included this new information in letters faxed to primary care providers when an infant screen positive for an NBS condition. Specialists maintain 24/7 call lines to support pediatricians providing services to infants and children with an NBS condition. The sickle cell follow-up teams provided supplementary guidance to pediatricians around initiating penicillin prophylaxis in cases where families are delayed in accessing follow-up or choose not to schedule an appointment with a hematologist during the pandemic. To maintain continuity of care, telephone visits are conducted for non-urgent patients.

Emerging Threat Response-Epidemiology
During the current year, several activities have been performed to maintain and enhance the surveillance of Zika-related health impacts through the development of the Congenital Infections Registry (CIR) and expansion of the Epidemic Response Team. Other congenital exposures have been included in the initial proposal of the CIR, including syphilis and hepatitis C. Most recently, with the ongoing COVID-19 pandemic, exposure to SARS-COV-2 began integration into the CIR as well.

MCH EPI was awarded Component W of the Epidemiology and Laboratory Capacity grant in August 2019. To accomplish longitudinal surveillance of emerging congenital infections, a SendSS module, the Congenital Infections Registry (CIR), began construction. Several staff have been hired to carry out the effort, including an Epidemiologist to serve as the Congenital Infections Registry Coordinator (CIRC2), a Medical Records Epidemiologist Liaison (MREL), and a CDC Contractual Field Staff (CFS). The CIRC2, MREL, and CFS joined the Newborn Surveillance Team to work closely with the Infant Outcomes Surveillance Manager (IOSM) on the CIR. Syphilis was the first congenital exposure selected for the CIR. The Newborn Surveillance Team have worked closely with the Technical Developer, STD EPI, and STD Program staff to (1) select with CDC key variables for surveillance; (2) map variables common among the STD Case Management module in SendSS, Vital Records (VRs), and variables requested by CDC for SET-NET; (3) create a workflow that triggers a case to be shared between the STD Case Management and CIR modules in SendSS; (4) develop a data export mechanism for validation and reporting to CDC on a quarterly basis; and (5) with the help of district Disease Investigation Specialists (DIS), collect, review, and abstract medical records for submission to CDC. To date, the CIRC2 and CFS have begun working on the 2018 syphilis cohort (N=207) by abstracting the birthing hospital records and initiating follow-up of 52 dyads composed of pregnant women with confirmed syphilis disease and infants with congenital syphilis exposure. The CIRC2 has successfully reported the initial forms (i.e., maternal health history and pregnancy outcome and birth forms) of these 52 dyads to CDC.

Safe Sleep
In the current year, all 77 Georgia birthing hospitals have participated in the hospital-based initiative. The following activities supported hospitals in their efforts to educate families about safe sleep practices:

- Distributed “this side up” infant gowns to birthing hospitals. This portion of the hospital-based program, as well as the travel bassinet distribution, ended in the current year.
- Distributed the “Sleep Baby Safe & Snug” board books to 75 of the 77 facilities.
- Developed a guide to assist Children’s Hospitals with implementing a safe infant sleep program.
- Expanded the Children’s Healthcare of Atlanta quality improvement project to all three campuses to improve modeling of safe infant sleep. Policy has been approved and put into place for safe sleep. A second article on the effort was accepted for publication in the Journal of Injury Epidemiology.
- Finalized an outcome evaluation of the hospital-based safe infant sleep program with the birthing hospitals. Kennesaw State University was the principal investigator. Results were positive.
- Participated in the Emory Healthcare baby shower program for expecting employees.
- Provided hospital representatives with an online safe sleep training that families and caregivers can take instead of traveling to an in-person class, to help with education during social distancing due to COVID19.

The safe infant sleep program distributed educational materials throughout the state, including safe infant sleep educational flipcharts for educators, one-page handouts on the safe sleep environments, safe sleep brochures, crib cards, Spanish language materials and safe sleep books. The program conducted focus group testing of newly created room sharing educational materials at six sites around the state. The materials were revised based on feedback. The materials were developed to specifically address the high number of sleep-related infant deaths that

occur within the adult bed each year (>50 percent of all deaths). Materials will be distributed through PCM sites, OBGYN offices and other locations.

The program also launched the “Safe Infant Sleep Collaborative Network”. The network is a tool meant to provide updated resources, peer support and education on safe infant sleep to anyone working with families. The program also continues to promote and teach the “train the trainer” sessions to help build local capacity to provide safe infant sleep education within their communities.

The program expanded the previously designed, developed and implemented, “floor talker” educational opportunity in collaboration with the Child Fatality Review Panel to 244 additional sites throughout Georgia, including MCH home visiting sites, with specific focus to the areas with the highest rates of sleep-related infant mortality.

The program designed, developed and began implementation of a “Safe Infant Sleep Education and Crib Distribution” program specifically designed for areas where the birthing hospital has a Medicaid-enrolled birth census at 75 percent or greater. The program is designed to address health inequity for families enrolled in Medicaid due to Medicaid-enrolled families having a four times greater risk of sleep-related death than families with any other insurance payer.

Additionally, the Safe Sleep program worked with the national representative assigned to Georgia, from the National Center on Shaken Baby Syndrome to help address areas with the highest reported numbers of abusive head trauma.

The program had two poster presentations and one oral presentation:

- Wisconsin Association for Perinatal Care Annual Conference: Salm Ward, T. C., Miller, T. J., & Naim, I. A. (2020). Evaluation of a multi-site safe infant sleep education and crib distribution program in Georgia. Poster.
- University of Georgia State of Public Health Conference: Salm Ward, T. C., Miller, T. J., & Naim, I. A. (2020). Evaluation of a multi-site safe infant sleep education and crib distribution program in Georgia. Poster
- American Academy of Pediatrics Annual Conference (2019) Lazarus, SG., Miller, T.J. Expansion of a multi-pronged safe sleep quality improvement initiative to three children’s hospital campuses. Oral Presentation

Family and Community Support Services

In the current year, the Family and Community Supports program continues its commitment to implement evidence-based, comprehensive and community-based maternal and early childhood programs. Home Visiting programs currently include the Early Head Start Home Based Option (EHS-HBO), Healthy Families Georgia (HFG), Nurse Family Partnership (NFP), and Parents as Teachers (PAT). Family and Community Supports partners with the MMRC and participates in their action-oriented processes providing education and resources for women and infants through outreach activities in the community.

To strengthen collaboration with the Healthy Start grantee sites and Title V, Family and Community Supports coordinates and conducts a quarterly call with the six Healthy Start sites in Georgia and the Healthy Start National Project Officer to foster collaboration and team building and identify opportunities to leverage resources for successful partnerships. The most recent quarterly call focused on home visiting protocols amid the COVID-19 pandemic which included Home Visiting sites developed strategies to provide services to clients via phone, virtual visits, and group activities. Several sites have implemented innovative strategies such as mailing educational materials and information to families as well as developing educational videos to send to families for review and participation with families at home. Home visitors have implemented strategies to deliver these items to the families

and observe the social distancing recommendation.

Continuous Quality Improvement Cohort
In the current year, FACS has participated in the Continuous Quality Improvement Cohort (CQI) The CQI approach assist home visiting programs to measure processes and outcomes, incorporate new knowledge and practices in a data-driven manner, highlight training and technical assistance needs, help monitor fidelity of program implementation and provide rapid information on a small scale about how change occurs. CQI also helps to identify key components of effective interventions and empower home visitors and program administrators to seek information about their own practices. CQI has the potential to be transformative for programs and is an opportunity to improve upon everyday practices in small ways that result in large gains in program efficiency and services delivery.

Specific Community of Practice

- January 14, Maternal Depression cohort- one Title V attendee, Bibb.
  Outcomes- Melissa Keane, a Perinatal Mental Health Counselor, Postpartum Support International's Georgia Chapter, provided a Perinatal Mental Wellness Presentation. Attendees were encouraged to take a CQI action step after the presentation and explored potential process steps for incorporating Postpartum Support International Georgia as a new resource for supporting participants with maternal depression.
- January 27, Parent Child Interaction cohort- two Title V attendees, Bibb and Gordon.
  Outcomes- The session focused on peer sharing of current tests, strategies for introducing PCI to newly enrolled families, strategies to increase PCI with existing families, and holding the gains from the previous year.

Power of Your Data Model Specific Webinar Series

- February 18, Parents as Teachers session- one Title V attendee, Gordon.
  Outcomes- The session focused on custom reports, trends observed in data cleaning efforts and using data for improvement. Participants gained new insights into how to use the Home Visiting Deliverable, Intake and newly added Home Visiting Referrals made to Service Providers reports in their ongoing supervision efforts; including the use of data for improvement. Highlighted current trends observed in data cleaning efforts, exploring potential challenges with collecting and documenting the Well Child Visit Record. Program Supervisors provided feedback on the type of data that would best support their work.

The tenth annual Georgia Home Visiting Institute (HVI) was held virtually on August 18, 2020, with 274 attendees present. Originally scheduled as in in-person meeting at the Peachtree City Hotel and Conference Center in Peachtree City, Georgia, the event was held virtually using the Zoom video conferencing platform due to the COVID-19 pandamic. The HVI was sponsored by DPH in partnership with United Way of Greater Atlanta. The Georgia Home Visiting Professional Development Work Group served as the HVI planning committee comprised of state leaders of Georgia's early childhood home visiting programs and state partners committed to strengthening and professionalizing the field of home visiting.

The primary objective of the HVI was to provide high-quality training for Georgia home visitors, supervisors, and community outreach staff to develop and enhance core competencies critical to their work. The HVI addressed strategies to improve the quality and effectiveness of home visiting services. The goal of the 2020 HVI was to provide quality learning and skill-building opportunities for home visiting and early childhood professionals in Georgia. Strategies for strengthening individual programs and services, networking with partners and peers in the field, and opportunities for collaboration to strengthen the system of family-serving programs throughout the state were also provided.

The keynote plenary was led by Dr. Junlei Li, the Saul Zaentz Senior Lecturer in Early Childhood Education at Harvard Graduate School of Education and Dr. Dana Winters, faculty director of the Fred Rogers Center for Early Learning and Children's Media, Saint Vincent College. The Fred Rogers' Center promotes the legacy of Fred Rogers' and his deep commitment to showing children the utmost respect and caring in every interaction. In the virtual plenary, Drs. Li and Winters co-led an overview of the Simple Interactions approach, designed to help affirm the power of human relationships in both ordinary and unusual times. Dr. Heather Forkey, Associate Professor of Pediatrics at the University of Massachusetts Medical School, and Division Director for the Child Protection Program and Foster Children Evaluation Service (FaCES) of the University of Massachusetts Memorial Children's Medical Center, also presented. Dr. Forkey presented on the concept of "self-regulation" and provided practical strategies for guiding caregivers to self-regulate, support attachment, address challenging behaviors, and promote co-regulation of kids.

Oral Health

The Oral Health Program provided Home Visitors a flipbook guide on oral health to help educate families on improving oral health behaviors. It was originally created by the Rhode Island state Oral Health Program and Oral Health Coalition with feedback from Home Visitors. The flipbook was adopted with permission and rebranded by Georgia DPH. Flipbooks were provided to all the Home Visitors in the state and are provided to families through home visits.

Challenges/barriers: The COVID-19 pandemic created a need for flexible and sustainable service delivery solutions to ensure that families continue to receive the benefits provided through home visiting programs. Although traditional, face-to-face home visits are currently discontinued, virtual visits are being conducted and the responses from home visit providers and clients are positive. MCH is committed to ensuring that families continue to be provided with evidence-based programs and support throughout the pandemic.

Improving Birth Outcomes

In the current year, MCH created the Improving Birth Outcomes Initiative to amplify efforts, identify gaps, and create a collective, streamlined set of priorities to reduce infant mortality rates. The Improving Birth Outcomes Initiative has developed strategies to support improving birth outcomes and reduce premature births and infant mortality among all infants, specifically black infants, by creating partnerships and collaborations aimed at focusing on the Social Determinants of Health (SDOH) and addressing the correlations between race, equity, infant mortality and pre-term birth. MCH has introduced a community approach that includes community-based outreach and education as an essential component that has the potential to substantially improve infant health outcomes.

During the current year the Improving Birth Outcomes Initiative, MCH in partnership with HMHB and the Georgia Bureau of Investigations, convened the Infant Mortality Working Group including representatives of area health and human service agencies to participate in a strategic planning process for the Georgia Improving Birth Outcomes Initiative. Strategies to improve infant mortality, specifically infant mortality in the Black population will be developed.

MCH is partnering with the Office of Vital Records to improve Fetal Death Certificate reporting. When reported accurately, Fetal Death Certificate data will positively impact the ability to interpret and draw conclusions on the Perinatal Periods of Risk analyses and/or other analyses involving fetal deaths, improving the ability to inform programmatic decision making and impacting conclusions on infant mortality.

MCH is collaborating with the Mercer University School of Medicine's Center for Rural Health and Health Disparities to conduct a qualitative mixed-methods analysis in rural areas of the state with high infant mortality rates to

understand the landscape of the community to better assess needs. Exploring rural and urban mortality differences examines the impact of rurality on infant mortality and explores regional differences in primary and underlying causes of infant mortality. The environmental scan will explore socio-economic determinants of health including poverty, education, rural attitudes and culture, psychosocial risk factors, access to healthcare, employment, transportation, insurance status and other risk factors such as smoking rates, obesity, and safe sleep practices. The environmental scan will guide strategic planning and decision making to lead to evidence-based responses that improve birth outcomes in rural communities.

MCH will continue to support evidence-based home visiting programs in communities where infant mortality rates are disproportionately impacted by the leading causes of infant mortality and encourage participation in the Healthy Start CANs to enact community-level change in reducing disparities.

Strategies are being developed to expand the MCH 1st Care Program to additional counties in the state in order to provide public health nursing in-home assessments and education to families after premature and low birth weight babies are discharged from the hospital.

Plans to develop a Community Engagement Toolkit to promote collective impact and health equity is being developed to provide community organizations with structured guidance on the issues to consider when planning and designing community engagement to improve birth outcomes in a community. The toolkit will focus on quality and effectiveness, process planning, and designing engagement tailored to the community and stakeholders affected.

Priority Need: Prevent Infant Mortality

NPM 3: Risk Appropriate Perinatal Care
Percent of Very Low Birth Weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Strategies:

3.5.1 Complete a Neonatal Center Designation for at least 10 hospitals annually.

3.6.1 Conduct one site visit annually at each RPC to verify RPC compliance with level III care in neonatal care.

Perinatal Regionalization
Infant mortality will continue to be a priority for MCH, stakeholders, and partners. As a priority for many agencies and partners, it is important for MCH staff to create synergy around strategies to reduce maternal and infant mortality. To verify all Georgia birthing hospitals are operating at the level of care designation authorized through the Department of Community Health Certificate of Need program, Perinatal Regionalization will continue campaigns and develop interventions to effectively reduce infant mortality. Staff will begin implementation of the Medical Director Regional Plan and the Developmental Clinic Quality Improvement Project. Neonatal Transportation teams will be incorporated and collaboration with Level of Care committee in the implementation of hospital assessments.

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

Strategies:

4.1: Promote the 10-Steps to Successful Breastfeeding training utilized by staff and providers from the state's birthing hospitals.

4.2: Provide training and education to increase home visitor's knowledge and best practices of breastfeeding.

4.3: Connect MIECHV and Healthy Start women to WIC services.

Breastfeeding
The Women's Health program will increase the number of hospital staff and providers trained on the Ten Steps to Successful Breastfeeding. Education and training opportunities on the Ten Steps to Successful Breastfeeding will be provided through the First Latch-Breast Feeding Hospital Initiative (BFHI) online training module. Hospitals will be recognized for completing steps towards the implementation of the Ten Steps to Successful Breastfeeding. A plaque will be presented to hospitals that successfully complete a minimum of six steps.

Women's Health will work with community partner, GA-AAP, to deliver the EPIC breastfeeding program and distributes information on how to access lactation support services in the community for patient education. Seventy EPIC trainings will be provided annually.

In collaboration with the district health departments, Women's Health will provide funding to two public health districts

to aid in developing and implementing programs to support breastfeeding duration.

In collaboration with WIC, Women's Health will provide an educational series to increase the breastfeeding knowledge base of public health and participating hospital staff throughout the state, including topics such as promoting the importance of breastfeeding, providing lactation support to working mothers, and other topics to support breastfeeding initiation and exclusivity at six months.

Women's Health will explore opportunities to determine the need for breastfeeding support for women with special health care needs to assess facilitators and barriers to improve breastfeeding practices among these women.

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

Strategies:

5.1: Promote the importance of hospitals and birthing facilities providing education and modeling safe infant sleep to parents with newborns or infants.

5.2: Promote the importance of professionals trained to educate to recognize, identify, and model safe infant sleep environments.

The Georgia Safe to Sleep Campaign will continue to work with participating birthing hospitals, Neonatal Intensive Care Units and Pediatric Units to meet the goals of the program. Training and education will continue for hospital staff, home visitors, local health departments, WIC offices, first responders, social workers, and other professionals, as requested. The program will improve local capacity to provide safe infant sleep training by hosting train the trainer sessions. Representatives of the program will continue to conduct research and participate in multidisciplinary team meetings to address infant mortality. Additionally, the program coordinator will also assist the Georgia Bureau of Investigation by participating in the Georgia Safe Infant Sleep Coalition to pilot new ideas to facilitate infant and child safety as well as participating on the statewide Infant Mortality Working Group collaboration between DPH, HMHB, and the Georgia Bureau of Investigations.

SPM: Congenital Syphilis

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

Congenital Syphilis
The STD Office will continue to promote first and third trimester testing for HIV and Syphilis, as well as improve the data quality of Congenital Syphilis. The STD Office will also work to improve the identification of pregnant females with syphilis to ensure timely and appropriate treatment.

SPM: Reduce Infant Mortality in the Black Population

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

Improving Birth Outcomes
The Georgia Improving Birth Outcomes Initiative will continue to develop strategies to support improving birth outcomes and reducing premature births and infant mortality among all infants and specifically black infants by

creating partnerships and collaborations aimed at focusing on SDOH and addressing the correlations between race, equity, infant mortality and pre-term birth.

The Infant Mortality Working Group will continue to be a lead agency in the Georgia Improving Birth Outcomes Initiative and will continue activities to develop and engage community initiatives to reduce disparities in Black infants compared to other populations and infant mortality. Strategies will be implemented to improve the quality of data reported for Fetal Death Certificates, support evidence-based home visiting programs, partner with the MCH 1st Care Program, and engage Healthy Start CANs. Mercer University School of Medicine will conduct the qualitative analysis to include focus groups, surveys, and key informant interview in rural counties with the highest infant mortality rates to understand the landscape of the community to better assess needs.

The Improving Birth Outcomes Initiative will focus on expanding the understanding of diversity to positively impact birth outcomes by expand understanding of the drivers of health and work across sectors exploring existing initiatives, perceptions, and knowledge about disparities within the community.

Other Perinatal/Infant Health Programs

Newborn Screening

The NBS program will continue efforts to ensure that every newborn is screened for heritable disorders with prompt identification and treatment. The NBS program will continue to be responsible for the administration of the NBS system, including educating families and practitioners about NBS, overseeing the follow up process for infants that screen positive for conditions identified via NBS, monitoring and evaluating the NBS system and reporting to state and federal officials and to the public.

Contracts with Emory University, Augusta University, and Children's Healthcare of Atlanta will continue to conduct short-term follow-up on abnormal NBS results. NBS short-term follow-up encompasses the time between receiving an abnormal result to the confirmation of a diagnosis and helps ensure that all diagnosed cases are referred to Children 1st leading to an assessment to determine the newborn's eligibility for Individuals with Disabilities Education Act (IDEA) Part C, BCW, CYSHCN, and CMS.

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

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

Neonatal Abstinence Syndrome

The Women's Health Program will continue implementation of a perinatal opioid advisory group to explore gaps and opportunities for maternal interventions to impact birth outcomes. Educational and training for providers and the public will continue to be developed as needed.

GaPQC will continue to address the opioid crisis' impact on perinatal care and outcomes. GaPQC launched the

NAS QI initiative to decrease the length of stay among babies born with NAS. Participation in the NAS QI initiative will continue with the 46 birthing hospitals and outreach will be ongoing to recruit more hospitals. To assist hospitals in implementing best practices and recommendations the Women's Health Program will continue using the VON Toolkit which includes sample policies and procedures, training modules, and data collection and analysis tools along with the annual audit. Monthly webinars to support hospital teams and provide technical assistance for the initiative will continue.

Beyond Zika Prevention

Although funding for Zika surveillance from an arboviral epidemiology perspective was discontinued, Zika surveillance will continue as it has been integrated into the case definition for the notifiable condition of all acute arboviral infections. In August 2019, Georgia was awarded Component W of the Epidemiology and Laboratory Capacity grant from CDC. Component W, or Surveillance of Emerging Threats to Mothers and Babies Network (SET-NET), has enabled Georgia to begin performing longitudinal surveillance of emerging congenital infections, including Zika. As a result, follow up of infants in the Zika Pregnancy Register has been extended to 36 months. Data collection and reporting for the new time points of 30 and 36 months is under way. Regarding Zika-associated birth defects, Georgia DPH will continue its implementation of a statewide surveillance system for birth defects. The registry has connected 12 reporting sources and will automate referral of affected infants and their families to early intervention services; and facilitate standardized, timely reporting and confirmation of all birth defects statewide, including those associated with Zika. Flexibility has been inherent to the design of the registry and will greatly enhance Georgia's capacity to respond to emerging infectious threats in the future. As part of the SET-NET award, DPH will continue follow up with infants who had in utero exposure to the Zika Virus and in addition, will also begin follow up with infants who had exposure to (a) Congenital Syphilis and (b) Perinatal Hepatitis Virus C. During the upcoming grant year, the technical infrastructure within the State electronic notifiable disease Surveillance System (SendSS) will continue to be developed. DPH will begin performing medical record review on these two additional conditions. The combination of the three conditions, in collaboration with the CDC and other sites performing similar surveillance activities, will lead to a better understanding of the health impacts of in utero exposure to each, as well as practical public health interventions to reduce the impact of such exposure.

Family and Community Support Services-Home Visiting

The Georgia Home Visiting Program will continue to strengthen its services and maintain its proven track record to positively impact the wellbeing of families, communities, and the state. FACS will continue to focus on diversifying funding to sustain and expand home visiting throughout the state, concentrate on strengthening the workforce through assessment and training, and improving maternal mental health. FACS will make maternal mental health a priority due to the approximately ten percent of pregnant women worldwide and 13 percent of women who have recently given birth experiencing a mental disorder, primarily depression, by training staff and identifying community partners for direct linkage.

The Georgia Strong Families Program (GSFP) Healthy Start managed by DPH will provide healthcare coordination, home visitation, and case management services to 700 participants each reporting year including pregnant women, new mothers, infants, and fathers. Home Visiting Program staff will facilitate the coordination of community service delivery systems and promote and improve health equity. GSFP will also implement supportive services led by a Nurse Practitioner as a supplement to the established Healthy Start program. The Nurse Practitioner will provide home visits to the highest risk pregnant women and deliver education to families, staff, and partners on the importance of postpartum visits and warning signs.

FACS will continue to support the Language Environment Analysis (LENA) Start Program in Muscogee county as an important component of the Healthy Start program. Parents participating in the LENA Start program groups use

regular feedback from LENA technology to help increase interactive talk to close the early-talk gap, support kindergarten readiness, and build stronger families. Families will continue to participate in ten weekly sessions that teach parents and caregivers the importance of interactive talk along with ways to incorporate more conversation into their daily routines. Funding and staff have been allocated to sustain the project in the coming year.

Child Health

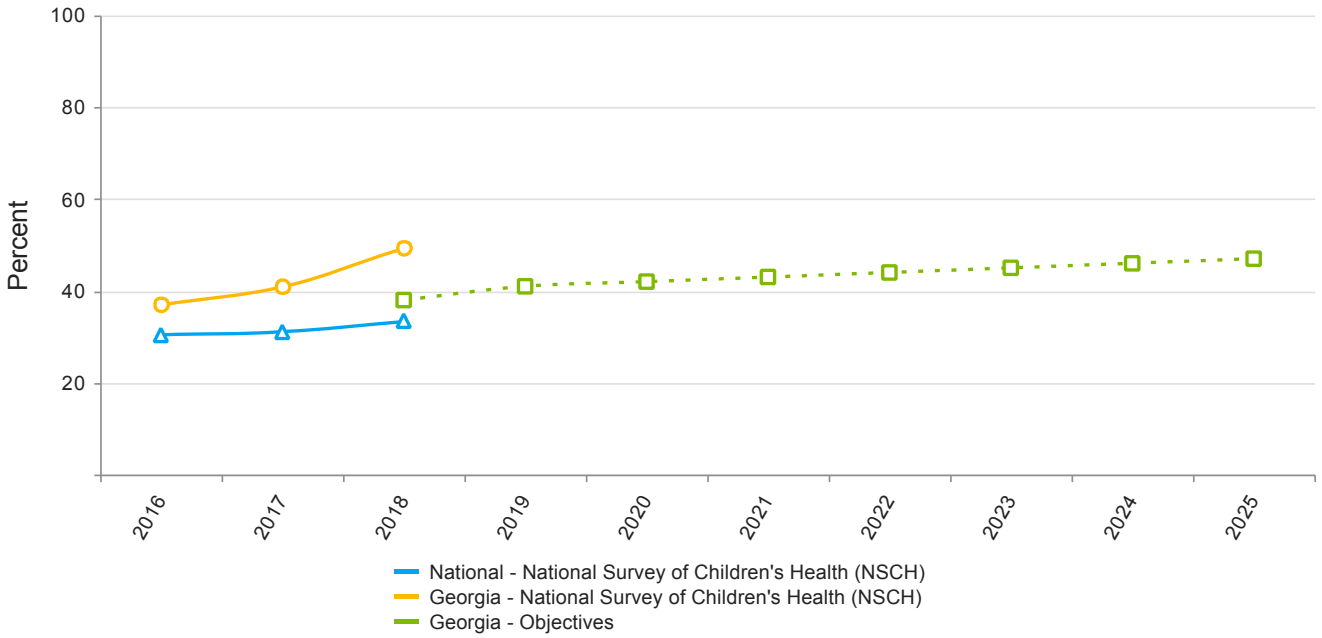
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	12.8 %	NPM 13.2
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
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 6 NPM 8.1 NPM 11 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2017_2018	16.0 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2016	12.5 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2013	12.8 %	NPM 8.1
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 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			38	41
Annual Indicator		37.1	40.8	49.4
Numerator		104,456	107,598	135,738
Denominator		281,856	263,952	274,649
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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	42.0	43.0	44.0	45.0	46.0	47.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	3.0	6.0	9.0	12.0

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

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	11.8
Numerator	951
Denominator	8,038
Data Source	SendSS
Data Source Year	SFY 2019
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12.0	13.0	14.0	15.0	16.0

ESM 6.3 - Number of new community partners who implement developmental screening and make referrals to their local public health district

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	1.0	2.0	3.0	4.0

ESM 6.4 - Percent of children, ages 0 through 5, who receive a developmental screening from DeKalb Board of Health Refugee Clinic

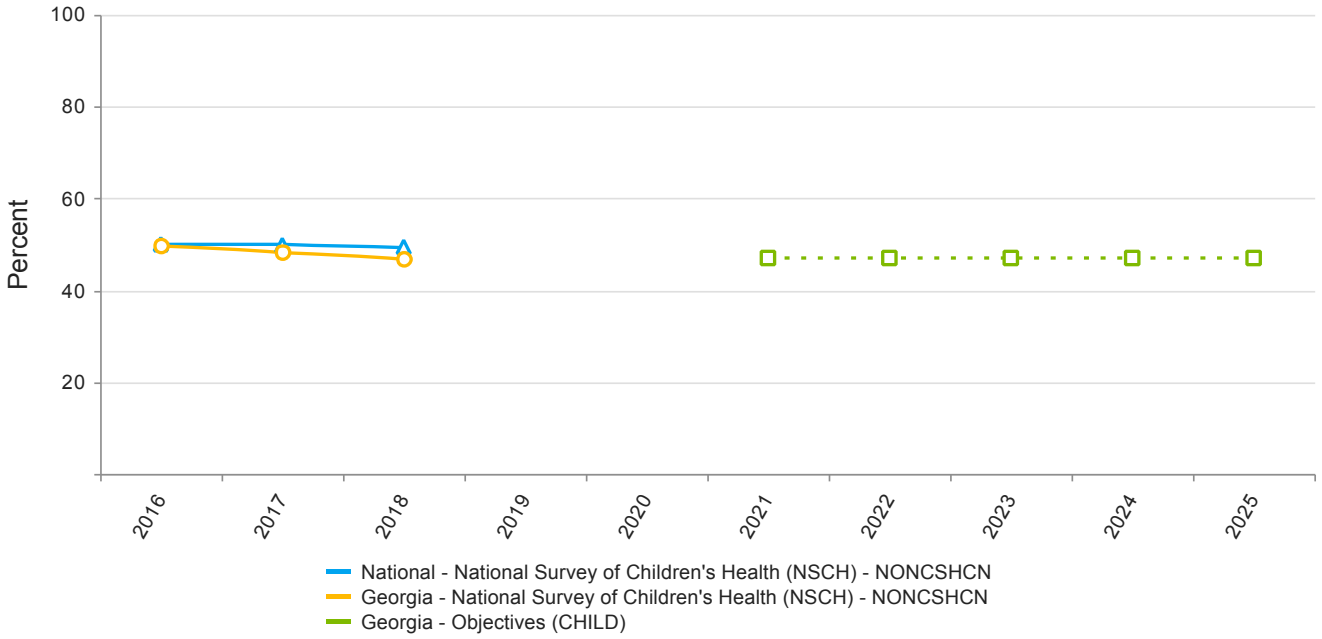
Measure Status:	Active

State Provided Data		
	2018	2019
Annual Objective		
Annual Indicator	85.4	89.3
Numerator	140	167
Denominator	164	187
Data Source	DeKalb Board of Health Refugee Clinic	DeKalb Board of Health Refugee Clinic
Data Source Year	CY 2018	CY 2019
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	93.0	97.0	100.0	100.0	100.0	100.0

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

Indicators and Annual Objectives



NPM 11 - Child Health - NONCSHCN

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN	
	2019
Annual Objective	
Annual Indicator	46.8
Numerator	948,129
Denominator	2,024,578
Data Source	NSCH-NONCSHCN
Data Source Year	2017_2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	47.0	47.0	47.0	47.0	47.0

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

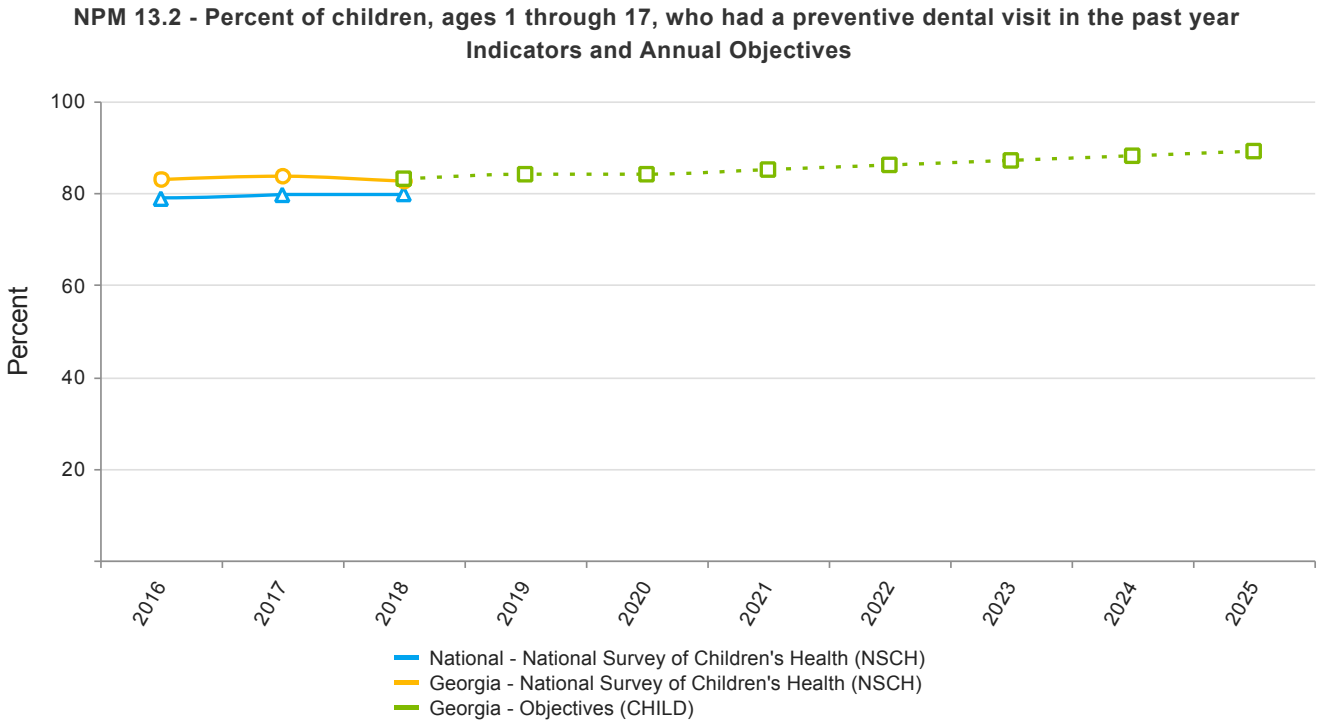
Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	3,809.0	4,000.0	4,190.0	4,381.0	4,571.0

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

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 13.2 - Child Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			83	84
Annual Indicator		83.0	83.5	82.4
Numerator		1,968,896	1,992,442	1,971,820
Denominator		2,372,620	2,384,889	2,393,072
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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	84.0	85.0	86.0	87.0	88.0	89.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2,500.0	2,500.0	2,500.0	2,500.0	2,500.0

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	200.0	200.0	200.0	200.0	200.0

State Action Plan Table

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

Priority Need

Promote developmental screenings among children

NPM

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

Objectives

6.1 By 2025, engage 15 new physician practices to conduct developmental screens and submit referrals to public health.

6.2 Identify and collaborate with 5 community-based organizations to initiate or increase developmental screening.

Strategies

6.1a Develop a Physician Outreach campaign to increase the number of providers utilizing standardized developmental screening and supportive services available through Public Health and Help Me Grow.

6.1b Identify a physician champion to provide peer-to-peer coaching and education regarding developmental screening.

6.1c Provide feedback on referrals to primary care providers to encourage care coordination and future referrals.

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

ESMs	Status
ESM 6.1 - Number of providers that receive developmental screening training who report initiating developmental screenings with parents in their practices	Active
ESM 6.2 - Percent of children that screen with concern that are referred to appropriate intervention services by providers	Active
ESM 6.3 - Number of new community partners who implement developmental screening and make referrals to their local public health district	Active
ESM 6.4 - Percent of children, ages 0 through 5, who receive a developmental screening from DeKalb Board of Health Refugee Clinic	Active

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

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

Priority Need

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

NPM

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

Objectives

11.1 By 2025, increase 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 needs 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

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

Priority Need

Promote oral health among MCH populations

NPM

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

Objectives

13.2.1 Develop, maintain, and update a state oral health surveillance system that helps capture data, and identify gaps in data related to oral health information pertaining to children.

13.2.2 Promote and monitor clinical dental visits within districts programs.

13.2.3 Increase the number of dental providers who accept Medicaid through activities such as provider training, increased reimbursements, and other incentives.

13.2.4 Increase access to oral health prevention services for low income children through school-based/school-linked programs.

13.2.5 Increase the number of Hispanic children receiving oral health education.

13.2.6 Maintain a high level of access for all Georgians, including children, who have access to optimally adjusted community water fluoridation as a means of reducing dental decay.

Strategies

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

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

13.2.3 Work with Healthy Mothers Healthy Babies and other external partners by providing subject matter expertise and strategic feedback.

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

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

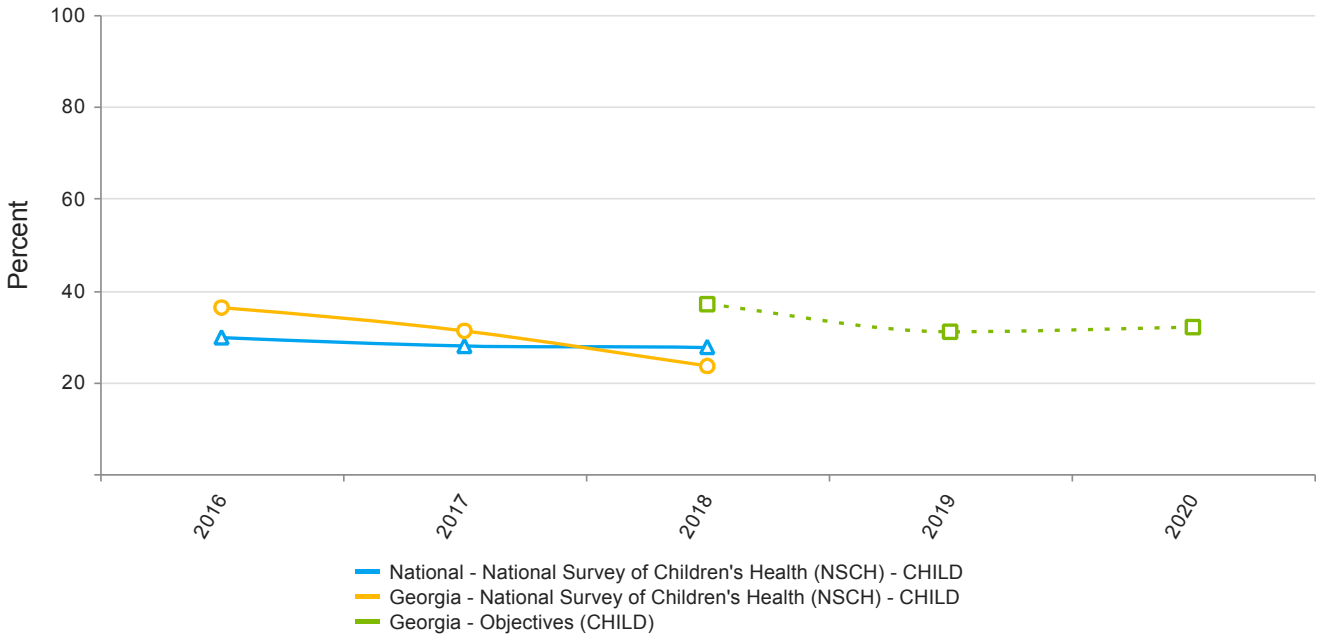
13.2.6 Provide trainings to local water plant operators on the value to community water fluoridation and technical assistance to improve monthly reporting from local community water systems.

ESMs	Status
ESM 13.2.1 - Number of children screened at school-based/ school-linked programs	Active
ESM 13.2.2 - Number of Hispanic children who are provided with oral health education	Active

NOMs
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

2016-2020: National Performance Measures

2016-2020: NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2016	**2017**	**2018**	**2019**
Annual Objective			37	31
Annual Indicator		36.4	31.3	23.4
Numerator		301,002	270,140	221,154
Denominator		826,166	863,542	944,551
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018

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.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 8.1.1 - Percent of children, in grades 4-12 enrolled in public school physical education class, who are in the Healthy Fitness Zone (HFZ) for Body Mass Index (BMI)

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			58
Annual Indicator			57.8
Numerator			173,583
Denominator			300,366
Data Source			DOE Fitnessgram
Data Source Year			2019-2020
Provisional or Final ?			Provisional

Priority Need: Promote Developmental Screenings Among Children

NPM 6: Developmental Screening for Children

Children 1st serves as the single point of entry to child health services through DPH connecting children and families with public health and other prevention-based programs and services. Children 1st aims to identify all children ages birth to five who are at risk for poor health and development. Children 1st is in all 159 counties in Georgia and its system includes partnerships with Department of Community Health (DCH), DOE, Department of Early Care and Learning (DECAL), Division of Family and Children Services (DFCS), primary care and specialty physicians, and DPH home visiting programs. Each of the public health districts have a Children 1st Coordinator who implements the Children 1st program in each of the counties within the catchment area. The Children 1st Coordinator identifies children birth to five years of age with social, environmental, behavioral or biologic risk factors that may result in poor health or development outcomes and link them to appropriate care. Children 1st Coordinators intake all referrals with identified risk factors, implement standard timelines, and review criteria to distribute referrals to the appropriate public health, private, and community-based programs. The Children 1st program functions within five core components to establish a baseline level of consistency and efficient service to all families referred regardless of location in the state. The first core component is to screen children for risk factors at birth. Children born in Georgia have their electronic birth certificate screened for risk factors present in the perinatal period. Children 1st has also cultivated relationships with birthing facilities throughout the state and often receive referrals for infants and their families before hospital discharge. Children with individual or maternal risk factors receive follow up contact by Children 1st. The second core component of Children 1st is to use validated developmental screening tools to determine a child's developmental attainment. Children 1st also assesses the strengths and needs of the family with a standard tool as an indicator of risk for poor health and developmental outcomes as well as protective factors in the family environment to mitigate risks. These three components of the Children 1st program are biological, developmental and socio-environmental inputs used to develop a comprehensive assessment of the needs of the child and family. Children 1st Coordinators use this information to make appropriate linkages to public health, private, and community-based resources that will meet the needs of the family and best support the healthy growth and development of the child. Linkage to appropriate resources and services is an important component of Children 1st as it impacts all other child health programs within public health. Monitoring is the final core function of the Children 1st program and is offered to families that do not qualify for early intervention but want to stay connected to a public health resource in case a delay in their child's development should arise. Families that are connected to monitoring services are linked to a medical home and educated about developmental screening and surveillance, so they are equipped to monitor their child's development and follow-up with their pediatrician or public health if concerns are identified.

In the reporting year, developmental screening has remained a priority. This priority has been addressed through promoting developmental screenings, increasing opportunities for developmental screening, and providing education and awareness to parents and health care providers about the importance of developmental screening and monitoring.

In the reporting year, Children 1st facilitated 107 trainings with 749 training participants. Thirty-six Ages and Stages Questionnaires trainings were provide to 126 training participants; 54 Child Health Referral System trainings were provided to over 450 training participants; two M-CHAT-R/F trainings were provided to more than 40 training participants; eight Talk With Me Baby (TWMB) trainings were provided to more than 70 training participants; and seven other developmental screening trainings were provided to more than 50 training participants. Children 1st participated in 340 outreach events and disseminated close to 40,000 pieces of literature.

Updates with ASD screening:
Since October 2018, Children 1st has documented ASD screenings for 1,018 children. Thirty-eight percent of the 1,018 ASD screenings were completed by the Children 1st team. Medical providers completed 50 percent of Autism Screenings and submitted them with Children 1st referrals. Twelve percent of ASD screenings were completed by other referral sources. Sixty-six percent of children who received ASD screenings were referred to the Babies Can't Wait early intervention program and nearly 30 percent were remitted for enrollment in Children 1st Engagement and Promoting program.

In the reporting year, Children 1st successfully re-branded promotional materials to include two brochures for two target audiences. The first brochure was developed for families and was written in lay language and included what families should expect after a Children 1st referral. The second informational brochure was developed to be used while conducting outreach to new and existing partners such as hospitals, physicians, DFCS and other partners. The brochure describes the Children 1st program, the programs a child may be further linked to as a result of a Children 1st referral, and a database that partners can use to communicate directly with the Children 1st Coordinator serving their community.

In addition to developing an informational brochure for providers, Children 1st launched a Physician Outreach Campaign. The goals of the Physician Outreach Campaign are to increase child health referrals and strengthen the relationship between Public Health programs and providers and their staff. The Campaign consists of targeted letters to over 100 physician's which detailed instructions on completing a Child Health referral, required documents for referral submission, and an invitation for the Children 1st team to provide an in-service. The Physician Outreach Campaign will be evaluated to determine if the campaign leads to an increase in referrals.

Children 1st continued to encourage staff at the local district level to establish partnerships and agreements with local referral sources. An example of a local district partnership is the South-Central Health District (Dublin) Children 1st program with local Head Start agencies. Children 1st established an agreement with Head Start agencies in two counties and in the City of Dublin. This was a timely partnership as Children 1st coordinators have requested the state office provide more materials that focus on developmental milestones to be shared with community daycares centers. This was an indication that the Children 1st program should maintain efforts to broadly distribute Learn the Signs. Act Early. materials developed by the CDC.

In January 2019, Children 1st began screening children newly and currently enrolled in the program for ASD. The goal of implementing ASD screening in the Children 1st program was to identify children with ASD as early as possible and link them to appropriate interventions and services. Children 1st recognizes the medical home as the primary environment in which developmental screening and monitoring should occur. Children 1st served as a safety net and worked closely with the medical home to identify children who have not been screened for ASD. If a child's medical home completed an ASD screening at 18 months and/or 24 months, the screening is not repeated by Children 1st. A copy of the completed screen(s) is gathered from the child's medical home and kept in the child's record. Children 1st is encouraged to complete ASD screenings only on children who have not previously been screened at their age interval. Children 1st has documented ASD screenings for 287 children. More than 100 screens have been completed by Children 1st staff and 100 children were referred to early intervention. Over half of the ASD screens documented in the Children 1st database were completed by a child's primary care provider or primary interventionist and sent to Children 1st with a referral for follow-up. Reducing duplicative screenings was an ongoing goal for the Children 1st program. As ASD screenings increased, Children 1st continued education for primary providers to submit a Children 1st referral with a completed ASD screen.

Children 1st continued to make consistent progress toward statewide implementation of the ASQ screenings online.

In February 2019, Children 1st facilitated an ASQ Online training with each of the public health districts to acclimate staff to using the ASQ Online developmental screening tool. More than 40 public health staff were trained to begin using the online ASQ database, and the training was recorded and stored on a web-based training platform to be accessed by new staff and re-accessed by those already trained. Another major accomplishment that moved the Children 1st team toward statewide implementation of ASQ Online was constructing a bridge between Brookes Publishing website and the database used by Children 1st staff at the state and district level. This bridge helped to more accurately and more rapidly integrate online ASQ screening results into the follow-up database for Children's 1st. This innovation also reduced data entry for Children 1st staff and allowed digital ASQs to be more easily incorporated into staff's workflow and case management. ASQ Online built efficiency for Children 1st staff as well as for those who administer developmental screenings using the tool. Children 1st offered a link for ASQ Online to daycare centers, Head Start agencies, primary care physician offices and local public health clinics. Once the screen is completed, it is immediately stored on a platform regularly accessed by Children 1st staff. Partner agencies will no longer need to score and fax the form to Children 1st to initiate follow up for families. The program will monitor the impact of this feature to see if it encourages screening by partners that have been reluctant to implement developmental screening within their agencies. Dissemination of the link for ASQ Online with key partners is an opportunity to re-introduce the Learn the Signs. Act Early. materials to the stakeholders. Bundling developmental monitoring educational materials and screening with a user-friendly screening tool will further promote developmental surveillance and screening with a validated tool.

Refugee Health

The State Refugee Health Program (SRHP) promotes the physical, mental, and social well-being of all newly arriving refugees in the state of Georgia. The program helps to ensure that refugees receive adequate healthcare. The refugee health screening has four purposes: (1) to reduce health-related obstacles to successful resettlement, (2) to protect the health of local, state, and national populations, (3) to identify health issues that may need continued care that public health departments cannot provide, and (4) to educate refugees about the United States of America Healthcare system and participate in making decisions about their health. The SRHP works in partnership and collaborations with the various stakeholders involved in refugee resettlement, U.S. resettlement agencies, County Health Departments, Community Health Centers, community-based organizations, mainstream social service providers, schools, members of charitable organizations, and church and community leaders. The SRHP also works with county health departments to screen all newly arriving refugees in Georgia for communicable and chronic diseases, and to administer immunizations. The State Refugee Health Program works with partners such as the Refugee Resettlement Agencies, County Health Departments, Schools, Community Based Organizations, and Community Service Providers to provide MCH program education. To increase access to the MCH program, BCW and WIC outreach and educational materials have been translated into refugee languages. SRHP has implemented a refugee health linkage coordination program to assist with education of health screenings and assessments.

In the reporting year, MCH Title V and the SRHP collaborated to create a plan to increase refugee community awareness of available MCH services seeking to ensure all eligible individuals and families have access to MCH programs such as WIC, BCW, and other child health programs. Refugee population needs were explored, and strategies were developed to best serve the refugee MCH population. The percent of children, ages 0-5, referred from Dekalb Board of Health Refugee Clinic to Child Health Services who received developmental screening was chosen as a focus and an ESM was developed. Ninety percent of health screenings for the refugee population are performed at the DeKalb county location. The MCH Child Health program provided autism training to the DeKalb Board of Health and verified current processes for child referrals for the refugee community. The collaboration provided outreach to the most vulnerable and hard to reach populations. The SRHP assisted in reducing barriers to MCH services that could result due to cultural and religious beliefs and language influences of the refugee.

Priority Need: Promote Physical Activity Among Children

NPM 8: Physical Activity for Children and Adolescents

Georgia Shape is a statewide, childhood obesity initiative that grew out of a 2009 policy, the Student Health and Physical Education (S.H.A.P.E.) Act. The S.H.A.P.E. Act requires that all K-12 students take part in an annual fitness assessment. Using that requirement as a springboard, Georgia Shape has grown into numerous programs, statewide coalitions, and annual events as the agency's child health and wellness program.

Partnerships
Georgia Shape convenes five sub-groups (Data and Evaluation, Healthcare, Marketing and Communication, Nutrition and Physical Activity) that meet quarterly and report about ongoing child health and wellness initiatives and projects statewide. Each sub-group is comprised of twenty-five to sixty academic, community, and subject-matter experts.

In addition, Georgia Shape has worked to create more specific coalitions to address pointed objectives. These include the Georgia Farm to Early Care Coalition, The Women, Infant, Children (WIC) Working Group, and the Physical Activity Data Group.

Working Group Objectives:

- Georgia Farm to Early Care Coalition: Main objective-increase awareness and understanding of Farm to School and Early Care & Education through strong "What is Farm to School and Early Care & Education" messaging through social media, workshops, webinars, and articles by 2024, aligning Farm to School and Early Care & Education data collection with USDA Farm to School Census and develop and support strategies to increase local food procurement to include identification, sourcing and distribution.
- WIC Working Group: Main objective-Facilitate increased WIC participation across the state of Georgia through a coalition of statewide non-profit, academic, government and professional organization partners
- Physical Activity Data Group: Main objective- Improve quality and quantity of physical activity for children, grades K-12 through the utility of FitnessGram outcomes in those students assessed in the Healthy Fitness Zone for aerobic capacity.

Programs
Health Behavior-Nutrition, Physical Activity and Education Programs and Training
Georgia Shape coordinates data analysis efforts with Cooper Institute and supports the Georgia Department of Education (DOE) with annual reports to the Office of the Governor. Georgia Shape also manages statewide FitnessGram® (FG) "booster session" (assessment refresher trainings) contracts with core partners, HealthMPowers and DOE. These contracts allow Georgia Shape to train Physical Education teachers to assess students effectively, yielding quality data collection across the state. Georgia Shape annually coordinates eight to twelve trainings.

The Power Up for 30 Program has 881 active schools across the state. The DOE and HMP provide technical assistance, in-person training and online resources. This program equips school administrators and staff opportunities to provide an additional 30 minutes of meaningful physical activity to students throughout the school day. In partnership with the University of West Georgia (UWGA) the program offers teacher training for all federally funded afterschool sites. The University of West Georgia developed a graduate certificate program for Early Education and Physical Education majors. The certificate is formalized on their transcripts. This program builds the capacity of future educators entering the field. Georgia Shape continues work to increase participation in the

following programs for children six to eleven years of age:

- Eat. Move. Talk! (EMT) is an early care and education (ECE) program designed for children aged zero to five to promote language nutrition through a combination of evidence-based messages on healthy behaviors and food nutrition. This program has an additional focus on brain development and language acquisition. The program is currently being implemented in Dalton, Clarkston and Valdosta, with current plans for expansion and outcome dissemination.

- Farm to Early Care and Education (F2ECE) began in 2013 with the first F2ECE Summit in the country (then called Farm to Preschool) with Georgia Shape partners leading the charge in hosting. In 2015, Georgia Shape built the Georgia F2ECE Coalition's statewide strategic map and programming that has been promoted statewide. The creation of the Coalition and Strategic Plan attracted the W.K. Kellogg Foundation to invest funding towards furthering F2ECE in Georgia in 2017. There are over 35 partners involved in Coalition and it has been recognized nationally.

Georgia Shape coordinates the Strong4Life (S4L) Cafeteria, Early Feeding and Provider trainings facilitated by Children's Healthcare of Atlanta (CHOA). DPH manages the Strong4Life Cafeteria Project based on Cornell's Smarter Lunchroom using behavioral economics as a framework. The Early Feeding and Provider trainings equip providers (physicians, nurses, physical assistants) with motivational interviewing (MI) tools and counseling techniques. These resources provide guides for patients, parents and caregivers to make goals based on the Transtheoretical Model to facilitate behavior changes. In the Strong4Life Women, Infants, Children (WIC) Champions Program, WIC staff are trained with content based on the provider trainings. Georgia Shape has trained 100 percent of the WIC Registered Dieticians and front-line staff and continues to train new staff on an annual basis. Online modules and refresher courses are being developed.

Mini-Grant Programs
The Georgia Shape Grantee Program awards 24 to 26 schools annually to assist in the implementation of best practices in physical activity and nutrition interventions into their school environment. Georgia Shape provides technical assistance and funding through our partnership with the Georgia Health Policy Center (GHPC) at Georgia State University (GSU). The program holds a summit for pre-awarded schools to attend annually. Awarded schools meet and receive one-two days of technical assistance. Over twenty partners are invited to attend and share their resources with schools, as well as provide subject matter expertise to select intervention areas.

The Rise Up 159 Mini Grant Program is funded by a two-year $240,000 award from the Arthur Blank Foundation. The goal of the mini-grant program aims to implement a Flag Football to youth serving organizations.

Awards and Recognition Programs
The Governor's Honor Roll Program within /Georgia Shape recognizes K-12 elementary, middle, and high schools for their dedication in creating a healthy school environment and a culture of wellness for staff, students, and the local community. Schools are awarded a certificate signed by the Commissioner of Public Health and DOE's State School Superintendent. In addition, awarded schools receive a banner for their school and an equipment package that promotes physical activity.

Early childhood education centers are recognized for implementing policies that support nutrition and physical activity through the Georgia Shape Quality Rated Recognition program. This program is a partnership between DPH and the Georgia Department of Early Care and Learning.

Georgia Shape also supports statewide recognition certificates for students that excel in Fitnessgram components. The Governor, DPH Commissioner and the DOE Superintendent sign roughly 100k certificates provided to DOE to disseminate to all state schools during the year.

In the reporting year, Georgia SHAPE continued the management of statewide Fittnessgram “booster session” contracts with HealthMPowers and the DOE. The contracts allowed DPH to train PE teachers to assess students effectively for fitness levels pertaining to Body Mass Index (BMI), aerobic capacity, flexibility, muscular strength and muscular endurance. Approximately eight to twelve trainings a year are conducted through DOE or state PE/Health conferences (GAHPERD association) and the FG Certificate program which coordinates state recognition certificates for students that excel in FG components. The Governor, DPH Commissioner, DOE Superintendent all sign the Certificate. DPH sends about 110,000 to DOE to send to all schools in the state to recognize participation and student achievement.

During the reporting year, SHAPE reach was as follows:

- Fitnessgram: 1,100,000 assessed
- Power-up for 30: 180,038 participants
- Eat. Move. Talk!: 102 early childhood educators trained
- Early Feeding Program: 69 providers
- WIC Online Module: 39 completions

Georgia Shape continues to work toward increasing participation in the following programs for children six to eleven years of age:

- PU30 Elementary Program- 881 active schools across the state participate with SHAPE providing TA and training components.
- PU30 Afterschool Program- DPH manages programs in partnership with HealthMPowers and DFCS. This partnership allows funding for HMP to do trainings in all DFCS funded afterschool sites.
- PU30 Pre-service teacher program- This program is managed through a partnership with the University of West GA (UWG). UWG developed a graduate certificate program for Early Education and Physical Education college majors with the help of HealthMPowers. Courses allow students to create educational opportunities for physical activity in the classroom. Upon graduation, a certificate is signed by the Governor, the DPH Commissioner, and the College President and is formalized on their college transcripts. In the reporting year, 58 students graduated with the PU30 Certificate.

Other Physical Activity programs provided during the current year:

- Georgia Shape Grantee Program- A mini-grant program allowed schools to choose what best practice interventions they want to introduce into the school environment. The program provided technical assistance and funding through the partnership with Georgia State University (GSU). The program’s summit in October 2018 included two staff members from the 24 awarded schools to meet and receive two days of technical assistance. Twenty partners were invited to attend and share their resources with schools, as well as provide technical assistance.
- Governor’s Honor Roll- Schools (K-12) applied for the award online and were awarded a certificate signed by the DPH Commissioner and the DOE Superintendent. In addition, they received a banner for their school and an equipment package that promotes PA.
- Rise up 159 Mini Grant Program- the Blank Foundation has awarded over $240k to implement a Flag

Football mini grant program. Shape worked with the NFL, Atlanta Falcons, and Blank Foundation on all aspects of program. Fourteen youth serving organizations have been funded to enhance existing or develop new NFL Flag Football programs across the state.

Early Care programs:

- In the reporting year, Georgia Shape will host a Farm to Early Care Education (ECE) Summit. Georgia Shape held the first ECE summit in the country in 2014. Georgia Organics leads much of this work under a SHAPE contract.
- Georgia Shape Quality Rated (QR) Recognition- Recognition program through a partnership with DECAL and the QR assessment.

Nutrition Based Programs and Projects:

- Strong4Life Provider Training- Managed contracts with CHOA to provide providers (physicians, nurses, physician's assistants) with motivational interviewing (MI) tools and counseling techniques to help with goal setting based on the transtheoretical model to facilitate behavior changes.
- Strong4Life Early Feeding Provider Training- Providers were trained to utilize MI in working with parents and caregivers about early feeding best practices, developmental concerns, etc. Take home kits for providers to give to patients were created to be disseminated statewide.
- Strong4Life WIC Champions Program- WIC staff (100 percent) statewide have been trained using the Strong4Life Early Feeding Provider Training.
- Zipmilk- Georgia used this platform to locate breastfeeding resources. The platform is updated by the Georgia Breastfeeding Coalition.

Georgia Shape coordinated data analysis with Cooper Institute and supported the
DOE with annual reports to the Governor. Georgia Shape also managed statewide Fitnessgram "booster session" contracts with HealthMPowers and DOE. These contracts allowed Georgia Shape to train PE teachers to assess students effectively for fitness levels pertaining to Body Mass Index, aerobic capacity, flexibility, muscular strength and muscular endurance. Georgia Shape provided approximately eight to twelve trainings throughout the year through DOE or state PE/Health conferences (GAHPERD association). Georgia Shape also coordinated the state recognition certificates for students that excel in Fitnessgram components. The Governor, DPH Commissioner, DOE Superintendent signed the certificates and funding was provided to Georgia schools.

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

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

The Oral Health Program provided financial support through grant in aid, supplies and other resources, as well as technical assistance and training to public health districts related to oral health. During the reporting year, 30,566 children in Georgia received oral health visits and 38,605 children received screenings through the Oral Health Program. Oral health education was provided to 89,331children, 10,204 sealants were placed, and 14,595 children received fluoride varnish applications for a total of 132,927 total treatments. A new school dental sealant program

was implemented in District 2 (Gainesville), in October 2018., All public health coordinated school sealant programs target schools with 50 percent or more of the student population eligible for free and reduced lunch programs.

In the reporting year, the Oral Health Program gained additional epidemiology support which allowed analysis of data collected on third graders oral health across the state through years 2016-2017. This provided rigorous and validated data on three critical indicators among Georgia third graders screened in the Basic Screening Survey – 1) Dental decay experience 2) active untreated dental decay (3) and presence of dental sealants. Data was also captured related to visits to the dentist in the previous 12 months. The epidemiology support has allowed for analysis of data collected on children participating in the Head Start program with a similar basic screening survey in 2014 and 2015. The program was previously unable to analyze the data due to turn over and vacancies in epidemiology support staff in previous years. A full report will be generated for the Head Start survey.

Two presentations were provided to family physicians during the reporting period on oral health and the role of the primary care provider to family practice residents. The presentations were given at teaching hospitals in Macon and Augusta and each was attended by approximately 30 residents. In addition to the in-person presentations to family practice physicians, an article was written by the Director of Oral Health on the importance of primary care providers in contributing to early oral health foundation building and screening for oral health. The article was published in the July 2019 Georgia Academy of Family Physicians newsletter and sent to members statewide.

The Oral Health Program participated on an advisory group for the Chief Turnaround Office (CTO) located within the DOE. The CTO was formed out of a Governor's
Initiative to look at the worst performing academic schools in the state of Georgia. Rather than looking at educational factors, children were screened for seven different health and environmental indicators that are possible contributors to poor classroom performance. Of these, one is oral health problems. Five schools in rural Georgia were identified and screened.

The Waycross Health District continues to maintain a teledentistry oral health program. The dental hygienist and a dental assistant spend the school year working out of three different elementary schools in the region where they set up dental clinics within the classroom using portable equipment. Children are screened, have a remote dentist provide a treatment plan using teleconferencing equipment, and then prevention oral health services are provided in the school including dental cleanings, fluoride varnish, x-rays, and dental sealants.

Other Child Health Programs

Early Brain Development initiative- Brain Trust for Babies
The stated goal of the Early Brain Development initiative was to establish early brain development as a public health imperative, establish a common set of agreed upon metrics to determine success by age three (as many children do not enter a shared database system for measuring health and academic outcomes until they enter the educational system) and to make sure that by 2020, every child in Georgia will achieve the promise for optimal brain development by age three.
Objectives aimed to improve development for children with hearing loss, autism and medical causes of developmental delay, as well as achieve healthy social and emotional outcomes for all children birth to three. Program goals included ensuring that all children who are deaf or hard of hearing are on a path to third grade reading by ensuring screening of hearing loss by one month, diagnosis by three months, and appropriate intervention by six months; achieving breakthrough outcomes for all children by building the self-regulation sills, executive functions and social-emotional health of the adults who care for them; and ensuring that children in Georgia are screened for Autism and Developmental Delays by 36 months and connected to appropriate intervention.

During the reporting year, DPH embraced the importance of early brain development as a public health priority. Research shows that early and frequent exposure to high quality and high quantity language nutrition is critical to optimal brain development and sets children on a trajectory for language acquisition, literacy and academic success. The amount of language nutrition a child receives between the ages of zero to three is a significant predictor of reading proficiency in third grade, when children switch from learning to read to reading to learn. Furthermore, third grade level reading proficiency is a primary predictor of future high school graduation rates, where children who are not at grade-level reading proficiency by third grade are four times more likely to not complete high school. Health studies show that high school graduation, in turn is a significant determinant in a variety of chronic health conditions, such as obesity, diabetes, substance abuse, cardiac and mental/behavioral health issues. Among the maternal and child health population, education is a life course factor that influences health outcomes on each life stage including that of the individual's offspring.

A unique and innovative program supported by the Brain Trust is TWMB. TWMB is a public action campaign aimed at coaching parents and caregivers on the primacy of language and language nutrition, or the rich language interactions between caregivers and infants, in the earliest stages of a child's development. A lack of early language exposure has lifelong consequences. Coaching caregivers to provide language nutrition to their children at an early age could drastically improve a child's lifelong trajectory. DPH has expanded its goal to reach three workforces by 2020. Currently, DPH and its various TWMB partners are working to training 14 different workforces that interact with new and expectant families. The goal is to create an ecosystem around families where everyone who interacts with that family is coaching and modeling the skills of language nutrition. TWMB at Work was implemented at DPH in 2018 with 75 public health staff participating in a three-part training. In total, TWMB at Work has reached 150 program participants at 11 host sites and has 30 trained volunteer facilitators.

Vision Screening

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

DPH, in cooperation with the DOE provided and monitored vision screening training and certification for local health department staff who perform vision screening on children three years of age and older. All staff within local health departments who administer vision screenings require certification prior to screening children and recertification every three years.

The vision certification process includes a didactic component as well as a demonstration of skills. The didactic portion of the vision screening training is available electronically through statewide training platform, TrainDPH. Following the didactic instructions, those seeking recertification must pass a post-test, and accurately demonstrate key screening competencies to a certified screener. Vision screeners will be recertified when they have passed the post-test and have competencies documented on a procedure's validation form.

Help Me Grow

Help Me Grow Georgia (HMG®) is a framework that builds collaboration across sectors, including child health care, early care and education, public health, and behavioral health and family support. HMG® does not provide direct services, rather, it is a system for improving access to existing resources and services for infants and children, through age eight. HMG® links families to the best services and resources available to meet their needs, regardless of the agency in which it is housed and is an affiliate of HMG® National. The program maintains fidelity to the national model to ensure the early childhood system in Georgia is successful in early identification of concerns and timely connection to services for families. The four core components of the HMG® framework are centralized access point, family and community outreach, child health care provider outreach and data collection and analysis. During

the budget year, HMG® has made progress across all core components to strengthen the implementation of the framework.

In the reporting year, HMG® transitioned from the exploration and fact-finding phase to the implementation phase with successfully launching the HMG® Centralized Access Telephone Line (CATL). The CATL is one phone number, 1-888-HLP-GROW, that providers and families can call to receive information about family and child serving programs and agencies across the state. The HMG® CATL received over 2,500 calls and provided over 3,600 child/family health and wellbeing referrals to callers. On August 16, 2019, in partnership with the West Central Health District, DPH held the first annual modeling HMG® Georgia Symposium with the goal of educating the community about the importance of early development while linking parents and caregivers to information, activities and local support systems that advance young children's health, well-being and school readiness. The Symposium's theme was Maximizing Our Communities' Potential and the program showcased system of care practices which included, Coalition Building/Innovative Partnerships, Leveraging Partnerships/Blended Funding, Pioneering Uses for Technology in Children's Health, Unconventional Solutions to Community-Wide Issues, and Using Parents as Partners in Systems Building. Attendees were also challenged to find new approaches to engage families, providers and children. HMG® encouraged traditional and non-traditional partners, representing a wide spectrum of the child health system to expand their focus to include the CDC's Learn the Signs Act Early (LTSAE) model. LTSAE materials were successfully used by several pediatricians, early interventionist, public health, and early learning programs. During the Symposium, facilitators explored ways LTSAE can be incorporated when developing policies and practices, programs and services, and outreach and communication, that address the health and developmental concerns of babies and young children.

The implementation phase promoted the major first step toward building a comprehensive and coordinated system to support young children's optimal development and well-being. HMG® held informational meetings with leadership from other state agencies which included the Department of Behavioral Health & Developmental Disabilities (DBHDD) and the Department of Early Care & Learning DECAL) to determine successful strategies that would promote partnerships, encourage interagency trainings and enhance the messaging of HMG®. HMG® successfully concluded the reporting year by brokering an opportunity with our partners at DBHDD to have all HMG®® staff trained in Mental Health First Aid & Suicide Intervention Skills Training.

HMG® participated in the Georgia Infant-Toddler Coalition whose goal is to advance the health, social, intellectual, and emotional well-being of infants and toddlers across Georgia. The shared vision is that all of Georgia's infants and toddlers receive the quality care and access to services needed in order to thrive. HMG® also participated in the Interagency Directors Team (IDT) which was created by DBHDD to design, manage, facilitate, and implement an integrated approach to a child and adolescent system of care that informs policy and practice, and shares resources and funding. IDT is comprised of over 20 representatives from state agencies and non-governmental organizations that serve children with behavioral health needs.

Family and Community Supports Home Visiting Program

A major service strategy within DPH is the Family and Community Supports Services Home Visiting Program. The program gives pregnant women and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn. Georgia continues its commitment to implementing comprehensive, community-based maternal and early childhood systems to include Evidence- Based Home Visiting (EBHV) programs. Georgia has instituted a comprehensive, high quality, community-based maternal and early childhood system, with EBHV as the major service strategy for improving child and family well-being. The framework seeks to assure the well-being of families with young children by identifying all expectant parents, children birth to five, and their families, offering a comprehensive screening to determine

strengths and needs, and linking families to community services and supports, including evidence-based home visiting.

Extensive research has shown the effectiveness of EBHV in improving outcomes for maternal and child health, home and child safety, school readiness, family safety, family economic self-sufficiency, and referrals and linkages to community resources. The EBHV programs available in Georgia are as follows: Early Head Start - Home Based Option, (EHS-HBO), Healthy Families Georgia (HFG), Nurse-Family Partnership (NFP) and Parents as Teachers (PAT).

Fatherhood Initiative
DPH supports the commitment to engage fathers through MCH programs and services by raising awareness of the impact of father involvement on children and family well-being. The Fatherhood Initiative was developed with the goal to create strategies that increase awareness and advocacy across intra and inter-agency partners, creating a culture of inclusion for fathers across the state.

The Fatherhood Initiative key priority areas include:

- Provide an understanding of Georgia's fatherhood landscape by conducting a comprehensive "father-friendly" assessment across programs and local public health districts that assists in measuring the current levels of engagement and participation.
- Build an infrastructure of father and family serving stakeholder organizations that address the need for coordinated strategies that connect initiatives with existing programs and services into an accessible system of care for fathers and their families.
- Increase collaboration among state and local programs using a collective impact approach, to develop and implement strategies that improve health outcomes for mothers and babies and strengthens families, impacting Title V state and national performance measures.

In March, 2019, the MCH Strong Fathers, Strong Families Georgia Coalition was established to create a partnership of family serving agencies and organizations to address the need for a coordinated strategy that connects initiatives with existing programs and services into an accessible "father-friendly" network. The Coalition is composed of twenty-five leaders representing state agencies, academic institutions, communities, and hospitals. The Coalition is designed to steer fatherhood-related communication, implementation, evaluation and dissemination activities.

In an effort to engage and provide education to community partners the Project LAUNCH Strong Fathers Strong Families Summit was held July 24, 2019 at Calloway Resort & Gardens. There were 78 attendees from across the state. The Summit increased knowledge, awareness, and capacity of agency partners, practitioners and public servants on the importance of intentionally engaging fathers and their impact on the health and development of their children and families. Education, training and increasing a network of practitioners with father-friendly resources, programs, and services was accomplished. Ken Harris, Senior Project Director at the National Institute for Children's Health Quality, was the keynote speaker.

Participation in the National MCH Workforce Development Center 2019 Cohort was completed during the reporting year. Over the course of seven months, Strong Fathers Strong Families Coalition worked collaboratively with the National Workforce Development Center increasing the capacity to support father engagement as an MCH transformational challenge. The Georgia team worked across sectors, developed strategies in the areas of change management/adaptive leadership, system integration, and evidence-based decision making. As a result, Georgia enhanced its collaboration and gained additional tools and resources to support work in the area of fatherhood.

In collaboration with Morehouse School of Medicine, Prevention Research Center, the Strong Fathers Strong Families Coalition received the Translational Research Grant to support a state fatherhood needs assessment. Despite extensive practice guidance and research evidence on the positive impact of father involvement on perinatal health disparities, involving fathers, specifically black fathers, is one of the least explored and implemented aspects of MCH services. The Translational Research Grant needs assessment will use a community-based participatory research approach through a collective impact framework. The assessment will identify strengths and gaps in father-friendliness, fathers' needs, and resources to better facilitate involvement in a scientific framework whereby new strategies to involve black fathers and coordinate services can be developed. The preliminary data that will be collected will contribute to the continued efforts to create a father-friendly network. The award amount is $75,000 over a two-year period.

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

In the reporting year, Georgia (GIP) sought to increase immunization rates for all Georgians and decrease the incidence of vaccine-preventable diseases. GIP educated medical providers through partnerships and collaborations about the importance of protecting their patient population from vaccine preventable diseases, in accordance with the Advisory Committee for Immunization Practices (ACIP) recommended immunization schedule. The Georgia Perinatal Hepatitis B Prevention Program increased postvaccination serologic testing completion rates from 73 percent in 2018 to 75 percent in 2019.

MCH programs strived to promote immunizations by providing education to women and families. Child health and home visiting programs assess clients' vaccination status, discuss the importance of recommended vaccinations, and refer to needed services. Educational materials are included in educational packets to families and messaging is included in newsletters and outreach materials.

Child Occupancy Safety Program (COSP)
Motor vehicle related injuries continue to be a leading cause of death for children under 14 years of age. The current method of child passenger safety (CPS) intervention through education, equipment distribution, enforcement, and policy change works to increase child safety seat use and is an evidence-based approach listed in the Centers for Disease Control and Prevention's Guide to Community Preventive Services.
The COSP has several initiatives focused on child passenger safety (CPS) education: Car seat Mini-Grant, Fire/EMS Outreach (including the Teddy Bear Sticker (TBS) Program), Hospital/Healthcare Training, Children with Special Healthcare Needs, and Law Enforcement Training, as well as CPST certification, recertification, and instructor development.

The Child Occupant Safety Project, utilizing local partners, conducted monthly education classes to train caregivers on proper use and installation of child safety seats. After participating in the classroom education, caregivers were provided an appropriate child safety seat (either a convertible or a booster). The caregivers then demonstrated proper installation technique before leaving the event. This education and distribution program is known as the Mini-Grant program. In the reporting year, 143 counties either directly participated in, or were covered by the Mini-Grant program. The Mini-Grant provided 2,843 monthly classes, trained 8,275 caregivers, and distributed 3,660 seats.

In addition to the conventional seats distributed, COSP worked with families of children with special healthcare needs to evaluate transportation needs and issues. Evaluations were provided to 18 children and ten seats were distributed. COSP staff previously developed a flow chart for use by Children's Medical Services and other field referrers to assist families through the process. Based on information received in the flow chart, many families have been able to receive seats through Medicaid funding, allowing COSP to transition to a funder of last resort.

Teddy Bear Stickers are placed on all car seats distributed to document the number of lives saved from injury/and or death due to program funded child safety seats. If a grant provided seat is involved in a crash, the caregiver may receive a replacement seat from the original issuing agency. That agency submits a report, along with the crash report, to Injury Prevention (IP) staff. IP staff received 20 Teddy Bear Sticker forms and replaced 20 seats.

Other trainings and presentations offered by IP staff include:

- "You have the Power in Your Pen" – 17 classes, trained 324 law enforcement officers
- Child Passenger Safety Technician course – 29 classes, trained 354 attendees
- CPST recertification class for current CPSTs – 30 classes, 341 attendees
- CPST Renewal course – 5 classes, 33 student attendees
- "Transporting Children with Special Health Care Needs Training" – three classes, 22 attendees
- Keeping Kids Safe – 18 classes at 9 hospitals, trained 152 nurses
- Transporting Children Safely in Ambulances – ten classes, trained 74 EMS personnel
- Instructor development – one class, trained 20 students

Building on our minority outreach efforts, the mini-grant training presentation and all training materials were translated in Spanish. Additionally, a Spanish-English flipbook was utilized by 28 counties to assist English speaking technicians when working with Spanish-speaking parents/caregivers.

The program continued a regional model approach within local regions with the bases being in Dalton, Athens, Atlanta, Macon, Augusta, Columbus, Valdosta, and Jesup. This modeling allows for more training coverage and outreach statewide.

Current Year: Oct 2019 – Sept 2020

Priority Need: Promote Developmental Screenings Among Children

NPM 6: Developmental Screenings for Children

In the current year, developmental screening remained a priority and has been addressed by working through partnerships to reinforce developmental screening as a key component of the child health system.

The Children 1st program continues to realize great success in the number of partners engaged annually in outreach and educational events and trainings opportunities where developmental screening, developmental monitoring and the benefit of the Children 1st referral system are the focus. Children 1st staff have participated in over 87 outreach events with more than 5,500 pieces of literature about DPH Child Health programs, developmental screening and milestones. Learn the Signs. Act Early. materials have been provided to families, physicians, daycares and Head Start centers, WIC and other public health programs and local schools. Children 1st completed several training activities that helped advance the goal of facilitating formal training opportunities on developmental screening in

each public health district. Children 1st district staff facilitated approximately 30 trainings with over 300 attendees across a varied audience including Head Start and daycare facilities, local public health staff, community-based non-profits, hospitals, and pediatric care offices. Trainings were facilitated across a variety of providers, including local public health staff, hospitals, daycares and Head Start centers, schools and community organizations. Nine of the trainings were facilitated using the train the trainer method. More than 47 percent of the trainings were conducted with local public health staff, 20 percent of training participants were affiliated with community organizations, and 33 percent of training participants worked at daycare or Head Start facilities. Over 30 percent of the trainings were facilitated on use of the ASQ developmental screening tool. Fifty-seven percent of the trainings were facilitated on the child health referral system, and how to make a referral to public health. The remaining trainings were facilitated on Safe Sleep, TWMB, and the SendSS-NB database used by Children 1st staff to capture all screenings, assessments and case management.

Children 1st and MIECHV programs worked to develop a more formal relationship. Each program drafted a policy guiding the scope of the collaboration and the parameters guiding referrals between programs. Each policy included that developmental screening outcomes would be shared across programs when a referral is made. to the programs. This process was piloted in two local communities over a three-month period, January 2020 – March 2020. The pilot sites were located in a metropolitan area and in a rural area of Georgia to best determine barriers and best practices. Approximately 50 referrals were made to the Home Visiting Program in Savannah. Seven referrals were made between Children 1st and the Home Visiting Program in Rome. Children 1st and Home Visiting teams in both sites indicated that the pilots were successful and sites plan to continue the local partnerships in the future. The COVID-19 pandemic stalled the scale-up of this referral process to all 11Children 1st districts that also have a MIECHV site. However, four additional sites are interested in partnering, particularly in response to the COVID-19 pandemic, to help ensure continuity of services for families and to increase capacity for both programs.

Children 1st is also exploring how to incorporate the distribution of developmental screens to the Information and Referral Center (IRC). The Information and Referral Center processes electronic birth certificate referrals and makes appropriate referrals to the Children 1st program, other Title V programs, and community-based programs. Providing families with access to developmental screening when they first contact IRC could allow for more timely services as they are further referred to child health programs.

Screening for ASD with the Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F) was fully implemented within the Children 1st program in January 2019. To reduce duplication of screening efforts, Children 1st first tries to retrieve ASD screenings conducted by the medical home prior to completing a screening within the program. An unanticipated challenge to this process is physicians often submit incomplete, outdated or unscored copies of the M-CHAT to the Children 1st program. To address this barrier, the Children 1st program shared a letter with the Georgia Chapter of the American Academy of Pediatrics to be disseminated amongst chapter membership. The letter, detailed instructions on completing a Child Health referral, the required documents for referral submission, and links to the most current versions of the ASQ and M-CHAT-R/F. This letter is also used in physician outreach on the local level by the Children 1st district coordinators. A physician champion also presented during two grand rounds on developmental screening with a validated screening tools and how to initiate a referral to Children 1st. The Children 1st program will continue to work with the Autism team at the state office and physician champions to find new solutions to address this challenge.

Previously, a bridge between Brookes Publishing website and the database used by Children 1st was constructed. With the bridge in place, screens completed on the Brookes Publishing website are immediately stored on a platform accessible by Children 1st staff allowing digital ASQs to be more easily incorporated into staff's workflow. However, the program has experienced challenges in completing full implementation of the ASQ Online and maintaining compliance with HIPAA guidelines and confidentiality policies related to electronic commination with

families. Staff must have signed consent before texting or e-mailing the link to the ASQ Online to parents. The recent pandemic highlighted the need to navigate these challenges to help guarantee continuity in services to families.

The recent COVID-19 pandemic emphasized the need to navigate challenges to help guarantee continuity of services to families. The Children 1st staff at the state office developed a Continuity of Operations Plan (COOP) to guide service provision and communication with the community during the pandemic.
The state office recommended Children 1st programs update the outgoing messages on phone lines to inform the public of any changes in services provision. Coordinators pre-emptively contacted families on their caseload to determine if new resource needs emerged and to inform families.

Refugee Health
To increase access to MCH programs, the SRHP recognizes the importance to create and work with partners who share goals to reach and educate the most vulnerable and hard to reach refugees and immigrant communities. In the current year, SRHP continued to strengthen partnerships and held ongoing meetings and workshops with the following partners: Refugee Resettlement Organizations: Catholic Charities of Atlanta (CCA),International Rescue Committee (IRC), New American Pathway (NAP), Inspirits (Lutheran Services of Georgia),Community Base Organizations: Center for Pan Asian Community Services (CPACs), Clarkston Community Center (CCC), One Economy's Georgia Refugee Page, Refugee Women's Network (RWN), Tapestri, Inc., Women Watch Afrika (WWA), Dekalb County Schools, Georgia Parent Mentor Partnership, Gwinnett County Schools- Parent Mentor. Autism Speaks, Parent to Parent of Georgia, Georgia Council on Developmental Disabilities, Georgia Department of Behavioral Health, Developmental Disabilities, The Georgia Community Health Worker Advocacy Coalition, Underserved Vulnerable Populations Coalitions, (Dekalb, Georgia).County Health Departments/ Community Health Centers: DeKalb Co. Board of Health Refugee Health Services, Gwinnett County Board of Health, Refugee Health Services, Cobb County Board of Health, Refugee Health Services, Clayton County Board of Health, Refugee Health Services, Positive Growth, Inc., Friends of Refugees.

The State Refugee Health Program Social Worker maintains on-going contact in person, via phone, or email, with Resettlement Agency Managers and Case Managers to address the medical needs of the refugee population, including but not limited to, scheduling/rescheduling client appointments and following-up with clients, referrals to primary care physicians/specialists to ensure that optimal care is delivered.
Priority Need: Promote Physical Activity Among Children

NPM 8: Physical Activity for Children and Adolescents
In the current year, Georgia Shape continues the management of the statewide fitness assessment, Fitnessgram, “booster session” contracts with HealthMPowers and DOE. The contracts allow DPH to train physical education (PE) teachers to assess students effectively for fitness levels pertaining to Body Mass Index (BMI), aerobic capacity, flexibility, muscular strength, and muscular endurance.

During the reporting year, Georgia Shape’s reach was as follows:

- Fitnessgram: 1,157,375 assessed
- Power-up for 30: 180,038 participants
- WIC Champions Training Program: 21 new champions
- S4L Cafeteria Program: 229 Toolkits distributed, 229 schools trained, 524 people trained
- PU30 Pre-service teacher program- Due to COVID-19 courses were not completed and certificates were not awarded.

Related legislation: HB 83 requires recess for students in kindergarten and grades one through five; recess may

not be withheld for disciplinary or academic reasons. This law encourages schools to include an average of 30 minutes per day and local boards of education shall establish written policies to ensure that recess is a safe experience for students, that recess is scheduled so that it provides a break during academic learning, and that recess is not withheld for disciplinary or academic reasons. Recess may allow more opportunity for schools to offer physical activity, and school districts and schools may need technical assistance developing written policies that allow for the opportunity of more physical activity.

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

During the current year, 9,921 children in Georgia received oral health screenings through the MCH Oral Health Program. Oral health education was provided to 15,076 children, 1,937 sealants were placed, and 932 children received fluoride varnish applications. A new school sealant program was initiated in District 3-1 (Cobb Douglas) during February 2019 where approximately 60 percent of the student population are from Spanish speaking homes where English is a second language. Services are targeted to schools with more than 50 percent of the student body eligible for the free or reduced lunch program. Approximately 40 school sealant programs across the state are coordinated and supported by the Oral Health Program.

Teledentistry is an effective way to provide oral health care to children who may not otherwise be able to access care. The Waycross Health District continued the Teledentistry program until school closures occurred due to COVID-19. During the reporting period, 266 children were seen in the elementary school settings through the teledentistry program. The reduction in the number of students served is due to the closure of schools during the COVID-19 crisis.

The Oral Health team led a school-based sealant and oral health prevention program at Dooly K-8 School in Dooly county. This was the first school-based program to be held in this health district. Forty-two children were screened and given preventive services including sealants and fluoride varnish. Children needing more extensive treatment were given referrals to the nearby dentists and the nearby District network of dental program and offices. This was done through a partnership with the Chief Turnaround Office within the DOE. This Office focuses on the worst performing schools in the state by looking at non-academic health and infrastructure indicators that are possibly contributing to poor classroom performance. One of seven variables screened is oral health and many schools identified over 70 percent of children screened were flagged as “high risk” for oral health issues.

The Director of Oral Health provided a statewide virtual presentation in April 2020 to School Nurses on *Oral Health 101*, what to look for in the elementary school children related to oral health, and how to carry out the 3300 school screening form required for all children in the state to enter the public school system.

The Oral Health Program continues to participate in two projects with the Center for Oral Health Systems Improvement and Integration, a joint consortium between the National Maternal and Child Oral Health Resource Center, the Dental Quality Alliance, and the Association of the State and Territorial Dental Directors funded by HRSA Maternal and Child Health Resource Bureau (MCHB). The first project involves a partnership with Albany Primary Care, a rural Federally Qualified Health Center involving medical dental integration with three school-based health centers where children’s oral health needs are treated in a school-based setting. Georgia is one of five pilot states to help develop and provide feedback on a set of national oral health indicators for MCH populations. The indicators were developed by national subject matter expert workgroups with the state providing feasibility assessment, practical implementation strategy, and the actual data from a set level. In March 2020, the Director of the Oral Health Program attended a round table work session in Washington DC with other pilot states, representatives from ASTDD, DQA, National Maternal and Child OHRC, and the HRSA MCH Bureau to provide feedback and updates.

The Oral Health team continuously collaborates with Georgia Oral Health Collation, Healthy Mothers and Health Babies Georgia as well as Home Visiting Programs to disseminate the message of drinking fluoridated water and oral health practices at all ages.

The Oral Health Director participated on a podcast with the Department of Early Care and Learning (DECAL) in March 2020 on importance of oral health in children and helpful tips. https://podcasts.apple.com/us/podcast/episode-30-childrens-oral-health/id1437194781?i=1000469442320

Challenges/barriers: State budget reductions and spending restrictions have created some barriers around oral health promotion and education. Travel opportunities are limited and have impacted the state program's ability to interact and meet with district staff. The State Fluoridation Administrator was not able to attend the Georgia Rural Water Association state conference which typically is a primary time to educate hundreds of water plant operators on community water fluoridation and the benefits to all populations.

Due to the current COVID-19 pandemic, all collaborations and partnerships from March 2020 until further notice are suspended with the exception of virtual interactions. This included the 2020 Hinman Dental Conference in Atlanta in March which usually has approximately 25,000 attendees comprised of oral health providers from around the southeast. The Director of Oral Health was scheduled to have a table along with Healthy Mothers Healthy Babies Georgia to provide education on treating pregnant women in dental offices at the conference.

The COVID-19 crisis caused dental offices and local public health clinical sites to close except for emergencies only on March 16th (American Dental Association guideline). Many oral health staff have been deployed by district leadership to the COVID-19 response. Some district oral health staff have reopened in a reduced capacity. New protocols create logistical challenges for patient flow and personal protective equipment (PPE) guidelines create significant added operational costs. The closures create an access to care concern for routine oral health services. The Oral Health Program provided resources, guidelines, webinars, and information to the district programs on topics such as CDC guidelines around COVID-19 and dentistry, proper infection control, how to define dental emergencies, screening protocols, teledentistry updates and strategies, and potential staffing adaptions in response to the crisis.

Other Child Health Programs

Early Brain Development initiative- Brain Trust for Babies

In the current year, MCH and the Title V program continue to support the Brain Trust by aligning goals within the Child Health Programs such as, Babies Can't Wait and Autism, Newborn Screening and Early Hearing Detection and Intervention, Children Medical Services, and Children 1st, with the objectives of the Brain Trust. DPH hosted four Brain Trust for Babies Advisory Board meetings.

Vision Screening

All children are required to have vision screening completed and documented on the Georgia state form 3300 prior to their initial entry into the Georgia school system.

DPH, in cooperation with the DOE provided and monitored vision screening training and certification for local health department staff who perform vision screening on children three years of age and older. All staff within local health departments who administer vision screenings require certification prior to screening children and recertification every three years.

The vision certification process includes a didactic component as well as a demonstration of skills. The didactic portion of the vision screening training is available electronically through statewide training platform, TrainDPH. Following the didactic instructions, those seeking recertification must pass a post-test, and accurately demonstrate key screening competencies to a certified screener. Vision screeners will be recertified when they have passed the post-test and have competencies documented on a procedure's validation form.

The DPH state office staff revised the vision screening certification process local public health staff must follow to provide vision screens to children. The state office incorporated feedback from certified vision screeners at several health departments throughout the state in the revision process.

Help Me Grow
In the current year, HMG® made progress across all core components to strengthen the implementation of the framework in the state. Based on the Annual Fidelity Assessment submitted in November 2019, HMG® National designated Georgia as moving forward to the next stage of implementation (from exploration to implementation) in all the core components of HMG®.

HMG® was added to the Healthy Mothers Healthy Babies Georgia website as a resource available to children and families. Healthy Mothers Healthy Babies Georgia houses the HMG® central access telephone line and the HMG® liaisons that provide navigation to the families that call the central access telephone line.

HMG® works to reach communities by engaging state and local agencies and promoting HMG® as a resource that front line staff may share when interacting with families. HMG® held partnership meetings with key program staff from DBHDD, DECAL, DFCS, and Mental Health America of Georgia. The resources offered by these agencies were added to the HMG® resource house and central telephone line, 1-888-HLP-GROW, was disseminated to staff. HMG® liaisons participated in trainings provided by DBHDD to learn how to better serve families who may need crisis support or support navigating resources for mental and behavioral health. HMG® participates in several workgroups and collaboratives to further identify opportunity for expanded collaboration.

The HMG® coordinator participates in the Georgia Infant-Toddler Coalition to advance the health, social, intellectual, and emotional well-being of infants and toddlers across Georgia. HMG® and the Georgia Infant-Toddler Coalition have a shared vision that Georgia's infants and toddlers receive the quality care and access to services they need in order to thrive.

Physicians play a key role in a young child's life. Outside of the parent and family, physicians are positioned to recognize when children have health or developmental concern and take action to connect the children to additional resources and support. To strengthen the accuracy and consistency of information shared with physicians about the referral process, HMG® works closely with the Child Health program to map the existing process for receiving and processing referrals from physicians, and the communication shared back with the referring entity. The HMG® state coordinator facilitated conversations and documented the existing processes across programs. The information was synthesized, and a process map was created to make physicians aware of the referral process and communication to expect when referring a child to the Child Health program.

HMG® participates in a National Alliance on Mental Illness (NAMI) brain trust geared towards advising the coordination, implementation and delivery of the Pediatric Professional Training funded by the Sandra Dunagen Deal Center for Early Language and Literacy. The trainings focus on the foundational strategies to support language development of young children and the impact key risk factors have on mental health and social-emotional well-being. This work can be aptly promoted to physicians.

HMG® assists families in supporting young children's healthy development and helps them easily access resources in the community during times of need. HMG® was recently surveyed by HMG® National to assess the impact of COVID-19 in supporting families and leveraging HMG® to activate community response. HMG® focused on ensuring that current and relevant information released by DPH was shared with HMG® liaisons through the central access telephone line. The information disseminated included recommended precautions, what to do if an individual or family member is ill, and steps to getting tested. As child health program and partner agencies issued communication related to updates to service provisions, information was also disseminated to those who accessed the HMG® central access telephone line.

Fatherhood Initiative

MCH continues its commitment to intentionally engage fathers through MCH programs and services by raising awareness of the impact of father involvement on children and family well-being. Fathers play an integral role in the lives of their families and communities. During early childhood and throughout the lifespan, children benefit in many ways from positive father-child relationships, including improved social-emotional development, academic achievement, and physical health. Mothers also benefit when fathers are involved, prenatally and beyond, using more health services on average, bearing lighter workloads that lead to lowered postnatal stress, and lowered risks of postpartum depression. The Fatherhood Initiative convenes partners around the common agenda, develops strategies to engage fathers, and maintains a repository of information to share across intra and inter-agency partners with the goal of creating a culture of inclusion for fathers across the state of Georgia.

The Healthy Start Georgia Collaborative Fatherhood Summit originally scheduled for March 30-31, 2020 was cancelled due to COVID-19. A speaker series was developed to replace the Fatherhood Summit and includes presentations on Strengthening Families Protective Factors Framework: A Father’s Approach. The Strengthening Families framework is a research-informed approach to increase family strengths and enhance child development. By focusing on the universal family strengths identified in the Strengthening Families Protective Factors Framework, community leaders and service providers can better engage, support, and partner with parents in order to achieve the best outcomes for children. This workshop offered concrete action steps to ensure fathers feel welcome and valued in the settings that serve young children so that they can also receive support to build protective factors and strengthen relationships.

The following presentations are offered during the current year:

- Strengthening Families - May 21
- Adjusting Attitudes and Actions - June 17
- Recruitment and Retention - July 15
- Father Engagement in MCH - August 19
- Father Inclusion in Programs and Services - September 16
- Mobilizing Communities - October 21
- Fatherhood Ten Years in the Making - November 18
- Child Support: Serving Dads - December 16

The Coalition developed the Fatherhood Service Map and Resource Guide Questionnaire to assess statewide agencies and organizations capacity to build and increase their ability to serve and support fathers and males.

The Coalition also developed the Measure of Fathers’ Challenges Survey to assess personal challenges that fathers may experience. Surveys were distributed to fathers through the Coalition agencies and partners. Responses will be analyzed and used to inform father serving agencies.

Immunizations
In the current year, the Georgia Perinatal Hepatitis B Prevention Program is contacting delivering hospitals and encouraging them to apply for the Immunization Action Coalition's Hepatitis B Birth Dose Honor Roll. The program ensures that hospitals have protocols in place to identify HBsAg-positive mothers and administer the hepatitis B birth dose to all infants born in Georgia, regardless of their mother's HBV status.

MCH and GIP developed a plan to increase collaboration and are looking forward to expanding the partnership. MCH will be added to all immunization communication listservs such as the Vaccines for Children (VFC) Programmatic Newsletters and the Immunize Georgia Newsletter. Immunizations will include MCH as an attendee for quarterly immunization meetings and the annual statewide Immunize Georgia Conference providing a platform for both programs to share and receive the most up-to-date immunization updates.

Challenges/barriers: Perinatal Hepatitis B prevention has been identified by the CDC as an essential public health service during the COVID-19 pandemic. However, distract and local public health staff who are typically involved with perinatal Hepatitis B follow up regarding postvaccination serologic testing may be currently involved with contact tracing of COVID-19 positive patients.

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

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

Child passenger safety trainings to internal and external stakeholders continue. Staff has developed online, modular trainings and has been utilizing non-traditional methods to conduct outreach with agencies, utilizing platforms like Zoom, Skype, GoToMeeting, and Microsoft Teams.

The program continues to offer the following training opportunities:

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

The program is working with DFCS staff and contractors to provide training on proper transportation of children, including Georgia law and best practice recommendations. Similar training is being offered to Head Start and other daycare agencies staff.

Regional modeling will continue with local staff serving as a community catalyst for all child occupant related activities

including car seat use, booster seat use, seat belt use, parent seat belt use modeling, vehicle hyperthermia prevention, and more.

Priority Need: Promote Developmental Screenings Among Children

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

Strategies:

NBS will continue early identification of developmental disorders as this is critical to the well-being of children and their families and it is an integral function of the primary care medical home. Over the last several years, MCH programs have been very successful in promoting developmental screening and developmental milestones to families and community partners during home visits, outreach activities, and back to school events. MCH will focus efforts on providing outreach and education to select physician offices and community partners to increase developmental screening within their facilities. The state office will work collaboratively with the local public health workforce to identify physician offices in their communities that do not include developmental screenings results with referrals to public health programs. Champions from medical societies, including GAAAP and GAFP will be engaged to help facilitate the delivery of outreach to physicians. The impact of targeted outreach will be assessed by the number of referrals that are generated from the physician offices that have been engaged that contain developmental screening results. A similar process will be established to identify and engage child-serving community partners. Through partnership with key leaders in the local public health workforce, select programs will receive education about developmental screening and will develop strategies to incorporate developmental screening into their protocols.

MCH programs will also work collaboratively to streamline internal opportunities to increase developmental screening of young children and establish a process to reduce duplicate and redundant screening and referrals. The success of these efforts will be measured by the coordination of screening in children participating in both Children 1st and Home Visiting Programs.

Children 1st will continue to implement and adjust practices around offering online developmental screening using the online ASQ tool to expand access to developmental screenings for partners, particularly daycares, physician offices and other child-serving organizations who routinely make Children 1st referrals.

Children 1st will also continue to promote awareness of the program and the child health referral system at the state and local level. Children 1st will continue to work with early intervention program partners, BCW and HMG, to promote the agency's Autism screening initiative to families and physicians.

Refugee Health
MCH will continue to collaborate with the SRHP, Child Health, and Health Promotion Evaluation staff to continue the development and implementation of promoting developmental screenings in the Refugee population. The Refugee Pediatric Center will continue to provide referrals to the DeKalb Board of Health Refugee Clinic (Kaiser Permanente). Interpreters will continue to be available at the Refugee Pediatric Center for Arabic, Somali, and Swahili languages. The Refugee Health team will monitor referrals and outreach materials will be provided on developmental screenings including C1st, BCW, CMS, EDHI, Autism, Learn the Signs. Act Early.

Priority Need: Promote Oral Health to All Populations

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

Strategies:

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

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

1.3 Work with Healthy Mothers Healthy Babies and other external partners by providing subject matter expertise and strategic feedback.

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

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

The Oral Health Program will continue to promote school sealant programs as a strategy to decrease access to care barriers by providing the evidence-based dental decay prevention measure of placing dental sealants on molar teeth in school settings. This allows the service to occur at a location where children are congregated and does not require parents to be present which could present barriers such as work schedules and childcare needs of other children in the home. Referrals to dental providers and efforts to find dental homes will continue in order meet other dental needs of children seen in school sealant programs. Dental screenings, fluoride varnish application, and oral health education are also components of the school-based programs and the Oral Health program will continue to partner with district staff as well as external partners to increase the presence of school sealant programs within Georgia.

SPM: Father Involvement
Percentage of fathers whose knowledge increased using the 24/7 Dads® curriculum in Georgia Home Visiting Program sites

SPM Goal: Increase the percent of fathers whose knowledge increased using the 24/7 Dads® curriculum in GHVP sites.

The Fatherhood Initiative will continue to increase father engagement and involvement in MCH programs through capacity building, collaboration, coordination, and providing resources to encourage father inclusion. In partnership with Morehouse School of Medicine Prevention Research Center (MSM PRC), the Strong Fathers Strong Families Fatherhood Coalition will continue to partner with the Morehouse School of Medicine Tx funding grant to support efforts in identifying the strengths and gaps in serving fathers across MCH services. Using the National Fatherhood Initiatives Father Friendly Check Up (FFCU), the pilot will continue to look at the level of “father-friendliness” across four MCH program sites including two Healthy Start sites, WIC, and Grady Hospital’s Centering Pregnancy Program. The project will also identify existing programs and services to be included in a statewide network to strengthen father involvement.
The Fatherhood Initiative will develop a “father-friendly” toolkit for organizations to utilize in creating efficiencies for

staff and to encourage the widespread adoption of best practices and tools to ensure fathers are better served in MCH programs. The Fatherhood Initiative will continue to assist MIECHV, Healthy Start, and MCH fatherhood partners and stakeholders with integrating father involvement curriculums and practices into program and service delivery to impact perinatal health outcomes for mothers, infants, children, and families.

Other Child Health Programs

Early Brain Development Initiative-Brain Trust for Babies
MCH and Early Brain Development will continue to work closely to monitor shared goals and improve processes and strategies to achieve goals in the coming year.

DPH will continue to support the implementation of Reach Out and Read in public health settings like WIC and immunization visits, and through home visiting programs. DPH will support 45 Reach Out and Read sites across the state and hopes to on board five additional sites this year and plans to expand TWMB for birthing hospitals to at least five birthing hospitals across the state.

Vision
DPH will continue to assist in the completion, compilation, and assessment of documents for certification and recertification for vision screening for local health department staff.
Help Me Grow®
HMG® will continue to be an area of focus for the MCH program. Liaisons will increase capacity to better support families that are referred and will participate in various learning and training opportunities to strengthen the repository of resources available to families. Liaisons will receive training on the importance of a medical home and knowledge to increase opportunities to identify children needing a medical home to support the new Medical Home priority.

HMG® will continue to focus on activities selected to strengthen the presence of the four core components of HMG® in Georgia; Centralized Access Point, Family and Community Outreach, Child Health Care Provider Outreach and Data Collection and Analysis. The program will evaluate the effectiveness and use of the HMG® Central Access Point to ensure a high-quality experience and customer service. HMG® will identify and share data for other child health call lines transferred to the HMG® Central Access Point (CAP).

Home Visiting
MCH will continue to support evidence-based home visiting programs, especially to the more vulnerable children in the most at-risk communities, to enhance parenting and support young children's early development with improved long-term outcomes for children, parents, and communities. The FACS program will continue to develop stronger partnerships and coordination between awardees of MIECHV and the Individuals with Disabilities Education Act, Part C Program (IDEA Part C Program). MIECHV and Part C Program staff will meet regularly to discuss best practices and steps necessary to ensure collaboration with programs and community partners.

Immunizations
The Georgia Registry of Immunization Services and Transactions (GRITS) will be implementing a new matching process in collaboration with SendSS to match "Baby Girl/Baby Boy" vaccine records to their legal name records to increase complete immunization records for infants. GIP will continue communication efforts with MCH to strengthen coordination and collaboration.

Child Occupant Safety Program (COSP)
Injury Prevention will continue to distribute child safety seats to children, including specialized child safety restraint

systems for children with special health care needs. The number of lives saved will continue to be documented through Teddy Bear Stickers (TBS) placed on the child safety seats that are distributed. Child passenger safety trainings to internal and external stakeholders will continue. Staff has developed online modular trainings and will continue utilizing non-traditional methods to conduct outreach with agencies utilizing virtual platforms. COSP will continue to offer a 16-hour Special Needs transportation program, “Safe Travel for All Children: Transporting Children with Special Health Care Needs.”

Physical Activity for Children

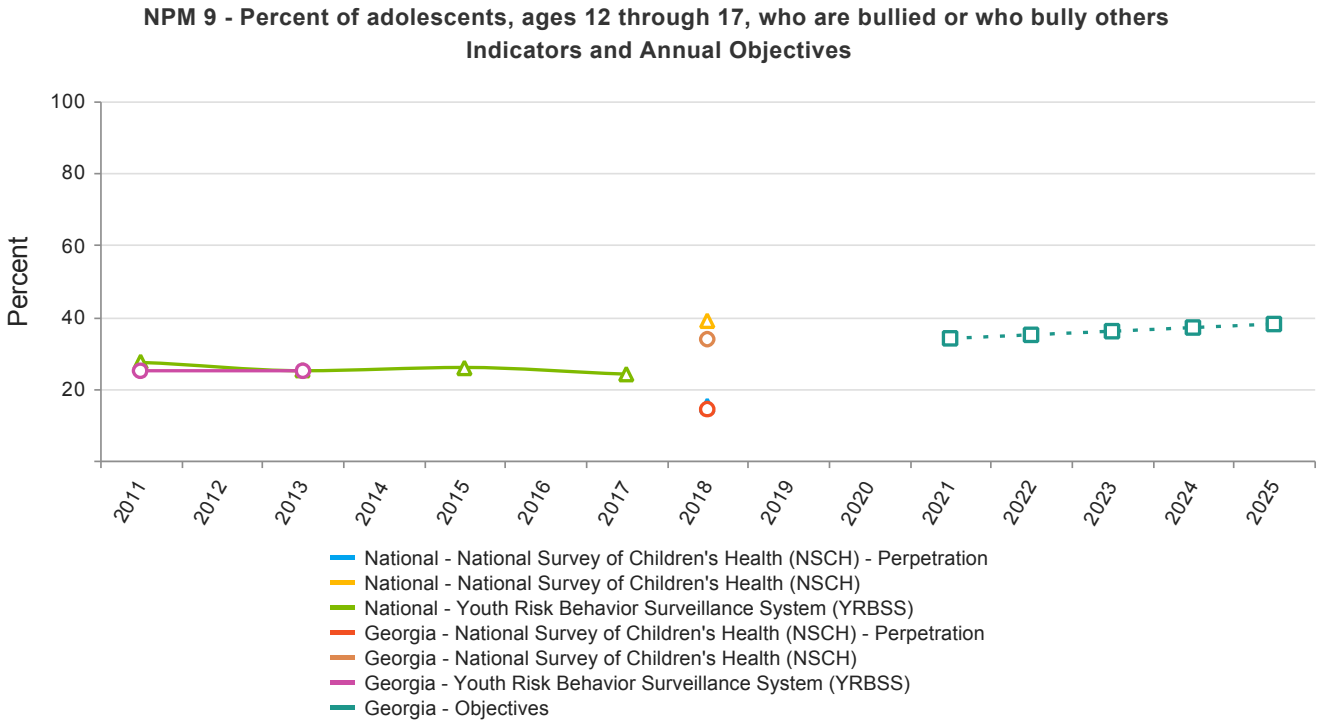
Georgia Shape will continue building a network of partners, agencies and athletic teams; including the Atlanta Falcons and Atlanta United. DPH and DOE are committed to improving the health of Georgia’s children by offering assistance and opportunity to achieve a greater level of overall fitness. The Fitnessgram tool will continue to be used for SHAPE’s annual standardized fitness assessment to evaluate five different parts of health-related fitness, including aerobic capacity, muscular strength, muscular endurance, flexibility and body composition using objective criteria. Reports will also be generated providing valuable individual, school, and state-level data to empower parents, schools, and the community to best access the current health needs for children. Georgia Shape will continue to work with 120 partners to decrease childhood BMI measures while increasing childhood aerobic capacity measures and physical activity levels.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	35.7	NPM 9
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	9.6	NPM 9
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	88.5 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2017_2018	16.0 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2016	12.5 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2013	12.8 %	NPM 8.2

National Performance Measures



Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	**2019**
Annual Objective	25.3	
Annual Indicator	25.1	25.1
Numerator	110,846	110,846
Denominator	442,284	442,284
Data Source	YRBSS	YRBSS
Data Source Year	2013	2013

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2019
Annual Objective	
Annual Indicator	14.2
Numerator	106,312
Denominator	750,443
Data Source	NSCHP
Data Source Year	2018

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2019
Annual Objective	
Annual Indicator	33.7
Numerator	257,779
Denominator	765,064
Data Source	NSCHV
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	34.0	35.0	36.0	37.0	38.0

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - Number of schools that receive guidance on laws, policies, and evidence-based strategies to prevent bullying

Measure Status:	Active

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

State Action Plan Table

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

Priority Need
Increase bullying and suicide prevention

NPM
NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Objectives
9.1 By September 2021, identify the prevalence and existing prevention programs and GA State policy and legislation on bullying.
9.2 By 2025, observe improvements in bullying prevention efforts by schools that service that service the target population (ages 12-17).
9.3 By 2025, increase use in clear and consistent use of language across organizations working bullying and suicide prevention and other relevant stakeholder groups.

Strategies
9.1 Conduct an environmental scan and needs assessment to determine the status of bullying in Georgia.
9.2 Provide guidance and/or recommendations to DOE and individuals schools on laws, policies, and evidence-based strategies to prevent bullying.
9.3 DPH IPP will engage in events hosted by agencies or organizations that include bullying prevention in their strategic plans and that align overall activities and policy contributions within a framework of shared risk and protective factors and/or social determinants of health, in order to support efforts to display and encourage the use of consistent language and communications around the public health issue of bullying.

ESMs	Status
ESM 9.1 - Number of schools that receive guidance on laws, policies, and evidence-based strategies to prevent bullying	Active

NOMs

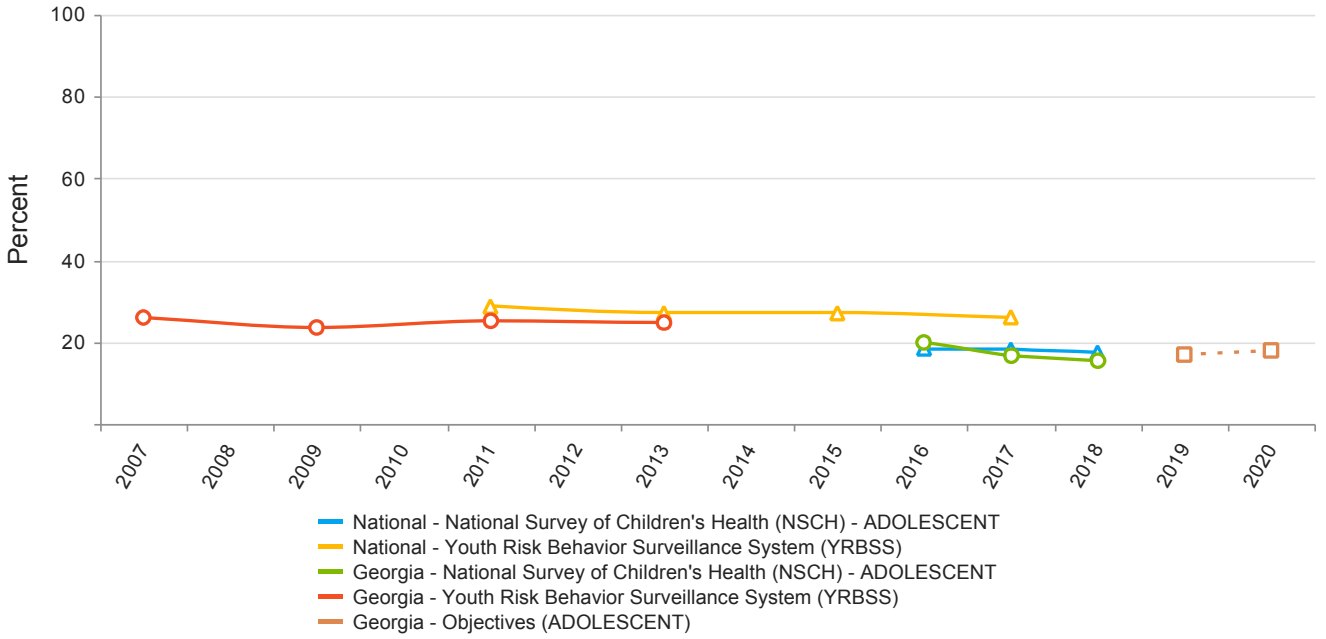
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

2016-2020: National Performance Measures

2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Indicators and Annual Objectives



Federally Available Data			
Data Source: Youth Risk Behavior Surveillance System (YRBSS)			
	2017	**2018**	**2019**
Annual Objective			17
Annual Indicator	24.7	24.7	24.7
Numerator	107,932	107,932	107,932
Denominator	436,871	436,871	436,871
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2013	2013	2013

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT			
	2017	**2018**	**2019**
Annual Objective			17
Annual Indicator	20.0	16.9	15.6
Numerator	186,178	154,649	129,201
Denominator	931,402	916,172	826,895
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2016	2016_2017	2017_2018

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 8.2.1 - 7.1.1. Average HFZ measure (aerobic capacity) among students in grades 4-12

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		56	57	50
Annual Indicator	53.5	52.4	50.4	50.3
Numerator	380,890	379,767	390,505	143,545
Denominator	711,312	724,839	775,490	285,135
Data Source	DOE Fitnessgram	DOE Fitnessgram	DOE Fitnessgram	DOE Fitnessgram
Data Source Year	2016-2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Provisional	Provisional

Priority Need: Promote Physical Activity Among Children

NPM 8: Physical Activity for Children and Adolescents

Georgia Shape is a statewide, multi-faceted childhood obesity initiative that grew out of a 2009 policy, the Student Health and Physical Education (SHAPE) Act. The SHAPE Act requires that all K-12 students take part in an annual fitness assessment. Using that requirement as a springboard, Georgia Shape has grown into 25 programs, nine statewide coalitions, and multiple annual events under DPH's leadership.

Georgia Shape piloted a PU30 Middle School Program with HealthMPowers. The PU30 Program equips school administrators and staff to provide meaningful physical activity opportunities to students throughout the school day to reach an additional 30 minutes of physical activity. This work is currently being implemented statewide.

Georgia Shape worked to increase physical activity measures for female adolescent populations through private funding in afterschool settings. In partnerships with DPH, DOE, and the Governor's office SHAPE continues to provide the following programs to children ages 12 to 17 years of age:

- PU30 Middle School Program- This program consists of seven pilot middle schools. Physical activity data is currently being collected and evaluated. Funding is available for approximately 40 to 50 more middle schools and a modified training will be offered statewide. During the 2017-2018 calendar year, one pilot school, an alternative school for students with previous behavioral issues removed from their zoned school, reported a 90 percent decline in behavior referrals after implementation.
- Middle School Girls Physical Activity Barriers and Facilitators project- Georgia Shape worked to identify best practices and ethnographic information from adolescent females to inform organizations and partners of the large gender gap for aerobic capacity statewide between male and female students. Currently there is approximately a 10-percentage point difference between males and females. Spitfire Consultant Firm did online listening, branding best practices, participant interviews and Subject Matter Expert interviews to create a road map of the Georgia initiative collaboration and best practices to motivate and engage the middle school population, whereby hopefully closing the gender gap.
- Middle School girls PAL project (Physical Activity Leader)- SHAPE received seed money from the Blank Foundation to identify barriers and facilitators to female activity levels, forming a partnership between Georgia Shape, GSU and HealthMPowers.

Other Adolescent Health Programs

Adolescent Health and Youth Development
The Adolescent Health and Youth Development Program (AYHD) targets youth ages 10 to 19 and provides comprehensive implementation guidelines for youth focused health care and services at all levels. It includes disability, mental health, environmental health, reproductive and sexuality, violence and injury prevention and more. It is integrated into the health system and the broader system including advocacy among teachers, families, and teens. Program goals include building support for providers of care and youth, improving accessibility and availability of health services, strengthening partnerships, mobilizing resources, and improving data collection and utilization.

In the reporting year, DPH partnered with twelve public health districts across the state. The AHYD program is administered by the Youth Development Coordinators (YDC) in these districts. The YDCs form critical partnerships with afterschool programs and county and community agencies, holding workshops with parents, faith-based

institutions, and public health leaders to foster collaboration around key adolescent health and youth development issue.

DPH continued to partner with the Georgia Department of Human Services, Division of Family and Children Services to offer the Personal Responsibility Education Program, a comprehensive approach to address teen pregnancy.

In the reporting year, AHYD engaged in the following activities:

- Implementation of evidence-based risk-reduction curricula in twelve public health districts.
- Youth development activities including karate, Youth Action Team, Georgia Teen Institute, Prom Safety seminars, Teen Maze, mentoring, Youth Fest, STD awareness and birth control methods presentation, gangs and violence, drugs, nutrition and wellnesses, summer camp health presentations, outreach on sexting and Georgia laws.
- Public awareness events including Teen Pregnancy Month, Human and Child Trafficking Awareness, teen dating violence, STD awareness, bullying and suicide prevention and bystander intervention. Media such as billboard, print and various apps were used in creating awareness of adolescent health-related issues.
- Youth-serving professional trainings including an asthma self-management pilot training program, educational information on areas of child abuse prevention, bullying prevention and stress management, Safe Dates, substance abuse, emergency preparedness, Sexual Violence Assault Prevention/Exploitation Training.

Suicide Prevention
Sources of Strength is a strength-based comprehensive wellness program that focuses on suicide prevention, however, as a wellness program it also seeks to impact social issues such as bullying, substance abuse, and violence. The program uses peer leaders and *Hope, Help, and Strength* messaging to positively change school and/or community cultures around help seeking behaviors, codes of silence, and perceptions of adult support. These strength messages are strategically designed by Sources of Strength and the local peer teams, to engage local culture and impact local groups of youth, teens, young adults, and/or parents.

Sources of Strength is based on a relational connections model that uses teams of peer leaders, mentored by adult advisors, to change peer social norms about help seeking and encourage students to individually assess and develop strengths in their life. Sources of Strength is often implemented as a school-based program in middle schools, high schools, and colleges. The model is also used effectively in community, faith-based, and cultural settings. The model promotes and focuses on connectivity, school or community bonding, peer-adult partnerships, protective factors and the promotion of help seeking behaviors.

The Suicide Prevention Program connected with the DOE and received recommendations for school systems at highest risk and those that were using Positive Behavioral Interventions & Supports (PBIS), an evidence-based framework to improve and integrate data, systems, and practices affecting student outcomes, in their curriculum. Dawson County schools was recommended as an initial implementation site due to an existing partnership with the Suicide Prevention Program contracted with the Suicide Prevention Action Network – Georgia (SPAN-GA), a non-profit agency providing suicide prevention, intervention, and aftercare services.

A contract was initiated with SPAN-GA to implement the Sources of Strength wellness program within several of Georgia's middle and high schools. While the intrapersonal and interpersonal needs of students were addressed by school peer teams, awareness and education surrounding mental health and suicide also took place through the engagement of community and family members.

In the reporting year, the Sources of Strength program continued to create a positive relationship with the Dawson County school system and school leadership, adult advisors, and students valued the program. The Dawson County Middle School Peer Team provided the following educational programs to 47 students:

- Brainstorming and Planning as a Team
- Trusted Adult Campaign
- I am Stronger Activity
- Thankful Thursday Campaign
- Suicide Awareness Week

The Dawson County Junior High School Peer Team provided the following educational programs to 55 students:

- Trusted Adult Activity
- 21-day Thankfulness Challenge
- Mindfulness Activity
- Community Service Project

Dawson County Junior High School Sources of Strength Program also created a “Mindfulness” room in coordination with a project led by a DCJHS student who currently serves on the state school superintendent student advisory council. The Mindfulness room is located near the school counselor and is open to students.

The Dawson County High School Peer Team provided the following educational programs to 80 students:

- Trusted Adult Activity
- 21 Day Thankfulness Challenge
- Thankfulness Journals
- Thankfulness Tree
- I’m a Connector Activity
- I am Stronger Activity

The Dawson County High School Peer Team also created a Twitter branding strategy to promote suicide prevention and wellness by adding *@DCHS_SOS!* to school posts.

Current Year: Oct 2019 – Sept 2020

Priority Need: Promote Physical Activity Among Children

NPM 8: Physical Activity for Children and Adolescents

In the current year, Georgia Shape continued the management of statewide Fitnessgram “booster session” contracts with HealthMPowers, a non-profit educational technical assistance provider with a national presence, and DOE. Approximately eight to twelve trainings were conducted through DOE or state PE/Health conferences (GAHPERD association) and the Fitnessgram Certificate program which coordinates state recognition certificates for students that excel in Fitnessgram components continued.

In partnerships with DPH, DOE, and the Governor’s office SHAPE continued to provide the following programs to

children ages 12 to 17 years of age.

- PU30 Middle School Program- In the reporting year, 351 staff and 9092 middle schools were reached by this initiative.
- Middle School Girls Physical Activity Barriers and Facilitators project –The project concluded during the reporting year with an understanding of girls' barriers to being active as well as motivations for continuous physical activity. The project goal was to create a road map of the Georgia initiative collaboration and best practices to motivate and engage the middle school population, whereby hopefully closing the 10% gender gap. Key barriers were summated to structural (limited access and opportunities), emotional (poor self-esteem), physical (uncomfortable in their own skin) and cultural/regional (lack of encouragement). Key motivators included completing a challenge, adding to their personality, a judgement free space, incorporation of their music, tangible rewards and others. The recommendations for next steps included leveraging technology, broadening participants understanding of health, incorporating the ideas of peer to peer learning and the power of choice. From this, the next phase includes the launch of a peer-to-peer network of middle school girls as peer leaders to encourage, promote and support physical activity. Middle School girls PAL project (Physical Activity Leader) - All focus groups have been completed and the results will available in the next reporting period.

Other Adolescent Health Programs

Adolescent Health and Youth Development

In the current year, AHYD implemented the following activities:

- Evidence-based risk-reduction curricula in 12 public health districts
- Youth Development activities using the Family Life and Sexual Health (FLASH) curriculum. The FLASH curriculum is an interactive science based sexual health education curriculum designed to prevent teen pregnancy, sexually transmitted disease, and sexual violence.
- Public health awareness events including a focus on five specific topics related to - Drugs and Alcohol, Teen Pregnancy & STDs/HIV, Puberty and Hygiene, Bullying, and Healthy Relationships & Teen Dating Violence.
- Youth-serving professional training opportunities
- AHYD Coalitions

Challenges/barriers: The following challenges were reported by external grantees:

- Identifying participating sites for implementation
- Enrolling youth at participating sites
- Obtaining approval of faculty/staff to obtain approval for curriculum implementation.
- Implementing age restricted curriculum (Making a Difference)
- Applying additional components added to an approved curriculum (Making Proud Choices)
- Executing required curricula due to capacity
- Coordinating with school systems calendar
- Cancelling programs due to inclement weather
- Inconsistency in program delivery due to high turnover of staff
- Implementation of evidence-based risk-reduction curricula was severely impacted due to COVID-19 and the closure of schools and other youth serving facilities. Programs transitioned to virtual platforms to remain engaged with youth and adolescents.

Suicide Prevention

In the current year, the Sources of Strength program continued to have a positive impact on student relationships in

the Dawson County School System. As the contract entered the third year of programming, school leadership, adult advisors and students valued the program and continued education and trainings. Throughout the school year, Sources of Strength trainings were provided to 27 adult advisors, 40 Dawson County Middle School students, 55 Dawson County Junior High School students, and 70 Dawson County High School students. Trainees received education to strengthen and secure peer networks to change unhealthy norms and cultures ultimately preventing suicide and bullying.

The Sources of Strength Peer Team Leaders created strategies for the year which included the Event of Roses. Peer Team Leaders provided 800 roses to the entire student body at Dawson County Junior High. Dawson County Middle School Peer Leaders created a plan for sharing positive messages during Suicide Prevention and Awareness Week.

Suicide awareness week activities included:

- Monday - Make a New Friend
- Tuesday - Give someone a compliment
- Wednesday - Wear yellow to support suicide awareness
- Thursday - Thank someone who is a positive influence in your life
- Friday - Find your source of strength - Suicide Hotline posters placed in the hallways

As the COVID-19 crisis changed the landscape of traditional schooling, the Director of Student Services developed strategies to encourage the Sources of Strength Peer Team Leaders to continue student support activities. Social media “You Matter” messages were created and shared with students to provide encouragement to students.

Adolescent Health - Application Year

Priority Need: Increase Bullying and Suicide Prevention

NPM 9: Bullying
Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Strategies:

1.1 Conduct an environmental scan and needs assessment to determine the status of bullying in Georgia.

1.2 Provide guidance and/or recommendations to DOE and individual schools on laws, policies, and evidence-based strategies to prevent bullying.

1.3 Injury Prevention will engage in events hosted by agencies or organizations that include bullying prevention in their strategic plans and that align overall activities and policy contributions within a framework of shared risk and protective factors and/or social determinants of health, in order to support efforts to display and encourage the use of consistent language and communications around the public health issue of bullying.

The Injury Prevention program will develop resources to assess needs and develop strategies to combat bullying among school-age children. Bullying experiences are associated with a number of behavioral, emotional, and physical adjustment problems. Adolescents who bully others tend to exhibit other defiant and delinquent behaviors, have poor school performance, are more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation as well as poor school performance, suicidal ideation, and suicide attempts. Bullying victims who also perpetrate bullying (i.e., bully-victims) may exhibit the poorest functioning, in comparison with either victims or bullies. Emotional and behavioral problems experienced by victims, bullies, and bully-victims may continue into adulthood and produce long-term negative outcomes, including low self-esteem and self-worth, depression, antisocial behavior, vandalism, drug use and abuse, criminal behavior, gang membership, and suicidal ideation.

Other Adolescent Health Programs

Adolescent Health and Youth Development
AHYD will continue to implementation evidence-based risk-reduction curricula in public health districts, youth development activities using the FLASH curriculum, and Adolescent and Young Adult Centered Care Clinic Trainings in the public health districts' Family Planning Clinic. AHYD will conduct ten Public health awareness events including a focus on five specific topics areas- Drugs and Alcohol, Teen Pregnancy & STDs/HIV, Puberty and Hygiene, Bullying, and Healthy Relationships & Teen Dating Violence. Adolescent and Youth Development Coalitions will continue to be established and supported.

Physical Activity for Adolescents
Georgia Shape will continue to build a network of partners, agencies and athletic teams to promote physical activity to adolescents ages 12-17 years of age. Georgia Shape will continue to work with 120 partners to decrease adolescent BMI measures while increasing aerobic capacity measures and physical activity levels. The PU30 Middle School Program, Middle School Girls Physical Activity Barriers and Facilitators project, Middle School Girls Physical Activity Leader (PAL) project, and PU30 Pre-service teacher program will continue.

Children with Special Health Care Needs

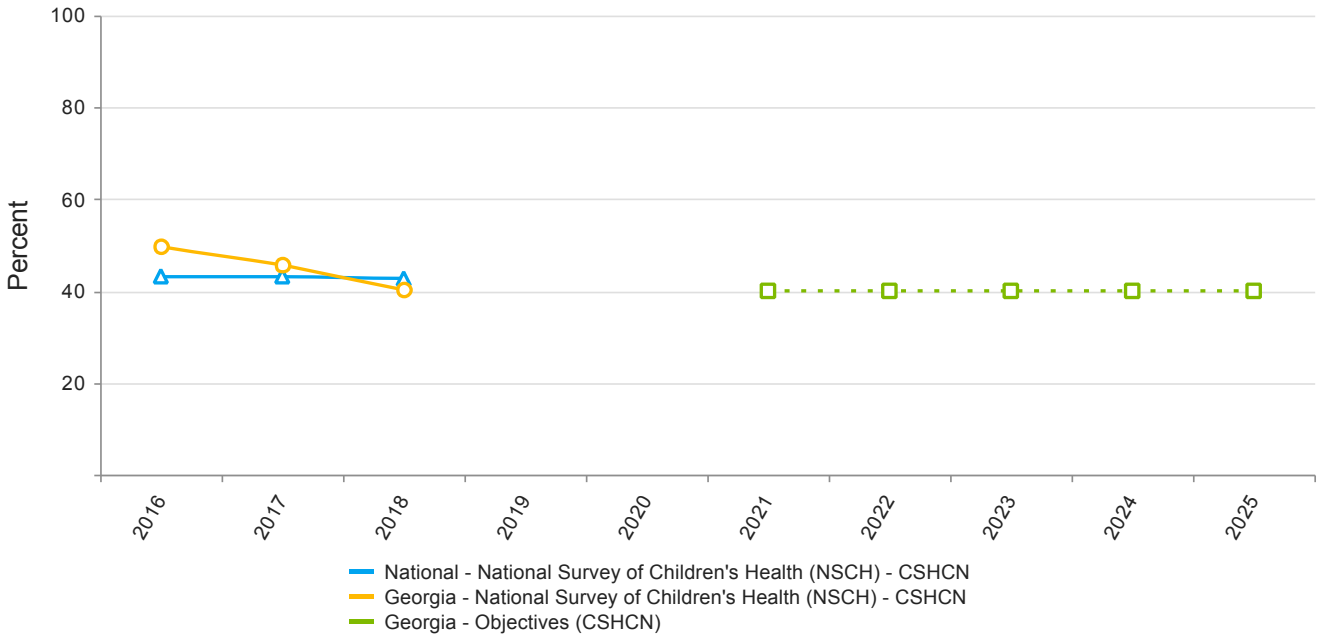
Linked National Outcome Measures

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

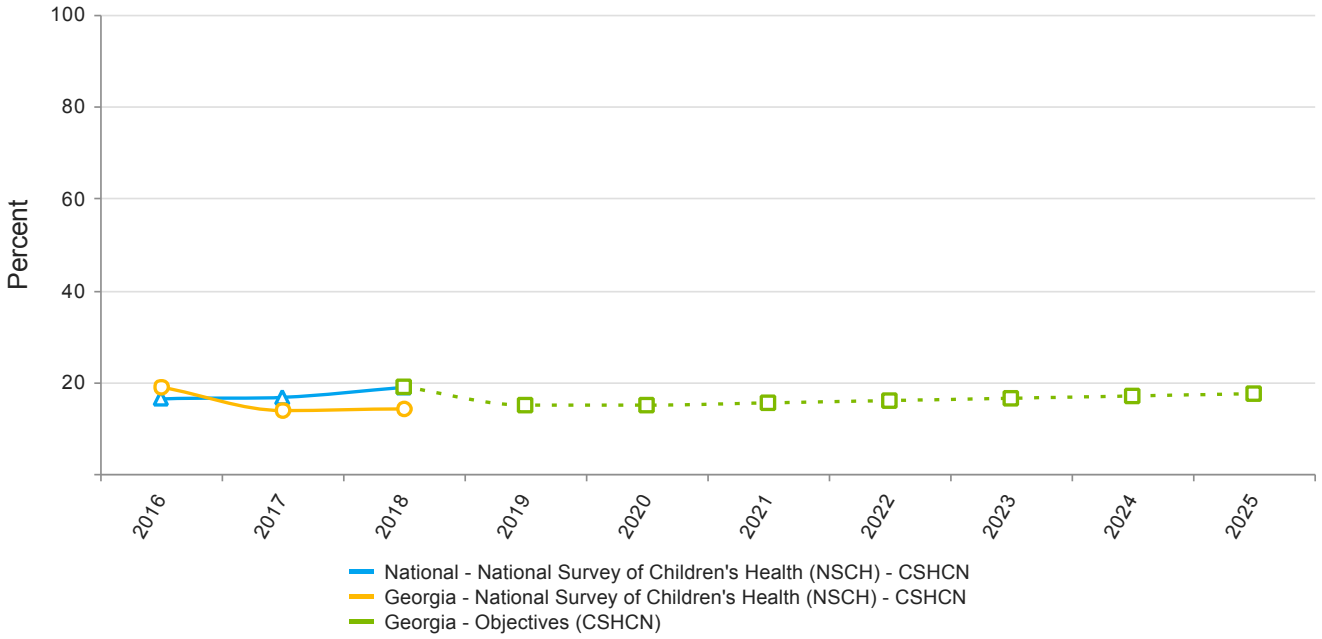
ESM 11.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs

Measure Status:	Active

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

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

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

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 medial 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

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, conduced 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 polies 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 tasks 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 to 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.

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.

Cross-Cutting/Systems Building

State Performance Measures

SPM 3 - Percent of fathers (ages 18-55) whose knowledge increased using a Father Involvement curriculum in Georgia Home Visiting Program (GHVP) sites.

Measure Status:	Active

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

State Action Plan Table

State Action Plan Table (Georgia) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Increase father involvement among MCH populations

SPM

SPM 3 - Percent of fathers (ages 18-55) whose knowledge increased using a Father Involvement curriculum in Georgia Home Visiting Program (GHVP) sites.

Objectives

3.1 By 2025, increase the number of Georgia Home Visiting Program sites that offer a Father Involvement curriculum.

3.2 By 2025, increase the number of fathers that are recruited and enrolled into Georgia Home Visiting Program sites fatherhood programs.

3.3 By 2025, increase the number of fathers that are retained and complete the fatherhood programs using a Father Involvement curriculum.

Strategies

3.1 Educate Georgia Home Visiting Program sites on evidence-based and best practice models to recruit and retain fathers in fatherhood programming.

3.2 Increase Georgia Home Visiting Program sites access to training on Fatherhood Involvement.

3.3 Collect pre- and post- test data of fathers at fatherhood program sites using a Fatherhood Involvement curriculum.

3.4 Increase Georgia Home Visiting Program sites participating in fatherhood action planning activities that include meetings, conferences, and other events.

3.5 Provide fatherhood curriculum tools and resources to the Georgia Home Visiting Program sites (i.e. marketing materials, needs assessments, forms and templates, etc.).

3.6 Establish a media campaign to increase agency and community awareness of fatherhood programming available through the Fatherhood Initiative.

Cross-Cutting/Systems Builiding - Annual Report

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

Promoting oral health among all populations was determined as a priority need through the 2015 Title V MCH Needs Assessment. The Title V MCH Section includes DPH's Oral Health program that oversees the agencies statewide oral disease prevention activities. The Oral Health program coordinates school-based oral health clinics, the state water fluoridation program, mobile oral health clinics, and co-leads coalitions, partnerships and stakeholder groups that promote oral health within Georgia. Dental diseases are a major health concern affecting many in Georgia. Dental caries and periodontal diseases have an economic and social cost and can result in serious systemic problems, pain, and suffering. Most oral diseases are preventable, and DPH's Oral Health program makes every effort to promote and implement preventive measures for all of Georgia's citizens. In the reporting year, the Oral Health program served a total of 34,095 people.

The Oral Health program staff helped update safety net resources and low-cost dental sites across the state with the Georgia Oral Health Coalition. Federally Qualified Health Centers (FQHC), public health departments, and nonprofit organizations provided updated information concerning dental services provided, age range of patients served, scope of services provided, hours of operation and contact information. The updates were reported to a care resource page on the Georgia Oral Health Coalition website. The website was also redesigned to be more user-friendly with support from the Oral Health program.

The Oral Health Director and Program Manager had an abstract accepted for the March 2019 AMCHP conference and presented a session on Oral Health Considerations in CYSHCN populations at the conference. The MCH Director was invited to participate on a panel at the National Oral Health Conference in Memphis in April 2019. Partnership experiences, strategies, and best practices on oral health integration/incorporation into state Title V programs was shared. In September 2019, The Director of Oral Health and the MCH Director participated on a four-person panel national webinar hosted jointly by AMCHP and the Association of State and Territorial Dental Directors on Oral Health integration/incorporation into state Title V programs. The webinar was attended by state MCH, Title V, and Oral Health program staff from across the country as well as other stakeholder and partner organizations. In June 2019 the Director of Oral Health was invited to present on Oral Health in Safety Net Settings at the Tri-State Oral Health Summit in Birmingham, Alabama.

Additional Oral Health program activities and initiatives are included in the Women's Health, Child Health, Adolescent Health, and CYSHCN narrative domain sections.

Community Water Fluoridation

The Community Water Fluoridation program (CWF) is mandated through state legislation requiring all public community water systems serving over 25 non-transient people to adjust their fluoride levels to the state mandated level. The Oral Health program contracts with the Georgia Rural Water Association to monitor and train water plant operators in the safety, benefits, and value of CWF. Water systems who adjust their fluoride level are required to monitor their fluoride level daily. Each month the Oral Health program monitors the water systems to ensure fluoridation levels are within the recommended range. The Oral Health program also leads the Georgia Fluoride Advisory Committee comprised of GRWA, Environmental Protection Division, DPH, Georgia Department of Natural Resources, Georgia Dental Association, and the Georgia Dental Hygienists Association. The committee guides the development of policies and advises on the daily operations of the CWF.

CWF is one of the most effective strategies to implement population based oral health improvement interventions which breaks down access to care barriers like socio-economic and rural status, as well as other demographics such as racial disparities. CWF cross cuts many social determinants of health and was listed by the CDC as one of the top ten public health achievements in the United States during the 20th century. Georgia has one of the highest population percentages of residents with access to community water fluoridation with 96% of those individuals on public water systems. The Oral Health program provides six trainings annually on community water fluoridation to water plant operators across the state, as well as works with long time partner Georgia Rural Water Association, to conduct evaluations and provide technical assistance and resources at approximately 330 adjusting community water systems across Georgia each year. This helps assure fluoridation is in the optimal and recommend range to provide the best clinical benefit to Georgia citizens.

Teledentistry
In the reporting year, a DPH hygienist and dental assistant provided clinics in three elementary schools with video conferencing equipment to consult with remote dentists. The hygienist provided preventive services including cleanings, x-rays, intra-oral diagnostic photos, dental sealants and fluoride varnish application on site in the elementary school setting and referred to local contracted dentist for restorative dental services. Approximately 600 children were seen in the elementary school settings through the teledentistry program.

MCH Emergency Preparedness
MCH understands the importance of Emergency Preparedness (EP) planning and response as it relates to MCH populations. During the reporting year, MCH made a conscience effort to develop a partnership with DPH's Emergency Preparedness (PHEP) and Healthcare Preparedness Program (HPP) Teams on the state and local levels to ensure that the needs of women of reproductive age, pregnant women, infants, children, adolescents, and CYSHCN were considered during emergency response and recovery phases of tornadoes, floods, hurricanes, and pandemics.

Current Year: Oct 2019 – Sept 2020

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

Community Water Fluoridation Program
In the current year, the Oral Health program monitors the water systems to ensure fluoridation levels are within the recommended range. The Oral Health program also leads the Georgia Fluoride Advisory Committee comprised of GRWA, Environmental Protection Division (EPD), Georgia Department of Natural Resources (DNR), Georgia Dental Association (GDA), Georgia Dental Hygienists' Association (GDHA) and DPH. The committee guides the development of policies and advises on the daily operations of the CWF program. The Oral Health program in collaboration with GRWA teaches six fluoridation training classes each year for water plant operators on the safety, benefits, and value of the Community Water. The trainings provide guidance on the benefits of community water fluoridation, and the importance of their role in their local communities providing a public health benefit to all including pregnant women and children from all backgrounds and demographics.

MCH Emergency Preparedness
In the current year, MCH Emergency Preparedness activities were focused on routine MCH Emergency Preparedness Operations, MCH and MCH Epidemiology special projects, Centers for Disease Control and Prevention (CDC) Association of Maternal and Child Health Programs (AMCHP)/ Emergency Preparedness and

Response Action Learning Collaborative (EPR-ALC), and MCH COVID-19 Preparedness and Response Activities.

Routine MCH Emergency Preparedness Operations

During the current year, the Title V Team coordinated and facilitated the development of an MCH EP Operations strategy. An annual MCH Emergency Work Plan was developed and EP training for the MCH Workforce was provided. Additional activities included participation on the EP Underserved Special Populations (USP) and Department of Health Emergency Assistance Resource Team (DHEART) Committees and EP conferences, state and local exercises. The Title V Team Lead also provided MCH training to EP leaders and local and district staff to ensure knowledge of MCH programs and services. The Title V team supported EP in the Emergency Operations Center (EOC) during EP response and recovery phases coordinating MCH staff rotation for EP operations assistance and providing support to the MCH Core Team which includes the CYSHCN Director, a Women's/Perinatal Health Nurse, WIC Liaison, and Communications.

MCH and MCH Epidemiology Special Projects

The Title V Team Lead and the Director of MCH Epidemiology collaborated to complete the CDC MCH Epi-Emergency Preparedness Capacity Assessment Key Informant Interview and the Council of State and Territorial Epidemiologist (CSTE) MCH Emergency Preparedness Survey. The Director of MCH Epidemiology serves on the CSTE committee during the current year and is a key participant in updating the Reproductive Health Assessment After Disaster (RHAD 2.0) Emergency Preparedness Toolkit.

Emergency Preparedness and Response Action Learning Collaborative (EPR-ALC)

The MCH Section was one of eight states selected to participate in the 2019-2020 CDC/AMCHP Emergency Preparedness and Response Action Learning Collaborative. States were required to complete a state-specific project in support of Maternal and Infant Health, and to complete a checklist of 22 activities with multiple steps during a ten-month period. The framework for the maternal and infant EPR plan at the state/territorial level included the following strategies:

A. Integrate MCH considerations into state/territory EPR Plan

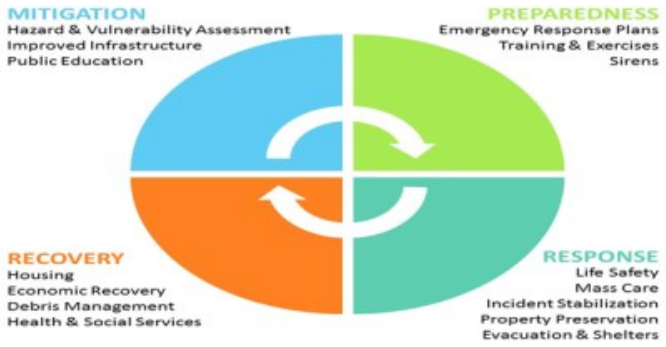
B. Develop a plan to gather epidemiologic/surveillance data on women of reproductive age and infants to guide action

C. Establish/promote EPR communication about target population with clinical partners, public health and governmental partners, and with the general pubic

D. Identify public health programs, interventions, and policies to protect/promote health and prevent disease and injury in emergencies among maternal and infant populations

Completing activities for the EPR-ALC unknowingly helped prepare MCH, MCH Epidemiology, Emergency Preparedness, Newborn Screening and Georgia's State Registrar to respond to COVID-19 for Georgia's MCH populations. Georgia's EPR-ALC Team consisted of members from Title V, Emergency Preparedness, CYSHCN, Women's Health, WIC and Home Visiting. The Scope of Work for this project was to ensure that MCH Populations, especially those that are most vulnerable, have access to education and materials on preparing for and coping with disaster.

Project Focus: EP Mitigation Phase



Project Activities:

- Hazard and Vulnerability Assessment
- Review Reproductive Health After Disaster (RHAD) Toolkit
- Review Pregnancy Estimator
- Review Community Assessment for Public Health Emergency Response (CASPER)
- Add four EP Questions to Pregnancy Risk Assessment Monitoring System (PRAMS)

Improved Infrastructure:

- Train MCH Workforce on Emergency Preparedness

Public Education: MCH Toolkit

- CYSHCN (special needs/disabilities
- Maternal Health & Perinatal Health (Infant Feeding (WIC), Safe Sleep, Breastfeeding, Pregnant Women, & Family Planning)
- Children (including Adolescents)
- Sheltering

MCH COVID-19 Preparedness and Response Activities

The MCH Section played an important leadership role in providing guidance and support to staff, district offices, health care providers, families, and community partners during the COVID-19 pandemic response. MCH programs were challenged to continue providing services to women, infants, children, fathers and families across the state while also providing emergency preparedness response activities.

MCH COVID-19 Preparedness and Response Activities:

- MCH Section: Developed Continuity of Operations Plans (COOPS) for all programs; assisted in staffing DPH Call Center and Call Tracing Activities; established protocols and guidelines to allow innovative service provisions - telephonic visits, telehealth and tele-audiology services, and other virtual visits for families and providers.
- MCH Nurses: Performed patient quarantine clinical support and supervision, staffed case management Isolation Site Referral Line
- MCH Epidemiologists: Georgia MCH Epidemiologists participated in CDC's COVIC-19 Optional Surveillance in Pregnancy initiative and served as members of State Core COVID-19 Team.

- District MCH Staff: Provided telephonic, virtual, telehealth, and limited in-person services to families; assisted with staffing District call centers and COVID testing sites.
- Title V: Coordinated response efforts with Emergency Preparedness; provided EP updates to MCH and Division Leadership; coordinated MCH volunteers; provided district level program update reports to MCH and Division Leadership
- Strategic Planning and Partnership: Developed MCH COVID-19 informational webpage https://dph.georgia.gov/women-and-children for the public; developed COVID-19 SharePoint Resource Page for Division Staff.
- Newborn Screening (NBS): Supported NBS, Sickle Cell Disease and Sickle Cell Trait Follow-up by developing supplementary guidance and operations protocols for providers supporting newborns during pandemic; maintaining 24/7 call line for consultation with NBS providers; developing new procedures to allow children with Sickle Cell Disease and Trait to attend Camp New Hope virtually by using tablets and internet hotspots.
- Early Hearing Detection and Intervention (EHDI): Outlined essential services related to 1-3-6 EHDI Benchmarks of Screening (by 1 month), Diagnosis (by 3 months) and enrollment in early intervention (by 6 months) in COOP. Developed guidelines for birthing facilities for screening and referrals to the EHDI program, and for District responsibilities, upkeep and tracking of available services for families.
- Children 1st and 1st Care: Provided guidance for telephonic case management for families.
- Georgia Home Visiting Program: Provided home visiting services to families via WebEx platform; provided telephonic contacts when virtual and in-person contacts were not available options; provided video demonstrations of home visiting evidence-based curriculum activities for families to emulate; delivered statewide virtual group connections for families.
- Healthy Start: Maintained contact with fathers in the fatherhood program using conference calling. Continued incentives for fathers. Developed virtual Fatherhood Speaker Series to replace in-person Fatherhood Summit scheduled for March 2020.
- CYSHCN: Conducted six-month and annual care coordination services telephonically; conducted specialty clinic services via telemedicine; provided reimbursement for three-month supply of medications where appropriate.
- Women/Maternal Health: Performed epidemiology case investigation activities; provided guidance for telephonic assessments and verbal consent for Perinatal Case Management; provided guidance for social distancing for Centering Pregnancy participants; provided support to sites to perform traditional in-person prenatal care for pregnant women.
- Infant/Perinatal Health: Developed virtual training for Georgia Perinatal Quality Collaborative (GaPQC) on the topic of Implicit Bias.
- Oral Health: Conducted virtual meetings for Fluoride Advisory Committee, Georgia Oral Health Coalition, Georgia Rural Water Association Site Visit, and Oral Health Coordinator's Meeting(s). Dentists and Dental Hygienists participated in district COVID-19 emergency operations.

Cross-Cutting/Systems Building - Application Year

Priority Need: Promote Oral Health to All Populations

NPM 13: Preventive Dental Visit
13.1 Percent of women who had a preventive dental visit during pregnancy
13.2 Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Strategy:

1.6 - Maintain a high level of access for all Georgian's including children who have access to optimally adjusted community water fluoridation as a means of reducing dental decay.

MCH will continue focus on cross-cutting public health issues such as oral health (activities specific to MCH domains are included in the State Action Plan Narrative) and MCH Emergency Preparedness that impacts multiple MCH populations and has an influence throughout the life-course. Issues such as community water fluoridation and emergency preparedness are often central to community and individual overall health status.

Community Water Fluoridation
The Oral Health Program will continue to ensure that Georgian's maintain a high level access to the dental benefits of fluoride through the monthly monitoring of water systems throughout the state, offering annual trainings to water plant operators, and partnering with the Georgia Rural Water Association to ensure systems are evaluated annually. The Oral Health Program will continue to promote the CDC's Fluoride Learning Online program.

Emergency Preparedness
MCH EP will continue to collaborate and coordinate efforts to develop strategies and plans to engage in emergency planning to ensure the needs of MCH populations are adequately addressed within state planning to address any gaps that may exist. MCH EP will provide education concerning preparing for, responding to, and recovering from an emergency. MCH EP activities will continue focus on four main areas: MCH Emergency Preparedness Operations, MCH and MCH Epidemiology special projects, CDC, AMCHP/ EPR-ALC, and MCH COVID-19 Preparedness and Response Activities. MCH EP will also participate with EP, MCH, and MCH Epidemiologists and Evaluation to evaluate the impact of COVID-19 on MCH populations.

III.F. Public Input

MCH strives to solicit public input to guide program development, implementation and evaluation. Title V staff seek new opportunities to invite stakeholders and the public to offer valuable input into policy and program development to ensure they are meeting the unique cultural needs of Georgia's diverse population and communities.

Title V is committed to collecting input throughout the year and works in partnership with local agencies to assess and identify needs. Title V staff develop opportunities to collect input and feedback through regular technical assistance calls and webinars as well as during local site visits, community meetings, and conferences/events.

To achieve greater public involvement during the development of the need's assessment, MCH took deliberate steps to incorporate public involvement early in the process leading up to the Application/Annual Report. In order to solicit as much awareness as possible about the importance of public input, a communications plan was developed to include presentations to the Georgia Public Health Association (GDPH), DPH Board of Public Health, DPH Health Promotion section, and various other partner meetings throughout the state. Public input was obtained using a variety of methods throughout the need's assessment process and in the development of the Application/Annual Report. Surveys and focus groups were used to access the health needs of women, children, adolescents, children and youth with special health care needs, adolescents and fathers. A Title V Stakeholder Survey was developed and made available at the Georgia Public Health Association's Annual Meeting in May 2019 and the MCH Workforce Survey was developed and provided at the Georgia Department of Public Health's MCH Conference in June 2019. The General Population Survey was made available in July 2019 via the DPH website and provided to agencies and organizations throughout the state to share with consumers as well as during various partner meetings and conferences. The MCH Workforce and Stakeholder Surveys were provided through emails and various meetings throughout the state.

Throughout the needs assessment process comments were received and used to inform the priority selection process and help inform decisions. Community members, partners, and families were grateful for the opportunity to provide input and participate in the development of the State Action Plan.
To increase the volume of feedback from stakeholders during the Title V Block Grant Annual Report and Application public comment period, MCH separated the block grant narrative sections by population domain and posted smaller draft documents to the DPH Title V webpage in lieu of one large document containing all domains. Stakeholders were given the choice of several methods for providing comments and input on the drafts. A public input survey was posted on the DPH Title V webpage (via SurveyMonkey) to collect information on the DRAFT Application and Annual Report from consumers and partners across the state that are informed of and concerned about the needs of MCH populations. An email was also sent to partners and District Health Directors statewide requesting input. Title V also invites partners and the public to email comments directly to the MCH Title V program.

Input is also solicited throughout the year from parent support groups and agency partners who are affiliated with programs funded by the grant. For example, the Babies Can't Wait State Interagency Coordinating Council receives public comment during quarterly council meetings which are open to the public. The Oral Health Program's Fluoride Advisory Committee promotes communication and input through quarterly meetings between multiple stakeholders. The Oral Health program seeks public input through conducting surveys to solicit input from stakeholders and program participants, most recently assessing the need for technical assistance in facilitating implementation of school-based/linked sealant programs. The Georgia Newborn Screening and Advisory Committee (NBSAC), a select review team with oversight and advisory responsibility for the Newborn Screening program, conduct bi-annual public meetings to determine selection of new conditions to the Georgia Newborn Screening panel. Individuals and organizations are invited to submit nominations to add new conditions for consideration.

The MCH Title V Director and Deputy Director were panelist for the GAAAP's Addressing Social Health and Early Childhood Wellness (ASHEW) webinar on September 12, 2020. The presentation titled "Understanding Performance Measures within the Maternal & Child Health Block Grant - Leveraging Resources to Support Communities" shared the 2020-2025 priorities and associated measures, objectives and strategies. Feedback from attendees was requested.

In the coming year, MCH will continue to develop and implement communication that increases visibility and strengthens outreach and utilization of MCH programs to the community. The Title V priorities, performance measures, and state action plan will be posted to the DPH website, Title V webpage.

III.G. Technical Assistance

As Georgia focuses on building capacity to meet the needs of fathers and improve outcomes for families, participation in the MCH Workforce Development Center Cohort 2019 to improve father engagement through awareness across the department and increase access to statewide resources for fathers and their families continued. Staff and partners worked to build a comprehensive fatherhood engagement plan connecting community and agency partners with state programs and services to create a “father friendly” network to serve fathers.

Over the nine-month period specific goals were accomplished during the MCH Workforce Development 2019 Cohort learning opportunity. A Fatherhood Advisory Group was convened representing various sections of internal DPH and the local public health districts, an academic research institution, community-based organizations, Department of Health and Human Services Department of Child Support Services (DCSS), WIC and a diverse group of consumer liaisons including fathers.

Application was accepted to participate in AMCHP’s Building Emergency Preparedness and Response (EPR) Capacity for Maternal and Infant Health Action Learning Collaborative (ALC), a technical assistance project geared to ensure Title V populations are planned for in the event of an emergency. A select team including members from the Title V team, WIC, Family and Community Supports, Health Promotion Communications, and Women’s Health participated in an eleven-month project to integrate MCH into the state response plan and compile a statewide list of MCH and EPR partners.

Members from the Title V team, Family and Community Supports, and Injury Prevention are participating in HRSA’s Child Safety Now Alliance, to reduce fatal and serious injuries among infants, children, and adolescents, assist with addressing the high rate of infant mortality due to SUID through evidenced-based strategies, engage with other state/jurisdiction colleagues to share successes and challenges and, advance the evidence-base for SUID prevention. The Georgia team selected SUID Prevention to implement and spread evidence-driven strategies and programs to prevent SUID. Participating in the collaborative will allow the program to select an evidence-based strategy to purposefully implement, test, and revise to ensure effective communication to our most at-risk families. Additional perceived benefits of participation in the collaborative involves sharing with colleagues any challenges, receiving feedback to guide revisions and efforts and, hearing about other's successes. The CSLC team’s focus will be to implement and spread the use of home visitors to distribute infant safe sleep educational materials.

If further technical assistance needs are identified through the year, Title V programs will contact the Maternal and Child Health Bureau.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - 2020 Georgia Title V and Title XIX MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MCH Advisory Council Membership .pdf

Supporting Document #02 - MCH NAW Membership.pdf

Supporting Document #03 - References Overview of State Block Grant 2020 final.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Health Promotion Org Charts.Updated8.17.20.pdf

VII. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Georgia

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 19,811,036	
A. Preventive and Primary Care for Children	$ 6,575,638	(33.1%)
B. Children with Special Health Care Needs	$ 7,512,066	(37.9%)
C. Title V Administrative Costs	$ 1,561,557	(7.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 15,649,261	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 109,975,740	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 165,826,555	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 6,578,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 282,380,295	
A. Your State's FY 1989 Maintenance of Effort Amount $ 36,079,622		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 302,191,331	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 35,533,337	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 337,724,668	

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,008,414
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,092,899
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 14,932,168
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 370,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	$ 200,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 10,404,529
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 1,106,289
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Partnership Grant Program To Improve Minority Health	$ 24,038

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 17,154,058		$ 17,153,951	
A. Preventive and Primary Care for Children	$ 6,213,920	(36.2%)	$ 5,411,961	(31.5%)
B. Children with Special Health Care Needs	$ 6,452,729	(37.6%)	$ 6,618,805	(38.5%)
C. Title V Administrative Costs	$ 1,569,693	(9.2%)	$ 988,015	(5.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 14,236,342		$ 13,018,781	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 112,090,944		$ 114,368,375	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 164,161,576		$ 158,710,749	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 6,857,920		$ 7,378,500	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 283,110,440		$ 280,457,624	
A. Your State's FY 1989 Maintenance of Effort Amount $ 36,079,622				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 300,264,498		$ 297,611,575	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 33,901,215		$ 34,776,278	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 334,165,713		$ 332,387,853	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 9,153,768	$ 9,064,433
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 200,000	$ 200,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 630,000	$ 1,560,502
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 570,000	$ 307,971
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	$ 200,000	$ 160,399
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,478,707	$ 7,042,016
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 250,000
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	$ 776,398	$ 776,398
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 14,642,342	$ 14,363,994
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation		$ 937,491
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Partnership Grant Program To Improve Minority Health		$ 113,074

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**

Field Note:
The FY 2021 Federal Allocation was increased to expand and maintain existing programs such as:
Program Expansions supported by Title V Funding:
• Family and Community Support -Home Visiting: funding will support implementation of Evidenced based home visiting programs. Evidenced -based home visiting can achieve positive outcomes for mothers, babies, and families.
• 1st Care: funding will support voluntary in-home nursing assessments, interventions, and follow-up for families with infants who need close monitoring of their health and medical status after hospital discharge.

Note: State of Georgia is under Executive Order to ensure a Safe and Healthy Georgia: Necessary Travel for Essential Services, Minimum Basic Operations, and Critical Infrastructure work (normal operations but may implement measures). During the two-year upcoming budget cycle, possible budget realignments will be based on the redirection of funding.

2.	**Field Name:**	**2. Subtotal of Lines 1A-C**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**

Field Note:
In Form 2: the subtotal amount reflects:
A. Preventive and Primary Care for Children
B. Children with Special Health Care Needs
C. Title V Administrative Costs

3.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**

Field Note:
The State Agencies received a reduction starting in FY 20 at 2.68% crossing over into FY 21 at 10.34%.

New Georgia's State Program Funding:
Newborn Screening for Krabbe Disease (KD): is a rare disorder with infantile and later onset forms. Infantile onset Krabbe Disease (IOKD) is the most critical form of Krabbe. IOKD is marked by symptoms that progress very rapidly, regression in developmental milestones and, for those with early infantile onset, often result in mortality by 2 years of age without intervention.

New Conditions Georgia Newborn Screening (NBS): program recognizes NBS as an equitable public health service available to all infants born in the state. Georgia typically follows the Recommended Uniformed Screening Panel (RUSP) to further maintain equity in the conditions that are screened for across stateliness. Screening for SMA began under a pilot project prior to the condition being formally added to the state NBS. Georgia will implement screening for all four n

4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Note: State of Georgia is under Executive Order to ensure a Safe and Healthy Georgia: Necessary Travel for Essential Services, Minimum Basic Operations, and Critical Infrastructure work (normal operations but may implement measures). During the two-year upcoming budget cycle, possible budget realignments will be based on the redirection of funding.	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Note: State of Georgia is under Executive Order to ensure a Safe and Healthy Georgia: Necessary Travel for Essential Services, Minimum Basic Operations, and Critical Infrastructure work (normal operations but may implement measures). During the two-year upcoming budget cycle, possible budget realignments will be based on the redirection of funding.	
6.	**Field Name:**	**8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Note: State of Georgia is under Executive Order to ensure a Safe and Healthy Georgia: Necessary Travel for Essential Services, Minimum Basic Operations, and Critical Infrastructure work (normal operations but may implement measures). During the two-year upcoming budget cycle, possible budget realignments will be based on the redirection of funding.	

7.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: FY 2019 Final Notice Award Amount (NOA) and actual expense amount reflects the final financial report (FFR).	
8.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: In Form 2: 1A: Primary Care for Children and Program decease to support the activities of Children with Special Health Care Needs functions.	
9.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: FY 2019 Title V Administrative Cost decreased to support the need of the following domain such as Children ages one (1) through 21, including Children with Special Health Care Needs.	
10.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: FY 19 Governor's Appropriation Bill HB 684 - Received New State Funds: 1. Maternal Mortality -Provide funds to address maternal mortality in Georgia 2. Sickle Cell Foundation of Georgia for sickle cell outreach offices to improve access to care and reduce unnecessary emergency room costs. 3. Autism -Provide funds to develop capacity for children under 21 who are diagnosed as Autistic. 4. Babies Can't Wait -Provide funds to increase the occupational and physical therapy rates in the Babies Can't Wait program. (CC:Provide funds to increase the occupational, speech, and physical therapy rates in the Babies Can't Wait program	
11.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2019**

	Column Name:	**Annual Report Expended**
	Field Note: FY 19 Other Funds Expenses is based on the following : 1. Federal Medical Assistance Percentages (FMAP) for Medicaid Match Contracts; Regional Perinatal Centers and Genetics/Sickle Cell Hospitals. 2. Babies Can't Wait Medicaid Reimbursement 3. Immunization Vaccines VFC/317 4. Children Elderly Trust Fund 5. AMCHP Developmental Monitoring Within State System	
12.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: FY 2019 Program Income expenses reflects: Medicaid Perinatal Case Management, Family Planning Fees, Health Check, Medicaid DSPS, Private Insurance, Outpatient Client Fees, and Medicaid Fees.	
13.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: FY 2021 TANF funding supports two programs: Family Planning and Adolescent Health.	
14.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Partnership Grant Program To Improve Minority Health**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: FY 19 Child Health and Wellness, Georgia Shape moved under Health Promotion. An Integrated Food and Language Nutrition Curriculum for Early Childcare Educators to Improve Health Outcomes Among Racial and Ethnic Minorities in Three Georgia Communities is managed by the GA Shape Director.	
15.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

	Field Note: FY 19 Preventive Health and Health Services Block Grant expenses increased due the new program changes of Child Health and Wellness, Georgia Shape joining Health Promotion Division in 2019.	
16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: FY 19 Oral Health Federal Grant Program: Georgia was not one of the states to be awarded the supplemental funding for the additional $200,000.	
17.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: FY 19 Maternal, Infant, and Early Childhood Home Visiting Program innovation grant received a No Cost Extension from the grantor, funds were expended during this grant period to support program functions under Family and Community Support Program.	
18.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Partnership Grant Program To Improve Minority Health**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: F 19 Child Health and Wellness, Georgia Shape moved under Health Promotion 2019. An Integrated Food and Language Nutrition Curriculum for Early Childcare Educators to Improve Health Outcomes Among Racial and Ethnic Minorities in Three Georgia Communities grant is managed by the GA Shape Director.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Georgia

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 2,920,779	$ 2,938,520
2. Infants < 1 year	$ 1,240,996	$ 579,657
3. Children 1 through 21 Years	$ 6,575,638	$ 5,411,961
4. CSHCN	$ 7,512,066	$ 6,618,805
5. All Others	$ 0	$ 616,993
Federal Total of Individuals Served	$ 18,249,479	$ 16,165,936

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 32,220,374	$ 27,964,127
2. Infants < 1 year	$ 102,805,754	$ 99,446,034
3. Children 1 through 21 Years	$ 125,515,370	$ 127,169,035
4. CSHCN	$ 21,838,797	$ 23,794,118
5. All Others	$ 0	$ 2,084,310
Non-Federal Total of Individuals Served	$ 282,380,295	$ 280,457,624
Federal State MCH Block Grant Partnership Total	$ 300,629,774	$ 296,623,560

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: FY 2021 funds under Pregnant Women decreased, reflected changes are shown under Georgia's State Appropriation Bill 2021.The State Agencies received a reduction starting in FY20 at 2.68% crossing over into FY21 at 10.34%.	
2.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: FY 2021 funds under Infants decreased, reflected changes are shown under Georgia's State Appropriation Bill 2021.The State Agencies received a reduction starting in FY20 at 2.68% crossing over into FY21 at 10.34%.	
3.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: FY 2021 funds under Children 1-21 decreased, reflected changes are shown under Georgia's State Appropriation Bill 2021.The State Agencies received a reduction starting in FY20 at 2.68% crossing over into FY21 at 10.34%.	
4.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: FY 2021 funds under CSHCN decreased, reflected changes are shown under Georgia's State Appropriation Bill 2021.The State Agencies received a reduction starting in FY20 at 2.68% crossing over into FY21 at 10.34%.	
5.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: FY 2021 funds under All Others decreased, reflected changes are shown under Georgia's State Appropriation Bill 2021.The State Agencies received a reduction starting in FY20 at 2.68% crossing over into FY21 at 10.34%.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Georgia

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 4,176,194	$ 5,882,219
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 961,377	$ 2,280,713
B. Preventive and Primary Care Services for Children	$ 1,748,371	$ 1,850,516
C. Services for CSHCN	$ 1,466,446	$ 1,750,990
2. Enabling Services	$ 5,593,141	$ 4,782,747
3. Public Health Services and Systems	$ 10,041,701	$ 6,488,985
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 314,494
Physician/Office Services		$ 42,653
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 85,484
Dental Care (Does Not Include Orthodontic Services)		$ 307,352
Durable Medical Equipment and Supplies		$ 159,253
Laboratory Services		$ 40,107
Other		
Various Programs and Services		$ 4,932,876
Direct Services Line 4 Expended Total		$ 5,882,219
Federal Total	$ 19,811,036	$ 17,153,951

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 35,912,210	$ 34,531,346
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 25,698,080	$ 22,633,519
B. Preventive and Primary Care Services for Children	$ 2,530,764	$ 3,038,697
C. Services for CSHCN	$ 7,683,366	$ 8,859,130
2. Enabling Services	$ 68,418,439	$ 71,786,687
3. Public Health Services and Systems	$ 178,049,646	$ 174,139,591
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 314,495
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 1,596,284
Durable Medical Equipment and Supplies		$ 65,206
Laboratory Services		$ 0
Other		
Various Programs and Services		$ 32,555,361
Direct Services Line 4 Expended Total		$ 34,531,346
Non-Federal Total	$ 282,380,295	$ 280,457,624

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. - Other - Various Programs and Services**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: In Form 3b Line 4 Other (Various Programs and Services) Direct services is used to support MCH programs and Grant-In-Aid (District to Counties). Various services provided through programmatic activities to evaluate for testing procedure, referrals, monitoring, Medical Diagnosis for normal/abnormal testing, Transportation, Medications etc.	
2.	**Field Name:**	**IIB. - Other - Various Programs and Services**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: In Form 3b Line 4 Other (Various Programs and Services) Direct services is used to support MCH programs and Grant-In-Aid (District to Counties). Various services provided through programmatic activities to evaluate for testing procedure, referrals, monitoring, Medical Diagnosis for normal/abnormal testing, Transportation, Medications etc.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Georgia

Total Births by Occurrence: 127,295 **Data Source Year: 2019**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	122,307 (96.1%)	9,855	338	338 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Hearing Loss	Holocarboxylase Synthase Deficiency	Homocystinuria
Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)
Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease
S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency				

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Hearing	118,375 (93.0%)	2,325	192	143 (74.5%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Emory University, Augusta University, and Children's Healthcare of Atlanta are contracted to conduct short-term follow up on abnormal NBS results. NBS short-term follow-up encompasses the time between receiving an abnormal result to the confirmation of a diagnosis. Each contractor utilizes a database to track newborns during the short-term follow-up process which includes a minimum of 12 steps to locate and recall infants who screen positive for a condition identified by NBS. All diagnosed cases are referred to Children 1st, the single point of entry for public health services, which leads to an assessment to determine the newborn’s eligibility for IDEA Part C, Babies Can't Wait, or Children and Youth with Special Health Care Needs Program, Children's Medical Services.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Receiving At Least One Screen**
	Fiscal Year:	**2019**
	Column Name:	**Core RUSP Conditions**
	Field Note: Determined by an algorithm to match newborn screens to vital records. Ninety-three percent of records matched automatically; 7% required manual matching. This is a deduplicated number of screens by kit number and patient ID for GA resident births. The Georgia Public Health Laboratory (GPHL) tested >140,000 blood samples in 2019, including repeat and unsatisfactory screens.	
2.	**Field Name:**	**Core RUSP Conditions - Confirmed Cases**
	Fiscal Year:	**2019**
	Column Name:	**Core RUSP Conditions**
	Field Note: Confirmed cares are provided through Emory Genetics Follow-up Program, Hemoglobin Follow-up Program at Children's Hospital of Atlanta (CHOA) and Augusta University Hospitals, Early Hearing Detection and Intervention (EHDI), and SendSS. This report was prepared on June 9th, 2020. Thus, it might be a possible that later on some numbers would be added in confirmatory cases due to delayed/late diagnosis.	
3.	**Field Name:**	**Core RUSP Conditions - Referred For Treatment**
	Fiscal Year:	**2019**
	Column Name:	**Core RUSP Conditions**
	Field Note: Emory University Department of Human Genetics refers and treats everyone confirmed with metabolic and other genetic disorders. CHOA, Augusta University Hospital, and the Sickle Cell Foundation provides referral services to all confirmed cases of Hemoglobinopathies. Early Hearing Detection and Intervention (EHDI) provides referral services for confirmed cases of Hearing Loss.	
4.	**Field Name:**	**Hearing - Referred For Treatment**
	Fiscal Year:	**2019**
	Column Name:	**Other Newborn**
	Field Note: Referral for treatment data retrieved from Enhanced Timeliness Report in SendSS on June 16, 2020, linked to EBC, screening, and diagnostic data. These numbers are subject to change as follow-up is completed on pending cases and cases are closed.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Georgia

Annual Report Year 2019

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	12,854	47.0	0.0	46.0	7.0	0.0
2. Infants < 1 Year of Age	2,449	47.0	0.0	46.0	7.0	0.0
3. Children 1 through 21 Years of Age	30,544	34.0	0.0	55.0	11.0	0.0
3a. Children with Special Health Care Needs	7,632	50.0	0.0	44.0	6.0	0.0
4. Others	0					
Total	45,847					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	126,172	No	118,711	100	118,711	12,854
2. Infants < 1 Year of Age	127,051	No	127,295	96	122,203	2,449
3. Children 1 through 21 Years of Age	2,955,825	No	2,970,925	17	505,057	30,544
3a. Children with Special Health Care Needs	583,184	No	359,481	17	61,112	7,632
4. Others	7,436,698	Yes	7,436,698	0	0	0

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2019**
	Field Note: Data Source: Hospital Discharge Data of women who received services at a Regional Perinatal Center (RPC) from October 2018-September 2019. The insurance data was provided by HRSA reference data (National Vital Statistics System- Pregnant Women/Infants, 2018).	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2019**
	Field Note: Data Source: Total number of infants less than 1 year of age who received a car seat through the Child Occupant Safety Project (COSP) from October 2018-September 2019. The insurance data was provided by HRSA reference data (National Vital Statistics System- Pregnant Women/Infants, 2018).	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: Data Source: Total number of children who received an oral health screening in a school-based program from October 2018-September 2019. The insurance data was provided by HRSA reference data (American Community Survey- Children 1-21, 2018).	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: Data Source: Total number of children served by the state's Title V Children and Youth with Special Health Care Needs program from October 2018-September 2019. The insurance data was provided by HRSA reference data (National Survey of Children's Health- CSHCN, 2017-2018).	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: Currently, Georgia does not have a way to collect and measure the individuals served by Title V in the Others category (women and men over the age of 21).	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2019**
	Field Note: Numerator: In the reporting year, 100% of the hospitals throughout the State of Georgia participated in the Safe Sleep Hospital Initiative. Denominator: Provisional Hospital Discharge Data for October 2018-September 2019 births from the Georgia Department of Public Health, Office of Vital Records.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2019**
	Field Note: Newborn screening data from Form 4 was used. 122,307 newborns received at least 1 screening. The total number of births by occurrence was 127,295. The total percentage served was 96.1. The system only allows whole numbers, so the percentage was rounded down to 96.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: Total percentage served for this population was pulled from six different sources (BCW, CMS, Georgia SHAPE, Family Planning, Live Birth Certificates, and Children First). Caution was taken to consider the ages of children served by the programs to reduce the likelihood a child was double counted. Denominator: based on the calendar year 2019 estimated population count of persons ages 1-21 per OASIS.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: Total percentage served for the CSHCN population using C1st, CMS and BCW data was lower than the population-based services for all children. Georgia is reporting service percentage for all children in this category as CSHCN are not excluded from general services. Denominator: OASIS population counts by age 1-22 years multiplied by US census state profile disability rate.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: Currently, Georgia does not have a way to collect and measure the total percentage of populations served by Title V in the Others category (women and men over the age of 21).	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Georgia

Annual Report Year 2019

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	118,711	50,327	42,167	15,161	397	4,756	203	4,944	756
Title V Served	12,854	4,471	6,622	610	17	125	47	886	76
Eligible for Title XIX	64,279	20,029	29,906	9,931	192	1,154	69	2,748	250
2. Total Infants in State	128,276	53,431	42,319	20,848	257	4,947	150	6,324	0
Title V Served	117,259	49,298	40,980	15,867	238	4,829	111	3,125	2,811
Eligible for Title XIX	69,824	21,264	30,014	13,656	124	1,200	51	3,515	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Georgia

A. State MCH Toll-Free Telephone Lines	2021 Application Year	2019 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(855) 707-8277	(855) 707-8277
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health Hotline	Maternal and Child Health Hotline
3. Name of Contact Person for State MCH "Hotline"	Paige Jones	Paige Jones
4. Contact Person's Telephone Number	(404) 656-4782	(404) 656-4782
5. Number of Calls Received on the State MCH "Hotline"		52,225

B. Other Appropriate Methods	2021 Application Year	2019 Annual Report Year
1. Other Toll-Free "Hotline" Names	Georgia Family Health Line, Help Me Grow, EBC Initial Screenings	Family Health Line, Help Me Grow, EBC Initial Screenings
2. Number of Calls on Other Toll-Free "Hotlines"		12,751
3. State Title V Program Website Address	https://dph.georgia.gov/MCH	https://dph.georgia.gov/MCH
4. Number of Hits to the State Title V Program Website		119,632
5. State Title V Social Media Websites	https://twitter.com/gadph https://facebook.com/gadph	https://twitter.com/gadph https://facebook.com/gadph
6. Number of Hits to the State Title V Program Social Media Websites		0

Form Notes for Form 7:

Georgia's Title V Media is housed within the department-wide social media; therefore, no individual analytics are captured for Title V.

Form 8
State MCH and CSHCN Directors Contact Information

State: Georgia

1. Title V Maternal and Child Health (MCH) Director	
Name	Jeannine Galloway
Title	Maternal and Child Health Director
Address 1	2 Peachtree Street NW
Address 2	11th Floor
City/State/Zip	Atlanta / GA / 30303
Telephone	(404) 657-3147
Extension	
Email	jeannine.galloway@dph.ga.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Sharifa Peart
Title	Program Director CYSHCN
Address 1	2 Peachtree Street NW
Address 2	11th Floor
City/State/Zip	Atlanta / GA / 30303
Telephone	(404) 657-2861
Extension	
Email	sharifa.peart@dph.ga.gov

3. State Family or Youth Leader (Optional)	
Name	Sherry Richardson
Title	Title V Team Lead
Address 1	2 Peachtree Street NW
Address 2	11th Floor
City/State/Zip	Atlanta / GA / 30303
Telephone	(404) 651-7692
Extension	
Email	sherry.richardson@dph.ga.gov

Form Notes for Form 8:

None

Form 9
State Priorities – Needs Assessment Year

State: Georgia

Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Prevent Maternal Mortality	Continued
2.	Prevent Infant Mortality	Continued
3.	Promote developmental screenings among children	Continued
4.	Increase the number of children, both with and without special health care needs, who have a medical home	New
5.	Increase bullying and suicide prevention	New
6.	Improve systems of care for CYSHCN	Continued
7.	Promote oral health among MCH populations	Continued
8.	Increase father involvement among MCH populations	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Georgia

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	74.4 %	0.1 %	91,781	123,321
2017	74.8 %	0.1 %	94,939	126,946
2016	74.8 %	0.1 %	92,505	123,648
2015	74.9 %	0.1 %	84,535	112,864
2014	74.6 %	0.1 %	80,348	107,749
2013	73.6 %	0.1 %	80,053	108,806
2012	73.1 %	0.1 %	82,491	112,902
2011	72.0 %	0.1 %	79,004	109,704
2010	73.0 %	0.1 %	74,389	101,886
2009	73.0 %	0.1 %	73,094	100,098

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	72.6	2.4	901	124,168
2016	77.6	2.5	971	125,149
2015	69.0	2.7	645	93,486
2014	79.4	2.5	992	124,890
2013	86.8	2.7	1,070	123,227
2012	80.3	2.6	1,002	124,847
2011	77.0	2.5	979	127,067
2010	85.4	2.6	1,131	132,475
2009	73.8	2.4	991	134,368
2008	73.3	2.3	1,060	144,536

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2018	32.9	2.3	213	647,807

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	10.1 %	0.1 %	12,733	126,106
2017	9.9 %	0.1 %	12,772	129,072
2016	9.8 %	0.1 %	12,704	129,769
2015	9.5 %	0.1 %	12,464	131,326
2014	9.5 %	0.1 %	12,385	130,738
2013	9.5 %	0.1 %	12,064	127,627
2012	9.3 %	0.1 %	12,014	129,553
2011	9.4 %	0.1 %	12,333	131,791
2010	9.7 %	0.1 %	12,912	132,745
2009	9.4 %	0.1 %	13,190	140,396

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	11.5 %	0.1 %	14,509	126,135
2017	11.4 %	0.1 %	14,756	129,184
2016	11.2 %	0.1 %	14,577	129,973
2015	10.8 %	0.1 %	14,133	131,349
2014	10.8 %	0.1 %	14,058	130,764
2013	10.7 %	0.1 %	13,665	128,164
2012	10.9 %	0.1 %	14,139	129,705
2011	11.0 %	0.1 %	14,473	131,865
2010	11.3 %	0.1 %	15,093	133,000
2009	11.3 %	0.1 %	15,859	140,367

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	28.3 %	0.1 %	35,660	126,135
2017	27.7 %	0.1 %	35,749	129,184
2016	27.1 %	0.1 %	35,177	129,973
2015	26.8 %	0.1 %	35,183	131,349
2014	26.0 %	0.1 %	33,960	130,764
2013	26.1 %	0.1 %	33,440	128,164
2012	27.8 %	0.1 %	36,044	129,705
2011	28.5 %	0.1 %	37,579	131,865
2010	29.4 %	0.1 %	39,104	133,000
2009	31.1 %	0.1 %	43,614	140,367

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	7.2	0.2	934	129,682
2016	7.7	0.2	1,008	130,519
2015	7.7	0.2	1,012	131,878
2014	7.2	0.2	946	131,369
2013	7.4	0.2	957	129,227
2012	6.6	0.2	867	130,753
2011	6.7	0.2	894	132,892
2010	6.3	0.2	843	134,409
2009	7.0	0.2	993	141,829

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	7.2	0.2	928	129,243
2016	7.5	0.2	972	130,042
2015	7.8	0.2	1,024	131,404
2014	7.5	0.2	985	130,946
2013	7.0	0.2	899	128,748
2012	6.2	0.2	812	130,280
2011	6.9	0.2	908	132,409
2010	6.3	0.2	849	133,947
2009	7.3	0.2	1,036	141,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	4.6	0.2	599	129,243
2016	5.0	0.2	648	130,042
2015	5.1	0.2	666	131,404
2014	5.0	0.2	654	130,946
2013	4.8	0.2	619	128,748
2012	4.1	0.2	534	130,280
2011	4.3	0.2	570	132,409
2010	3.9	0.2	516	133,947
2009	4.9	0.2	696	141,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	2.5	0.1	329	129,243
2016	2.5	0.1	324	130,042
2015	2.7	0.1	358	131,404
2014	2.5	0.1	331	130,946
2013	2.2	0.1	280	128,748
2012	2.1	0.1	278	130,280
2011	2.6	0.1	338	132,409
2010	2.5	0.1	333	133,947
2009	2.4	0.1	340	141,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	251.5	14.0	325	129,243
2016	290.7	15.0	378	130,042
2015	292.2	14.9	384	131,404
2014	287.1	14.8	376	130,946
2013	281.9	14.8	363	128,748
2012	234.1	13.4	305	130,280
2011	216.8	12.8	287	132,409
2010	221.0	12.9	296	133,947
2009	258.2	13.5	365	141,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	132.3	10.1	171	129,243
2016	123.8	9.8	161	130,042
2015	129.4	9.9	170	131,404
2014	123.0	9.7	161	130,946
2013	105.6	9.1	136	128,748
2012	104.4	9.0	136	130,280
2011	125.4	9.7	166	132,409
2010	120.9	9.5	162	133,947
2009	96.9	8.3	137	141,377

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.3 %	1.2 %	7,527	119,374
2017	5.6 %	1.1 %	6,824	122,368
2013	4.4 %	1.1 %	2,852	64,607
2012	3.9 %	0.8 %	4,881	125,314
2011	6.2 %	1.1 %	7,842	127,353
2010	6.1 %	1.2 %	7,754	128,235
2009	5.1 %	1.1 %	6,938	134,961
2008	6.6 %	1.2 %	9,282	141,155
2007	4.9 %	1.2 %	7,094	144,786

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	3.4	0.2	413	120,117
2016	3.3	0.2	401	122,474
2015	2.8	0.2	255	91,918
2014	2.9	0.2	358	122,387
2013	2.3	0.1	275	118,735
2012	1.8	0.1	218	123,712
2011	1.5	0.1	182	123,707
2010	1.2	0.1	157	128,527
2009	0.8	0.1	110	138,677
2008	0.7	0.1	103	144,048

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

NOM 13 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	12.8 %	1.5 %	306,995	2,394,967
2016_2017	12.9 %	1.5 %	305,114	2,371,509
2016	13.3 %	2.0 %	312,525	2,356,995

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	19.3	1.3	235	1,216,366
2017	19.7	1.3	241	1,223,518
2016	20.9	1.3	257	1,230,747
2015	21.0	1.3	259	1,234,835
2014	19.7	1.3	244	1,238,114
2013	21.8	1.3	271	1,240,503
2012	18.8	1.2	234	1,243,459
2011	20.2	1.3	251	1,245,086
2010	23.8	1.4	297	1,248,768
2009	22.4	1.3	279	1,247,044

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	35.7	1.6	520	1,456,128
2017	35.3	1.6	510	1,446,100
2016	38.0	1.6	543	1,429,712
2015	36.5	1.6	518	1,418,744
2014	31.5	1.5	443	1,405,878
2013	33.6	1.6	470	1,400,810
2012	29.1	1.4	408	1,402,316
2011	32.6	1.5	456	1,398,831
2010	35.4	1.6	495	1,399,683
2009	31.8	1.5	444	1,396,065

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	14.2	0.8	308	2,167,363
2015_2017	15.1	0.8	325	2,146,364
2014_2016	14.3	0.8	302	2,118,795
2013_2015	13.8	0.8	289	2,098,804
2012_2014	12.4	0.8	260	2,091,081
2011_2013	13.0	0.8	272	2,095,858
2010_2012	13.3	0.8	281	2,110,591
2009_2011	13.2	0.8	280	2,123,186
2008_2010	14.9	0.8	318	2,129,778
2007_2009	18.8	0.9	398	2,114,902

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	9.6	0.7	209	2,167,363
2015_2017	9.5	0.7	203	2,146,364
2014_2016	8.1	0.6	172	2,118,795
2013_2015	7.9	0.6	166	2,098,804
2012_2014	6.8	0.6	143	2,091,081
2011_2013	6.7	0.6	141	2,095,858
2010_2012	6.0	0.5	126	2,110,591
2009_2011	6.1	0.5	129	2,123,186
2008_2010	6.1	0.5	130	2,129,778
2007_2009	5.4	0.5	114	2,114,902

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	19.3 %	1.6 %	485,463	2,510,041
2016_2017	20.5 %	1.6 %	512,169	2,502,041
2016	19.8 %	2.0 %	494,310	2,497,183

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	15.5 %	3.7 %	75,282	485,463
2016_2017	17.8 %	3.4 %	90,927	512,169
2016	15.1 %	3.3 %	74,664	494,310

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	4.3 %	1.0 %	91,914	2,157,943
2016_2017	3.2 %	0.9 %	69,912	2,181,524
2016	1.5 %	0.5 %	32,685	2,165,278

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	12.0 %	1.4 %	253,601	2,121,962
2016_2017	10.4 %	1.3 %	225,262	2,170,039
2016	8.9 %	1.4 %	192,003	2,157,314

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	48.9 %	6.1 %	139,803	286,014
2016_2017	42.3 %	5.6 %	128,623	304,159
2016	41.1 %	7.1 %	112,671	274,010

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	88.5 %	1.4 %	2,221,452	2,509,218
2016_2017	89.3 %	1.4 %	2,234,510	2,501,317
2016	90.3 %	1.6 %	2,253,994	2,495,736

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	12.5 %	0.1 %	9,778	78,023
2014	13.0 %	0.1 %	12,165	93,386
2012	13.4 %	0.1 %	14,527	108,699
2010	14.4 %	0.1 %	15,122	104,959
2008	15.3 %	0.1 %	14,377	93,912

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	12.8 %	0.8 %	55,187	431,505
2011	14.9 %	1.1 %	65,360	437,619
2009	12.2 %	1.0 %	54,154	443,841
2007	13.7 %	1.0 %	61,213	447,943
2005	12.3 %	1.0 %	51,651	419,688

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	16.0 %	2.3 %	179,021	1,122,017
2016_2017	18.4 %	2.5 %	202,978	1,100,842
2016	18.6 %	3.3 %	207,930	1,118,321

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	7.6 %	0.3 %	190,101	2,503,080
2017	6.9 %	0.3 %	172,717	2,512,910
2016	6.4 %	0.3 %	161,540	2,511,414
2015	7.0 %	0.3 %	174,459	2,502,055
2014	7.5 %	0.3 %	187,590	2,490,299
2013	9.5 %	0.3 %	236,951	2,487,378
2012	8.9 %	0.4 %	221,352	2,490,232
2011	9.5 %	0.4 %	236,836	2,488,159
2010	9.8 %	0.3 %	245,304	2,492,676
2009	10.7 %	0.3 %	277,133	2,583,204

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	76.7 %	3.3 %	147,004	191,697
2017	65.6 %	3.7 %	125,502	191,399
2016	77.3 %	3.1 %	145,534	188,384
2015	75.6 %	3.4 %	140,850	186,272
2014	74.0 %	3.9 %	142,195	192,050
2013	69.8 %	5.0 %	133,873	191,743
2012	74.7 %	3.5 %	146,814	196,476
2011	69.5 %	3.3 %	143,703	206,821
2010	49.6 %	3.5 %	108,443	218,575
2009	45.8 %	3.8 %	102,118	222,822

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	55.5 %	1.4 %	1,315,708	2,371,928
2017_2018	51.3 %	1.5 %	1,208,749	2,355,023
2016_2017	54.4 %	1.8 %	1,271,860	2,337,119
2015_2016	51.3 %	1.7 %	1,186,889	2,311,822
2014_2015	58.0 %	2.0 %	1,344,382	2,319,499
2013_2014	51.4 %	2.0 %	1,197,580	2,328,179
2012_2013	52.4 %	2.4 %	1,209,331	2,310,105
2011_2012	44.4 %	2.7 %	1,077,374	2,425,933
2010_2011	48.8 %	2.7 %	1,173,494	2,404,700
2009_2010	36.0 %	2.2 %	885,197	2,458,880

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	68.1 %	3.1 %	491,901	721,869
2017	64.3 %	3.3 %	463,334	720,279
2016	67.3 %	3.1 %	482,021	715,804
2015	52.6 %	3.2 %	372,693	708,217

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	94.2 %	1.4 %	679,936	721,869
2017	93.3 %	1.7 %	672,313	720,279
2016	92.8 %	1.8 %	664,117	715,804
2015	90.2 %	2.0 %	639,026	708,217
2014	86.1 %	2.4 %	606,772	704,533
2013	82.0 %	3.4 %	570,798	696,071
2012	80.5 %	3.1 %	554,543	688,649
2011	68.0 %	3.0 %	470,206	691,435
2010	62.2 %	3.0 %	412,380	662,735
2009	50.8 %	3.1 %	350,121	689,156

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	94.8 %	1.4 %	684,621	721,869
2017	95.3 %	1.3 %	686,645	720,279
2016	91.4 %	1.8 %	654,281	715,804
2015	87.0 %	2.4 %	615,842	708,217
2014	74.9 %	3.1 %	527,722	704,533
2013	76.9 %	3.6 %	535,512	696,071
2012	73.1 %	3.5 %	503,360	688,649
2011	67.7 %	3.0 %	467,831	691,435
2010	63.5 %	2.9 %	420,582	662,735
2009	53.3 %	3.1 %	367,515	689,156

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	20.6	0.2	7,385	357,658
2017	21.9	0.3	7,778	354,918
2016	23.6	0.3	8,248	350,110
2015	25.5	0.3	8,829	345,650
2014	28.4	0.3	9,661	340,458
2013	30.4	0.3	10,322	339,239
2012	33.7	0.3	11,488	341,282
2011	37.9	0.3	12,991	343,097
2010	41.5	0.4	14,378	346,765
2009	47.0	0.4	16,345	347,660

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	13.6 %	1.6 %	16,088	118,626
2017	12.4 %	1.6 %	15,049	120,978
2013	9.2 %	1.7 %	5,936	64,349
2012	8.1 %	1.1 %	10,035	124,724

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	5.7 %	1.1 %	143,892	2,504,234
2016_2017	5.5 %	1.1 %	136,676	2,491,340
2016	5.6 %	1.4 %	139,440	2,483,820

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Georgia

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

Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	62.1	62.1	70	71
Annual Indicator	67.7	69.7	70.4	75.5
Numerator	1,258,025	1,321,663	1,335,604	1,443,474
Denominator	1,857,538	1,895,900	1,898,399	1,912,418
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	72.0	73.0	74.0	75.0	76.0	77.0

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data				
	2016	2017	2018	2019
Annual Objective	81.8	80	83	84
Annual Indicator	80.9	83	83.9	84.6
Numerator	1,950	1,947	1,951	1,947
Denominator	2,409	2,347	2,326	2,302
Data Source	State Statistical File	State Statistical File	State Statistical File	State Statistical File
Data Source Year	2016	CY 2017	CY 2018	CY 2019
Provisional or Final ?	Final	Final	Provisional	Provisional

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	85.0	86.0	87.0	88.0	89.0	90.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data Sources: OHIP - Final Birth Table, OASIS Final, and Vital Records Provisional Birth File	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data Source: GA DPH, Office of Health Indicators for Planning (OHIP)	

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	79.3	80.9	80	81
Annual Indicator	69.2	79.9	84.0	84.1
Numerator	80,818	100,061	106,087	109,903
Denominator	116,817	125,213	126,348	130,643
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	84.0	84.0	85.0	85.0	86.0	86.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	20.2	21.6	21	22
Annual Indicator	25.4	20.7	22.1	27.0
Numerator	29,130	25,611	26,140	33,943
Denominator	114,622	123,723	118,097	125,804
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	23.0	23.5	24.0	24.5	25.0	25.5

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	73.7
Numerator	87,074
Denominator	118,209
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	74.0	74.0	74.0	74.0	74.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	21.7
Numerator	25,317
Denominator	116,405
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	22.0	22.0	22.0	22.0	22.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	44.0
Numerator	50,752
Denominator	115,426
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	44.0	44.0	44.0	44.0	44.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			38	41
Annual Indicator		37.1	40.8	49.4
Numerator		104,456	107,598	135,738
Denominator		281,856	263,952	274,649
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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	42.0	43.0	44.0	45.0	46.0	47.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2020**

   Column Name: **Annual Objective**

   Field Note:
   The annual objectives will be updated next year when there is more available data from NSCH.

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	**2019**
Annual Objective	25.3	
Annual Indicator	25.1	25.1
Numerator	110,846	110,846
Denominator	442,284	442,284
Data Source	YRBSS	YRBSS
Data Source Year	2013	2013

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2019
Annual Objective	
Annual Indicator	14.2
Numerator	106,312
Denominator	750,443
Data Source	NSCHP
Data Source Year	2018

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2019
Annual Objective	
Annual Indicator	33.7
Numerator	257,779
Denominator	765,064
Data Source	NSCHV
Data Source Year	2018

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	34.0	35.0	36.0	37.0	38.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
In 2018, the survey question and timeframe changed to ask about the frequency of the occurrence during the past 12 months rather than the degree of accuracy of the statement. The annual objectives will be updated next year when there is more available data from NSCH.

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2019
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

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives will be updated next year when there is more available data from NSCH.

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN	
	2019
Annual Objective	
Annual Indicator	46.8
Numerator	948,129
Denominator	2,024,578
Data Source	NSCH-NONCSHCN
Data Source Year	2017_2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	47.0	47.0	47.0	47.0	47.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The annual objectives will be updated next year when there is more available data from NSCH.

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 - 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

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

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	39.5	41.1	29	39
Annual Indicator	29.3	29.3	39.3	37.9
Numerator	18,443	18,443	48,597	45,805
Denominator	63,060	63,060	123,575	120,710
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2013	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	40.0	41.0	41.0	42.0	43.0	44.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			83	84
Annual Indicator		83.0	83.5	82.4
Numerator		1,968,896	1,992,442	1,971,820
Denominator		2,372,620	2,384,889	2,393,072
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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	84.0	85.0	86.0	87.0	88.0	89.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Georgia

2016-2020: NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2016	**2017**	**2018**	**2019**
Annual Objective			37	31
Annual Indicator		36.4	31.3	23.4
Numerator		301,002	270,140	221,154
Denominator		826,166	863,542	944,551
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018

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.

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data			
Data Source: Youth Risk Behavior Surveillance System (YRBSS)			
	2017	**2018**	**2019**
Annual Objective			17
Annual Indicator	24.7	24.7	24.7
Numerator	107,932	107,932	107,932
Denominator	436,871	436,871	436,871
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2013	2013	2013
Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT			
	2017	**2018**	**2019**
Annual Objective			17
Annual Indicator	20.0	16.9	15.6
Numerator	186,178	154,649	129,201
Denominator	931,402	916,172	826,895
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2016	2016_2017	2017_2018

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Georgia

SPM 1 - Percent of congenital syphilis cases averted

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	80.3
Numerator	
Denominator	
Data Source	SendSS
Data Source Year	CY 2018
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	81.0	81.6	82.3	83.0	83.7

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	10.7
Numerator	
Denominator	
Data Source	Vital Records- Birth and Death Certificates
Data Source Year	CY 2019
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	9.5	9.0	8.6	8.2	7.7

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Percent of fathers (ages 18-55) whose knowledge increased using a Father Involvement curriculum in Georgia Home Visiting Program (GHVP) sites.

Measure Status:	Active

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

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
This is a new activity/measure. We are currently gathering baseline data. The lack of baseline data precludes projecting target objectives. Targets will be provided once baseline data is obtained.

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Percent of women (ages 15-44) served in the Georgia Family Planning Program (GFPP) who use long-acting reversible contraceptives (LARC).

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		11	16.5	15
Annual Indicator	16.6	15.6	17	18.1
Numerator	9,714	9,175	10,348	10,613
Denominator	58,434	58,675	60,860	58,568
Data Source	GFPP	GFPP	GFPP	GFPP
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Georgia Family Planning Program Data 2016 Projections	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Georgia Planning Program Data	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Source: Georgia Family Planning Program	

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

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Children's Medical Services Program Data (Numerator), Kids Count (Denominator)	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Children's Medical Services Program Data (Numerator), National Survey of Children's Health 2011/2012 prevalence multiplied by Census Population Estimates (Denominator)	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Children's Medical Services Program Data (Numerator), National Survey of Children's Health CSHCN Prevalence Estimates 1-17 (2016-2017) multiplied by US Census Bureau Population Estimates 1-21, 2017 (Denominator)	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Children's Medical Services Program Data (Numerator); National Survey of Children's Health CSHCN Prevalence Estimates 1-17 (2017-2018) multiplied by US Census Bureau Population Estimates 1-21, 2018 (Denominator)	

2016-2020: SPM 3 - Rate of congenital syphilis.

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		13	12.7	12.4
Annual Indicator	16.2	17.8	24.6	29.3
Numerator	21	23	31	37
Denominator	129,940	129,158	126,051	126,250
Data Source	STD Program Data and OASIS	STD Program Data and OASIS	STD Program Data	STD Program Data and OASIS
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Numerator: STD Program Data; Denominator: OASIS	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Numerator: STD Program Data; Denominator: OASIS	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data Source: Numerator: STD Program Data	

2016-2020: SPM 4 - Rate of infants diagnosed with Neonatal Abstinence Syndrome (NAS).

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		6.1	13.2	13.1
Annual Indicator	10.9	12	12.4	8.2
Numerator	1,310	1,438	1,430	962
Denominator	120,005	119,901	115,716	117,214
Data Source	Hospital Discharge Data, Vital Records	Hospital Discharge Data, Vital Records	Hospital Discharge Data, Vital Records	Hospital Discharge Data
Data Source Year	FY 2016	FY 2017	FY 2018	FY 2019
Provisional or Final ?	Final	Final	Final	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Data Source; OHIP Hospital Discharge Data, Vital Records

Method:The numerator is the number of infants younger than 1 year of age diagnosed with NAS in Georgia. Diagnosis was defined using ICD codes. For the first three quarters of 2015, NAS was indicated by ICD-9 codes of 779.5 (drug withdrawal syndrome in a newborn) and 760.72 (narcotics affecting fetus or newborn via placenta or breast milk). For the last quarter of 2015, the ICD-10 codes P96.1 (neonatal withdrawal symptoms from maternal use of drugs of addiction) and P04.4 (newborn affected by maternal use of drugs of addiction) were used. The denominator is the total number of hospital births in Georgia.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Neonatal Abstinence Syndrome (NAS) became a reportable condition in Georgia in 2016. With the rise of opioid use, there has been an increase in NAS education and outreach to increase public awareness. Excluding military facilities and two stand-alone birthing hospitals that do not report the hospital discharge data, approximately 90% of the 76 birthing hospitals reported at least 1 baby with a NAS-related ICD code.

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
In Q4 2018, several new ICD-10-CM codes were added by CMS to capture the specific substances neonates may have been exposed to in utero. At the Council for State and Territorial Epidemiologist (CSTE) Annual Conference in June 2019, a new standardized case definition for NAS was approved. The new case definition focuses in utero exposure to opioids, benzodiazepines, and barbiturates. Georgia is in the process of implementing the new CSTE NAS case definition. As such, the ICD codes recommended by CSTE to use for identifying potential exposure to opioids, benzodiazepines, and barbiturates were included (P04.14, P04.17, P04.1A) once they became available in Q4 2018, in addition to the usual NAS ICD codes used for case identification, P96.1 and P04.49.

2016-2020: SPM 5 - Percent of birthing hospitals, NICUs, and Pediatric Departments with policies and education that adhere to the American Academy of Pediatrics (AAP) Safe Sleep guidelines

Measure Status:		**Active**	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			51.1
Annual Indicator		49.6	60.3
Numerator		70	85
Denominator		141	141
Data Source		GA Safe to Sleep Program Data	Georgia Safe to Sleep Program Data
Data Source Year		FFY 2018	FFY 2019
Provisional or Final ?		Final	Final

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measure (ESM)

State: Georgia

ESM 1.1 - Percent of initial program cervical screening tests that are conducted among women who have never been screened or not screened within the last 10 years

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	20.0	20.0	20.0	20.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
CDC recently changed the definitions/algorithms for calculating this indicator and other core indicators but have not determined the goal(s) yet. In the past, CDC's goal for this indicator was 20%. We will currently leave 20% as a placeholder until CDC releases the new guidelines regarding annual goals.

ESM 1.2 - Number of LARCs utilized among women of reproductive age (15-44 years) served in local Public Health Departments

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	6,960
Numerator	
Denominator	
Data Source	SENDSS
Data Source Year	CY 2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	7,169.0	7,378.0	7,587.0	7,796.0	8,005.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The Neonatal Center Designation Program is in development. Once the program is operationalized, we hope to verify at least 10 hospitals a year.

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	0.0	0.0	0.0	85.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
The 10-Steps to Breastfeeding Training is a new activity that has yet to begin. The lack of available baseline precludes projecting target objectives. Targets will be provided once baseline data is obtained.

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

Measure Status:	Active

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
This is a new activity/measure. The lack of available base precludes projecting target objectives. Targets will be provided once baseline data is obtained.

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

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	65
Numerator	
Denominator	
Data Source	GHVP Data
Data Source Year	CY 2018
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	65.0	70.0	75.0	80.0	85.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	60.3
Numerator	85
Denominator	141
Data Source	Georgia Safe to Sleep Program Data
Data Source Year	FFY 2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	64.0	67.0	71.0	74.0	78.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
This is a new measure. The lack of available baseline precludes projecting target objectives. Targets will be provided once baseline data is obtained.

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	3.0	6.0	9.0	12.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: This is a new measure.	

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

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	11.8
Numerator	951
Denominator	8,038
Data Source	SendSS
Data Source Year	SFY 2019
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12.0	13.0	14.0	15.0	16.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.3 - Number of new community partners who implement developmental screening and make referrals to their local public health district

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	0.0	1.0	2.0	3.0	4.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: This is a new measure.	

ESM 6.4 - Percent of children, ages 0 through 5, who receive a developmental screening from DeKalb Board of Health Refugee Clinic

Measure Status:	Active

State Provided Data		
	2018	2019
Annual Objective		
Annual Indicator	85.4	89.3
Numerator	140	167
Denominator	164	187
Data Source	DeKalb Board of Health Refugee Clinic	DeKalb Board of Health Refugee Clinic
Data Source Year	CY 2018	CY 2019
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	93.0	97.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 9.1 - Number of schools that receive guidance on laws, policies, and evidence-based strategies to prevent bullying

Measure Status:	Active

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
This is a new measure. The lack of available baseline precludes projecting target objectives. Targets will be provided once baseline data is obtained.

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

Field Level Notes for Form 10 ESMs:

None

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2019
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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
There were 3,809 calls to HMG during SFY 2020 with 5,869 referrals to services/resources.

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

Measure Status:	Active

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
This is a new measure. The lack of available baseline precludes projecting target objectives. Target will be provided once baseline data is obtained.

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

Measure Status:	Active

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

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

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
This is a new measure. The lack of available baseline precludes projecting target objectives. Targets will be provided once baseline data is obtained.

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

Measure Status:	Active

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
This is a new measure. The lack of available baseline precludes projecting target objectives. Targets will be provided once baseline data is obtained.

ESM 13.1.3 - Number of views of the oral health videos and social media clips

Measure Status:	Active

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
This is a new measure. The lack of available baseline precludes projecting target objectives. Targets will be provided once baseline data is obtained.

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	2,500.0	2,500.0	2,500.0	2,500.0	2,500.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	200.0	200.0	200.0	200.0	200.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.4 - 1.4. Proportion of birthing hospitals that implement Alliance for Innovation on Maternal Health Bundles or approved quality improvement measures

Measure Status:		**Active**	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective	10	13.2	58.7
Annual Indicator	0	58.7	70.7
Numerator	0	44	53
Denominator	76	75	75
Data Source	GaPQC Data	GaPQC Data	GaPQC Data
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Implementation of AIM Bundles in birthing hospitals started April 2018. There are 76 birthing hospitals.

2016-2020: ESM 1.5 - 1.5 Number of clicks received from the family planning marketing campaign

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			3,000
Annual Indicator			2,938
Numerator			
Denominator			
Data Source			Vendor analytics (Chemistry Atlanta)
Data Source Year			2018
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
There was a total number of 2,938 clicks (or page views), of which 2,524 were unique page views.

2016-2020: ESM 1.6 - 1.6 Number of impressions based on media target audience

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			14.4
Annual Indicator			14
Numerator			
Denominator			
Data Source			Vendor analytics (Chemistry Atlanta)
Data Source Year			FY 2018
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 1.7 - 1.7 Number of calls received from the family planning marketing campaign

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			20
Annual Indicator			1
Numerator			
Denominator			
Data Source			MCH Hotline
Data Source Year			FY 2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 3.2 - 3.6.1. Proportion of Regional Perinatal Centers that receive a process evaluation

Measure Status:		**Active**	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective	6	100	100
Annual Indicator	100	100	100
Numerator	6	6	6
Denominator	6	6	6
Data Source	Womens Health Program Data	Womens Health Program Data Data	Womens Health Program Data
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The annual indicator and 2018-2023 annual objectives were changed from count to percentage to match the ESM data sheet. Georgia has 6 Regional Perinatal Centers (RPCs). It is required that all centers must complete this process as a part of each center's SOPs.

2016-2020: ESM 4.1 - 3.1.1 Number of birthing hospitals that participate in the 5-STAR Hospital Initiative

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			40	46
Annual Indicator	39	40	45	48
Numerator				
Denominator				
Data Source	Womens Health Program Data	Womens Health Program Data	Womens Health Program Data	Womens Health Program Data
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 4.2 - 3.1.2 Number of Train-the-Trainer workshops conducted

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		1	3	4
Annual Indicator	2	3	4	3
Numerator				
Denominator				
Data Source	Womens Health Program Data	Womens Health Program Data	Womens Health Program Data	Womens Health Program Data
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 6.1 - 6.1.1. Number of public health districts using at least two developmental screening methods regularly

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			8	10
Annual Indicator	8	8	8	8
Numerator				
Denominator				
Data Source	Children 1st Program Data	Children 1st Program Data	Children 1st Program Data	Children 1st Program Data
Data Source Year	2016	2017	2017	2017
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: In previous years, the districts were surveyed on whether they used more than one developmental screening tool. An ASQ Online platform became open for the district use across all the districts in May 2019.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: In previous years, the districts were surveyed on whether they used more than one developmental screening tool. An ASQ Online platform became open for the district use across all the districts in May 2019.	

2016-2020: ESM 6.3 - 6.2.1. Number of formal training opportunities on developmental screening conducted in each public health district health districts each year

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		2	20	28
Annual Indicator	9	20	28	38
Numerator				
Denominator				
Data Source	Children 1st Program Data	Children 1st Program Data	Children 1st Program Data	Children 1st Program Data
Data Source Year	FFY 2016	FFY 2017	FFY 2018	FFY 2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
There is new leadership within the C1st team in charge of training. The Standard Operating (SOP) Manual associated with training tools and developmental screening resources was revised to increase training efforts.

2016-2020: ESM 8.1.1 - Percent of children, in grades 4-12 enrolled in public school physical education class, who are in the Healthy Fitness Zone (HFZ) for Body Mass Index (BMI)

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			58
Annual Indicator			57.8
Numerator			173,583
Denominator			300,366
Data Source			DOE Fitnessgram
Data Source Year			2019-2020
Provisional or Final ?			Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.2.1 - 7.1.1. Average HFZ measure (aerobic capacity) among students in grades 4-12

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		56	57	50
Annual Indicator	53.5	52.4	50.4	50.3
Numerator	380,890	379,767	390,505	143,545
Denominator	711,312	724,839	775,490	285,135
Data Source	DOE Fitnessgram	DOE Fitnessgram	DOE Fitnessgram	DOE Fitnessgram
Data Source Year	2016-2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.1 - 9.1.1 Number of youth, families and professionals trained on health care transition

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			450	400
Annual Indicator	250	434	321	689
Numerator				
Denominator				
Data Source	Children Medical Services	Children Medical Services	Children Medical Services	Children Medical Services
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The number of workshops were increased from 4 to 6 to reach more of the State.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Based on the annual medical provider assessments conducted with our partner organizations, GA AAP and GAFP, the was an increase in the number of practices that states having a transition policy which addressed consent issues at age 18. The assessment also requested information as to whether the physician had one on one time with their adolescent patients.	

2016-2020: ESM 12.2 - 9.3.1. Number of pediatric and adult medical providers who have a health care transition policy within their practice

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		5	3	8
Annual Indicator	0	1	7	68
Numerator				
Denominator				
Data Source	Children Medical Services Program	Children Medical Services Program	Children Medical Services	Children Medical Services
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Based on the annual medical provider assessments conducted with our partner organizations, GA AAP and GAFP, the was an increase in the number of practices that states having a transition policy which addressed consent issues at age 18. The assessment also requested information as to whether the physician had one on one time with their adolescent patients.

2016-2020: ESM 13.1.1 - 11.1.1. Number of comprehensive webinars/presentations offered

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective				20
Annual Indicator	0	20	22	25
Numerator				
Denominator				
Data Source	Oral Health Program Data	Oral Health Program Data	Oral Health Program Data	Oral Health Program Data
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 13.2.1 - 11.1.2. Number of dentists, hygienists and staff educated on four specific dental services for individuals with special needs and the oral health connection and services

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			20	25
Annual Indicator	15	32	32	32
Numerator				
Denominator				
Data Source	Oral Health Program Data	Oral Health Program Data	Oral Health Program	Oral Health Program Data
Data Source Year	2016	2017	2017	2017
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Dental care services for individuals with special needs was a topic of discussion and education during one of the annual Coordinators' Meeting.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Presentation topics and agenda items are rotated to provide comprehensive information and resources to district staff. A presentation on oral health in CYSHCN populations was not given at a coordinator meeting in FY 2018.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Presentation topics and agenda items are rotated to provide comprehensive information and resources to district staff. A presentation on oral health in CYSHCN populations was not given at a coordinator meeting in FY 2019.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Georgia

SPM 1 - Percent of congenital syphilis cases averted
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	By 2025, increase the percentage of congenital syphilis cases averted from 80.3% to 85%
Definition:	**Numerator:** Number of reported pregnant women with syphilis - the number of reported congenital syphilis cases **Denominator:** Total number of reported pregnant women with syphilis **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: SendSS surveillance data
Significance:	Congenital syphilis can cause miscarriage, stillbirth, deformed bones, meningitis, and nerve problems leading to blindness or deafness. The CDC considers congenital syphilis to be a winnable battle, partly because it can be prevented by testing the mother in the first and third trimesters and providing treatment at least 30 days before delivery. In 2018, Georgia reported 31 congenital syphilis cases and ranked 10th in the U.S. for congenital syphilis. Georgia has seen an increase in syphilis cases among women for the past 5 years. As syphilis cases rise in women, there is an increased potential for rises in congenital syphilis cases.

SPM 2 - Rate of infant mortality (per 1,000 live births) in the Black Population
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Reduce the rate of infant mortality (per 1,000 live births) in the Black Population
Definition:	**Numerator:** Number of deaths among Black children less than 1 year of age **Denominator:** Number of infants identified as Black on their birth certificates **Unit Type:** Rate **Unit Number:** 1,000
Data Sources and Data Issues:	Data Source: Georgia Vital Statistics Records
Significance:	Infant mortality, or the death of a child within the first year of life, is a sentinel measure of population health that reflects the underlying well-being of mothers and families, as well as the broader community and social environment that cultivate health and access to health-promoting resources. The U.S. infant mortality rate has continued to decline to record low levels below 6 per 1,000 live births. However, significant disparities continue to persist between racial groups, especially for infants born to non-Hispanic black women. The infant mortality rate in Black, non-Hispanic, infants in Georgia is two times higher than White, non-Hispanic or Hispanic infants supporting the need to expand collaborative capacity to decrease the prevalence of, and disparities surrounding, infant mortality.

SPM 3 - Percent of fathers (ages 18-55) whose knowledge increased using a Father Involvement curriculum in Georgia Home Visiting Program (GHVP) sites.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the percentage of fathers whose knowledge increased using a Father Involvement curriculum in GHVP sites.
Definition:	**Numerator:** Number of fathers who reported increase in knowledge using a Father Involvement curriculum in GHVP sites **Denominator:** Number of fathers who used a Father Involvement curriculum in GHVP sites **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Father Involvement curriculum Pre- and Post- Test conducted at the GHVP sites
Significance:	In the United States, about 700 women die each year of pregnancy or delivery related complications, causing the U.S. ranks as one of only thirteen countries in the world where maternal mortality is worse now than it was 15 years ago. Representative of the data, Black women are three to four times more likely to die from pregnancy-related complications than white women, and disparities persists across socioeconomic and educational levels. Data shows Georgia as having one of the highest mortality rates among African American mothers and infants in the nation. Ranking number one, Georgia has the worst maternal mortality rates at 46.2 deaths per 100,000 live births, with a 60% higher mortality for Black women at 95.6 per 100,000 live births compared to all racial and ethnic groups, surpassing that of the U.S (66.3 per 100,000). Father involvement in Maternal and Child Health has been recognized as a strategy to reduce disparities in perinatal health outcomes. However, there is currently a shortage of the data that indicates father's impact on perinatal health outcomes for our state. The Georgia Department of Public Health Fatherhood Initiative is working to increase father engagement and involvement opportunities in Maternal and Child Health programs and services through three main strategies, capacity building, collaboration, and coordination, including providing resources that encourage father inclusion.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Percent of women (ages 15-44) served in the Georgia Family Planning Program (GFPP) who use long-acting reversible contraceptives (LARC).
Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health

Measure Status:	Active
Goal:	By 2020, Increase the percentage of women (ages 15-44) served in the Georgia Family Planning Program (GFPP) who use long-acting reversible contraceptives (LARC) from 11% to 15%.
Definition:	**Numerator:** Number of women ages 15-44 that used a LARC **Denominator:** Total number of women ages 15-44 served in GFPP **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Family Planning (FP) Objective 1: Increase the proportion of pregnancies that are intended
Data Sources and Data Issues:	Data Source: Georgia Family Planning Program Clinic Data
Significance:	The availability of family planning services allows individuals to achieve desired birth spacing and family size, and contributes to improved health outcomes for infants, children, women, and families. In 2002, 51% of all pregnancies were intended in the U.S. In Georgia unplanned births increased in percentage from 52.6% to 54.8% between 2009 and 2011. According to the American College of Obstetricians and Gynecologists, intrauterine devices and contraceptive implants, long-acting reversible contraceptives (LARCs), are the most effective reversible contraceptives. The major advantage of LARCs compared with other reversible contraceptive methods is that they do not require ongoing effort on the part of the user for long-term and effective use, and return fertility quickly after removal.

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.
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2020, increase the rate of children and youth with special health care needs that have accessed their specialty health care visit through a telehealth clinic from 1.3 (per 1000 CYSHCN) to 2.0.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of children and youth that have seen a specialty provider within the last 12 months at the Children's Medical Services (CMS) Program telehealth clinic</td></tr>
<tr><td>Denominator:</td><td>Total number of children and youth with special health care needs</td></tr>
<tr><td>Unit Type:</td><td>Rate</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>Related to Maternal, Infant, and Child Health (MICH) Objective 31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive and coordinated systems

Related to Access to Health Services (AHS) Objective 5.2: Increase the proportion of children and youth age 17 years and under who have a specific source of ongoing care</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Sources: Georgia Children's Medical Services Program Database, Kids Count Data Center</td></tr>
<tr><td>Significance:</td><td>According to the American Telemedicine Association, telemedicine/telehealth has been used to bring health care services to patients in distant locations, improving access to patients in both rural and urban areas.Georgia's CSHCN families travel on average 300 miles round trip for specialty care visits. Often resulting in missed appointments, disruption in health care, missed school, and increased emergency room visits. Telehealth is a proven effective tool in providing specialty care services and care coordination to children with special health care needs.</td></tr>
</table>

2016-2020: SPM 3 - Rate of congenital syphilis.
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	By 2020, decrease the rate of congenital syphilis from 13 (infants per 100,000 live births) to 11.7.
Definition:	**Numerator:** Number of infants born with congenital syphilis **Denominator:** Total number of live births **Unit Type:** Rate **Unit Number:** 100,000
Healthy People 2020 Objective:	Sexually Transmitted Diseases-Objective 8: Reduce congenital syphilis
Data Sources and Data Issues:	Data Source: State Electronic Notifiable Disease Surveillance System (SendSS)
Significance:	Congenital syphilis can cause miscarriage, stillbirth, deformed bones, meningitis, and nerve problems leading to blindness or deafness. The CDC considers Congenital Syphilis to be a winnable battle, partly because it can be prevented by testing the mother in the first and third trimesters and providing treatment at least 30 days before delivery. In 2014, Georgia ranked 12th in the U.S. for the congenital syphilis case rate (13 cases per 100,000 live births). There were 20 U.S. states with no congenital syphilis cases reported. Between 2010-2015, Georgia has had no less than 11 cases in a given year.

2016-2020: SPM 4 - Rate of infants diagnosed with Neonatal Abstinence Syndrome (NAS).
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	By 2020, decrease the rate of infants diagnosed as having NAS from 1.2 (per 1,000 live births) to 13.0.
Definition:	**Numerator:** Number of infants discharged with NAS **Denominator:** Total number of live births **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 11: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women
Data Sources and Data Issues:	Data Source: Georgia Resident Hospital Discharge Data, Georgia Resident Births, State Electronic Notifiable Disease Surveillance System (SendSS)
Significance:	There has been a significant increase in the prevalence of NAS, from 1.20 per 1,000 U.S. hospital births in 2000 to 3.39 per 1,000 U.S. hospital births in 2009. In Georgia, NAS increased from 2.07 per 1000 live births in 2010 to 13.23 per 1000 live births in 2016. A public health approach to NAS that includes averting maternal substance use and routine screening for unhealthy substance use in women at every health care visit will help increase the opportunities for primary prevention. Additionally, providing women with history of substance use connections to peer support and treatment/recovery services, as well as reducing barriers to family planning services, as well as reducing barriers to family planning services are critical prevention strategies. According to the Association of State and Territorial Health Officials (ASTHO), state health agencies play a key role in linking various resources and providers by tracking substance-exposed infants through screening, assessment, and service delivery.

2016-2020: SPM 5 - Percent of birthing hospitals, NICUs, and Pediatric Departments with policies and education that adhere to the American Academy of Pediatrics (AAP) Safe Sleep guidelines
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	By 2020, 25% of birthing hospitals, NICUs, and Pediatric Departments will have policies and education that adhere to the American Academy of Pediatrics (AAP) Safe Sleep guidelines
Definition:	**Numerator:** Number of birthing hospitals, NICUs, and Pediatric Departments that have policies and education adhere to the American Academy of Pediatrics (AAP) Safe Sleep guidelines **Denominator:** Total number of birthing hospitals, NICUs, and Pediatric Departments **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH Objective 21: Increase the proportion of infants who are put to sleep on their backs
Data Sources and Data Issues:	Safe Sleep Program Data
Significance:	The single most effective action that parents and caregivers can take to lower an infants risk of SIDS is to place the baby to sleep on his or her back for naps and at night. National Institute of Childhood and Human Development (NICHD) research has led to significant advances in our understanding of SIDS. For example, the current definition of SIDS resulted from an Institute-led conference of experts in infant mortality. In addition, the American Academy of Pediatrics Task Force on SIDS uses results from NICHD research as the basis for its safe sleep recommendations. Institute research informed the recommendation that the back sleep position carries the lowest risk of SIDS and that this sleep practice does not increase risks for other problems.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Georgia

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Georgia

ESM 1.1 - Percent of initial program cervical screening tests that are conducted among women who have never been screened or not screened within the last 10 years
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Meet or exceed the CDC guideline for the percentage of initial program cervical screening tests that are conducted among women who have never been screened or not screened within the last 10 years.
Definition:	**Numerator:** Number of initial program cervical screening tests (first ever valid Pap test or HPV test) that are conducted among women who have never been screened or not screened within 10 years **Denominator:** Number of women with their first ever valid Pap test or HPV test, funded through the Breast and Cervical Cancer Program (BCCP) **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Breast and Cervical Cancer Program (BCCP) Clinical Data
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of diseases to optimize the health of women before, between, and beyond potential pregnancies. A key component of a well-woman visit for a reproductive-aged woman is the development and discussion of her reproductive life plan to align with her current and future plans. Prevention, screening, and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced with a well-woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit is recommended by the American College of Obstetrics and Gynecologists (ACOG).

ESM 1.2 - Number of LARCs utilized among women of reproductive age (15-44 years) served in local Public Health Departments
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of LARCs utilized among women of reproductive age (15-44 years) served in local Public Health Departments by 3% annually
Definition:	**Numerator:** Number of LARCs (IUDs and implants) utilized by among women of reproductive age (15-44 years) served in local Public Health Departments **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20,000
Data Sources and Data Issues:	Data Source: SENDSS
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of diseases to optimize the health of women before, between, and beyond potential pregnancies. A key component of a well-woman visit for a reproductive-aged woman is the development and discussion of her reproductive life plan to align with her current and future plans. Prevention, screening, and management of chronic conditions such as diabetes, and counseling to achieve a health weight and smoking cessation, can be advanced with a well-woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit is recommended by the American College of Obstetrics and Gynecologists (ACOG).

ESM 3.1 - Number of hospitals verified annually through the Neonatal Center Designation Program
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Verify all Georgia birthing hospitals are operating at the level of care designation authorized through the DCH Certificate of Need program.
Definition:	**Numerator:** Number of hospitals verified annual through the Neonatal Center Designation Program **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Data Source: DPH Office of Women's Health- Neonatal Center Designation Program Data
Significance:	Very low birth weight infants (<1,500 grams or 3.25 pounds) are the most fragile newborns. Although they represented less than 2% of all births in 2010, VLBW infants accounted for 53% of all infant deaths, with a risk of death over 100 times higher than that of normal birth weight infants (≥2,500 grams or 5.5 pounds). VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a subspecialty facility equipped to handle high-risk neonates. In 2012, the AAP provided updated guidelines on the definitions of neonatal levels of care to include Level I (basic care), Level II (specialty care), and Levels III and IV (subspecialty intensive care) based on the availability of appropriate personnel, physical space, equipment, and organization. Given overwhelming evidence of improved outcomes, the AAP recommends that VLBW and/or very preterm infants (<32 weeks' gestation) be born in only level III or IV facilities.

ESM 4.1 - Percent of the 10-Steps to Successful Breastfeeding training slots utilized by staff and providers from the state's birthing hospitals
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	By 2025, have at least 85% of the 330 available 10-Steps to Successful Breastfeeding training slots utilized annually by staff and providers from the state's birthing hospitals.
Definition:	**Numerator:** Number of training slots utilized by staff and providers from the state's birthing hopsitals **Denominator:** Total number of available training slots (330) **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Women's Health 5-STAR Initiative Program Data
Significance:	The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer.

ESM 4.2 - Number of home visitors who report increased knowledge of breastfeeding best practices
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of home visitors who reported increase knowledge of breastfeeding best practices from trainings and coaching.
Definition:	**Numerator:** Number of MIECHV and Healthy Start Home Visiting Staff who report increased knowledge of breastfeeding best practices **Denominator:** N/A **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	Data Source: Loving Support Training Pre-/Post-Test
Significance:	The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer.

ESM 4.3 - Number of MIECHV and Healthy Start women who are referred to WIC services
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of MIECHV and Healthy Start women who are referred to WIC services
Definition:	**Numerator:** Number of MIECHV and Healthy Start women who are referred to WIC services **Denominator:** N/A **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	Data Source: Georgia Home Visiting Program (GHVP) Data
Significance:	The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer.

ESM 5.1 - Percent of hospitals and birthing facilities providing education and modeling safe infant sleep to parents with newborns or infants
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the percentage of hospitals and birthing facilities (pediatric departments, NICUs, and Children's Hospitals) providing education and modeling safe infant sleep to parents with newborns or infants
Definition:	**Numerator:** Number of hospitals and birthing facilities (pediatric departments, NICUs, and Children's Hospitals) actively participating in the Georgia Safe to Sleep hospital-based program and providing safe infant sleep education to parents/caregivers **Denominator:** Total number of hospitals and birthing facilities **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Georgia Safe to Sleep Program Data
Significance:	Safe sleep guidelines are endorsed by the American Academy of Pediatrics, the National Institutes of Health, the CDC and other nationally recognized programs. A hospital safe sleep program ensures that participating hospitals develop a policy to support safe sleep efforts and that trusted hospital professionals provide accurate and consistent safe infant sleep messaging to parents/caregivers.

ESM 5.2 - Number of professionals trained to education on, identify, and model safe infant sleep environments NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the number of professionals (e.g. nurses, home visitors, first responders) trained in safe infant sleep practices.
Definition:	**Numerator:** Number of professionals that attend safe infant sleep trainings **Denominator:** N/A **Unit Type:** Count **Unit Number:** 500
Data Sources and Data Issues:	Data Source: Safe Infant Sleep Program Data
Significance:	Successful methods for improving parent safe sleep knowledge range from hospital staff education to crib distribution programs. Such efforts have been shown to increase parental knowledge, reduce bed-sharing rates, increase supine sleeping rates, and decrease incidences of Sudden Unexpected Infant Death (SUID). An increase in the number of professionals modeling safe sleep behaviors/environments should lead to an increase in parents following best practices related to safe sleep environments.

ESM 6.1 - Number of providers that receive developmental screening training who report initiating developmental screenings with parents in their practices
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of providers that receive developmental screening training who report initiating developmental screening with parents in their practices
Definition:	**Numerator:** Number of providers that receive developmental screening training who report developmental screenings with parents in their practice **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Children 1st Quarterly Report Data as reported by C1st District Coordinators and programmatic reports from medical societies
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.

ESM 6.2 - Percent of children that screen with concern that are referred to appropriate intervention services by providers
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the percentage of children that screen with concern that are referred to appropriate intervention services by providers
Definition:	**Numerator:** Number of children that screen with concern that are referred to appropriate intervention services by providers **Denominator:** Total number of children referred to intervention services **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: SendSS
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.

ESM 6.3 - Number of new community partners who implement developmental screening and make referrals to their local public health district
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of new community partners who implement developmental screening and make referrals to their local public health districts
Definition:	**Numerator:** Number of new community partners who implement developmental screenings and make referrals to their local public health district **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Data Source: Children 1st Quarterly Report as reported by C1st District Coordinators and other Maternal and Child Health Program Data
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.

ESM 6.4 - Percent of children, ages 0 through 5, who receive a developmental screening from DeKalb Board of Health Refugee Clinic
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of children, ages 0 through 5, who receive a developmental screening from Dekalb Board of Health Refugee Clinic.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of children screen for developmental concern</td></tr>
<tr><td>Denominator:</td><td>Total number of children seen at DeKalb Board of Health Refugee Clinic</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: DeKalb Board of Health Refugee Clinic Data</td></tr>
<tr><td>Significance:</td><td>Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.</td></tr>
</table>

ESM 9.1 - Number of schools that receive guidance on laws, policies, and evidence-based strategies to prevent bullying
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To increase the number of schools that receive guidance on laws, policies, and evidence-based strategies to prevent bullying
Definition:	**Numerator:** Number of schools that receive guidance **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Data Source: Injury Prevention Program Data
Significance:	Bullying, particularly among school-age children, is a major public health problem. Estimates suggest nearly 30% of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. Bullying experiences are associated with a number of behavioral, emotional, and physical adjustment problems. Adolescents who bully others tend to exhibit other defiant and delinquent behaviors, have poor school performance, be more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation; poor school performance; suicidal ideation; and suicide attempts. Bullying victims who also perpetrate bullying (i.e., bully-victims) may exhibit the poorest functioning, in comparison with either victims or bullies. Emotional and behavioral problems experienced by victims, bullies, and bully-victims may continue into adulthood and produce long-term negative outcomes, including low self-esteem and self-worth, depression, antisocial behavior, vandalism, drug use and abuse, criminal behavior, gang membership, and suicidal ideation. www.stopbullying.gov.

ESM 11.1 - Number of telehealth/telemedicine patient encounters
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN and non-CSHCN
Goal:	Increase the number of telehealth/telemedine patient encounters
Definition:	**Numerator:** Number of telehealth/telemedicine patient encounters **Denominator:** N/A **Unit Type:** Count **Unit Number:** 2,000
Data Sources and Data Issues:	Data Source: CYSHCN program/ DPH Office of Telehealth and Telemedicine/ BCW, EHDI and Screening Programs
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org

ESM 11.2 - Number of telehealth/telemedicine providers in the network
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of telehealth/telemedicine providers in the network
Definition:	**Numerator:** Number of telehealth/telemedicine providers in network **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Data Source: CYSHCN program/ DPH Office of Telehealth and Telemedicine
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org

ESM 11.3 - Number of callers connected to resources through Help Me Grow (HMG)
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the number of callers connected to resources through HMG
Definition:	**Numerator:** Number of HMG callers connected to resources **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10,000
Data Sources and Data Issues:	Data Source: Help Me Grow Data Unable to link number of individuals who are connected to resources as there may be repeat callers asking for different/additional resources. Will track the number of callers connected to resources.
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org

ESM 11.4 - Percent of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the percentage of families that receive a follow-up call from HMG that report they were linked to a medical home, or any other service to meet their needs.
Definition:	**Numerator:** Number of families that report linkage to a medical home/service during follow-up call from HMG **Denominator:** Total number of families contacted during follow-up call from HMG **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Help Me Grow Data
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org

ESM 12.1 - Percent of youth/young adults enrolled in the Department's Title V program for Children and Youth with Special Health Care Needs (CYSHCN) that transfer to an adult provider.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Increase the percentage of youths/young adults enrolled in the Department's Title V program for Children and Youth with Special Health Care Needs (CYSHCN) that transfer to an adult provider.
Definition:	**Numerator:** Number of youths/young adults enrolled in the Department's Title V program for CYSHCN that report successful transfer to an adult provider **Denominator:** Number of youths/young adults enrolled in the Department's Title V program for CYSHCN who need to transfer to an adult provider **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Children's Medical Services Quarterly Report
Significance:	Health care transition is an importance process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.

ESM 12.2 - Number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Increase the number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs.
Definition:	**Numerator:** Number of stakeholders, state agencies, and community partners in collaboration with the Department **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Data Source: CYSHCN Annual Assessment Survey
Significance:	Health care transition is an importance process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.

ESM 13.1.1 - Percent of medical providers who reported an increase of oral health knowledge from trainings and presentations
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Increase the percentage of medical providers who reported an increase of oral health knowledge following trainings and presentations throughout the year
Definition:	**Numerator:** Number of medical providers who indicated an increase of oral health knowledge **Denominator:** Total number of medical providers who attended the trainings and presentations **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Georgia OBGyn Society (GOGS) and Georgia Academy Family Physicians (GAFP) Survey Data
Significance:	Oral health is a vital component of overall health. Access to oral health care, oral health education and improved oral health literacy, good oral hygiene, practicing good oral health behaviors and adequate nutrition are essential components of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at great risk for oral diseases. Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Poor oral health during pregnancy has been linked to preterm birth, low birth weight babies, gestational diabetes, and preeclampsia. Therefore oral health should be considered a vital component of comprehensive prenatal care. Additionally, pregnant women who receive oral health care are more likely to take their children to get oral health care. State Title V Maternal and Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increase the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increase the number of community health centers with an oral health component.

ESM 13.1.2 - Number of oral health resource bags distributed to pregnant women and caregivers of young children through internal and external partners
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Increase the number of oral health resource bags distributed to pregnant women and caregivers of young children through internal and external partners annually
Definition:	**Numerator:** Number of oral health resource bags distributed **Denominator:** N/A **Unit Type:** Count **Unit Number:** 5,000
Data Sources and Data Issues:	Data Source: Oral Health Program Data
Significance:	Oral health is a vital component of overall health. Access to oral health care, oral health education and improved oral health literacy, good oral hygiene, practicing good oral health behaviors and adequate nutrition are essential components of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at great risk for oral diseases. Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Poor oral health during pregnancy has been linked to preterm birth, low birth weight babies, gestational diabetes, and preeclampsia. Therefore oral health should be considered a vital component of comprehensive prenatal care. Additionally, pregnant women who receive oral health care are more likely to take their children to get oral health care. State Title V Maternal and Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increase the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increase the number of community health centers with an oral health component.

ESM 13.1.3 - Number of views of the oral health videos and social media clips
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Increase oral health literacy in pregnant women through views of oral health videos and social media clips
Definition:	**Numerator:** Number of times the oral health videos and social media clips were viewed annually **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10,000
Data Sources and Data Issues:	Data Source: Social Media Platform(s) Data and DPH website data
Significance:	Oral health is a vital component of overall health. Access to oral health care, oral health education and improved oral health literacy, good oral hygiene, practicing good oral health behaviors and adequate nutrition are essential components of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at great risk for oral diseases. Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Poor oral health during pregnancy has been linked to preterm birth, low birth weight babies, gestational diabetes, and preeclampsia. Therefore oral health should be considered a vital component of comprehensive prenatal care. Additionally, pregnant women who receive oral health care are more likely to take their children to get oral health care. State Title V Maternal and Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increase the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increase the number of community health centers with an oral health component.

ESM 13.2.1 - Number of children screened at school-based/ school-linked programs
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase access to oral health prevention services to low-income children through school-based/ school-linked programs
Definition:	**Numerator:** Number of children screened at school-based/ school-linked programs **Denominator:** N/A **Unit Type:** Count **Unit Number:** 5,000
Data Sources and Data Issues:	Data Source: CDC SEALS database system
Significance:	Oral health is a vital component of overall health. Access to oral health care, oral health education and improved oral health literacy, good oral hygiene, practicing good oral health behaviors and adequate nutrition are essential components of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at great risk for oral diseases. Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Poor oral health during pregnancy has been linked to preterm birth, low birth weight babies, gestational diabetes, and preeclampsia. Therefore oral health should be considered a vital component of comprehensive prenatal care. Additionally, pregnant women who receive oral health care are more likely to take their children to get oral health care. State Title V Maternal and Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increase the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increase the number of community health centers with an oral health component.

ESM 13.2.2 - Number of Hispanic children who are provided with oral health education
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the number of Hispanic children who receive oral health education
Definition:	**Numerator:** Number of Hispanic children provided with oral health education **Denominator:** N/A **Unit Type:** Count **Unit Number:** 500
Data Sources and Data Issues:	Data Source: Department of Education (DOE) Data
Significance:	Oral health is a vital component of overall health. Access to oral health care, oral health education and improved oral health literacy, good oral hygiene, practicing good oral health behaviors and adequate nutrition are essential components of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at great risk for oral diseases. Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Poor oral health during pregnancy has been linked to preterm birth, low birth weight babies, gestational diabetes, and preeclampsia. Therefore oral health should be considered a vital component of comprehensive prenatal care. Additionally, pregnant women who receive oral health care are more likely to take their children to get oral health care. State Title V Maternal and Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increase the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increase the number of community health centers with an oral health component.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.4 - 1.4. Proportion of birthing hospitals that implement Alliance for Innovation on Maternal Health Bundles or approved quality improvement measures
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the proportion of birthing hospitals that implement the use of one of three AIM Bundles
Definition:	**Numerator:** Number of birthing hospitals implementing at least one of three AIM Bundles **Denominator:** Number of birthing hospitals for year of reporting (number may fluctuate) **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Vital Records, GaPQC Data
Significance:	Preventing maternal mortality is essential to improving the health of women in the state. Both quantitative and qualitative data examined in the needs assessment indicated the need to prevent maternal mortality in Georgia. Georgia's maternal mortality ratio increased from 11.5 (n=16) in 2004 to 43.6 (n=56) in 2013. Additionally, Georgia has been identified as among states with the highest maternal mortality ratio. Interviews with leaders in the field recommended this priority. Preventing maternal mortality was also a clear priority of stakeholders involved in the needs assessment. Maternal mortality was rated highest in the maternal/women's health domain at the stakeholder meetings and second overall.

2016-2020: ESM 1.5 - 1.5 Number of clicks received from the family planning marketing campaign
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of clicks received from the family planning marketing campaign
Definition:	<table><tr><td>**Numerator:**</td><td>Total number of clicks</td></tr><tr><td>**Denominator:**</td><td>Not Applicable</td></tr><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>5,000</td></tr></table>
Data Sources and Data Issues:	Vendor analytics (Chemistry Atlanta)
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.

2016-2020: ESM 1.6 - 1.6 Number of impressions based on media target audience
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Number of impressions (i.e., estimated number of times ad is seen by target population)
Definition:	**Numerator:** Total number of impressions (in millions) based on media target audience (women 18-49) in districts with marketing **Denominator:** Not Applicable **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Vendor analytics (Chemistry Atlanta)
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.

2016-2020: ESM 1.7 - 1.7 Number of calls received from the family planning marketing campaign
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of calls received from the family planning marketing campaign
Definition:	**Numerator:** Total number of calls referred by the family planning marketing campaign **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Vendor analytics (Chemistry Atlanta)
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.

2016-2020: ESM 3.2 - 3.6.1. Proportion of Regional Perinatal Centers that receive a process evaluation
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Increase the proportion of RPCs that receive a process evaluation to ensure maintenance of subspecialty services and other components consistent with Level III designation from 0 to 6 each year for five years
Definition:	**Numerator:** Number of RPCs receiving one annual evaluation **Denominator:** Number of RPCs **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Women's Health Program Data, Regional Perinatal Center Data
Significance:	Very low birth weight infants (<1,500 grams or 3.25 pounds) are the most fragile newborns. Although they represented less than 2% of all births in 2010, VLBW infants accounted for 53% of all infant deaths, with a risk of death over 100 times higher than that of normal birth weight infants (≥2,500 grams or 5.5 pounds). VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a subspecialty facility equipped to handle high-risk neonates. In 2012, the AAP provided updated guidelines on the definitions of neonatal levels of care to include Level I (basic care), Level II (specialty care), and Levels III and IV (subspecialty intensive care) based on the availability of appropriate personnel, physical space, equipment, and organization. Given overwhelming evidence of improved outcomes, the AAP recommends that VLBW and/or very preterm infants (<32 weeks' gestation) be born in only level III or IV facilities. This measure is endorsed by the National Quality Forum (#0477).

2016-2020: ESM 4.1 - 3.1.1 Number of birthing hospitals that participate in the 5-STAR Hospital Initiative
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of birthing hospitals that participate in the 5-STAR Hospital Initiative</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of birthing hospitals participating in the 5-STAR Hospital Initiative</td></tr>
<tr><td>Denominator:</td><td>Not applicable</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>80</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Women's Health 5-STAR Initiative Program Data</td></tr>
<tr><td>Significance:</td><td>The health effects of breastfeeding are well recognized. Breast milk is uniquely suited to the human infant’s nutritional needs and is a live substance with unparalleled properties that protect against a host of illnesses and diseases for both mothers and children. Breast milk promotes sensory and cognitive development, and protects the infant against infectious and chronic diseases. Exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhea or pneumonia, and helps for a quicker recovery during illness. These effects can be measured in resource-poor and affluent societies (Kramer M et al Promotion of Breastfeeding Intervention Trial (PROBIT): A randomized trial in the Republic of Belarus. Journal of the American Medical Association, 2001, 285(4): 413-420). The Baby-Friendly Hospital Initiative (BFHI) is a global program that was launched by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) in 1991 to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding.Becoming a Baby-Friendly facility is a comprehensive, detailed and thorough journey toward excellence in providing evidence-based, maternity care with the goal of achieving optimal infant feeding outcomes and mother/baby bonding. It compels facilities to examine, challenge and modify longstanding policies and procedures. It requires training and skill building among all levels of staff. Georgia's 5-STAR Initiative models the Baby-Friendly Initiative encouraging 5 of the 10 steps towards a baby-friendly designation.</td></tr>
</table>

2016-2020: ESM 4.2 - 3.1.2 Number of Train-the-Trainer workshops conducted
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	increase the number of Train-the-Trainer workshops conducted from 0 to 6
Definition:	**Numerator:** Number of Train-the-Trainer workshops conducted **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 6
Data Sources and Data Issues:	Data Source: Women's Health Program Data
Significance:	The health effects of breastfeeding are well recognized. Breast milk is uniquely suited to the human infant's nutritional needs and is a live substance with unparalleled properties that protect against a host of illnesses and diseases for both mothers and children. Breast milk promotes sensory and cognitive development, and protects the infant against infectious and chronic diseases. Exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhea or pneumonia, and helps for a quicker recovery during illness. These effects can be measured in resource-poor and affluent societies (Kramer M et al Promotion of Breastfeeding Intervention Trial (PROBIT): A randomized trial in the Republic of Belarus. Journal of the American Medical Association, 2001, 285(4): 413-420). The Baby-Friendly Hospital Initiative (BFHI) is a global program that was launched by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in 1991 to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding.Becoming a Baby-Friendly facility is a comprehensive, detailed and thorough journey toward excellence in providing evidence-based, maternity care with the goal of achieving optimal infant feeding outcomes and mother/baby bonding. It compels facilities to examine, challenge and modify longstanding policies and procedures. It requires training and skill building among all levels of staff. Georgia's 5-STAR Initiative models the Baby-Friendly Initiative encouraging 5 of the 10 steps towards a baby-friendly designation.

2016-2020: ESM 6.1 - 6.1.1. Number of public health districts using at least two developmental screening methods regularly
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the types of developmental screening methods that are regularly used in each public district from one to a minimum of two
Definition:	**Numerator:** Number of districts with at least two developmental screening methods being used regularly **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 18
Data Sources and Data Issues:	Data Source: Child Health Program Data
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.

2016-2020: ESM 6.3 - 6.2.1. Number of formal training opportunities on developmental screening conducted in each public health district health districts each year
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of formal training opportunities on developmental screening conducted in each public health district each year
Definition:	**Numerator:** Total number of formal training opportunities on developmental screening conducted in each public health district each year **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 45
Data Sources and Data Issues:	Data Source: Child Health Program Data
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.

2016-2020: ESM 8.1.1 - Percent of children, in grades 4-12 enrolled in public school physical education class, who are in the Healthy Fitness Zone (HFZ) for Body Mass Index (BMI)
2016-2020: NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of children, in grades 4-12 enrolled in public school physical education class, who are in the Health Fitness Zone (HFZ) for Body Mass Index (BMI)</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of children enrolled in public school physical activity class, in grades 4-12, who are in the HFZ for BMI</td></tr>
<tr><td>Denominator:</td><td>Total number of children enrolled in public school physical education class, in grades 4-12</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Georgia SHAPE, DOE Fitnessgram</td></tr>
<tr><td>Significance:</td><td>Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.</td></tr>
</table>

2016-2020: ESM 8.2.1 - 7.1.1. Average HFZ measure (aerobic capacity) among students in grades 4-12
2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the average HFZ measure (aerobic capacity) among students in grades 4-12 by 4%
Definition:	**Numerator:** Aerobic capacity, HFZ measure (males and females), for students grades 4-12 **Denominator:** Total attempts (males and females) for students grades 4-12 **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data Source: Georgia SHAPE
Significance:	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

2016-2020: ESM 12.1 - 9.1.1 Number of youth, families and professionals trained on health care transition
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

Measure Status:	Active
Goal:	Increase the number of youth, families and professionals trained on health care transition
Definition:	**Numerator:** Number of youth, families, professionals trained on health care transition **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Data Source: Children's Medical Services Program Data
Significance:	Health care transition is the process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.

2016-2020: ESM 12.2 - 9.3.1. Number of pediatric and adult medical providers who have a health care transition policy within their practice
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of pediatric and adult medical providers who have a health care transition policy within their practice</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of pediatric and adult medical providers who have a health care transition policy within their practice</td></tr>
<tr><td>Denominator:</td><td>Not applicable</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Children's Medical Services Program Data</td></tr>
<tr><td>Significance:</td><td>Health care transition is the process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.</td></tr>
</table>

2016-2020: ESM 13.1.1 - 11.1.1. Number of comprehensive webinars/presentations offered
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of comprehensive webinars/presentations offered to health professionals from 0 to 20</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of comprehensive webinars/presentations offered</td></tr>
<tr><td>Denominator:</td><td>Not applicable</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>30</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Oral Health Program Data</td></tr>
<tr><td>Significance:</td><td>Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.

State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.</td></tr>
</table>

2016-2020: ESM 13.2.1 - 11.1.2. Number of dentists, hygienists and staff educated on four specific dental services for individuals with special needs and the oral health connection and services
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of dentists, hygienists and staff educated on four specific dental services for individuals with special needs and the oral health connection and services from 0 to 40</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>number of dentists, hygienists and staff educated on four specific dental services for individuals with special needs and the oral health connection and services</td></tr>
<tr><td>Denominator:</td><td>Not applicable</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>40</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Oral Health Program Data</td></tr>
<tr><td>Significance:</td><td>Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.

State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.</td></tr>
</table>

Form 11
Other State Data

State: Georgia

The Form 11 data are available for review via the link below.

Form 11 Data